THE ASSOCIATION OF SELF-CARE, BURNOUT AND SECONDARY TRAUMATIC STRESS AMONG MENTAL HEALTH PROFESSIONALS

by

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ABSTRACT

EMILY GRACE HARTUNG The Association of Self-care, Burnout and Secondary Traumatic Stress Among Mental Health Professionals.
(Under the direction of DR. HENRY HARRIS)

Burnout and secondary traumatic stress are critical issues for those in the mental health profession with rates of burnout at around 60% (Chen et al., 2019; Kelly et al., 2022; Morse et al., 2012). Additionally, due to the nature of their work mental health professionals are at a greater risk of experiencing secondary traumatic stress (Canfield, 2005; Cook et al., 2021; Garcia et al., 2015; Kelly et al., 2022; Wardle & Mayorga, 2016). Both of these phenomena negatively impact the effectiveness and ability of mental health professionals. While self-care is often recommended as a means of prevention, the data to support that claim has been paltry up until now. Thus, a structural equation model was used to demonstrate the effect of self-care on burnout and secondary traumatic stress. A total of 1550 licensed mental health professionals participated in this study and the findings of this study that investigated the effect of self-care on burnout and secondary traumatic stress revealed significant results. When it came to the effect of self-care on burnout there was a significant negative relationship of -0.73 meaning that engaging in self-care led to a decrease in burnout. There was also a significant negative relationship of self-care between secondary traumatic stress at -0.37 meaning that as self-care increased secondary traumatic stress decreased. Furthermore, this study highlights the most beneficial areas of self-care for mental health professionals to implement and gives insight into how work setting influences the experience of these phenomena.

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CHAPTER 1: INTRODUCTION

There is a cost of caring for those who work in the helping professions such as counselors. In a 2022 study on psychologists, half of all psychologists in the United States reported feeling burnt out (American Psychological Association, 2022). Those who work as mental health counselors and therapists experience burnout at a similar rate as half of all mental health counselors surveyed identified as burned out in a 2020 survey (Kelly et al., 2022). This statistic falls on the heels of the Covid-19 pandemic which contributed to overall burnout and secondary traumatic stress (Litam et al., 2021). Burnout is defined as a state of physical, emotional, psychological, and spiritual exhaustion (Pines & Arrason, 1988). In addition, many counselors, particularly those who work with individuals who have experienced trauma, often experience secondary traumatic stress. Secondary traumatic stress which is also referred to as vicarious trauma, is the change that the therapist undergoes as a result of working with individuals who have experienced trauma. Secondary traumatic stress, was defined as a reduced capacity to be empathetic as a result of knowing about a traumatizing event experienced by another person (Figley, 1995). Secondary traumatic stress is characterized by the helper experiencing the same trauma symptoms as those they help. Being aware of the impact and prevalence of burnout and secondary traumatic stress among counselors is not enough to address this issue therefore self-care must be taken into consideration. Self-care is defined as actions focused on the maintenance and sustainment of a holistic sense of self and wellness (Pennington, 2021).

Significance of the Study

While burnout and secondary traumatic stress are often associated, they are distinct phenomena with their own characteristics (Alkema et al., 2008). When burnout levels were high, levels of secondary traumatic stress also tended to be higher, and the opposite was true as well.

When burnout levels were lower, secondary traumatic stress also tended to be lower (Beaumont et al., 2016; Ciesklak et al., 2014). The experience of burnout and secondary traumatic stress has led professionals to engage in ineffective work and to leave their profession entirely (McCormack et al., 2018). Burnout and secondary traumatic stress have similar negative impacts on counselors. However, burnout has a more gradual onset and can be present without exposure to trauma. Conversely, secondary traumatic stress is caused by exposure to the traumatic experiences of others. Secondary traumatic stress is caused by long-term and constant exposure to the trauma of others, and has been well-documented and studied among counselors and social workers (Cieslak et al., 2014; Clarkson et al., 2019; Cocker & Joss, 2016; Conrad & Kellar-Guenther, 2006; Cook et al., 2021; Duarte & Pinto-Gouveia, 2017; Figley et al., 1995; Figley, 2002; Fye et al., 2021). Understanding the factors that exacerbate burnout and secondary traumatic stress is important. Knowing what factors may serve to ameliorate or protect against burnout and secondary traumatic stress is essential so that steps can be taken to mitigate them. When counselors suffer from secondary traumatic stress, they begin to experience the negative effects of trauma in their own lives (Figley, 1995; Rivera-Kloeppel & Mendenhall, 2021) which impedes their ability to practice effectively. This impacts the work that the therapist can accomplish, their efficacy, and their ability to cope. This can result in ineffective counseling, counselor impairment, and leaving the profession entirely (McCormack et al., 2018).

The global prevalence of trauma was estimated to be around 70% (Cardoso et al., 2020). Due to the prevalence of trauma and its association with mental health, all counselors come into contact with individuals who have experienced trauma. In a survey of Adverse Childhood Experiences which measures trauma exposure in children, 63% of all individuals identified experienced at least one traumatic event during their childhood (Swendo et al., 2023). Seventeen

percent of the individuals surveyed identified having experienced four or more traumatic events before the age of eighteen (Swendo et al., 2023). According to the American Psychological Association (2021), the number of individuals seeking counseling as a result of trauma has increased and this demand for services has placed counselors at a higher risk of developing secondary traumatic stress and burnout. Burnout and secondary traumatic stress are critical issues for counselors as they lead to negative patient outcomes (Henson, 2020) and can result in unethical practice. Thus, addressing the issues of burnout and secondary traumatic stress is of critical importance among mental health counselors.

The American Counseling Association Code of Ethics (2014) cites the need for counselors to practice self-care. Self-care was identified as beneficial to prevent both burnout and secondary traumatic stress (Alkema et al., 2008; Litam et al., 2021; Posluns & Gal, 2021; Pennington, 2021; Mollica et al, 2021; Mott & Martin, 2019). While research exists that supports this association, little research has focused directly on the relationship between self-care, secondary traumatic stress, and burnout. This presents a notable lack of empirical support for self-care which is important for counselor well-being. One of the reasons for this lack of research has been the absence of an assessment that adequately measures self-care. Thus, this study will examine what self-care is, what it looks like, and what level of self-care practice is beneficial for mitigating or preventing burnout and secondary traumatic stress. These findings will support recommendations for counselors and counselor educators to create and provide guidelines for mental health professionals entering the field to avoid burnout and secondary traumatic stress. Additionally, the number of mental health professionals working in private practice is growing and much of the past research on burnout and secondary traumatic stress has focused on organizational factors. This study included individuals employed in both agency and private

practice settings to understand if there are differences in the experience of these phenomena across groups.

Purpose of the Study

While research on this topic has increased in recent years the direct link between self-care, burnout, and secondary traumatic stress among counselors warrants further attention (Beaumont et al., 2016; Killian, 2008; Mott & Martin, 2019; Rivera-Kloeppel & Mendenhall, 2021; Rocach & Boulazreg, 2020). This void in research indicates a need to understand better the relationship between burnout, secondary traumatic stress, and self-care, to assess if self-care has an impact on the development of burnout and secondary traumatic stress. Understanding this association is critical as it would allow for better recommendations for counselors and counselor educators to strengthen the profession. If self-care is beneficial in the prevention of burnout and secondary traumatic stress this can inform and encourage counselors to adopt self-care practices to practice effectively and ethically. As burnout can lead to unethical practice, understanding factors that protect against burnout is important for ethical practice so that counselors can practice ethically and effectively (American Counseling Association, 2014). Three primary types of mental health professionals were examined in this study that included Clinical Mental Health Counselors, Marriage and Family Counselors, Social Workers, Licensed Psychologists, and Psychiatrists. These groups were specifically identified and chosen for this study because they all provide mental health counseling services.

Theoretical Framework

The theoretical basis for this study is humanistic theory as developed by Carl Rogers (Rogers, 1947). Rogers emphasizes the person of the therapist and the role of the person of the therapist in the therapeutic process. In person-centered theory it is the person of the counselor

who is the tool in the counseling session, therefore, the care of the counselor is of paramount importance. This underscores the necessity of self-care as therapists need to care for themselves and their own needs to provide counseling to others. Secondly, burnout and secondary traumatic stress hinder the ability of the counselor to engage in effective counseling. Therefore, counselor wellness is of critical importance, which is where self-care comes in as the practice of self-care is focused on tasks that support the maintenance of the health and well-being of the therapist (Pennington, 2021).

Variables

Burnout

Burnout and secondary traumatic stress are the dependent variables that will be examined in this study. Burnout is an important area of concern for counselors as it negatively impacts their ability to counsel effectively (Chirico, 2016). Counselors have an increased risk of developing burnout due to the nature of the profession (Canfield, 2005; Newall & MacNiel, 2010). Counselors who work specifically with those who have experienced trauma are at a higher risk of burnout due to the nature of their work (Craig & Sprang, 2010). Rates of burnout among counselors have been found to range from 21-67 percent (Chen et al., 2019; Morse et al., 2012). The most recent research on burnout among counselors identified the current rate of burnout at 50 percent (Kelly et al., 2022), which demonstrates that burnout among counselors is a critical issue.

Burnout is a condition that impacts many mental health providers and it is important to understand how it is defined and the signs and symptoms of burnout. Burnout is defined as a syndrome characterized by chronic emotional exhaustion, depersonalization, and a decreased sense of accomplishment (Nagoski, 2020). The experience of these three separate aspects

together comprise burnout. Burnout can have both physical and emotional components and is also related to somatic experiences through illness (Acker, 2010). Burnout was closely related to feelings of cynicism and hopelessness (Alkema et al., 2008). Burnout was characterized by hopelessness in dealing with one's job and carrying it out effectively. Additionally, the onset of burnout tended to be gradual so awareness of risk factors and signs of developing burnout are critical (Bhutani et al., 2012).). It is imperative that counselors differentiate between normal levels of stress, fatigue, and burnout (Canfield, 2005). Because of this, counselors need to engage in ongoing self-assessment and monitor themselves for signs of burnout. These may include sensitivity, feelings of dread relating to work, feelings of flatness, and pessimism about the future (Canfield). Salvagioni (et al., 2017) looked at the overlap of burnout and negative health outcomes citing the importance of prevention and early identification of burnout. This information was critical for counselor awareness of burnout to identify it and address it as needed.

Secondary Traumatic Stress

The term compassion fatigue or secondary traumatic stress refers to the emotional toll that takes place as a result of being in the helping profession (Figley, 1995). As the term suggests, this phenomenon reduces the ability of the helper to be empathetic (Turgoose & Maddox, 2017). While secondary traumatic stress and burnout have many similarities there are distinct differences. First of all, secondary traumatic stress develops only after exposure to the trauma or life experiences of other individuals. It is characterized by a sudden onset and can have both emotional and physical exhaustion, feelings of helplessness, desensitization, and depersonalization (Figley, 1995, Henson, 2020). Due to the constant exposure to the experiences of others, individuals suffering from secondary traumatic stress become desensitized to the

suffering of others. Another component of secondary traumatic stress is that the helper begins to take on the characteristics of those they help, and the counselor can begin to experience symptoms of PTSD similar to those of their clients (Craig & Sprang, 2010; Figley, 1995). The effects of this may include the development of sleep issues, intrusive images, and avoiding reminders of the trauma an individual has heard about (Zerach, 2013). Given the nature of their work, counselors that provide services to those who have experienced trauma are more likely to develop secondary traumatic stress (Keim et al., 2008). Additionally, when individuals experienced burnout at work they were more likely to develop secondary traumatic stress (Shoji et al., 2015). This indicates that burnout makes individuals more susceptible to secondary traumatic stress.

Self-Care

The independent variable in this study is self-care. Self-care refers to actions and behaviors that one undertakes for the overall sake of their health and well-being (Pennington, 2021). These are actions either to provide or to maintain the overall health and well-being of individuals (Pennington, 2021). There are different dimensions of self-care and the ones that will be focused on in this research study are as follows: physical care, supportive relationships, mindful self-awareness, self-compassion and purpose, mindful relaxation, and supportive structure (Cook-Cottone & Guyker, 2018). The practice of self-care was connected to greater psychological well-being (Xue Feng et al., 2019). Self-care has been utilized to prevent burnout as well as secondary traumatic stress and the link between these two components has been studied (Alkema et al., 2008; Litam et al., 2021; Mott & Martin, 2019). When individuals engaged in one dimension of self-care, they were more engaged with other dimensions of self-care as well (Alkema et al., 2008). This indicates that this is a holistic practice that focuses on

overall well-being. When counselors did not practice adequate self-care, they were at a higher risk of developing secondary traumatic stress and burnout (Baker & Gabriel, 2021; Hotchkiss, 2018; Rivera-Kloeppel & Mendenhall, 2021; Rokcach & Boulazreg, 2020; Salloum et al., 2015; Turgoose & Maddox, 2017). In a study, focused on counselors, it was found that counselors who were feeling burnt out were less likely to engage in self-care practices (Baker & Gabriel, 2021).

Due to the nature of work focused on caring for others, counselors are prone to burnout and secondary traumatic stress. Individuals who enter the helping professions want to help others, however, they may be tempted to neglect themselves to do so which makes them prone to burnout and secondary traumatic stress. As a result, self-care is critical for counselors as they need to care for and prioritize themselves so that they can care for others (Fiebig et al., 2021; Polsuns & Gall, 2020). This is why self-care is so critical for counselors as they need to care for and prioritize themselves so that they can care for others (Fiebig et al., 2021; Polsuns & Gall, 2020). Lack of self-care on the part of the helping professional has been identified as a chronic issue (Figley et al., 2002). Self-care has been noted to be essential for counselors who work with those who have experienced trauma (Killian, 2008). While burnout and secondary traumatic stress were associated with poor psychological health, self-care is associated with better psychological health. Therefore, the practice of self-care should lead to better levels of psychological health and lower levels of both burnout and secondary traumatic stress . Understanding this relationship is critical to understand and support the need for counselors to practice self-care.

Assumptions

The assumptions in this study are as follows:

- Participants will complete all scores and scales voluntarily.

- Participants will answer all surveys and scales honestly.
- Instruments will be valid and will measure variables appropriately.

Limitations

The following limitations for the study were identified:

- Social desirability bias was a limitation. Mental health professionals have an ethical mandate to practice self-care as well as to monitor themselves for burnout or secondary traumatic stress to prohibit impaired practice. The sample and participants were anonymous to mitigate the effect of this however social desirability may have impacted participant response.
- The sample was randomly selected and comprised of indivduals whom the researcher was able to contact either by email, Listserv or snowball sampling.
- There could be a difference in the experience between individuals who choose to participate and those who choose not to participate.

Delimitations

The factors that the researcher could control in this study were: The study included individuals who perform the work of counseling in the United States providing therapy, including marriage and family therapists, clinical mental health counselors, social workers, psychologists, and psychiatrists.

Internal Validity

Threats to internal validity assume that the changes in the dependent variable were due to the changes in the independent variable and not to another variable (Mertens, 2020). The threats to internal validity in this study included instrumentation and social desirability. The survey included three questions to measure exposure to trauma and workload. These questions had not

been studied for reliability and validity. Social desirability was another limitation addressed by the survey's anonymous nature. Social desirability refers to the tendency for individuals to respond in ways that are socially desirable (Chung & Monroe, 2003, Zerbe & Paulus, 1987).

Threats to External Validity

External validity relates to the generalizability of the study (Mertens, 2020). The results of this study will not be generalizable to all those who work as counselors in the United States due to the sampling method. Counselors who were not in the Listseve, had unavailable email addresses, who did not receive the survey invitation or who chose not to respond were not included in this study.

Operational Definitions

The following operational definitions were used in this study.

Counselors

This term was used to refer to individuals who engaged in and performed the work of counseling in the United States. This term was used to include Clinician Mental Health Counselors, Social Workers, Marriage and Family Therapists, Licensed Psychologists, and Licensed Psychiatrists.

Burnout

Burnout is a state of physical, emotional, psychological, and spiritual exhaustion (Nagoski, 2020; Pines & Arrason, 1988). This was measured using the burnout subscale of version five Professional Quality of Life Assessment (Hudnall-Stamm, 2009).

Secondary Traumatic Stress

Secondary traumatic stress was defined as physical and mental exhaustion, emotional erosion, and emotional withdrawal from indirect trauma exposure (Cocker & Joss, 2016). This

was measured using the compassion fatigue subscale of the version five Professional Quality of Life Assessment (Hudnall-Stamm, 2009).

Self-Care

Self-care was defined as actions focused on the maintenance of or sustainment of a holistic sense of self and wellness. (Pennington, 2021, p.10). While self-care refers to an overarching sense of wellness, six primary dimensions were used to measure self-care. They were as follows: physical care, supportive relationships, mindful self-awareness, self-compassion and purpose, mindful relaxation, and supportive structure (Cook-Cottone & Guyker, 2018). The Mindful Self-Care scale (MSCS) broke down each dimension of self-care and asked about self-care practices specific to that dimension of self-care (Cook & Cottone, 2018). With the MSCS there was a composite self-care score used to measure self-care as the independent variable.

Demographic Questions

Years in the field. This was defined by the number of years that an individual had been practicing counseling. Options for this question were given in the following increments: Less than one, 1-3 years, 4-5 years, 6-10 years, 11-15 years, 16-20 years, and 21+ years.

Number of counseling sessions per week. This was defined by the number of hour-long therapy sessions that an individual performed over a typical week. Options for this question were given in the following increments 5-10, 11-15, 16-20, 21-25, 26-30, 31-35, 36-40.

Race and Ethnicity. Individuals were asked about their primary race or ethnicity, the following options were provided to choose from: White/Caucasian, Black/African American, Asian/Asian American, Hispanic, American Indian/Alaskan Native, Native Hawaiian/ Pacific Islander, Biracial/Multiracial and Other.

Type of License. Individuals were given options to choose from to differentiate their licensure, these were Licensed Clinical Mental Health counselor (LCMHC) or equivalent Licensed Professional Counselor (LPC), Licensed Clinical Mental Health Counselor Associate (LCMHCA) or equivalent, Licensed Marriage and Family Therapist, (LMFT), Licensed Marriage and Family Therapist Associate (LMFTA), Licensed Clinical Social Worker (LCSW), Licensed Clinical Social Worker Associate (LCSWA), Licensed Psychologist, or Licensed Psychiatrist.

Age. Individuals wrote in their age.

Gender. Individuals were given the option to choose Male, Female, Transgender male, Transgender female, Gender non-conforming, and other.

Marital Status. Individuals were given the option to choose, married, divorced or single.

Experience of trauma. Individuals were asked whether or not they had experienced a traumatic event in their own lives.

What percentage of clients on your caseload have experienced a traumatic event? Individuals were provided with a fill-in-the-blank to write in a percentage.

