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Relationship Between Wellness, Resilience, and Vicarious Trauma Among Clinical Mental Health Counselors Serving Interpersonal Violence Survivors

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Walden University

College of Counselor Education & Supervision

This is to certify that the doctoral dissertation by

Elizabeth O. Hunter

has been found to be complete and satisfactory in all respects,
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Review Committee
Dr. Shelli Friess, Committee Chairperson, Counselor Education and Supervision Faculty
Dr. Rebecca Cowan, Committee Member, Counselor Education and Supervision Faculty
Dr. Brooks Hanks, University Reviewer, Counselor Education and Supervision Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2021

Abstract

Relationship Between Wellness, Resilience, and Vicarious Trauma Among Clinical Mental Health Counselors Serving Interpersonal Violence Survivors

by

Elizabeth O. Hunter

MA, Regent University, 2011

BS, Old Dominion University, 2009

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Counselor Education and Supervision

Walden University

May 2021

Abstract

Interpersonal violence (IPV) can result in the traumatization of primary survivors, as well as the mental health professionals who support them, which is referred to as vicarious trauma (VT). VT is an occupational hazard that if unaddressed can lead to significant personal and professional disruption. Clinical mental health counselors (CMHCs) who provide counseling services to IPV survivors are at increased risk of integrating the traumatic session content into their worldview. VT can lead to psychological distress including symptoms of post-traumatic stress disorder and can threaten the quality and ethical nature of the counseling relationship. The purpose of this quantitative survey study was to examine for a predictive relationship between VT, wellness, and resiliency among CMHCs who provide counseling services to IPV survivors. The theoretical framework was constructivist self-development theory. Survey data were collected from a purposive sample of 119 CMHC participants. Results of multiple linear regression analysis indicated resiliency levels predicted VT but wellness levels did not. Results extended current knowledge and understanding of VT among professionals, with specific consideration of wellness, resiliency, professional discipline (CMHC), and caseload composition (IPV). Results may inform education, professional development, and practice within the counseling profession. Healthier counselors may result in more effective counseling and healthier clients and communities.

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Dedication

This research is dedicated to the Lord for laying passionate interest on my heart and guiding my professional journey to a place of leadership and continued effective service. To my support system: Without my family, friends, and colleagues, this dream would not be a reality. To my endlessly supportive and encouraging husband, Chuck, who cheered for me every single step of the way. To my beautiful children who often saw the backside of the laptop as opposed to my face over the last few years: Your patience, grace, and glowing smiles bring me such joy and motivation to be the best version of myself. To my incredible parents for instilling in me a sense of purpose, drive, and vision for greatness as a professional in service to my community. To aunt Tink, for always supporting Chuck, Jack, the kids, and me as we tried to balance all the things, and whose relentless support, encouragement, and respite allowed for healthy balance throughout this process. To Gumby and Poppy, for the countless play dates and sleepovers to keep our beautiful babies smiling despite the relentless academic deadlines and assignments. To my fellow Walden cohort girls, for the late night and early morning support sessions, endless perspective, friendship, and unique lens of empathy. Perhaps most importantly, I dedicate this work to the interpersonal violence survivors everywhere whose resilience and strength inspired this work and continues to inspire me daily to provide the best care possible as a counselor, clinical supervisor, and aspiring counselor educator.

Acknowledgments

All Walden University CES faculty, supervisors, and committee members who provided clarity, mentorship, guidance, and perspective when I needed it most. Especially my committee members, Dr. Friess and Dr. Cowan, who always supported me through my ambitious writing goals, helped me to remain grounded, and focused with collegial perspective. Especially Dr. Coule, for modeling that quality motherhood and passionate CES professionalism is a possibility and reality.

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Chapter 1: Introduction to the study

Interpersonal violence (IPV) is an important social problem with far-reaching and lasting consequences including not only the traumatization of the survivor but also the vicarious traumatization of the professionals involved. Clinical mental health counselors (CMHCs) who provide counseling services to IPV survivors are at increased risk of integrating the traumatic session content into their own cognitive and emotional schemas (Maguire & Byrne, 2017; McCann & Pearlman, 1990; Sommer, 2008). Continued exposure to and integration of the traumatic counseling session content places these professionals at risk of experiencing negative traumatization of their own, often referred to as vicarious trauma (VT; Brockhouse et al., 2011). If left unaddressed, VT can threaten the quality and ethical nature of the counseling relationship (Foreman, 2018; Maguire & Byrne, 2017). Using a multiple regression analysis, I tested for a predictive statistical relationship between wellness levels, resiliency levels, and VT levels among IPV CMHCs.