Summary

The field of counseling benefits from greater exploration of burnout and secondary traumatic stress related to counselor self-care. This chapter covered why this is an area of important awareness for counselors. This chapter included an overview of the variables to explore these including burnout, secondary traumatic stress and self-care. It covered the purpose and goals of the study as well as potential limitations and delimitations. It encompassd the threats to validity that were present and included operational definitions of each variable.

Organization

There are five chapters in this proposal. Chapter one introduced the topic and impact of counselor burnout and secondary traumatic stress. It explained the significance of this as an area of study, the purpose of this study and the reason for choosing each variable to study. Assumptions, delimitations, and operational definitions were also included. The second chapter reviewed the literature on burnout, secondary traumatic stress, self-care, and factors that may impact a counselor's experience of them. Chapter three focused on the methodology which encompassed; participants, instrumentation, design, procedures, data collection, and analysis. Chapter four addressed the results of the research questions and chapter five provides and in-depth discussion of the results of the study.

CHAPTER 2: LITERATURE REVIEW

The purpose of this study was to understand the impact of self-care on burnout and secondary traumatic stress among counselors. Working longer hours and being exposed to higher levels of trauma from traumatized clients was associated with burnout and secondary traumatic stress (Beaumont et al., 2016; Boscarino et al., 2006; Nimmawwitt et al., 2020; O'Halloran & Linton, 2000). Self-care was associated with lower levels of burnout and secondary traumatic stress (Alkema et al., 2008; Beaumont et al., 2016; Pennington et al., 2021). Therefore, the goal of this study was to understand how counselor self-care impacts the counselor's experiences of burnout and secondary traumatic stress. This chapter covered the theoretical basis that provides the framework for this study and the literature overview of the independent variable of self-care as well as the dependent variables of burnout and secondary traumatic stress.

Theoretical Framework

Person-Centered Philosophy

The theoretical basis for this study was humanistic theory developed by Carl Rogers (Rogers, 1947). Rogers emphasized the person of the therapist and the role of the person of the therapist in the therapeutic process. From a person-centered approach, it is the person of the counselor who is the tool in the counseling session, therefore, the care of the counselor is of paramount importance. From a person centered approach the goal of counseling is movement towards wholeness (Haynes et al., 2003; Rogers, 1942). Burnout and secondary traumatic stress are the opposite of wholeness as they often lead to fragmentation and disconnection. This results in disconnection within the person of the therapist.With burnout and secondary traumatic stress, the ability of the counselor to care for others is compromised. Part of the goal of the person-centered counselor is the installation of hope. This is something that is depleted when the counselor is experiencing burnout and secondary traumatic stress (Joseph, 2015).

The goal for clients in person-centered counseling is that they will be real, authentic, and integrated as disconnection from self results in disconnection from others. Therefore, the person of the counselor needs to be real, authentic, and integrated to be connected to oneself in order to be connected to the clients they serve (Rogers, 1961). Furthermore, the necessary conditions for person-centered psychotherapy are congruence, unconditional positive regard, and empathic understanding. All three of these necessary conditions can be impaired by the presence of burnout and secondary traumatic stress in counselors. This underscores the necessity of identifying factors to prevent the development of burnout and secondary traumatic stress. Thus, self-care comes in as it has been identified as a means to prevent burnout and secondary traumatic stress. Thus, understanding the impact of self-care on the therapist is critical for counselors to be able to practice with authenticity and congruence. Therefore, it is important to understand the role of self-care on secondary traumatic stress and burnout in counselors.

Burnout

Burnout is an important area of concern for counselors as it negatively impacts their ability to counsel effectively (Chirico, 2016). Counselors are at a higher risk of developing burnout due to the nature of the profession (Canfield, 2005; Newall & MacNeil, 2010). This literature review focused on past research on burnout by examining the risk factors, and its prevalence among the helping professions. In a 2022 study on psychologists, half of all psychologists in the United States reported feeling burnt out (American Psychological Association, 2022). Those who work as mental health counselors and therapists experience burnout at a similar rate with half of all mental health counselors surveyed identifying as burned out in a 2020 survey (Kelly et al., 2022). This overview provided insight into what burnout is,

the prevalence of burnout, and factors that influence it as well as factors that may serve to mitigate the effects of burnout.

Burnout Symptoms

To be aware of what burnout is it is important to understand how it is defined and the signs and symptoms of burnout. Burnout is a syndrome characterized by chronic emotional exhaustion, depersonalization, and a decreased sense of accomplishment (Nagoski & Nagoski, 2020). The experience of these three components together comprise burnout. Burnout has been on the rise and was defined as an occupational phenomenon according to the World Health Organization (World Health Organization, 2019). Burnout may present with both physical and emotional components and is also related to somatic experiences through illness (Acker, 2010). Burnout is closely related to feelings of cynicism and hopelessness (Alkema et al., 2008). The experience of burnout may cause some professionals to engage in ineffective work and to leave their profession entirely (McCormack et al., 2018). Counselors that remained in the field while experiencing burnout were less effective (Rocach & Boulazreg, 2020; Yang & Hayes, 2020). Burnout has an impact on therapist work, their ability to cope, and their efficacy as a counselor (Yang & Hayes, 2020). When severe, counselor impairment may lead to an increased risk of unethical practice (American Counseling Association, 2014).

Burnout was characterized by hopelessness in dealing with one's job and carrying it out effectively. Additionally, the onset of burnout tends to be gradual so being aware of risk factors and signs of developing burnout is critical (Bhutani et al., 2012). In order to provide optimal services, counselors must be able to differentiate between normal levels of stress, secondary traumatic stress, and burnout (Canfield, 2005). Counselors were encouraged to engage in ongoing self-assessment and be aware of the signs of burnout. These may include sensitivity,

feelings of dread relating to work, feelings of flatness, and pessimism about the future (Canfield, 2005). Salvagioni et al. (2017) investigated the overlap of burnout and negative health outcomes for counselors citing the importance of prevention and early identification of burnout. Burnout was found to result in overall poor health outcomes, to increase the risk of a variety of illnesses, and was also linked to severe injuries and premature death. This demonstrates that burnout is a critical issue that counselors be able to effectively identify and take proactive steps to address when needed.

Burnout and Depression

A discussion on burnout would not be complete without considering the overlap of burnout and depression. Chirico (2016) investigated burnout as a stress-related phenomenon that has significant negative effects on individuals and society. This research also indicated a close association between burnout and depression. Madsen et al (2015) investigated a large population of mental health counselors and identified a connection between burnout and subsequent depression. The findings indicated that burnout may lead to depression and that higher levels of burnout were more closely associated with depression. Similar results were found by others indicating that depression was closely associated with burnout (Schonfeld & Bianchi, 2016).

Morse et al. (2012) noted that while burnout was closely correlated with mental health conditions, it was distinct from them and had long-term negative impacts. In another study comprised of social workers working in child welfare, results indicated that work stress was associated with burnout which often led to disengagement (Travis et al., 2016). Additional findings indicated that there was inadequate research on what steps to take to prevent burnout and thus there is a need for continued study on interventions to appropriately address burnout.

The overlap of depression and burnout was discussed, as were the negative implications of burnout and the need for early identification to prevent burnout.

Organizational Factors Related to Burnout

Organizational factors related to burnout has been an area of focus in understanding the role of the workplace environment on counselor burnout. Acker (2010) investigated the levels of burnout among social workers working within the confines of managed care. This work involves more guidelines for clinicians which can adversely affect their feelings of competence and contribute to higher levels of burnout. Additionally, this type of work follows the medical model of diagnosis with short-term treatment. This can be frustrating for social workers as that model may not be congruent with their treatment goals for their clients. Having to adapt to these changes and work with more external restrictions was challenging and led to burnout (Aker, 2010).

Alkema et al. (2008) investigated burnout by viewing both physical and emotional components as burnout can present in both domains. Burnout may present as a somatic experience such as illness. Working with clients with severe mental illnesses such as trauma was positively associated with burnout and somatic experiences of burnout. Social support is negatively correlated with burnout. Younger clinicians with fewer years of experience had higher levels of burnout. This suggests that over time social workers may adjust to avoid burnout to stay in the field. When examining burnout among social workers who worked in hospice those who engaged in self-care experienced lower levels of burnout (Alkema et al., 2008). Overall more years of experience in the profession was associated with higher levels of self-care and lower levels of burnout. This indicates that with time in the field individuals may adopt more self-care

which then mitigates the prevalence of burnout. The majority of participants in this study had medium to high levels of burnout indicating that this was an area of concern.

Garcia et al (2015) discovered that mental health providers who worked with service members were found to be at additional risk of stress due to the combat stress their clients experienced. The study also discovered that levels of burnout among military members were similar to those of civilian mental health providers. When factors related to burnout were discussed, working more hours, increased patient caseloads, being female, and being a psychiatrist were all associated with higher levels of burnout. Ballenger-Browning et al. (2011) discovered that rates of PTSD among service members were approximately 20%. Furthermore, the level of exposure to traumatic events among service members who have been deployed was 95% and above which is important as exposure to trauma is associated with secondary traumatic stress. Individuals in this study who had more years of experience were less likely to experience burnout. Social support was also positively associated with lower levels of burnout (Ballenger-Browning et al.).

Lizano and Barak's (2015) inquiry found high levels of burnout when assessing factors related to job burnout. The results suggested that training may be associated with lower levels of burnout and that the workplace environment itself had an impact on levels of burnout. Maslach and Leiter (2008) investigated job engagement as the opposite of burnout since burnout involves a level of disengagement from work and an overall sense of cynicism surrounding it. The results indicated that job overload contributed to burnout and that a supportive work environment was associated with lower levels of burnout. This same inquiry also explored exhaustion and cynicism as two primary measures of burnout and offered appropriate steps to take to identify symptoms of burnout early on to intervene promptly. Additionally, demanding aspects of a job

such as crisis management were identified as contributing to burnout when individuals were not provided with adequate time to rest and recover. This speaks to the need for the continual practice of self-care, as self-care activities can meet those needs for rest and recovery. These results reiterate the need to understand to what degree self-care can prevent the development of burnout and secondary traumatic stress in counselors.

Burnout in the Mental Health Profession

It is crucial to recognize burnout among mental health professionals and the risk factors for burnout. Canfield (2005) examined burnout among therapists who treat trauma. The prevalence of trauma worldwide is estimated to be around 70% (Cardoso et al., 2010). Thus, many counselors work with individuals who have experienced trauma, which increases their risk of developing burnout. Recognizing the early signs of burnout enables individuals to take action to prevent the development of burnout. Counselors need to be able to differentiate between normal stress and burnout. Thus, awareness of the signs and symptoms of burnout was critical. This study also found that adequate training on trauma was associated with lower levels of burnout. McCormack et al. (2018) conducted a meta-analysis of 24 studies to examine burnout among applied psychologists and its implications. These studies primarily focused on the emotional exhaustion aspect of burnout and revealed high levels of emotional exhaustion. The emotional exhaustion was linked to high workloads, lack of support, and young age.

Chen et al. (2019) used the Counselor Burnout Inventory to look at levels of counselor burnout. Individuals who worked in agency settings had higher levels of burnout. Furthermore, females had higher levels of exhaustion and experienced more negative effects on their personal lives. The implications for supervisors were covered noting the need for supervisors to be aware of the symptoms of burnout in their supervisees to address it.

Hoge (2010) examined burnout and the relationship of burnout to job turnover. High rates of turnover within the helping professions have been attributed to burnout. Hoge looked at all literature on burnout from 1990-2009. These findings indicated high levels of at least one of the measures of burnout among the majority of individuals in the helping professions. However, this study did not indicate a causal link between burnout and individuals leaving the profession. Overall, these reviews indicated that burnout was a significant issue among the helping professions.

Factors that Affect Burnout

It is critical to understand the factors that affect burnout. Allen et al. (2019) examined burnout through the lens of character strengths and examined the relationship between character strength and burnout. These findings indicated that strength of character and engagement in meaningful work were negatively associated with burnout. This study also found that older age was negatively associated with burnout. This finding has been supported by prior research on burnout (Aker, 2010; Alkema et al., 2008). In another study, Kumar (2012) investigated burnout among psychiatrists and discovered that burnout affected job satisfaction long term. This was important as individuals who are more satisfied in their jobs are more effective and more likely to continue in their chosen field. This is supported by prior research as overall older age is negatively associated with burnout. Thus, it seems that over time individuals find a way to address and manage their burnout to stay in the mental health field.

Aker (2010) explored factors that increased the likelihood of burnout. They found a relationship between adverse life experiences, positive childhood experiences, compassion satisfaction, and burnout. The need for counselor well-being and the need for counselors to be aware of burnout and their risk of developing burnout was noted. Wellness and resilience were

associated with lower levels of burnout. Personal experiences that were related to burnout were included, although counselors in this study were overall not experiencing burnout. Conrad and Kellar-Guenther (2006) examined the risks of secondary traumatic stress and burnout. They also investigated the relationships between secondary traumatic stress, compassion satisfaction, and burnout. The results revealed a low risk of burnout among their participants but a high risk of secondary traumatic stress. Compassion satisfaction also seemed to mitigate the effects of burnout (Conrad &Kellar-Guenther, 2006).

Bhutani et al. (2012) examined burnout and secondary traumatic stress among counselors. The findings revealed higher levels of compassion satisfaction for counselors in private practice and counselors who had more years of experience. Conversely, poor working conditions were associated with burnout. Overall, the character strengths of the therapist, their wellness practices, their ACE score, and compassion satisfaction were all found to have an impact on their experience of burnout. Adverse childhood experiences (ACEs) of the counselor were positively associated with burnout. Counselors who had experienced more ACEs were more likely to experience burnout (Brown et al., 2022).

Craig and Sprang (2010) investigated a large sample of trauma specialists who were licensed clinical social workers and psychologists. The findings indicated low levels of secondary traumatic stress and burnout and high levels of compassion satisfaction. Age was negatively correlated with burnout as older individuals experienced less burnout. Individuals who worked with clients diagnosed with PTSD had higher levels of burnout. Higher levels of burnout were also present in individuals who had not received training in trauma counseling.

Deighton et al. (2007) explored factors affecting burnout and secondary traumatic stress among counselors with a focus on counselor attitudes. This study examined two groups of

counselors: one group was in an advocacy role and the second group helped clients work through their past trauma. The counselors who helped clients work through past trauma experienced lower levels of burnout compared to the counselors in the advocacy role.

Fares et al. (2016) examined factors relating to burnout among medical students. The focus was on using healthy coping strategies to decrease the prevalence of burnout. Factors that impacted burnout included being a trauma specialist, training in trauma treatment, directly working through traumatic events, and using healthy coping strategies. Experiencing burnout was associated with decreased life satisfaction, wanting to drop out, and suicidal ideation. Thus, it is clear that burnout is a key issue that affects counselors.

Organizational Factors for Burnout

Galek et al. (2011) investigated the relationship of work-related variables to burnout and the impact of social support to mitigate these effects. This study found that the number of years worked in a particular organization was associated with burnout and that social support was negatively related to burnout. Greenglass et al. (1996) explored factors that may serve to mitigate the impact of burnout. Social support was found to be a protective factor against the development of burnout. The relationship between the work environment and burnout was addressed. Social support in the work environment was found to have an impact on burnout.

Garcia et al. (2015) found burnout to be prevalent among psychiatrists who work for the Veterans Administration (VA). 86%, of psychiatrists reported high levels of exhaustion and 90% of them reported high levels of cynicism. These are two of the subscales for burnout. This study encompassed both workplace factors and patient characteristics along with their impact on burnout. Yanchus et al. (2015) conducted a qualitative study of individuals working at the VA who were asked questions about their perceptions of positive and negative traits of their

workplace. The two aspects of burnout that were most salient were emotional exhaustion and depersonalization. This is important to note because individuals may feel a sense of personal accomplishment but do so at the expense of their well-being.

Burnout and Coping

Killian et al. (2008) explored therapists' engagement in self-care activities along with protective factors. An important theme that emerged was that therapists recognized their symptoms of burnout. Risk factors that emerged associated with burnout were: high caseloads, lack of supportive work environment or supportive colleagues, and an inability to recognize and meet one's own needs. Lower levels of morale were associated with higher levels of burnout. This study highlighted a need for counselor self-care and support to prevent burnout. Participants also discussed their self-care practices which included having time to process their cases, supervision, quality time with friends and family, exercise, and spirituality (Killian, et al. 2008). In another study, Allan et al. (2019) looked at burnout and character strengths. This study found that meaningful work was associated with lower levels of burnout.

Cook et al. (2021) investigated burnout among counselors and found that counselors experiencing negative emotions were more likely to engage in negative and ineffective coping strategies. Providing ongoing mental health support for individuals who have experienced trauma was associated with burnout. Additionally, burnout was found to impact the counselor’s relationships, emotional health, and well-being. Common symptoms of burnout that were identified included: fatigue, tiredness, feeling unfulfilled, questioning career choice, and psychological distress. Overall, individuals experiencing higher levels of burnout were engaged in fewer self-care practices (Cook et al., 2021).

In a study investigating factors affecting burnout and secondary traumatic stress: mindfulness, perceived working conditions, use of healthy coping strategies and compassion satisfaction were all influential. These factors accounted for 33% of the variance in secondary traumatic stress but 66% of the variance in burnout (Thompson et al., 2014). This implies that there is a difference in how individuals experience burnout and secondary traumatic stress and what may be effective to mitigate each of them.

Shin et al. (2014) investigated the connection between coping and burnout. A relationship was found between coping strategies and burnout. Another study exploring burnout in doctors found that burnout was associated with negative patient outcomes (Sweileh, 2020). In another study, Duarte and Pinto-Gouveia (2017) examined the role of empathy and guilt on burnout and secondary traumatic stress. Empathy led to higher levels of burnout and secondary traumatic stress. Additionally, a sense of over-responsibility led to higher levels of burnout and secondary traumatic stress as well. Feeling a sense of over-responsibility and guilt is a negative coping strategy whereupon the helper takes on responsibility that is not theirs. This is the opposite of a healthy coping strategy which would focus on the influence that the counselor does have and identifying their own sphere of influence.

Burnout in Training

Wardle and Mayorga (2016) examined burnout in future counselors and found high levels of burnout. This is concerning because some individuals may be entering the field already experiencing burnout which indicates a need to address this issue while students are in their master's programs. Fye et al. (2021) explored secondary traumatic stress and burnout in a sample of counselors who were not fully licensed. The results indicated that counselors began to experience burnout as early as their internship. A connection was also found between client

hours and burnout as counselors who saw more clients weekly were more likely to experience burnout.

In a similar study, Harrichand et al. (2021) explored burnout in counselor educators. This study examined the relationship between leadership experience, competence, and burnout. Individuals who reported greater competence in their leadership roles experienced lower levels of burnout related to leadership. However, they experienced higher levels of burnout in their personal life and working with students. Thus the importance of counselor educators practicing self-care was reiterated.

When looking at burnout among those in the helping professions, Paris and Hoge (2010) found high levels of burnout among these individuals in these professions demonstrating that this is a serious issue. In the Schilling and Randolph (2021) study, burnout in school counselors was explored. The results indicated that 90% of school counselors identified as having experienced burnout over their careers.

Secondary Traumatic Stress

Given the nature of their work, mental health counselors are at an increased risk of developing secondary traumatic stress (Rivera-Kloeppel & Mendenhall, 2021; Singh et al., 2020; Turgoose & Maddox, 2017; West, 2015). Secondary traumatic stress is also sometimes referred to as compassion fatigue but the term secondary traumatic stress will be utilized throughout for continuity. Burnout and secondary traumatic stress have frequently been studied together in the past. The literature review here will focus on aspects of secondary traumatic stress that have not yet been covered.

Symptoms

Secondary traumatic stress differs from burnout in a variety of ways. One of these is that it has a sudden onset. Secondary traumatic stress stems from the helper vicariously experiencing the trauma that their clients have experienced (Figley, 2002). This secondary exposure to trauma is part of the work of the therapist. Often secondary traumatic stress leads to the individual beginning to present with symptoms of PTSD due to this secondary traumatic exposure (Rivera-Kloeppel & Mendenhall, 2021). Given that the criteria for PTSD include exposure to trauma as a result of work, counselors with high levels of secondary traumatic stress may meet the criteria for PTSD (American Psychiatric Association, 2013).

Secondary traumatic stress has three primary components. These are reexperiencing the traumatic event of those they help, avoidance of reminders and numbing to avoid them, and persistent arousal (Figley, 1995a; Jenkins & Baird, 2002, p. 424). Furthermore, secondary traumatic stress has a sudden onset with emotional and physical exhaustion, apathy, helplessness, desensitization, and depersonalization (Henson, 2020).

Risk Factors

Beaumont et al. (2016) examined secondary traumatic stress in counselors, psychiatrists, and healthcare workers. Those who work with trauma were at a higher risk of burnout and secondary traumatic stress. Findings also revealed that higher levels of compassion satisfaction were associated with lower levels of secondary traumatic stress and burnout (Beaumont et al., 2016).

Boscarino et al. (2006) investigated secondary traumatic stress in social workers in New York City following the September 11, 2001 terrorist attacks. The researchers specifically focused on the impact of a large-scale traumatic event on the helper's burnout and secondary

traumatic stress. The results indicated differences in the levels of burnout and secondary traumatic stress. As is consistent with other findings, individuals who worked with those who had experienced trauma were at a higher risk of secondary traumatic stress (Boscarino et al., 2006).

Benuto et al. (2013) explored secondary traumatic stress among victim advocates. Contrary to prior research this study revealed no difference in the experience of secondary traumatic stress based on whether or not the helper had experienced a traumatic event. Cunningham (2003) also examined secondary traumatic stress among social workers. This study found that the experience of secondary traumatic stress was influenced by the type of trauma that individuals on a counselor's caseload had experienced. Individuals who worked with those who had experienced sexual abuse were more likely to experience secondary traumatic stress than those who worked with individuals who had experienced natural disasters (Cunningham). Thus, the type of trauma experienced may play a role in the development of secondary traumatic stress on the part of the helper.

Pearlman (1995) examined secondary traumatic stress in individuals who self-identified as trauma therapists. The findings suggested that individuals with a personal experience of trauma were more likely to experience secondary traumatic stress. This is important as it indicates that there is a need to find something that will serve to mitigate the effects of secondary traumatic stress on counselors.

Singh et al. (2020) examined the role of secondary traumatic stress on counselors. Secondary traumatic stress was identified as negatively impacting the health and well-being of counselors. This led to impairment which is harmful to client outcomes. There was a focus on factors that contributed to secondary traumatic stress in counselors. These included exposure to

client trauma and high workloads. Conversely, a supportive work environment was found to be beneficial in preventing secondary traumatic stress. The need to minimize the negative impact of secondary traumatic stress on counselors is paramount.

Hong et al. (2023) examined secondary traumatic stress in counselors in private practice in China. The respondents in this study reported moderate levels of secondary traumatic stress and burnout. The results of this study indicated higher levels of secondary traumatic stress compared with prior research (Hotchkiss, 2018). The following factors were identified as impactful in the role of secondary traumatic stress: these were education, more years in practice, and fewer clients.

Burnout and Secondary Traumatic Stress

The focus of this part of the literature review is on the connection between burnout and secondary traumatic stress. These two syndromes although unique are frequently studied together. Shoji et al. (2015) assessed whether job burnout or secondary traumatic stress came first among mental health providers. These findings indicated that job burnout can increase susceptibility to secondary traumatic stress, but the findings indicated that secondary traumatic stress did not lead to burnout. Buselli et al. (2020) looked at burnout and secondary traumatic stress in healthcare workers during the Covid-19 pandemic. These findings were consistent with prior research with females experiencing higher levels of secondary traumatic stress. Both burnout and secondary traumatic stress were associated with both depression and anxiety in the individuals studied. This is important as counselor' well-being impacts that of their patients.

Cieslak et al. (2014) performed a meta-analysis on job burnout and secondary traumatic stress among workers with indirect exposure to trauma. These findings revealed that job burnout and secondary traumatic stress were closely related. These findings also indicated that both

burnout and secondary traumatic stress occurred more frequently among professionals who were exposed to trauma as part of their work. Kiem et al. (2008) also found high levels of burnout and secondary traumatic stress among trauma counselors. Therefore, a link was found between burnout and secondary traumatic stress, particularly among individuals who work with trauma.

Burnout and Secondary Traumatic Stress Risk Factors

There are a number of risk factors associated with burnout and secondary traumatic stress. West (2015) investigated the relationship between burnout and secondary traumatic stress and attachment. The results indicated that counselors with secure attachment experienced lower levels of burnout and secondary traumatic stress. In addition, counselors with insecure or anxious attachment experienced higher levels of both burnout and secondary traumatic stress. It is plausible that counselors possessing a more secure relationships were more likely to have support which can prevent burnout and secondary traumatic stress.

Cocker and Joss (2006) examined the risk factors for burnout and secondary traumatic stress to understand the relationship between these two phenomena. The population surveyed were individuals working in child welfare. The individuals in this study experienced low levels of burnout and high levels of secondary traumatic stress. This implies that there is a difference in the experiences of these phenomena. Jenkins and Baird (2002) examined secondary traumatic stress and burnout and discovered that individuals that experienced a prior traumatic event scored higher on secondary traumatic stress; however they did not score higher on burnout. These findings further reveal that burnout and secondary traumatic stress have unique characteristics and do not always occur together at the same rate. Secondly, these findings reveal the impact of personal traumatic experiences on the development of secondary traumatic stress.

Newall and MacNiel (2010) highlight concerns that arise for those in the helping professions. Secondary traumatic stress is a key consideration for those who work with individuals who have experienced trauma. Conversely, burnout can occur in a variety of professional settings as exposure to trauma is not needed to develop burnout. When it comes to secondary traumatic stress prior mental health conditions and negative coping methods play a large role. On the other hand, burnout is often related to the setting or organizational factors at one's place of employment. However, burnout has not been well studied in private practice where many of those organizational factors are not present.

Leone et al. (2008) examined the long-term experiences of burnout and secondary traumatic stress. Individuals were more likely to recover when they only experienced burnout as opposed to experiencing both burnout and secondary traumatic stress. In general, individuals who experienced higher levels of burnout experienced a longer duration of symptoms and difficulty recovering from burnout.

Self-Care

The next variable that will be understood in detail is self-care which is the exogenous or independent variable. Self-care was often associated with a decrease in burnout and secondary traumatic stress (Alkema et al., 2008; Sadler-Gerhardt & Stevenson 2012). Self-care was defined as actions focused on the maintenance of or sustainment of a holistic sense of self and wellness. (Pennington, 2021). Cook-Cottone and Guyker (2018) developed the MSCS to measure engagement in mindful self-care. This assessment breaks down self-care into six dimensions: physical care, supportive relationships, mindful self awareness, self-compassion and purpose, mindful relaxation, and supportive structure. Self-care was the foundation of physical and emotional well-being. Physical self-care includes nutrition, hydration, sleep, and exercise.

Included in that is engagement in activities to manage health and prevent disease by engaging in activities such as regular medical check-ups. The next dimension was supportive relationships which relate to overall well-being. Next is mindful self awareness to help individuals understand their self-care practices and reflect upon them. Self-compassion was a dimension of this scale and refers to treating oneself with kindness. An additional facet of self-compassion was purpose which can include a connection to spirituality as a source of support and meaning. Another dimension, mindful relaxation focused on self-soothing, calming, and relaxation. Lastly, supportive structure referred to the balance of environmental factors that support rest. These were all salient aspects of self-care which was important for counselors to engage in particularly when they are at risk of burnout and secondary traumatic stress.

Posluns and Gall (2020) completed a literature review on counselor self-care and its role in the promotion of counselor well-being. Burnout and secondary traumatic stress were associated with lower levels of engagement in self-care activities. In this study, self-care was identified as actions taken to care for oneself. The primary self-care strategies identified were awareness, balance, flexibility, physical health, social support, and spirituality. Awareness included being self-aware and responsive to one's own needs. Balance was identified as equilibrium across personal and professional domains. Engaging in leisure activities was included as part of balance. Flexibility was identified as the ability to adapt to meet various needs. Three key aspects of physical self-care were identified: sleep, exercise, and diet. Social support included supportive personal and professional relationships. Spirituality was identified as a search for the sacred with a focus on mindful engagement. The aforementioned literature review revealed a lack of focus on counselor training and continuing education focused on self-

care. Thus, there is a need to integrate self-care into those areas. Additionally, a lack of empirical support for the practice of self-care was identified denoting a need for further research.

Sansbury et al. (2015) identified four steps to engage in self-care that consisted 1) counselor self-awareness, 2) committing to address stress, 3) make a plan of action, and 4) carry out the plan. Counselors were encouraged to practice these four steps regularly to prevent the development of burnout and secondary traumatic stress.

Role of Self-Care

Chen et al. (2019) identified that a challenge in practicing self-care was that it varied based on the needs of each person. Moreover, this study revealed that individuals engaged in self-care activities, after experiencing burnout instead of using self-care to prevent burnout. In this study, self-care was broken down into three facets: social/emotional, physical, and time management. Thus, self-care is comprised of several components.

Interventions that decrease burnout and secondary traumatic stress are important to be aware of to prevent or mitigate the effects of burnout. Clarkson et al. (2019) examined the relationship between mindfulness, burnout, secondary traumatic stress, and resilience among radiology students. These findings indicated a relationship between these variables and revealed high levels of burnout among participants. In this study, mindfulness was a primary method of self-care. The practice of mindfulness-based self-care was found to be negatively correlated with burnout. Therefore, self-care can be beneficial to prevent burnout and secondary traumatic stress and contribute to resilience.

Rokach and Boulazreg, (2020) provided an overview of the factors that impact burnout. These include physical isolation, emotional isolation, patient behaviors, therapeutic relationships, and life events in the therapist's personal life. The article identified the need to recognize the

stressors that counselors face. Steps to mitigate the effects of burnout were identified and self-care was identified as a primary means of prevention. Sadler-Gerhardt and Stevenson, (2012) also discussed the steps needed for counselor wellness and resiliency to prevent counselor impairment. Self-care, mindfulness, the life of the therapist, and relationships were all associated with burnout.

In a qualitative study on the practice of self-care among counselors during times of personal distress, self-care was identified as a way to keep oneself intact (Baker & Gabriel, 2021). Individuals tended to adopt self-care strategies after working a longer amount of time in the counseling field and after experiencing burnout. Thus, self-care was identified as fundamental to incorporate into counselor education programs as a means of prevention (Baker & Gabriel). This reaffirms the role of self-care in the counseling profession.

Engagement in Self-Care

Pennington (2021) looked at self-care in marriage and family counselors using the self-care assessment worksheet. In this study, the relationship of self-care on burnout and secondary traumatic stress was assessed. This was investigated through the use of self-care subscales focused on various behaviors. These subscales were physical self-care, psychological self-care, emotional self-care, spiritual self-care, workplace self-care, and overall balance. Overall burnout was negatively correlated with all aspects of self-care. When individuals engaged in self-care, they experienced lower levels of burnout. A statistically significant negative relationship was found between secondary traumatic stress with physical self-care, psychological self-care, professional self-care, and spiritual self-care. Self-care was negatively correlated with burnout and secondary traumatic stress. Thus, engagement in self-care activities resulted in lower levels of burnout and secondary traumatic stress. Out of all the variables, physical self-care had the

largest impact. Therefore, engaging in physical self-care was the most effective practice to reduce burnout. Furthermore, this demonstrated that self-care was beneficial in preventing burnout and secondary traumatic stress in counselors.

A daily and regular practice of self-care is a means to maintain well-being. The Self-Care Assessment scale (Cook & Cottone, et al., 2018) emphasizes this, particularly with questions about physical self-care. These include; movement, drinking water, and eating healthy food throughout the day. While these activities may fall by the wayside during a busy day full of clients, they are critical for counselor wellness. For counselors to engage in physical self-care they have to take mini breaks throughout their work. This was critical as Albulescu (et al., 2022) found that engaging in small breaks and recovery activities was associated with enhanced well-being and better performance among employees. These micro-breaks enhanced cognition. Furthermore, higher-performance tasks required longer breaks. This is important as a counselor needs to have a high level of cognition to balance the content of their client sessions along with their recommended treatments and conceptualizations. In the counseling session, the focus of the counselor is on the client which is a high-performance task. Therefore, breaks to practice self-care are essential for counselors.

Mindful self-care was an important part of self-care among counselors. Clarkson et al. (2019) examined the relationship between mindfulness, burnout, secondary traumatic stress, and resilience. A relationship was found among these variables additionally the participants in this research study were also experiencing high levels of burnout.

Litam et al. (2021) found that more resilient individuals experienced lower levels of secondary traumatic stress. Resilience is the capacity to withstand challenging experiences. In this study, individuals with higher levels of resilience experienced more burnout. Self-care

mitigated the effects of both burnout and secondary traumatic stress (Litam). Mollica et al. (2021) studied psychiatrists and found an overall prevalence of burnout at 50%. Robust self-care was recommended to address the prevalence of burnout. Research on self-care indicates that it mitigates the effects of secondary traumatic stress (Adimando, 2018; Cohen & Koenig, 2003; Klein et al., 2018).

Mott and Martin (2019) examined the effect of self-care on counselors who had experienced prior traumatic events. They also examined burnout and secondary traumatic stress. Self-care did serve to moderate the effects of prior trauma, burnout, and secondary traumatic stress. This is important as it indicates that practicing self-care can result in more positive outcomes overall.

Need for Self-Care

Barnett and Cooper (2009) discussed the importance of self-care for psychologists. Self-care was identified as significant due to ethical mandates. The overlap between stress in one's personal and professional life was identified and determined as a reason to practice self-care. One recommendation was for self-care to be included in training programs so that students would develop a self-care practice along with their developing professional identity. A recommendation was made to include self-care practices and counselor wellness as part of the licensure renewal process. This highlights how essential the practice of self-care is for individuals in the helping professions.

Self-Care in Training

Fares et al. (2017) examined burnout in medical students and found that students engaging in healthy coping strategies such as self-care experienced lower levels of burnout. This

is vital as high stress and burnout were associated with decreased life satisfaction and increased suicidal ideation.

Maranzan et al. (2018) examined self-care in psychology training programs. The results demonstrated a significant lack of training focused on self-care. Self-care was identified as a means of prevention. A suggestion was made for self-care to be practiced to enhance wellness and be integrated as a competency. This speaks to the essential need for the practice of self-care and the need for continued focus on and promotion of it.

Bamonti et al. (2014) examined self-care in clinical psychology training programs by reviewing program handbooks. These results showed that while many programs mentioned self-care the terminology around self-care was ambiguous. The information presented around self-care was most commonly presented when discussing student impairment. This indicates a need for self-care to be utilized as a preventative rather than a cure for when individuals become impaired due to their work. Notably, a focus on how self-care should be incorporated into training programs and practice was missing. Thus, there is a need to promote the practice of self-care and incorporate it into training programs.

Myers et al. (2012) assessed self-care practices in a sample of psychology graduate students. Sleep, social support, emotional regulation, and mindful acceptance were all identified as important in managing stress. These are all aspects of self-care. The importance of incorporating the practice of self-care into graduate programs was reinforced. This is important as research on those in the helping professions indicate an inadequate focus on self-care in training programs.

Barnett et al. (2007) identified the role of self-care to prevent the development of burnout and secondary traumatic stress among psychologists. Self-care was described as a means to

prohibit impairment as psychologists experience the same stresses and anxieties as other individuals along with the added stress of caring for their clients. Regular practice of self-assessment to address self-care in psychologists was encouraged. Additionally reframing self-care as imperative for psychologists to be able to do their jobs was identified.

Xue Feng et al. (2019) did a study on the effects of self-care on individuals. The practice of self-care was associated with better psychological well-being even when controlling for gender, age, race, and socioeconomic status. Social support, which is an aspect of self-care emerged as critical for psychological well-being. Self-care also insulates individuals from the negative impacts of stress.

Self-Care Strategies

Dyrbe et al. (2017) examined the effect of exercise on burnout among a large sample of medical students. The findings suggested that engaging in exercise resulted in lower levels of burnout. This is important as exercise was identified as a critical aspect of self-care. That was true even when accounting for contributing factors. Toker and Biron (2012) looked at the connection between burnout and depression. They also examined the role of exercise on depression. Exercise and physical health are components of self-care. Therefore this suggests that engaging in exercise can serve to prevent burnout.

Plath and Fickling (2022) brought up the idea of task-oriented self-care to provide counselors with more specific examples of self-care. This study identified three dimensions of self-care, these are creative self-care, supervision, and mindfulness. One example of creative self-care provided was the counselor thinking of themselves using a plant to identify what they need. It was perceived as beneficial to focus on counselor wellness and awareness of burnout in

supervision. Lastly, steps were identified to engage in task-oriented self-care. These included setting the intention, identifying what was needed to carry it out, and mindful engagement.

Mindfulness has many benefits so mindful self-care has emerged as a means to practice self-care (Rokach & Boulazreg, 2022, Rudaz et al., 2017). Lu et al. (2023) examined burnout in vocational rehabilitation counselors. Mindfulness was named as a key factor in the prevention of burnout. Additionally, early identification of the symptoms of burnout was promoted. Self-care was established as critical for the prevention of burnout. Thus, suggestions were made to incorporate mindful self-care practices among counselors. Rudaz et al. (2017) identified mindfulness as a critical part of counselor self-care in a review of articles on the topic. The research reviewed on burnout and mindfulness supported this indicating that the practice of mindfulness led to a decrease in stress.

Self-Compassion as Self-Care

Nelson et al. (2018) identified self-compassion as a means of practicing self-care. A lack of clear steps to integrate self-care was identified and in response to that, a model of self-compassion was pinpointed. Counselors were encouraged to practice self-compassion through self-kindness, a focus on common humanity, and mindfulness. Self-compassion was recognized as pivotal in building supportive relationships and well-being. The authors established a need to incorporate the practice of self-care through self-compassion into counselor training programs.

Fiebig et al. (2020) looked closely at the role between self-compassion and self-care. Caring for oneself was identified as critical for individuals in care-taking roles. This replenishment of self through self-care led to an increased sense of efficacy in a caretaking role. This is critical as feeling ineffective is closely linked to the development of burnout. Even small acts of self-care contributed to an overall sense of well-being and resiliency. When working with

individuals in situations that those in a care-taking role cannot change, the counselor was encouraged to focus on their well-being to be present for their clients (Fiebig et al.). Furthermore, this is the crux of self-care for those in the counseling profession as self-care must be practiced so that the counselor can continue to care for others.

Secondary Traumatic Stress and Self-Care

Preston et al. (2022) examined the relationship between secondary traumatic stress and self-care. Self-care served as a mediator of secondary traumatic stress. Additionally, secondary traumatic stress was related to overall poor health outcomes and a decreased quality of life for the counselor. This aligns with prior research on the impact of trauma on health and functioning. These same negative effects can be experienced secondhand. A supportive environment was found to have the most impact in preventing secondary traumatic stress. One of the reasons given for high levels of secondary traumatic stress was a chronic lack of self-care (Figley et al., 2002).

Vance et al. (2021) performed a large-scale study on the incidence and development of PTSD among first-year residents in medical school. This is included here as secondary traumatic stress leads to the development of PTSD-like symptoms from exposure related to one's occupation (American Psychiatric Association, 2013). The rate of PTSD varied across disciplines with the lowest incidence across any specialty of 7.5% which is 1% higher than the average incidence of PTSD in the general population. The highest rate of PTSD across any specialty was 30%. More than half of all students who responded to this questionnaire reported exposure to trauma and 20% met the criteria for PTSD. Working longer hours was associated with a greater likelihood of developing PTSD. These statistics are concerning as they indicate high levels of secondary traumatic stress. Therefore, it is critical to research interventions to prevent the development of PTSD and secondary traumatic stress.

Rivera-Kloeppel and Mendenhall (2021) examined the relationship between secondary traumatic stress and self-care in counselors through a review of the literature on these topics. In the overwhelming majority of the articles reviewed the Professional Quality of Life assessment (Hudnall-Stamm, 2009) was used to assess for secondary traumatic stress. A clear connection supporting the effect of self-care on secondary traumatic stress was not found. However, this could be due to the variety of studies and the methods that were utilized in this assessment, which indicates a need for more rigorous research in this area.

Self-Care, Burnout, and Secondary Traumatic Stress

Velez-Cruz and Holston (2021) looked at the relationship between self-care and burnout. Self-care was found to have a significant negative relationship with burnout. This same study looked at the significant negative relationship between self-care and secondary traumatic stress. Hotchkiss (2018) examined burnout, self-care, and secondary traumatic stress. In this study, engagement in mindful self-care was impactful in preventing burnout. When individuals scored high in self-care they scored low in burnout. This indicates that self-care can prevent the development of burnout which matters as burnout was identified as a contributor to secondary traumatic stress (Henson, 2020).

Salloum et al. (2015) looked at the impact of self-care on burnout and secondary traumatic stress. In this study, self-care was found to be associated with lower levels of burnout. Sorenson et al. (2016) examined secondary traumatic stress and burnout among nurses. These findings revealed that nurses frequently experienced secondary traumatic stress which was detrimental to the nurse's health and well-being. Adequate sleep, which is an aspect of self-care was beneficial in preventing the development of burnout and secondary traumatic stress. This is

important as sleep is an aspect of self-care therefore understanding the impact of self-care on burnout and secondary traumatic stress is paramount.

Borges et al. (2019) examined secondary traumatic stress and burnout in a sample of E.R. nurses. These findings indicated high levels of secondary traumatic stress at around 59% and high levels of burnout at 56%. This further reinforces that burnout and secondary traumatic stress are key issues across the helping professions. As in previous research, females experienced higher levels of secondary traumatic stress than men. Nurses with fewer years of experience reported higher levels of secondary traumatic stress which is also consistent with prior research. An additional area that was studied was leisure activities, nurses who engaged in more leisure activities experienced decreased secondary traumatic stress and burnout. This is important as leisure activities such as those described are part of self-care. Thus the idea that engaging in self-care may lead to lower levels of burnout and secondary traumatic stress was supported.

Influential Factors

Zerach et al. (2013) looked at secondary traumatic stress in individuals working in child welfare. Due to the nature of their work, this population is at a higher risk of developing secondary traumatic stress. Additionally, insecure attachment was found to contribute to the development of secondary traumatic stress. Conversely, spirituality which is an aspect of self-care had a role in preventing the development of secondary traumatic stress.

Bhutani et al. (2012) examined burnout, secondary traumatic stress, and self-care in counselors. These findings indicated that when a clinician experiences burnout and secondary traumatic stress their patients suffer as a result. Individuals in this study who worked in private practice and had been working longer experienced lower levels of secondary traumatic stress. This is consistent with prior research as individuals with more years of experience have

consistently reported lower levels of burnout and secondary traumatic stress. However, the findings on clinicians in private practice are impactful as this is a population upon which there is little research.

Turgoose and Maddox (2017) reviewed the literature on secondary traumatic stress in clinical mental health counselors to understand the factors that contributed to the development of secondary traumatic stress. The trauma history of the mental health professional was identified as a factor in developing secondary traumatic stress. Self-care was found to serve as a mediating factor to prevent the development of secondary traumatic stress. Mindfulness, an aspect of self-care, served as a protective factor against the development of secondary traumatic stress. High levels of empathy were negatively correlated with the development of secondary traumatic stress. Numerous studies reported that burnout was positively correlated with secondary traumatic stress. Can and Watson (2019) looked at factors that impacted secondary traumatic stress in counselors. They found that self-care practices were associated with lower levels of secondary traumatic stress.

Summary

While the research covered has discussed burnout and secondary traumatic stress there has been little research that looks directly at the impact of self-care on burnout and secondary traumatic stress among counselors. Additionally, statistical analysis examining the relationship of self-care on burnout and secondary traumatic stress is limited despite clear directions to practice self-care as a means of prevention. Despite these recommendations, there is inadequate empirical data to support this relationship. This represents a gap in the literature and is the purpose of this research to find out if self-care does impact secondary traumatic stress and burnout as well as to what degree and the strength of that relationship. Few studies have looked

at the relationship of self-care on burnout, and secondary traumatic stress in counselors. This is an important area to study to understand the relationship between self-care burnout and secondary traumatic stress. The goal here is to provide empirical support for the practice of self-care and identify if the practice of self-care can protect against burnout and secondary traumatic stress.

CHAPTER 3: METHODOLOGY

Research Question

This study aimed to examine if self-care affects burnout and secondary traumatic stress among counselors. The first research question was what is the evidence for structural aspect of the construct validity of responses to the MSCS? Cook-Cottone & Guyker (2018) developed the MSCS to assess engagement in self-care activities and the connection between engagement in those activities and wellness. Previous research confirmed that the mindful self-care questionnaire accurately measures self-care (Cook-Cottone & Guyker, 2018; Ju et al., 2024; Sunbul et al., 2018). Cook-Cottone & Guyker, (2018) developed the MSCS and normed it on a sample of university students in the United States. Ju et al. (2024) confirmed the accuracy of the MSCS using a confirmatory factor analysis with a sample of Chinese university students. Sunbul et al. (2018) found satisfactory evidence for the six-factor MSCS using a confirmatory factor analysis (GFI = 0.87, CFI = 0.92; TLI = 0.91; RMSEA = 0.05) with a Cronbach alpha of .89 in a sample of Turkish university students. The results of the confirmatory factor analysis in these populations of university students have been consistent. However, while the MSCS has been used to accurarely assess self-care among university students it has not been used to assess self-care among counselors. This study assessed the construct validity of the MSCS on this population. The second research question: What is the impact of self-care on secondary traumatic stress and burnout among counselors? The third research question: What is the impact of each of the subscales of the MSCS on burnout and secondary traumatic stress? The fourth research question: Does work setting affect levels of burnout, secondary traumatic stress, and engagement in self-care among mental health professionals?

Participants

Participants in this study included a sample of therapists primarily from the southern part of the US. Participants included marriage and family therapists, social workers, clinical mental health counselors, Psychologists, and Psychiatrists who perform the work of counseling in the United States. The inclusion criteria was individuals engaging in at least 5 counseling sessions per week who hold a master's degree in either Social Work, Clinical Mental Health Counseling Marriage and Family therapy, or a terminal degree that allows them to perform therapy. It included individuals with a license in their required discipline or were working towards licensure.

Data Collection Procedures

The researcher received permission from the Institutional Review Board at UNC Charlotte to ensure that the rights of human subjects were not violated. Once approval was received participants were recruited using a convenience sample with the survey posted on professional Listservs and sent to a state licensure-provided email list. The researcher asked several state licensing boards for access to email lists for research. The State Licensing Board of West Virginia provided email addresses for Licensed Professional Counselors and Licensed Marriage and Family Therapists who the researcher then emailed with the survey participation request. The State Licensing Board of Florida provided email addresses for Licensed Professional Counselors, Licensed Marriage and Family Therapists, Licensed Clinical Social workers, and Telehealth-only licensced counselors. The researcher then emailed the survey participation request to all individuals on these email lists. Additionally, recruitment took place through the use of snowball sampling. This means that individuals who completed the survey were encouraged to forward it to other individuals who meet the inclusion criteria. The survey was online and provided through Qualtrics. The survey began with the inclusion criteria and

informed consent. If individuals met the criteria for inclusion and agreed to the terms of the informed consent, they were taken to the next page to fill out the survey. Individuals were asked how many clients they had seen in the last week and chose the corresponding interval. Participants completed the burnout and secondary traumatic stress subscales of the Professional Quality of Life Assessment (Hudnall & Stamm, 2012) to assess burnout and secondary traumatic stress. They completed the MSCS (Cook-Cottone & Guyker, 2018) to understand counselor engagement in self-care. Lastly, the questionnaire included a series of demographic questions to understand the population surveyed.

The number of items on this survey included the burnout and secondary traumatic stress subscales of the Professional Quality of Life (Hudnall-Stamm, 2012) each subscale had ten questions for a total of 20 items. The Mindful Self-Care Short Questionnaire had 33 items. There were nine demographic questions. Combined, this was a 62-item assessment that took approximately 10 minutes to complete. The researcher sent the participant request once. Once data collection was completed the researcher closed the survey and downloaded the data into SPSS. The researcher then screened the data and deleted responses missing more than half of the survey questions. Once the data was screened it was analyzed using SPSS Amos.

Instrumentation

Mindful Self-Care Scale

The MSCS had good internal consistency with a =.89 (Sunbul et al., 2018) for the overall score. It had strong internal consistency and construct validity (Hotchkiss et al., 2018, Sunbul et al., 2018). It consisted of 33 items and participants were to choose the option that best represents the frequency of their behavior in the last week. These options were given on a Likert scale with items ranging from 1-Never (0 days), 2-rarely (1 day), 3-Sometimes (2-3 days), 4-

Often (4-5 days), 5-Regularly (6-7 days) (Cook-Cottone & Guyker, 2018). The six main areas of self-care that were assessed were as follows: physical self-care, supportive relationships, mindful self awareness, self-compassion, and purpose, mindful relaxation, and supportive structures (Sunbull et al., 2018). Some example questions from the mindful self-relaxation subscale were"I did something intellectual (using my mind) to help me relax (e.g. read a book/wrote)", "I listened to relax (e.g., to a podcast, radio, rainforest sounds)". For the physical self-care scale an example question was "I ate a variety of nutritious foods (e.g., vegetables, protein, fruits, and grains)". The score for every item was added for an overall composite self-care score. There was one item that was reverse-scored. Overall, a higher score indicated engagement in more self-care behaviors. The total score was used as an independent variable to measure self-care for this study.

Professional Quality of Life Assessment

To study burnout and secondary traumatic stress, the two subscales of the PQRL that measure burnout and secondary traumatic stress were utilized. This measure was found to have good reliability and validity (Mott & Martin, 2019) and has been used in hundreds of studies (Bride et al., 2007. Hudnall-Stamm (2010) identifies it as having strong construct validity. While there is a shared variance between secondary traumatic stress and burnout this is likely attributed to the distress that is shared by both conditions. "The shared variance between these two scales is 34% (r =.58; co-σ= 34%; n =1187)" (Hudnal-Stamm, 2010, p. 13-14). For the burnout scale the alpha level =.75 and for secondary traumatic stress the alpha level =.81 (Hudnall-Stamm). Construct validity for the PQRL was found by Geoffrion (et al., 2019). Internal consistency for the subscale of burnout was .75. Internal consistency for the subscale of secondary traumatic stress was .81 (Duarte, 2016). Sample items that measure burnout include "I am happy" and "I

feel connected to others." Items that measure secondary traumatic stress include "I am preoccupied with more than one person I help" and "I jump or am startled by unexpected sounds". Some of the items in the burnout subscale were reverse-scored. The composite score for each subscale was used in the analysis. There were cut-off scores for the burnout and secondary traumatic stress assessments measuring low, medium, and high levels and these were used in the analysis.

Demographic Questions

The demographic questions were chosen to provide information on the sample. They were also chosen if they were identified as a factor in burnout and secondary traumatic stress in prior studies on this topic. The questions were as follows, what is your race or ethnicity, age, years in practice, master's degree attained, number of counseling sessions per week, gender, marital status, own personal experience of trauma, and percentage of clients seen in the past week who have experienced a traumatic event.

Research Design

This study utilized a non-experimental survey design with a confirmatory factor and path analysis to examine how counselor self-care was related to burnout and secondary traumatic stress. A confirmatory factor analysis was chosen to assess the construct validity of the MSCS. Structural equation model (SEM) was chosen to understand the associations of self-care with secondary traumatic stress and burnout (Lleras, 2005). SEM allows for an understanding of the correlation between variables. This is important as understanding the relationship of self-care on secondary traumatic stress and burnout had not been well studied through prior research. Additionally, to assess differences across groups a Multivariate Analysis of Variance (MANOVA) was used to examine differences related to work setting.

Data Analysis

Screening Data

All data was screened before running the analysis. Data was screened for missing data and outliers. Data that was missing more than half of the responses was deleted. Outliers were deleted as well. Collinearity among the predictor variables was checked.

Descriptive Statistics

The questions in the demographic questionnaire were used for descriptive statistics to gain information about the population sampled. Descriptors included information on race and ethnicity, gender, marital status, licensure type, years in practice, number of clients seen in the past week, the levels of trauma of those clients, and the counselor's own experience of trauma. Descriptive statistics provide information on frequencies, means, and percentages.

Confirmatory Factor Analysis

Prior research examined the MSCC to measure the efficacy of the construct to accurately assess and measure self-care. Past confirmatory analyses displayed satisfactory evidence for this scale which has six factors (Sunbul et al., 2018). The first research question of this study was what are the evidences for the construct validity of responses to the MSCS? To accomplish this the data was assessed and all assumptions were met. Screening of Skewness and Kurtosis parameters for normality and linearity were assessed. Model fit was assessed using model chi-square, comparative fit index (CFI), standardized root mean square residual (SRMR), and root mean square error of approximation (RMSEA). Secondly, the SRMR should be less than 0.08. The RMSEA was 0.08 or lower with a lower value indicating better goodness of fit. The CFI was 0.90 or higher with higher values indicating good fit (Bentler, 1990; Furr, 2011; Hu & Bentler, 1999).

Structural Equation Model (SEM)

An SEM was used to assess the relationship between the independent and dependent variables. A path of an SEM is an extension of regression and provides explanations of possible causal relationships among the set of variables studied. This method examines the pattern of intercorrelations among the variables to assess if the underlying theory was supported (Mertler & Vannatta, 2005). The underlying theory supported by prior literature was that self-care affects burnout and secondary traumatic stress. The independent variable was the self-care of the therapist. The dependent variables were burnout and secondary traumatic stress. The data was examined to assess that all assumptions for structural equation modeling were met. In other words, the model accurately reflected the casual sequence, all variables that were direct causes of a dependent variable were included and not correlated with the determinant variables. That there was no reciprocal causation between variables, that the relationships among variables were linear, additive, and casual and in nature. The data included no outliers, had a normal distribution of variables, and was assessed for collinearity and multicollinearity. Additionally, the assumptions of linearity and homoscedasticity were met (Mertler & Vannatta). The goodness of fit was assessed. The SRMR was less than 0.08, the RMSEA was 0.08 or lower with a lower value indicating better goodness of fit. The CFI was 0.90 or higher with higher values indicating good fit (Bentler, 1990; Furr, 2011).

SEM was chosen to estimate and describe the causal relationship of self-care on burnout and secondary traumatic stress. The independent or predicting variable was the self-care of the therapist. The dependent variables that were affected were burnout and secondary traumatic stress (Mertler & Vanatta, 2005). In countless research articles on burnout and secondary traumatic stress, self-care was identified as an important practice to prevent the development of

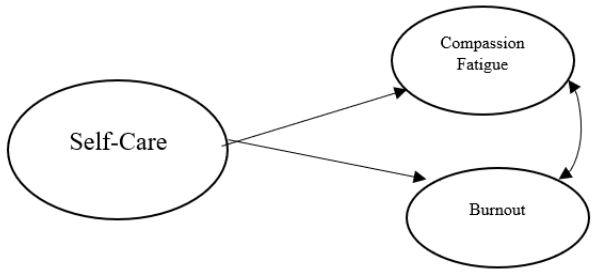
both burnout and secondary traumatic stress (Alkema et al., 2008; Barnett et al., 2007; Beaumont et al., 2016; Baker & Gabriel, 2020; Chen et al., 2019; Clarkson et al., 2019; Fares et al., 2017; Hotchkiss, 2018; Killian et al., 2008; Litam et al., 2021; Mott & Martin, 2019; Pennington et al., 2021; Preston et al., 2022; Rivera-Kloeppel & Mendenhall 2021; Rokach and Boulazreg, 2020; Velez-Cruz & Holston, 2021). Therefore this model was plausible for this field of study and reasonable within the context of the current research on this topic. Moreover given the high rates of burnout and secondary traumatic stress among counselors as well as their increased risk of developing both conditions (Canfield, 2005; Cook et al., 2021; Garcia et al., 2015; Kelly et al., 2022; Wardle & Mayorga, 2016) a proven method to prevent their development is crucial. The SEM's intention is to examine the causal relationship of self-care on burnout and secondary traumatic stress.

MANOVA

Prior research that has looked at burnout, secondary traumatic stress, and self-care has often focused on organizational factors (Garcia et al., 2015; Hotchkiss, 2018). Research looking at differences in rates of burnout, and secondary traumatic stress as well as engagement in self-care across work settings has been lacking. A MANOVA was chosen as there were more than two groups and multiple dependent variables. The groups were private practice, agency, agency and private practice while the dependent variables were burnout, secondary traumatic stress and mindful self-care. Additionally, a MANOVA is used to assess if there is a statistically significant difference in the mean scores across different groups that is not due to chance (Amouzadeh & Arjmandnia, 2023). All assumptions were checked prior to data analysis and met before running the MANOVA.

Figure 1

Path Model



Summary

This chapter covered the overall methods and steps needed for this research. This included the purpose of the research, participants, inclusion criteria, and data collection procedures. It covered the instrumentation and the reliability and validity of the responses to the instruments reported in previous studies. Lastly, it covered the data analysis methods used for this research.

CHAPTER 4: RESULTS

Description of Participants

Data collection began on May 28 2024 and was completed July 19, 2024. A total of 1550 responses were collected. 100 responses were deleted as they were missing all data. 50 responses were deleted as responses were missing for more than half of all the survey items. This resulted in a total of 1400 participants to be analyzed. Of these participants, 17 did not answer any demographic questions. However, their results were still included in the data analysis but listed as "Prefer not to answer" in the following tables. As is consistent with prior research the majority of participants were female 86.1%, (n=1211) (Fitchner, 2024). This was followed by males 11.4% (n=160), non-binary 0.9% (n=13), and transgender 0.3% (n=4). 1.3% (n=18) did not provide information on gender.

Regarding Race and Ethnicity 77.5% (n=1090) of participants identified as White. This was followed by Latino/Latina with 7.8% (n=190) and Black/African American 7.2% (n=101). 2.8% (n=40) of participants identified as Biracial or Multiracial, 0.7& Asian (n=10), 0.5% (n=7) Middle Eastern or Arab American, 0.1% (n=1) Native American or Alaskan Native. Lastly, 3.4% (n=48) did not list race. With regards to age, participants were asked to write in a number. The reported ages were then broken down into categories. These are as follows, 0.1% (n=1)were 18-24 years old, 15.1% (n=212) were 25-34, 5.8% (n=363) were 35-44, 24.2% (n=340) were 45-54, 19.2% (n=270) were 55-64, 12.8% (n=180) were 65+ and 2.8% (n=40) who did not provide an age.

Regarding years in practice, participants were provided with the following ranges less than 1, 1-3, 4-6, 7-10, 11-15, and 16+. 0.4% (n=5) had been practicing for less than a year, 4.1% (n=58) had been practicing for 1-3 years. 14.6% (n=205) individuals had been practicing for 4-6 years, followed by 20.1%, (n=281) practicing for 7-10 years, and 19.9% (n=279) had been

practicing for 11-15 years. Individuals who had been practicing for 16+ years constituted 39.8% (n=557). Lastly, 1.1% (n=16) did not report how long they had been in practice.

With regard to education level, 14.6% (n=204) had a doctorate, and 1.1% (n=16) individuals did not answer. The majority of the participants, 84.3% (n=1180) had a Master's degree. Individuals reported their highest level of education attained but were also provided a write-in option for other degrees. Thus, within the group of individuals with a Master's degree, several participants reported working on a doctorate or holding an Educational Specialist degree. Participants were also asked about their licensure. The bulk of participants either had a license as a Licensed Clinical Mental Health Counselor (LCMHC) or a Licensed Professional Counselor (LPC). The difference in the name of these licenses is state-specific and as participants were recruited from more than one state both terms were included. However, these terms are equivalent with 58.2% (n=815) participants identifying as an LCMHC or LPC. Individuals with a Licensed Clinical Mental Health Counselor Associate (LCMHCA) or equivalent licensure indicating that they are still under supervision made up 1% of participants (n=14). There were 17.8% (n=109) Licensed Marriage and Family Therapists (LMFT). 0.1% (n=2) were Licensed Marriage and Family Counselor Associates meaning that they were under supervision. The second largest group was Licensed Clinical Social Workers (LCSW) with 29.3% (n=410). There were 0.8% (n=11) Licensed Clinical Social Work Associates and 0.1% (n=2) identified as Licensed Addiction Specialists. 1.1% (n=15) identified as Psychologists and 0.3% (n=4) identified as Psychiatrists while 1.4% (n=19) did not report their licensure.

With regard to marital status, 62.1% (n=870) identified as married. 11.9% (n=167) were divorced or separated, and 15.6% (n=219) were single constituting the second largest group. 8.8% (n=123) indicated a long-term partner and 1.6% (n=22) did not report. Participants were

asked to indicate whether or not they had experienced a traumatic event throughout their life as that has been identified as a factor in burnout and secondary traumatic stress levels in prior research (Aker, 2010; Jenkins & Baird, 2022; Pearlman, 1995). The overwhelming majority 90.1% (n=1262) reported that they had experienced a traumatic event. 8.6% (n=121) reported that they had not experienced a traumatic event and 1.3% (n=18) did not respond.

Table 1

Sociodemographic Characteristics of Participants

Variable	N	%
Gender		
Female	1211	86.1
Male	160	11.4
Transgender	4	0.3
Non-Binary	13	0.9
Prefer not to answer	18	1.3
Race		
White	1090	77.5
Black or African American	101	7.2
Asian	10	0.7
Native American/Alaska Native	1	0.1
Middle Eastern/Arab American	7	0.5
Latino/Latina	109	7.8
Biracial/Multiracial	40	2.8
Other/Prefer not to say	48	3.4
Age		
18-24	1	0.1
25-34	212	15.1
35-44	363	25.8
45-54	340	24.2
55-64	270	19.2
65+	180	12.8
Prefer not to say	40	2.8
Years in practice		
Less than 1	5	0.4
1-3	58	4.1
4-6	205	14.6
7-10	281	20.1
11-15	279	19.9
16+	557	39.8
Prefer not to say	16	1.1
Education		
Master's	1180	84.3
Doctoral Degree	204	14.6
Prefer not to say	16	1.1
Licensure	N	%
LMHC/LPC	815	58.2
LCMHCA	14	1
LMFT	109	7.8
LMFTA	2	0.1
LCSW	410	29.3

Table 1 Sociodemographic Characteristics of Participants (Continued)

LCSWA	11	0.8
Licensed Addiction Specialist	2	0.1
Psychologist	15	1.1
Psychiatrist	4	0.3
Prefer not to say	19	1.4
Marital Status		
Married	870	62.1
Divorced/Separated	167	11.9
Single	219	15.6
Long term partner	123	8.8
Prefer not to say	22	1.6
Experienced trauma		
Yes	1262	90.1
No	121	8.6
Prefer not to say	18	1.3

Table 2

Counseling Practice Demographics

Variable	N	%
Therapy format		
Face to face	160	11.4
Online	355	25.3
Combination of both	867	61.9
Prefer not to say	19	1.4
Counseling Sessions		
1-5	190	13.6
6-10	193	13.8
11-15	216	15.4
16-20	286	20.4
21-25	244	17.4
26-30	133	9.5
31 or more	121	8.6
Prefer not to say	18	1.3
Percentage of clients with trauma		
0-25	306	21.8
26-50	216	15.4
51-75	262	18.7
76-100	574	41
Prefer not to say	43	3.1
Workplace setting		
Private practice	893	63.8
Agency	315	22.5
Agency & Private practice	177	12.6
Prefer not to say	15	1.1
Specialty Area		
Addiction/Substance Abuse	287	8.3
Trauma/Crisis Counseling	707	20.4
Eating Disorders	76	2.2
Multicultural Diversity	150	4.3
Individual Adult	936	27
Child/Adolescent	331	9.5
Grief & Loss	371	10.7
Couple's Family Counseling	332	9.6
Other	283	8.1

With regards to the modality through which therapy was provided 11.4% (n=160) provided only in-person therapy. 25.3% (n=355) of participants provided telehealth-only therapy.

The majority of participants 61.9% (n=967) provided therapy both in person and via telehealth. 1.4% (n=19) did not report what format they used to provide therapy services.

In regards to sessions held in the past week 13.6% (n=190) of participants reported completing 1-5 sessions in the past week. This was closely followed by 13.7% (n=193) reporting 6-10 sessions in the past week. 15.4% (n=216) reported 11-15 sessions in the past week. 20.4% (n=286) reported 16-20 sessions in the past week. This group represents the largest percentage of reported sessions in a week. This was closely followed by 17.4% (n=244) reporting 21-25 sessions in the past week. 9.5% (n=133) reported 26-30 sessions in the past week, this was followed by 8.6% (n=121) reporting 31 or more sessions in the past week. individuals 1.3% (n=18) did not report how many clients they had seen in the past week. This means that over 52% (n=746) of all participants had 11-25 sessions each week. This provided valuable information on the number of clients seen per week by counselors.

Participants reported the percentage of clients they had seen in the past week who had experienced trauma. Participants were provided a write-in option to write in the percentage, the percentages were then broken down as follows 0-25%, 26-50%, 51-75%, and 76-100%. 21.8% (n=306) reported 0-25% of the clients they had seen in the past week had experienced trauma. 15.4% (n=216) reported that 26-50% of clients they had seen in the past week had experienced trauma. 18.7% (n=262) reported 51-75% of clients seen in the past week had experienced trauma. The largest group 41.1% (n=574) reported 76-100% of clients seen in the past week had experienced trauma. Within that group, many individuals reported that 100% of their caseload was comprised of individuals who had experienced trauma. 3.1% (n=43) did not report a percentage. This gives valuable insight into the makeup of this sample as 59.8% (n=836) reported that 51-100% of the clients they had seen in the past week had experienced trauma.

With regard to work setting individuals were able to choose from private practice, agency, agency and private practice or "other" where they were provided with a write-in option. 63.8% (n=893) reported working in private practice. 22.5% (n=315) reported working in an agency. Many individuals who wrote in "other" were included in this group due to the nature of the work that they reported. This included inpatient and outpatient hospitalization programs, the Veterans Administration, Employee Assistance Programs as well as Corrections to name a few. The next group was agency and private practice with 12.6% (n=177), 1.1% (n=15) did not report a workplace setting. This means that collectively 76.4% (n=1070) worked in private practice in some capacity.

Lastly, individuals were asked to report a specialty area or specialty areas and many participants selected multiple specializations. The following are the specialty areas with Addiction/Substance abuse 8.3% (n=287), Trauma/Crisis Counseling 20.4% (n=707), Eating Disorders 2.2% (n=76), Multicultural Diversity 4.3% (n=150), Individual Adult counseling 27% (n=936), Child/Adolescent 9.5%(n=331), Grief & Loss 10.7% (n=371), Couple's/Family Counseling 9.6% (n=332) and Other 8.1% (n=283). It is clear from the numbers reported that most participants chose to report more than one specialty area. Within the area of "other" participants reported specializing in ADHD, Adoption, OCD, Anxiety and Depression, Perinatal and mood disorders, Cancer, and Chronic illness to name a few.

Confirmatory Factor Analysis

Data were screened for outliers and missing values first. Results from Little's missing completely at random (MCAR) test showed that the missing values were completely at random, χ^2 (df = 1238) = 1166.87, p = .93. Multiple imputation was used to impute the missing data values. The first research question was what are the evidences of the structural aspect of

construct validity of responses to the MSCS? First of all, reliability of responses to the survey items were examined with Cronbach's alpha. Then, the results of the confirmatory factor analysis provided evidence for the structural aspect of construct validity of responses to the MSCS. The data fit the measurement model well, which provided evidence for the validity of the responses. The Conbach's alpha for the MR was .67; that for the PC was .82; that for the SC was .83; that for the SR was .82; that for the SS was .76; that for the MA was .89; that for the BQ was .80, and that for the SQ was .83. All these values for Cronbach's alpha were indicators of satisfactory internal consistency of participants' responses to the survey.

Table three presents the results of the CFA for the measurement model and the structural model. As we can see from Figure 2 three pairs of items were allowed to covary because these pairs were in the same construct and measured the same construct: Y8 & Y9; Y19 & Y20; and Y40 & Y41.

Table 3

Goodness of Fit indices for the Measurement and Structural Model

	$\chi 2$	*df*	ratio	NNFI	CFI	SRMR	RMSEA	90%LL	90%UL
Measruement	6050.48	1294	4.68	0.96	0.96	0.07	0.052	0.051	0.055
SEM	6713.7	1297	5.18	0.94	0.95	0.09	0.055	0.054	0.056

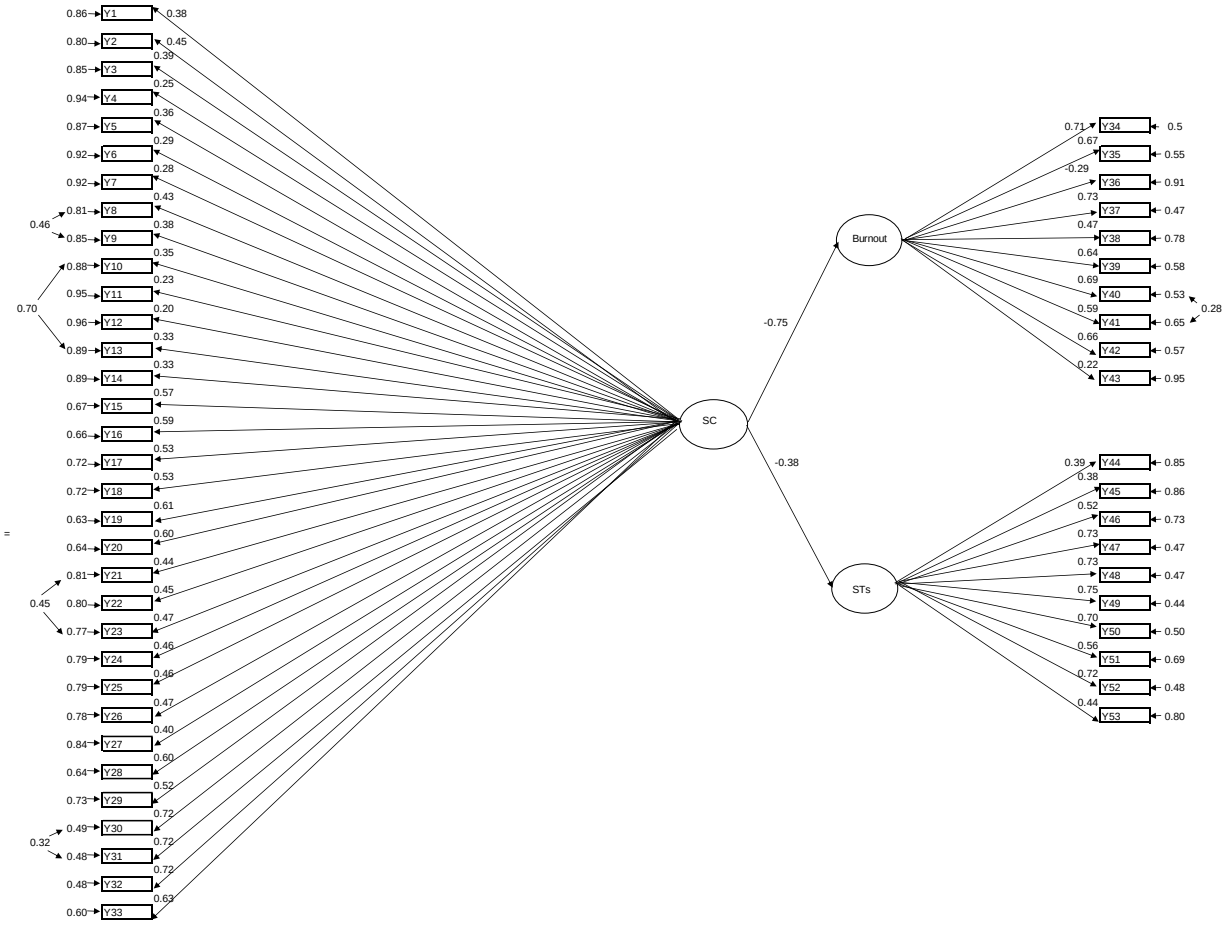
Structural Equation Model

The second research question was what is the impact of self-care on burnout and secondary traumatic stress among mental health professionals? The findings indicated that burnout and secondary traumatic stress were negatively correlated with self-care (Figure 2). Specifically, the path from self-care to burnout was -0.75 and that from self-care to secondary traumatic stress was -0.38, which means that 56% of individual differences in burnout were explained by self-care and 14% of individual differences in secondary traumatic stress were

explained by self-care. Thus, engaging in more self-care practices resulted in lower levels of burnout and secondary traumatic stress.

Figure 2

The Structural Model for the Relationship between Self-Care, Burnout, and Secondary Traumatic Stress

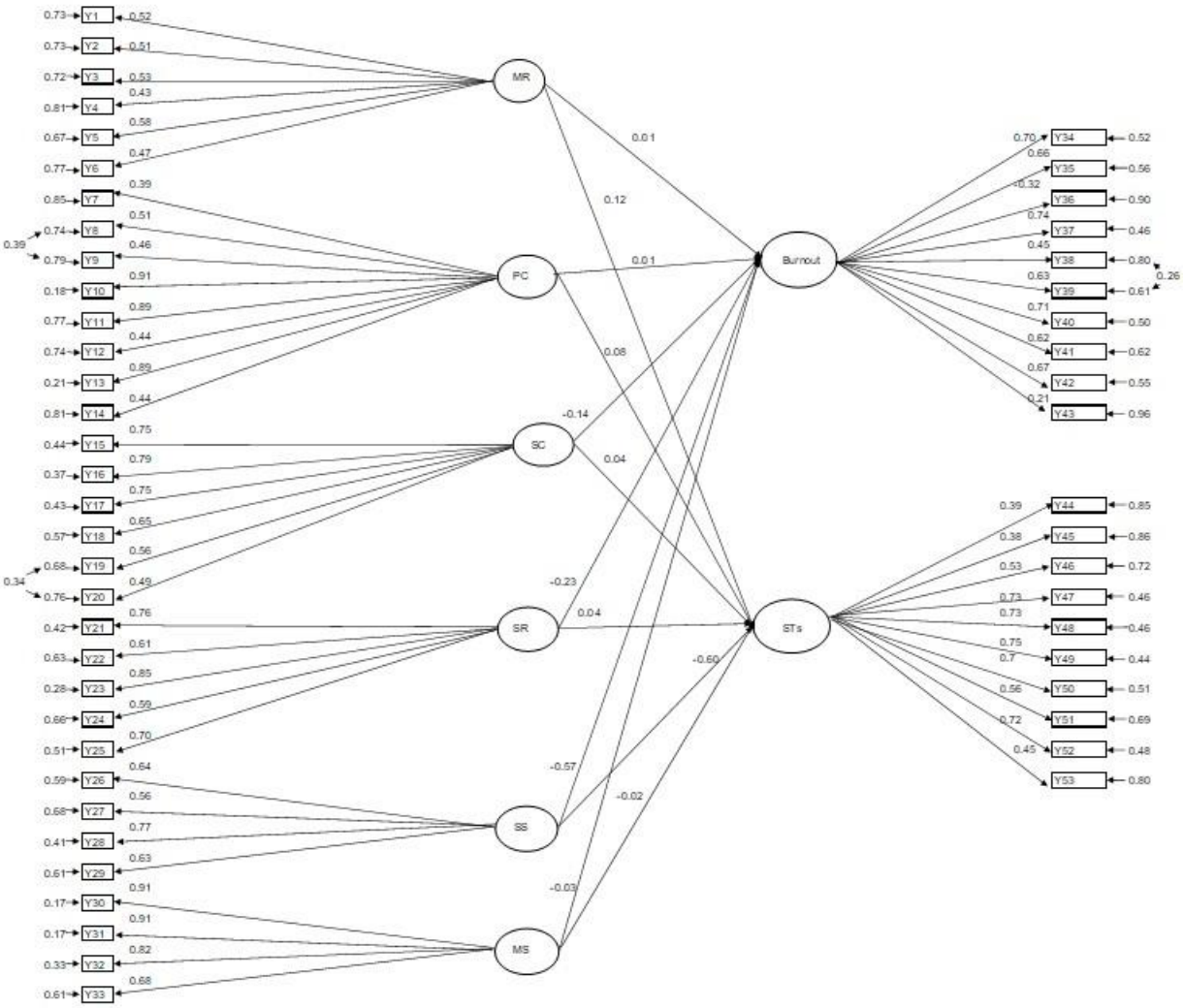


The third research question looked at the impact of each of the subscales of the MSCS on burnout and secondary traumatic stress as the MSCS measures engagement in six types of self-care activities. Therefore examining the impact of each of the subscales on burnout and secondary traumatic stress to understand the relationship is important. This helps to guide

engagement in self-care activities as it allows for inferences to be made about the most effective self-care strategies to engage in to address burnout and secondary traumatic stress. The six subscales of the MSCS are as follows: Mindful Relaxation (MR), Physical Care (PC), Self-Compassion and Purpose (SC), Supportive Relationships (SR), Supportive Structure (SS) and Mindful Self-Awareness (MS). Figure 3 presents the paths from each of the subscales of mindful self-care to burnout and secondary traumatic stress. There was a covariance of 0.39 between two items on the physical care scale. These two items were “I ate a variety of nutritious foods” and “I planned my meals and snacks.” Given that eating a variety of nutritious foods likely involves needing to plan meals and snacks in advance the correlation between these items makes sense. The two items that were correlated on the Self-Compassion and purpose scale were “I experienced meaning and/or larger purpose in my work/school life” and “I experienced meaning and/or larger purpose in my private/personal life.” Mindful Self-Awareness (MS) and Supportive Relationships (SR) both had a high impact on burnout and secondary traumatic stress.

Figure 3

Structural Model of the Paths from Each Subscale of Self-Care to Burnout and Secondary Traumatics Stress



Multivariate Analysis of Variance

A group of individuals who have not been well studied is mental health professionals in private practice. This is an important area to understand as the rates of individuals in private practice are increasing (American Counseling Association, 2024). Furthermore, there is a wide range of research on burnout and secondary traumatic stress among individuals who work in an agency setting (Aker, 2010; Alkema et al., 2008; Canfield, 2005; Chen et al., 2019; Garcia et al.,

2015; Maslach & Leiter, 2008; Travis et al., 2016). Thus, the fourth research question examined burnout, secondary traumatic stress, and engagement in self-care among mental health professionals across work settings. Individuals in the study were given the option of choosing private practice, agency, and then agency and private practice. Thus these are the variables that will be examined for between group differences using a MANOVA. All of the assumptions were met to run the MANOVA. The data was screened for outliers and the groups were normally distributed. With a p-value of .001 which is significant one can conclude that the difference in mean values between groups did not occur by chance. There was a statistically significant interaction effect of burnout, secondary traumatic stress and engagement in self-care related to work setting. The F value (6, 2756) =3.874, p=0.001; Wilks' Λ=.956 which is a large effect size. Box's M was 46.726 and the equality of covariances was valid. The results of this analysis found that individuals who worked in private practice experienced lower levels of burnout and secondary traumatic stress along with higher levels of engagement in self-care. This was followed by individuals who worked in agency settings experiencing higher levels of burnout and secondary traumatic stress as well as lower levels of engagement in self-care. The last group was individuals who worked both in private practice and agency settings these individuals had the highest levels of burnout and secondary traumatic stress as well as the lowest levels of engagement in self-care of all three groups.

Table 4

Rates of Burnout, Secondary Traumatic Stress and Self-care

Variable	N	%
Burnout		
Low 22 or less	587	41.9
Moderate 23-41	796	56.9
High 42 or more	7	0.5
Secondary traumatic stress		
Low 22 or less	1130	80.7
Moderate 23-41	254	18.1
High 42 or more	1	0.1
Self-Care		
Low 94 or less	235	17.2
Moderate 95-120	690	50.5
High 121+	421	32.3

Burnout and Secondary traumatic stress were assessed through the use of the Burnout and Secondary traumatic stress subscales of the Professional Quality of Life Assessment (Hudnall-Stamm, 2009). These subscales provide cutoff scores for low, moderate, and high scores. 56.9% (n=766) met the criteria for moderate levels of burnout, 41.9% (n=587) met the criteria for low levels of burnout and 0.5% (n=7) met the criteria for high levels of burnout. For secondary traumatic stress, 80.7% (n=1130) experienced low levels of secondary traumatic stress. 18.1% (n=254) experienced moderate levels of secondary traumatic stress and 0.1% (n=1) reported a high level of secondary traumatic stress. The MSCS was used to assess self-care. There are cutoff scores for low, moderate and high levels of engagement in self-care activities. The highest percentage of individuals 50.5 (n=690) had moderate levels of self-care. This was followed by 32.3% (n=421) with high levels of self-care. The smallest percentage 17.2% (n=235) had low levels of self-care. This means that they engaged in fewer self-care activities in the past week.

Table 5

Descriptive statistics of predictor and outcome variables

Variable	N	Minimum	Maximum	Mean	Std. Deviation
Burnout	1390	13.00	44.00	24.5007	5.91282
Secondary traumatic stress	1385	9.00	42.00	18.1697	5.25169
Self-Care	1366	41.00	159.00	112.0388	18.02967

*The Self-Care score denoted here refers to the total score.

Table 6

Descriptive statistics of subscales of Mindful Self-Care Scale

Variable	N	Minimum	Maximum	Mean	Std. Deviation
Mindful Relaxation	1394	1.17	5.83	3.5788	.90327
Physical Care	1395	1.00	4.88	2.8273	.78617
Self-compassion	1390	1.24	5.00	3.6502	.82676
Supportive Relationships	1394	1.00	5.00	3.9552	.78486
Supportive Structure	1394	1.00	5.00	3.7869	.78629
Mindful Self Awareness	1393	1.00	5.00	3.6613	.85714

Table 7

Burnout, Secondary Traumatic Stress and Self-care Correlations

	Burnout	Secondary trauma	Self-care
Measure			
Burnout	1	.530	-.253
Secondary trauma	.530	1	-.156
Self-care	-.253	-.156	1
N	1390	1385	1399

*Correlation is significant at the 0.01 level.

The evidences of the MSCS were assessed using a confirmatory factor analysis. Table 1 presents the goodness-of-fit indices for the SEM, and provides the evidences for the internal structural aspect of construct validity of responses to the MSCS. The MSCS was found to have an acceptable model fit. There were no error values greater than 1. To answer the second

research question a path analysis was used to examine the impact of self-care on burnout and secondary traumatic stress. Again there was acceptable fit and there were no error values greater than 1. Using this model, there was collinearity between two items on the Burnout subscale of the Professional Quality of Life Assessment. The collinearity was 0.28 between items Y40 and Y41. These items are "I feel worn out because of my work as a helper" and "I feel overwhelmed because my case [work] load seems endless." For this model, there was also collinearity between various items on the MSCS scale. The first was between items Y8 and Y9 with collinearity of 0.45. These items were Y8 "I ate a variety of nutritious foods" and Y9 "I planned my meals and snacks." Additionally, there was an overlap between Y10 and Y13 of 0.70 These items are Y10 "I exercised at least 30-60 minutes" and Y13 "I planned/scheduled my exercise for the day." Similarly as with the prior two items that had collinearity planning for something likely makes individuals more likely to engage in that action and behavior. Y21 and Y23 were also correlated at 0.45. Y21 is "I spent time with people who are good to me" and Y23 "I felt supported by people in my life." It follows that spending time with people who are good to you likely leads to individuals feeling supported by people in their life. The last two items of this scale with collinearity were Y30 and Y31 with 0.32. Y30 was "I had calm awareness of my thoughts" and Y31 was "I had calm awareness of my feelings." It does follow that being more aware of one's own thoughts likely leads to individuals having a higher degree of awareness of their own feelings. This path analysis looked at the overall impact of engagement in self-care activities on both burnout and secondary traumatic stress. With this model, the overall relationship of self-care on burnout was -0.73. This means that engaging in more self-care activities resulted in lower levels of burnout. The overall relationship of self-care on secondary traumatic stress was also a negative relationship of -0.37. This means that engaging in more self-

care activities was associated with lower levels of secondary traumatic stress. However, the relationship of self-care on secondary traumatic stress was not as strong as the relationship of self-care on burnout.

MSCS examined six primary types of self-care activities. These included mindful relaxation which focuses on engagement in activities focused on relaxation using a variety of sensory activities. This is followed by physical care which focused on actions taken for the maintenance and enhancement of health and well-being. This includes things like adequate sleep, healthy nutrition, and adequate exercise. Self-compassion and purpose is the next category which focuses on having self-compassion as well as focusing on one's overall sense of meaning and purpose. Next is supportive relationships which focus on having support people in one's life to rely on and having a support network. This is followed by a supportive structure which relates to an overall sense of balance and a supportive environment. The last area is mindful self-awareness which involves self-awareness of thoughts and feelings. Each of these six areas is made up of several items that compose each subscale. The number of items in each subscale ranges from 4 to 8 and there are a total of six subscales that comprise the MSCS. Prior research using the MSCS (Hotchkiss, 2018) found that engagement in different mindful self-care activities had varied impacts on both burnout and secondary traumatic stress. This question was answered using SEM.

When examining the relationship between each of the subscales of the MSCS on burnout and secondary traumatic stress, all error terms were less than 1. There was collinearity between two items on the burnout subscale of the PQRL. The collinearity was between Y8 and Y9 with a value of 0.26. Item Y8 was "I feel overwhelmed because my caseload seems endless" and Y9 was "I feel bogged down by the system." It follows that feeling overwhelmed may result from

feeling bogged down by the system. For the MSCS there was also a correlation of 0.39 between Y8 and Y9. These items are Y8 “I ate a variety of nutritious foods” and Y9 “I planned my meals and snacks.” These two items were also correlated in the prior model using the total score of the MSCS. Two other items from this scale were also correlated these were Y19 and Y20 with a correlation of 0.34. Y19 was “I experienced meaning and purpose in my work/school life” and “I experienced meaning and purpose in my private/personal life.”

When looking at the subscales of the MSCS and the relationship between each of the subscales on burnout and secondary traumatic stress the following patterns emerged. Self-compassion and purpose was associated with lower levels of burnout (r = .14)and with secondary trauma (r = .04). Supportive relationship was also associated with lower levels of burnout (r = .23) and with secondary trauma (r = .04). Supportive structure was associated with lower levels of burnout (r = .57) and with secondary trauma (r = .60). The other subscales did not have statistically significant relationships between burnout and secondary traumatic stress.

The differences in levels of burnout and secondary trauma as well as engagement with self-care among individuals in different work settings was examined with the fourth research question. This was answered using a Multivariate Analysis of Variance (MANOVA) to examine if there were mean differences across the various groups. To answer this question a one way MANOVA was used to assess the analysis of variance across these groups. The following assumptions were met: the dependent variables were measured at the interval level. The independent variable consisted of two or more categorical independent variables. There was independence of observations and adequate sample size. There were no outliers, multivariate normality was met. Of note is the fact that the sample size among the three groups varied widely.

Table 8

Work Setting

	N	%
Private Practice	892	64.5
Agency	314	22.7
Agency & Private Practice	177	12.8

Table 9

Burnout, Secondary Traumatic Stress and Self-care across Work Setting

	Private Practice		Agency		Agency & Private Practice	
	M	SD	M	SD	M	SD
Burnout	2.3659	.55826	2.5650	.61811	2.6519	.60706
Secondary trauma	1.9747	.55024	2.1201	.65633	2.1928	.63404
Self-care	3.4653	.53881	3.3303	.52480	3.2180	.55748

The differences in the linear combination of self-care, burnout, and secondary trauma among the three groups (i.e., private practice, agency, and agency & private practice) were statistically significant, $F(6, 2756) = 10.42$, $p < .001$, partial $\eta^2 = .02$ (medium effect size). The findings revealed significant differences across all three groups. Tests of between-subjects effects revealed statistically significant differences between the three groups in self-care, $F(2, 1380) = 19.30$, $p < .001$, partial $\eta^2 = .03$ (medium effect size); in burnout, $F(2, 1380) = 26.39$, $p < .001$, partial $\eta^2 = .04$ (medium effect size); and in secondary trauma, $F(2, 1380) = 14.41$, $p < .001$, partial $\eta^2 = .02$ (medium effect size). Post-hoc multiple comparisons with Tukey's adjustment indicated that individuals in private practice reported the lowest levels of burnout and secondary traumatic stress as well as the highest levels of engagement in self-care. As the prior research questions have revealed lower levels of burnout and secondary traumatic stress are associated with higher levels of engagement in self-care. Individuals who worked in agency settings had higher levels of burnout and secondary traumatic stress as a statistically significant

level as well as lower levels of engagement in self-care. The last group was individuals who worked in both private practice and agency settings, this group experienced the highest levels of burnout and secondary traumatic stress along with the lowest levels of engagement in self-care at a statistically significant level.

Summary

This chapter provided an overview of the research questions and their findings. These questions included a confirmatory factor analysis of the MSCS whereby the evidences for the MSCS were supported. It covered the relationship of self-care on burnout and secondary traumatic stress using the MSCS as a means to measure self-care. A relationship was found between engagement in self-care activities on rates of burnout and secondary traumatic stress. Engagement in self-care activities was broken down into the six dimensions of self-care as identified by the MSCS. Each of these dimensions of self-care was then examined to understand it's impact on burnout and secondary traumatic stress. With both questions relating to the practice of self-care on burnout and secondary traumatic stress, engagement in self-care was found to have an impact on burnout and secondary traumatic stress. For the second research question using the subscales the level of impact varied based on the areas of self-care. Finally, a MANOVA was used to look at differences in burnout, secondary traumatic stress and self-care across work setting. These findings revealed that individuals in private practice experienced lower levels of burnout and secondary traumatic stress along with higher levels of engagement in self-care. These findings will be explored in greater depth in the next chapter to understand what these findings mean and their implications for the profession.

CHAPTER 5: DISCUSSION

To answer the first research question for the evidences of the MSCS, the model was correctly specified and model fit was achieved supporting the use of the MSCS for the second research question. The second research question was what is the impact of self-care on burnout and secondary traumatic stress among mental health professionals? The findings indicated that burnout and secondary traumatic stress were negatively correlated with self-care. Thus, engaging in more self-care practices resulted in lower levels of burnout and secondary traumatic stress. The third research question is what is the impact of each of the subscales of the MSCS? The MSCS measures engagement in six types of self-care activities. Therefore examining the impact of each of the subscales on burnout and secondary traumatic stress to understand the relationship is important. This helps to guide engagement in self-care activities as it allows for inferences to be made about the most effective self-care strategies to engage in to address burnout and secondary traumatic stress. The final research question looked at the experience of burnout, secondary traumatic stress, and engagement in self-care in regard to work setting. As the previous research questions have revealed there is an impact of self-care on burnout and secondary traumatic stress. Therefore, understanding the levels of engagement in self-care along with the levels of burnout and secondary traumatic stress is important as it provides valuable insight into how work setting influences the experience of these variables.

Discussion of Demographics

First, the demographic information and descriptive statistics will be discussed. Due to the number of responses, there is a large sample size of 1400 participants. All of the participants held at least a Master's degree and performed the work of counseling in the United States engaging in at least 5 counseling sessions per week. The majority of the participants, 86.1% (n=1211) identified as female. This is important as prior research has shown that females are more likely to

experience burnout (Buselli et al., 2020; Borges et al., 2019; Garcia et al., 2015). This was followed by males with 11.4% (n=160), identifying as transgender 0.3% (n=4), 0.9% non-binary (n=13), and 1.3% (n=18) who did not answer. This is consistent with prior research as the demographic makeup of the mental health field is predominantly female and white (National Center for Health Workforce Analysis, 2023). In terms of race/ethnicity 77.5% (n=1090) the majority of the participants identified as white. This was followed by 7.8% Latino/Latina (n=190), 7.2% (n=101) Black/African American 101. 2.8% identified as Biracial or Multi-racial (n=40), 0.7% (n=10) as Asian (0.7%), 0.5% (n=7) as Middle Eastern or Arab American, 0.1% (n=1) identified as Native American or Alaskan Native, and 3.4% (n=48) did not list a race. These demographic percentages are similar to those done by the American Psychological Association in 2022.

With regard to the length of time in the counseling profession, 39.8% (n=557) had been practicing for 16+ years. This is a higher percentage than prior research done by the American Counseling Association (2024). More years in the profession have often been associated with lower levels of burnout therefore this study provides unique insight with a high percentage of individuals who have been in the field longer participating (Alkema et al., 2008; Ballenger-Browning et al, 2011; Craig & Sprang, 2020; Fye et al., 2021). 19.9% (n=279) had been practicing for 11-15 years. 20.15% (n=281) had been practicing for 7-10 years and 14.% (n=205) had been practicing for 4-6 years. Past research has shown that counselors are more likely to experience burnout early on in the profession (Cook et al., 2021; Fye et al., 2021; Wardle & Mayorga, 2016) The demographic data reveals a low sample size of counselors who are early on in their profession. 0.4% (n=5) had been practicing less than a year, 4.1% (n=58) individuals

had been practicing 1-3 years. This means that collectively 4.5% (n=63) of the survey respondents were early on in their profession.

The inclusion criteria for this study included having a Master's or higher degree as that is a prerequisite for performing counseling in the United States. 84.3% of all participants (n=1180) had a Master's degree while 14.6% held a doctorate (n=204). Exposure to trauma or personal experience of trauma has long been identified as a factor in both burnout and secondary traumatic stress (Brown et al., 2022). Therefore participants in this study were asked if they had experienced a traumatic event as some point throughout their lifetime. The overwhelming majority of participants 90.1% (n=1262) indicated that they had experienced trauma. This is a higher experience of trauma than is reported by the general population which is around 70% (Cardoso et al., 2020). This may be due to the nature of counseling and a counselor's exposure to and awareness of the definition of trauma. Another possibility is that those who have experienced trauma are drawn to the counseling profession.

With regards to counseling practice, the responses from this survey indicate the changing landscape of the counseling profession. 87.2% (n=1222) of respondents delivered counseling services both in person and online. This is consistent with findings reported by the American Counseling Association (2024) with 83% of counselors delivering services both in person and online. 11.4 % (n=160) only delivered services in person and 25.3% (n=355) delivered services only through telehealth. These findings as evidenced by the number of counselors who see clients online only 25.3% and those who see clients both in person and online 87.2% (n=1222) means training programs need to work to prepare students for both online and in-person counseling.

Seeing more clients weekly as well as seeing more individuals with higher levels of trauma have both been associated with higher levels of burnout and secondary traumatic stress in counselors (Brown et al., 2022; Fye et al., 2021; Garcia et al., 2015). The percentage of sessions provided weekly varied considerably among this sample size. While the highest percentage of sessions held in the past week 20.4% (n=286) was 16-20 sessions 52% (n=746) of all participants held between 11-25 sessions weekly. This can provide valuable insight for counselors and training programs as to the average number of clients sessions held weekly. With regards to trauma, participants were asked to report what percentage of the clients they had seen in the past week had experienced trauma 59.7% (n=836) reported that 51-100% of the clients they had seen in the past week had experienced trauma. This is a high percentage and may indicate that individuals who have experienced trauma are beginning to seek out counseling at a higher rate. This is also important to note when it comes to training in trauma as 75.1% (n=1052) reported that 26% or at least one-fourth of their caseload had experienced trauma. Training in trauma is associated with lower levels of burnout and secondary trauma (Cardoso et al., 2020; Craig & Sprang, 2010; Fares et al., 2016; Lizano & Barak, 2015). Therefore training in trauma should be included in all counseling education programs as counselors are likely to work with individuals who have experienced it.

When it comes to workplace setting the number of counselors who work in private practice is increasing (American Counseling Association, 2022). 76.4% (n=1070) worked in private practice. This was broken down between only private practice 63.8% (n=893) and both agency and private practice 12.6% (n=177). Given that this sample included a greater percentage of individuals who had been practicing for more years it may be that counselors with more years of experience tend to shift to private practice. However, it is important for counselor educators to

prepare students to work in private practice as more counselors are likely to be employed in private practice. This is also critical as the final research question reveals insight into how the prevalence of burnout, secondary traumatic stress, and engagement in self-care varied across work setting.

With regard to specialty area while only 2 individuals reported being Licensed Addiction Counselors 8.3% of respondents (n=287) reported specializing in addiction and substance abuse. Thus it seems that many individuals specialize in this area without the formal licensure to accompany it. Although 20.4% (n=707) reported specializing in Trauma/Crisis Counseling 59.7% (n=836) reported that more than half of their caseload had experienced trauma. Thus it seems that more individuals worked with those who had experienced trauma than identified primarily as engaging in Trauma/Crisis Counseling. This again indicates the need for counselors to have training in trauma as they are likely to be exposed to it throughout their work. While 7.9% (n=111) identified as Licensed Marriage and Family Therapists (LMFT) or LMFT Associates, 9.6% (n=332) identified as specializing in Couples and Family Counseling. This indicates that individuals without an LMFT specialization are still doing work with couples and families. Therefore a focus on this should be included in counselor education. Lastly, 4.3% (n=150) reported a focus on Multicultural Diversity, reflecting a growing focus on this important area.

When it comes to burnout 59.6% (n=766) reported moderate levels of burnout with 0.5% (n=7) reporting high levels of burnout. This means that 60.1% (n=773) reported moderate to high levels of burnout. This is consistent with prior research indicating burnout rates at around 60% among counselors (American Psychological Association, 2022; Kelly et al., 2022; Litam et al., 2021). However, comparatively, the levels of secondary traumatic stress were lower with 80.7%

(n=1130) reporting low levels of secondary traumatic stress. 18.1% (n=254) reported moderate levels of secondary traumatic stress and 0.1% (n=1) reported a high level of secondary traumatic stress. While the percentage of individuals experiencing moderate to high secondary traumatic stress 18.2% (n=255) is concerning this percentage is lower than reported in some prior research. In a meta-analysis, Singh et al. (2020) found rates of secondary traumatic stress to be at 19.8%.

The MSCS revealed similar findings to prior research. Hotchkiss (2018) used the MSCS with hospice professionals. For the total score of each subscale the mean of each subscale reported in this study and the one done by Hotchkiss were within 1.0 of each other. Often the mean subscales were closer than that revealing that individuals in this study were participating in mindful self-care activities at a similar rate. This also gives insight into the average range of self-care activities as this study had a much larger sample size but reported similar results. The overall self-care score between this study and the one done by Hotchkiss also reported a mean total score within 1 unit of each other. The total score result for this scale can range from 33-165. Participants in this study had scores ranging from 41 which was the lowest score, to 159 which was the highest score. However, the overall mean score of 112.0388 indicates a high level of engagement in self-care activities. This is supported by the findings looking at low, moderate, and high levels of self-care. Individuals engaging in moderate to high levels of self-care made up 82.8% (n=1131). This shows a high level of engagement in self-care activities for the majority of participants.

Bivariate

The bivariate correlation between burnout, secondary traumatic stress, and self-care all reveal significance at the 0.01 level. The bivariate correlation between burnout and secondary traumatic stress is a positive relationship of .530. Between burnout and self-care, there is a

negative relationship of -.253. For secondary trauma and self-care, there is a negative relationship of -.156. Thus engagement in self-care decreases both burnout and secondary traumatic stress. However, the impact of self-care on burnout is more significant. This finding was supported by the path analysis that found a more significant relationship of self-care on burnout.

Summary of findings

For the first research question a confirmatory factor analysis was used to assess the evidences for the MSCS.These findings supported the use of the MSCS to accurately measure and assess self-care. This is important as this is the largest study to date using the MSCS. Therefore it adds to the reliability and validity of this assessment and its continued use to assess engagement in self-care. With the evidence for the MSCS supported, this assessment was used to examine the path relationship of mindful self-care on burnout and secondary traumatic stress. This path relationship revealed a statistically significant relationship of self-care on burnout and secondary traumatic stress. The relationship of self-care on burnout was 0.75 while the relationship of self-care on secondary traumatic stress 0.38. Thus, these findings are significant. Furthermore, this indicates that engagement in self-care activities was more impactful on burnout than on secondary traumatic stress. Thus, engagement in self-care is associated with overall lower levels of burnout and secondary traumatic stress although the effect was stronger for burnout.

A third research question was added to examine the relationship of each of the subscales of the MSCS on burnout and secondary traumatic stress. Each of the subscales of the MSCS highlight a different area of engagement in self-care. Thus, understanding the impact of each subscale on burnout and secondary traumatic stress enables more targeted implementation of

self-care towards that which is most beneficial. While the prior research question found a relationship between overall engagement in self-care on burnout and secondary traumatic stress this question provided insight into what specific actions were most beneficial. The following subscales emerged as impactful these were self-compassion and purpose, supportive relationships, and supportive structure. These subscales were all impactful at a significantly significant level on both burnout and secondary traumatic stress.

The fourth research question examining differences across work setting on burnout, secondary traumatic stress, and self-care found that these phenomena did vary considerably in regards to work setting. Individuals in private practice of which this study had a high percentage experienced the lowest levels of burnout and secondary traumatic stress along with the highest levels of engagement in self-care. This was followed by individuals who worked in agencies with higher levels of burnout and secondary trauma along with lower levels of engagement in self-care. Individuals who worked in both agency and private practice reported the highest levels of burnout and secondary traumatic stress along with the lowest levels of engagement in self-care. These findings are supported by the prior research questions which indicated that lower levels of engagement in self-care were associated with higher levels of burnout and secondary traumatic stress.

Interpretation of Findings

The first research question examined the evidences for the MSCS. The evidences for this assessment were supported with this large sample size which supports the continued use of this scale to assess and measure self-care. This is important as it can be used in future research on self-care and thus this research study builds on the prior research studies that have used this measurement (Cook-Cottone & Guyker, 2018; Hotchkiss, 2018). This is important as it supports

the continued use of this measurement to assess self-care allowing for further research in this area.

When it comes to the second research question; what is the impact of self-care on secondary traumatic stress and burnout among counselors? The path relationship between self-care with burnout and secondary traumatic stress was utilized. While there has long been an ethical mandate in place for counselors to practice self-care to decrease burnout and secondary traumatic stress this study provided data to support this claim. These findings support that engagement in self-care leads to lower levels of burnout and secondary traumatic stress. This is congruent with prior research (Baker & Gabriel, 2021; Barnett et al., 2007; Can &Watson, 2019; Clarkson et al., 2019; Cook et al., 2011; Litam, 2022; McCormack et al., 2018; Mott & Martin, 2019; Pennington, 2021; Preston et al., 2022; Thompson et al., 2014; Turgoose & Maddox, 2017; Sadler-Gerhardt & Stevenson, 2012; Salloum et al., 2015; Velez-Cruz & Holston, 2021; Xue-Feng, 2019). Hotchkiss (2018) who also used the MSCS to examine the path relationship between burnout and secondary traumatic stress found similar results for the overall path coefficients, with a correlation between burnout of -0.726 and secondary traumatic stress of -0.276. This study found the correlation between burnout and mindful self-care to be -0.73 and secondary traumatic stress of -0.38. Thus the findings were similar despite the disparity in sample size and variability across work settings.

These findings are important as burnout and secondary traumatic stress have been found to have negative impacts on mental health professionals and those they serve (Baker & Gabriel, 2021; Fares et al., 2018; Hotchkiss, 2018; Rivera-Kloeppel & Mendenhall, 2021; Rokcach & Boulazreg, 2020; Salloum et al., 2015; Turgoose & Maddox, 2017). Additionally, mental health professionals are at a greater risk of experiencing these phenomena due to the nature of their

work (Fiebig et al., 2021; Figley et al., 2002; Killian, 2008; Polsuns & Gall, 2020). Thus, the evidence supporting the use of self-care to mitigate the effects of burnout and secondary traumatic stress is pivotal.

When it comes to the third research question; what is the impact of each of the subscales of the MSCS on burnout and secondary traumatic stress? This allows for an understanding of the relationship of each of the subscales to burnout and secondary traumatic stress. This allows for an understanding of specific self-care strategies to engage in to address the issues of burnout and secondary traumatic stress. This study had a large sample size of 1400 participants and the findings related to the prevalence of burnout at around 60% are consistent with prior research (American Psychological Association, 2022; Kelly et al., 2022; Litam et al., 2021). This prevalence of burnout consistent with prior research indicates that it is an ongoing issue in the mental health profession that needs to be addressed. Similar to prior research done by Hotchkiss (2018) the subscale of self-compassion and purpose, supportive structure, and supportive relationships were correlated with lower levels of burnout. Supportive relationships have been found to have an impact on the development of burnout and secondary traumatic stress in additional studies (Ballenger-Browning et al., 2011; Killian et al., 2018; Galek et al., 2011; Maslach & Leiter, 2008; Sadler-Gerhardt & Stevenson, 2012; Singh et al., 2020; Xue-Feng, 2019). These results are supported by other research that has demonstrated a relationship between engagement in self-care through self-compassion and purpose as associated with lower levels of burnout and secondary traumatics tress (Fiebig et al., 2020; Nelson et al., 2018; Zerach et al., 2013). The subscale of supportive structure was also protective against secondary traumatic stress. However, Hotchkiss found additional self-care subscale activities to be protective against burnout and secondary traumatic stress. While both studies had similar results for the overall

impact of self-care on burnout and secondary traumatic stress there was greater variability among the impact of various subscales. However, this may be due to the fact that this study had an n=1400 while Hotchkiss had an n=324. Individuals in this study were in private practice, agency settings and agency and private practice. While the study done by Hotchkiss was done exclusively on hospice care professionals who all worked in an agency setting.

While burnout and secondary traumatic stress have long been examined through the lens of organizational factors (Aker, 2010; Chen et al., 2019; Garcia, 2015; Lizano & Barak, 2015; Hotchkiss, 2018) this study was able to examine differences across groups. These findings are such that individuals in private practice were found to experience lower levels of burnout and secondary traumatic stress. This indicates that organizational factors likely do play a role in the development of burnout and secondary traumatic stress as indicated by prior research (Chen et al., 2019; Garcia, 2015; Lizano & Barak, 2015) Furthermore, individuals who worked in both private practice and agency settings had the highest levels of burnout and secondary traumatic stress along with the lowest levels of engagement in self-care. This may be due to the fact that working longer hours (Garcia et al., 2015) and job overload (McCormack et al., 2018) are both associated with higher levels of burnout and secondary traumatic stress. This finding is interesting to note although the reason for these differences is unknown.

The issue of burnout and secondary traumatic stress has long been of importance to the mental health profession (Aker, 2010; Bhutani et al., 2012; Brown et al., 2022l; Canfield, 2005; Cook et al., 2021; Garcia et al., 2015; Jenkins & Baird, 2022; Kelly et al., 2022; Wardle & Mayorga, 2016; Pearlman, 1995). Understanding the impact of self-care on burnout and secondary traumatic stress supports the implementation of self-care into counselor training programs. As counselors are more likely to experience burnout and secondary traumatic stress at

higher rates earlier on in their careers (Alkema, 2008; Fye et al., 2021; Wardle & Mayorga, 2016), implementing self-care into their training as an important practice to prevent the development of both burnout and secondary traumatic stress. Secondly, this indicates that implementing self-care strategies can be helpful to prevent burnout and secondary traumatic stress. Thus, engagement in self-care should be encouraged for all mental health professionals. While individuals in this study were not asked about prior experience of burnout and secondary traumatic stress, their current engagement in self-care had an impact on both burnout and secondary traumatic stress. Therefore, it follows that engaging in self-care may be a beneficial way to address both burnout and secondary traumatic stress or prevent further development of it.

Implications

For Counselor Educators

Research has shown that individuals are more likely to experience burnout and secondary traumatic stress early on in their career (Cook et al., 2021; Fye et al., 2021; Wardle & Mayorga, 2016). Some individuals report experiencing both burnout and secondary traumatic stress as early as their internships which results in individuals entering the field experiencing burnout. This is a critical issue and this is something counselor educators need to address and take steps to prevent. First of all counselor education programs need to provide psychoeducation on the phenomena of burnout and secondary traumatic stress. Students need to be aware of these phenomena, the warning signs, and the steps to address them. The role of self-care in preventing burnout and secondary traumatic stress along with specific practices to implement are crucial. Therefore counselor education programs need to include a focus on the intentional practice of self-care as a necessity for counseling students entering this profession.

Counselor educators also need to prepare students to counsel both in person and via telehealth. All counselor education programs whether in-person or hybrid must focus on preparing students for telehealth practice. This means being aware of laws, guidelines, and best practices for telehealth. Counselor educators need to ensure that they are preparing students for telehealth practice. Secondly, the research showed a high percentage of individuals in private practice. This is not something that counselor education programs have historically focused on, which has resulted in a crucial lack of information and training. Consequently, students are not prepared to go into private practice, although many of them are entering private practice. Thus, counselor educators need to prepare individuals for private practice. Running a private practice is a business as well as a counseling practice and thus it is governed by rules and policies. Without any preparation for going into private practice, this is something that counseling students have to navigate on their own, often without helpful guidelines. This is an area of training and support that is sorely lacking. Additionally, many private practices take insurance which makes critical mental health care accessible to many individuals. However, for many, the insurance process, the confusion around it, and the lack of knowledge and uniformity in navigating it serve as a barrier. Therefore counselor educators need to prepare students for private practice and perhaps provide some preparation on how to run a business and navigate insurance which would increase accesibility to mental health care.

For Supervisors

While the time frame and requirements for supervised practice vary by state, individuals generally practice under supervision for the first few years of their careers. As previously noted this is also the time when rates of burnout and secondary traumatic stress tend to be the highest (Cook et al., 2021; Fye et al., 2021; Wardle & Mayorga, 2016). This places supervisors in a

critical role in ensuring the safety and delivery of counseling services as well as overseeing the development of the counselor. The role of supervisor requires a unique balance of being supportive so that the supervisee will be open with their supervisor and have them as a source of support and encouragement. However, the supervisor both in practicum and internship during training programs as well as during the licensure process is also in somewhat of an authoritarian role as a gatekeeper of the profession. It is a similar balance to that of the counselor educator as they are also gatekeepers for the profession. However the role of supervisor and supervisee after graduation tends to be a closer relationship. The supervisor must balance the standards of practice and support for the person of the counselor. For many individuals entering counseling practice, if they are unaware of the experience of burnout and secondary traumatic stress, there may be a lot of confusion around it. There can even be feelings of shame as burnout can include feeling ineffective or useless. Additionally, one's sense of self can be harmed, leaving the individual vulnerable.

One role of the supervisor is to normalize this transition to being a counselor. The feelings of imposter syndrome and often the reactions or experiences to trauma that many counselors experience are normal. The supervisor needs to normalize and support the supervisee throughout this process. They also need to help the supervisees be aware of their burnout, secondary traumatic stress, and need for self-care. The supervisor needs to do this in a way that is supportive and walking alongside their supervisee to develop. However, at the same time, the supervisor needs to be aware of and take steps to address these phenomena when severity necessitates it. Many supervisors are navigating a variety of roles and responsibilities, sometimes as a practice owner or agency supervisor. Thus, the self-care of the supervisor is critical to prevent both burnout and secondary traumatic stress. A supervisor who is burnt out and/or

experiencing secondary traumatic stress should be engaged in regular consultation and seek additional support to address their own burnout and secondary trauma. They should be engaged in a rigorous self-care practice to address these phenomena within themselves. Furthermore, supervisors must be aware of their own limitations and finite capacity to prioritize the development of their supervisees.

For Counselors

The findings of this research study give some practical strategies for counselors to engage in to prevent and address burnout and secondary traumatic stress. The subscale of Supportive Structure (SS) was most impactful on both burnout and secondary trauma. Supportive structure refers to the balance of environmental factors that support rest. The specific items on this scale were as follows “I maintained a manageable schedule”, “I kept my work/schoolwork area organized to support my work/school tasks”, “I maintained a balance between what is important to others and what is important to me” and “I maintained a comforting and pleasing living environment”. The activities listed in each of these items are ones that counselors can incorporate into their lives. Counselors can use these activities as a guideline to follow and regularly assess themselves on. Thus, having a manageable work schedule, balance and a comforting living environment are all critical for counselor well-being.

In regards to burnout, the subscales of Supportive Relationship (SR) and Self-Compassion and purpose (SC) were both significant. Activities to engage in on the SR subscale included “I spent time with people who are good to me”, “I felt supported by people in my life”, “I felt confident that I would have someone to listen to me if I felt upset” and “I felt confident that people in my life would respect my choice if I said no”. These specific activities underline healthy supportive relationships focused on the well-being of each individual. Given the nature

of counseling work having supportive personal and professional relationships such as these is paramount. For counselor well-being, it is important to nourish, strengthen, and prioritize healthy relationships in their lives. Healthy relationships with good personal boundaries are pivotal for counselors due to the interpersonal nature of their work. As a therapist one's own personal counseling is often a key component. A counselor for the counselor can be part of that support network and attend to the specific needs and challenges of those in the helper role. Additionally, having supervision and making the most of it can be another support network. When supervision is no longer required engaging in ongoing consultation, peer groups, and having colleagues to reach out to discuss a case with are part of that essential support network.

Another subscale that was impactful when it came to burnout was Self Compassion and Purpose (SC). Items from this subscale included "I kindly acknowledged my own challenges and difficulties", "I gave myself permission to feel my feelings" and "I experienced meaning and/or larger purpose in my professional life". These items indicate what it means to be mindfully self-aware and to practice self-compassion. Counselors often work with clients to embrace these same areas and the reason behind it is clear. In responding to ourselves with kindness we are less likely to experience burnout. This kind of compassionate caregiving cannot start and end with the clients that counselors serve, it must be practiced towards oneself.

When it comes to secondary traumatic stress there were two additional self-care subscales with significance. These were Mindful Relaxation (MR) and Physical Care (PC). Mindful relaxation focused on strategies to relax using a variety of the senses. Items on this subscale included "I did something intellectual to help me relax", "I did something interpersonal to relax" and "I listened to relax." Thus engaging in these specific strategies such as intellectual stimulation through learning something new, spending time with people, and listening to music

or other sounds, are all ways in which counselors can take practical steps to implement self-care into their lives. Physical care also played a role in the experience of secondary traumatic stress. Items on this subscale included “I ate a variety of nutritious foods”, “I exercised at least 30-60 minutes” and “I took part in sports, dance or other scheduled physical activities”. Thus when individuals are experiencing secondary traumatic stress taking the steps to care for their physical health is important. This can include simple things like eating healthy balanced meals and getting regular exercise. Implementing these strategies before secondary traumatic stress occurs may serve to prevent or ameliorate against it.

In regards to the overall effects of self-care on burnout and secondary traumatic stress, it is important to note that self-care was more impactful on burnout than on secondary traumatic stress. While the reasons for this are unknown it does provide some helpful insight. Thus, counselors can be encouraged to practice all areas of self-care to prevent burnout. Some specific strategies are having a supportive structure, supportive relationships and self-compassion and purpose. This gives counselors a good place to start by focusing on and addressing the factors that constitute a supportive structure and then working to implement other self-care approaches from there. These findings also provide hope as they indicate that the issue of burnout can be addressed and prevented.

For Agencies

The aspect of self-care that emerged as most impactful for both burnout and secondary traumatic stress was in regard to supportive structure. This provides agencies with some best practice guidelines. The first of these is for counselors to have a manageable schedule. Agencies may be tempted to overbook their therapists or to request them to see a number of clients per week that is not compatible with counselor well-being. Another aspect of this is for a counselor

to have some control and influence over their own schedule to ensure that it is manageable for them. This may include having a say over the type of client issues on their caseload. For many therapists variety among issues treated is important. The majority of individuals surveyed in this study had 11-25 sessions per week. Individuals who worked more than that were in the minority which indicates that 25 or fewer sessions per week were manageable for most individuals. In order to have a manageable schedule counselors need to be paid a fair wage per hour. This is important for counselors to be well compensated as this supports a manageable schedule and prevents the need to seek additional employment due to financial constraints. On the part of the agency, this may include advocating for and negotiating higher insurance reimbursement rates. Additionally, it is not by mere circumstance that individuals surveyed in this study experiencing the highest levels of burnout and secondary traumatic stress were working in both private practice and agency settings. This is often done because one's financial needs are not met by working in only one setting. Therefore, agencies should take care to provide an adequate living wage that is compensatory with the amount of education achieved. Additionally, the findings of this study indicated that individuals in private practice had the highest levels of self-care. Knowing this agencies need to take steps to ensure that their employees can engage in more self-care. This may also mean addressing any unique barriers in this setting. Thus, having a focus on self-care as well as utilizing it to address both burnout and secondary traumatic stress is a key consideration for agencies.

Other aspects of supportive structure included having an organized working environment. This is something that agencies may have a role over or even control when it comes to ensuring that there is adequate workspace for each therapist. Additionally, these spaces should be comforting and pleasing. Agencies would do well to take care of counselors in these

ways as addressing and preventing burnout serves to decrease and prevent future job turnover and additional days missed due to illness the risk of which is increased by burnout. Another aspect that agencies can address is that of supportive relationships. The work environment and the company culture are key in this regard. Creating a collaborative work environment and ensuring that employees feel and are supported by each other and the administration is important.

For Counseling Organizations and Policy Makers

The guidelines and the importance of self-care is critical for counseling organizations to focus on. In counselor training and continuing education, there needs to be a focus on self-care. Organizations can advocate for this and stress the importance of self-care to their members. By taking these critical steps, the profession will be strengthened. This focus will likely include advocating for adequate insurance reimbursement. Counselors being paid fairly for their time is principle to enable them to have a manageable workload. This is an issue for both counseling organizations and policymakers to ensure that counselors' well-being is prioritized as well as accessibility to counseling. Having organizations aware of the impact of burnout and secondary traumatic stress and promoting the solutions to these phenomena will enhance the well-being of the counseling profession. Policies in place that address these issues and provide ongoing support are critical. Many licensing boards have continuing education requirements, thus incorporating self-care into this ongoing continuing education would encourage counselors to care for themselves enhancing longevity in the field.

Limitations

As with all survey research, there may have been a difference in the results of those individuals who received the survey invitation but did not choose to participate as those who did chose to participate. It may be that mental health professionals who were experiencing high

levels of burnout and secondary traumatic stress may have not participated due to their experiences of these phenomena. Thus, generalizability is limited in this regard secondly this study is not representative of all of the United States. Therefore these results should be interpreted with caution. Another limitation is not knowing what area of the United States participants were from.

A variety of demographic questions were asked regarding the number of clients individuals saw per week and the percentage of clients with trauma on the practitioner's caseload. Additionally, individuals were asked about area of specialty, licensure, years in practice, age, gender, race, marital status, and whether or not the individual had experienced a traumatic event throughout their own life along with the work setting of the therapist. Due to the scope of this study, this data was utilized to provide a rich background of participants. However, further research is warranted on the data already collected to examine more differences across groups and to deepen understanding of these phenomena.

Another limitation of the study is that individuals were not asked about income. While the focus of the study was on the relationship between self-care on burnout and secondary traumatic stress, financial stress can be a contributing factor. Secondly, extenuating circumstances may have an impact on burnout and secondary traumatic stress. Individuals were not asked about extenuating circumstances and therefore their impact on burnout and secondary traumatic stress was not assessed. Additionally, while individuals were asked if they had experienced trauma, individuals were not asked about the nature of the trauma and at what age they had experienced it which may have an impact. As mentioned previously while the survey responses were anonymous social desirability or the desire to appear better than they are may have had an impact on the results of this study. Mental health professionals are well aware of the

ethical mandates to practice self-care and they may have over-estimated their engagement in self-care activities as a result.

Recommendations for Future Research

While this study looked at the relationship of self-care on burnout and secondary traumatic stress the findings of this study were consistent with prior research on the rates of burnout. Thus, an experimental study with some individuals engaging in self-care activities and a control group not currently engaged would be an important step. Thus, a study that used self-care as an intervention would add to the body of data on the effects of self-care.

While the MANOVA test showed differences across groups when it came to work setting it did not give insight into the reasons behind that. This is particularly true when it comes to the differences in burnout and secondary traumatic stress, along with self-care among individuals who work in both agency and private practice settings. One can hypothesis that this may be related to workload or perhaps added pressure of balancing both roles. However, this is an area for further research to understand why this is occurring so as to prevent it.

While the results of this study indicated that individuals who engaged in higher levels of self-care experienced lower levels of burnout and secondary traumatic stress the results were more significant when it came to burnout. This begs the question of what other mediating factors may be at play when it comes to secondary traumatic stress. As secondary traumatic stress is a significant issue and can have significant negative impacts on both a mental health professional and their patients it is essential to do further research to understand this phenomena and identify ways to address it.

Conclusion

The findings of this study indicate that engagement in self-care activities influences the experience of burnout and secondary traumatic stress. This is an important finding as the results of this study identify that overall individuals who engaged in self-care are more likely to experience lower levels of burnout and secondary traumatic stress. Furthermore, specific areas of self-care which are most impactful when it comes to preventing burnout and secondary traumatic stress are identified. Given the prevalence of and the impact of both burnout and secondary traumatic stress on mental health professionals, this study provides valuable practical steps for practitioners to engage in to address these key issues. These steps can be implemented throughout the training process and their regular practice will serve to address and protect against burnout and secondary traumatic stress both of which are key issues. Thus, this study serves as a valuable contribution to the mental health profession and to those it serves.

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APPENDIX A: DEMOGRAPHIC QUESTIONNAIRE

1. What is your age?____Fill in the Blank

2. With what gender do you identify?

1) Male
2) Female
3) Transgender
4) Non-Binary
5) Other

3. How would you describe your race?

1) White
2) Black or African American
3) Asian
4) Native American or Alaska Native
5) Native Hawaiian or Pacific Islander
6) Middle Eastern/Arab American
7) Biracial or Multiracial
8) Other/Prefer not to say

4. How many years have you been practicing as a counselor?

1) Less than 1
2) 1-3
3) 3-5
4) 5-10
5) 15-20
6) 20+

5. What is your licensure?

1) Licensed Clinical Mental Health Counselor (LCMHC) or equivalent Licensed Professional Counselor (LPC)?
2) Licensed Clinical Mental Health Counselor Associate (LCMHCA) or equivalent?
3) Licensed Marriage and Family Therapist (LMFT)
4) Licensed Marriage and Family Therapist Associate (LMFTA)
5) Licensed Clinical Social Worker (LCSW)?
6) Licensed Clinical Social Worker Associate (LCSWA)?

6. What is your marital status?
1) Married
2) Divorced/Separated

3) Single
4) Long term partner

7. Have you experienced a traumatic event throughout your lifetime?
1) Yes
2) No

8. How many counseling sessions have you held in the past week?
1) 5-10
2) 10-15
3) 15-20
4) 20-25
5) 25-30
6) 30-35
7) 35-40

9. What percentage of the clients you have seen in the past week have experienced a traumatic event? _____fill in the blank

APPENDIX B: PROFESSIONAL QUALITY OF LIFE BURNOUT AND SECONDARY TRAUMATIC STRESS SUBSCALES

When you help people you have direct contact with their lives. As you may have found your compassion for those you help can affect you in positive and negative ways. Below are some questions about your experiences both positive and negative as a helper. Consider each of the following questions about your current work situation. Select the answer that correctly reflects how frequently you experienced these things in the past 30 days. Items labeled with a B stand for Burnout, items labeled with an S stand for secondary traumatic stress. Items with an R are reverse coded.

1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often

1. ____I am happy. B
2. ____I feel connected to others. B(R)
3. ____I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help]. B
4. ____I feel trapped by my job as a [helper]. B
5. ____I have beliefs that sustain me. B(R)
6. ____I am the person I always wanted to be. B(R)
7. ____I feel worn out because of my work as a [helper]. B
8. ____I feel overwhelmed because my case [work] load seems endless. B
9. ____I feel "bogged down" by the system. B
10. ____I am a very caring person. B(R)
11. ____I am preoccupied by more than one person I [help]. S
12. ____I jump or am startled by unexpected sounds. S
13. ____I find it difficult to separate my personal life from my life as a [helper]. S
14. ____I think that I might have been affected by the traumatic stress of those I [help]. S
15. ____Because of my [helping], I have felt "on edge" about various things. S
16. ____I feel depressed because of the traumatic experiences of the people I [help]. S
17. ____I feel as though I am experiencing the trauma of someone I have [helped]. S
18. ____I avoid certain activities or situations because they remind me of frightening experiences of the people I [help]. S
19. ____As a result of my [helping], I have intrusive, frightening thoughts. S
20. ____I can't recall important parts of my work with trauma victims. S

Source: Hudnall-Stamm, B. (2019). Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (Proquol). www.proquol.org

Permission: This scale is available for public use.

APPENDIX C: MINDFUL SELF-CARE QUESTIONNAIRE

Circle the number that reflects the frequency of your behavior (how much or how often) within past week (7 days):

Never (0 days)	Rarely (1 day)	Sometimes (2 to 3 days)	Often (4 to 5 days)	Regularly (6 to 7 days)
1	2	3	4	5

Reverse-Scored:

Never (0 days)	Rarely (1 day)	Sometimes (2 to 3 days)	Often (4 to 5 days)	Regularly (6 to 7 days)
5	4	3	2	1

Mindful Self-Care Scale

Mindful Relaxation (6 items)

I did something intellectual (using my mind) to help me relax (e.g., read a book, wrote)	1	2	3	4	5
I did something interpersonal to relax (e.g., connected with friends)	1	2	3	4	5
I did something creative to relax (e.g., drew, played instrument, wrote creatively, sang, organized)	1	2	3	4	5
I listened to relax (e.g., to music, a podcast, radio show, rainforest sounds)	1	2	3	4	5
I sought out images to relax (e.g., art, film, window shopping, nature)	1	2	3	4	5
I sought out smells to relax (lotions, nature, candles/incense, smells of baking)	1	2	3	4	5

Physical Care (8 items)

I drank at least 6 to 8 cups of water	1	2	3	4	5
I ate a variety of nutritious foods (e.g., vegetables, protein, fruits, and grains)	1	2	3	4	5
I planned my meals and snacks	1	2	3	4	5
I exercised at least 30 to 60 minutes	1	2	3	4	5
I took part in sports, dance or other scheduled physical activities (e.g., sports teams, dance classes)	1	2	3	4	5
I did sedentary activities instead of exercising (e.g., watched tv, worked on the computer) **reverse scored**	5	4	3	2	1
I planned/scheduled my exercise for the day	1	2	3	4	5
I practiced yoga or another mind/body practice (e.g., Tae Kwon Do, Tai Chi)	1	2	3	4	5

Mindful Self-Care Scale

Self-Compassion and Purpose (6 items)

I kindly acknowledged my own challenges and difficulties	1	2	3	4	5
I engaged in supportive and comforting self-talk (e.g., "My effort is valuable and meaningful")	1	2	3	4	5
I reminded myself that failure and challenge are part of the human experience	1	2	3	4	5
I gave myself permission to feel my feelings (e.g., allowed myself to cry)	1	2	3	4	5
I experienced meaning and/or a larger purpose in my *work/school* life (e.g., for a cause)	1	2	3	4	5
I experienced meaning and/or a larger purpose in my *private/personal* life (e.g., for a cause)	1	2	3	4	5

Supportive Structure (4 items)

I maintained a manageable schedule	1	2	3	4	5
I kept my work/schoolwork area organized to support my work/school tasks	1	2	3	4	5
I maintained balance between the demands of others and what is important to me	1	2	3	4	5
I maintained a comforting and pleasing living environment	1	2	3	4	5

Mindful Awareness (4 items)

I had a calm awareness of my thoughts	1	2	3	4	5
I had a calm awareness of my feelings	1	2	3	4	5
I had a calm awareness of my body	1	2	3	4	5
I carefully selected which of my thoughts and feelings I used to guide my actions	1	2	3	4	5

Source: Cook-Cottone, C. P., & Guyker, W. M. (2018). The development and validation of the Mindful Self-Care Scale (MSCS): An assessment of practices that support positive embodiment. *Mindfulness*, *9*(1), 161-175.
Permissions: This scale is available for public use.

APPENDIX D: INFORMED CONSENT

Agreement to Participate in a Research Study: The Association of Self-Care, Burnout, and Compassion fatigue in counselors

Principal Investigator: Emily Hartung, doctoral candidate, The University of North Carolina at Charlotte. Co-investigator: Dr. Hank Harris, Professor, The University of North Carolina at Charlotte Study

You are invited to participate in this research study. Participation in this research study is voluntary. The information provided below will help you decide whether or not to participate.

- The purpose of this study is to examine the impact of self-care on burnout and compassion fatigue among counselors
- To participate in the study, you will be asked to complete a survey asking a series of questions about self-care, burnout, and compassion fatigue
- You will also be asked to answer a series of questions relating to your demographic characteristics.
- It will take you about 10 minutes to complete the survey
- We do not believe that you will experience any risk from participating in this study.

This study may benefit you by providing an opportunity to reflect on your own self-care practices as well as your experience of burnout and compassion fatigue

- You are eligible for this study if you are a Licensed Clinical Mental Health Counselor or equivalent such as a Licensed Professional Counselor, a Licensed Mental Health Counselor Associate, a Licensed Marriage and Family Counselor, a Licensed Marriage and Family Counselor Associate, a licensed Clinical Social Work or licensed Clinical Social Work Associate and if you you engage in at least 5 counseling sessions per week and work in a private practice setting.

Throughout this study, your privacy will be protected, and confidentiality will be maintained. No identifying information will be collected. After this study is complete, study data may be shared with other researchers for use in other studies without asking for your consent again.

Participation is voluntary and you can withdraw at any time.

If you have questions concerning the study or would like to receive a copy of this agreement contact the principal investigator, Emily Hartung, by email at ehartun2@uncc.edu or the Faculty Advisor, Dr. Hank Harris by e-mail at hharris2@uncc.edu If you have further questions or concerns about your rights as a participant in this study, contact the Office of Research Protections and Integrity at (704) 687-1871 or at uncc-irb@uncc.edu.

If you meet the criteria for this study, have read and understand the information provided and freely consent to participate in the study, you may proceed to the survey [Click I Agree to Participate or I Do Not Agree to Participate].

APPENDIX E: INTRODUCTORY LETTER

Dear Counselors,

My name is Emily Hartung and I am a doctoral candidate in the Counselor Educator and Supervisor program at the University of North Carolina at Charlotte. My dissertation chair is Dr. Hank Harris.

My dissertation study is on the impact of self-care on burnout and compassion fatigue among counselors.

I am inviting you to participate in this study. You are eligible to participate in this study if you are a Licensed Clinical Mental Health Counselor or equivalent such as a Licensed Professional Counselor, a Licensed Mental Health Counselor Associate, a Licensed Marriage and Family Counselor, a Licensed Marriage and Family Counselor Associate, a licensed Clinical Social Work or licensed Clinical Social Work Associate, Psychologist or Psychiatrist and if you engage in at least 5 counseling sessions per week.

We also ask you to pass this email message along to anyone you know who also meets the above criteria. Your participation in this study is voluntary and you can leave the study at any time. Completing the survey will take around 10 minutes. This study has been approved by the University of North Carolina's Institutional Review Board.

If you decide to participate in this study please proceed to the survey by clicking this link.

Sincerely,

Emily Hartung
Doctoral Candidate
Department of Counseling
University of North Carolina at Charlotte

Dr. Hank Harris
Dissertation Chair
Department of Counseling
University of North Carolina at Charlotte