The positive social change implications of this study may include improved professional outcomes for IPV CMHCs, clinical supervisors, and counselor educators and enriched services provided to IPV clients. The current study extended the existing literature and understanding of VT among professionals, with specific consideration of wellness practices, resiliency levels, professional discipline, and caseload composition. With healthier counselors comes healthier, more effective counseling and subsequently healthier clients and communities (Foreman, 2018; Hill, 2004; Lawson & Myers, 2011; Witmer & Young, 1996).

In this chapter a summary of background information on VT is provided, followed by a description of the research problem and purpose. The quantitative research questions and hypotheses are provided, with the theoretical foundation for the study. The chapter also includes a description of the assumptions, scope, limitations, and delimitations associated with the current study. The chapter concludes with a summary.

Background

There is an array of literature regarding VT that stretches across various methodologies, theoretical orientations, and variables. A major theme in the research indicates that VT development involves personal and professional factors (Branson et al., 2013; Brend et al., 2020; Figley, 1995; McCann & Pearlman, 1990). The VT literature reflects an exploration of the personal variables of resiliency and wellness/self-care practices across various professional factors including professional discipline, length of time in the profession, caseload trauma ratios, occupationally based social support, and organizational and supervisory factors (Brend et al., 2020; Foreman, 2018; Hayden et al., 2015; Hensel et al., 2015; Masson, 2019).

Researchers have examined personal factors associated with VT. Specifically, wellness and adaptive coping habits can have a mitigating impact on VT prevention or recovery (Foreman, 2018; Hayden et al., 2015). Masson (2019) examined resiliency as a personality trait and coping skill that can mitigate VT development among mental health professionals. Although exposure to traumatic client content can result in VT, it can also lead to positive results such as vicarious post-traumatic growth, vicarious resilience, and even increased appreciation for the opportunity to serve this client population (Brend et

al., 2020). Other factors such as organizational support, time in the profession, integration of wellness-based supervision, and caseload composition have been explored within the context of VT development, prevention, and mitigation (Hayden et al., 2015; Hensel et al., 2015). Studies have demonstrated an association between increased resiliency and decreased VT levels, as well as increased wellness and decreased VT across various mental health professions (Finklestein et al., 2015; Foreman, 2018).

The current quantitative study extended the existing knowledge and addressed a gap in the behavioral health sciences literature through examination of the predictive relationship between wellness levels, resiliency levels, and VT levels among CMHCs serving IPV survivors. The results of this study extended the knowledge of personal and professional factors associated with VT for counseling professionals and provided information for CMHCs regarding the impact of wellness practices and resiliency on VT. Increased knowledge regarding these predictive variables may assist counseling professionals in addressing, mitigating, preventing, or recovering from this occupational hazard. Increased information about factors associated with VT may contribute to quality counselor education, training, clinical supervision, professional development, and counseling services. The current study may inform the training and professional development process for CMHCs. Specifically, clinical supervisors and counselor educators may benefit from an increased understanding of personal and professional factors associated with VT. Leaders in the counseling profession, such as clinical supervisors and counselor educators, may benefit from this study by gaining an increased understanding of how each variable influences not only the VT of CMHCs but also the

subsequent quality of the counseling services provided. These leaders may disseminate and integrate the knowledge into daily practice with counselors across developmental levels. The findings from the current study may assist in promoting the delivery of quality and ethical counseling services for IPV clients, and in limiting the adverse implications of VT.

Problem statement

IPV is a significant public health concern that can adversely impact the physical and psychological functioning of millions of Americans each year (Centers for Disease Control and Prevention [CDC], 2015). IPV survivors can experience mental health struggles such as symptoms of post-traumatic stress disorder (PTSD), chronic feelings of fear, chronic mood disruption, and ongoing safety concerns (CDC, 2014; Maguire & Byrne, 2017). CMHCs who provide counseling services to IPV survivors are at increased risk of integrating the traumatic session content into their own cognitive and emotional schemas (Maguire & Byrne, 2017; Sommer, 2008). Recurrent exposure to client trauma can leave a counselor with altered or challenged beliefs or cognitions about themselves and the world around them, most notably their concept of safety (Brockhouse et al., 2011; Sommer, 2008). Continued exposure to and integration of the traumatic counseling session content places these professionals at risk of experiencing negative traumatization of their own, often referred to as VT (Brockhouse et al., 2011). VT is characterized by alterations in worldview, feelings of distrust in the world, and even a PTSD diagnosis (American Psychiatric Association (APA), 2013; Brend et al., 2020; Foreman, 2018; Rothschild, 2006). If left unaddressed, VT can lead to significant personal and

professional disruption, including psychological distress, impairment of clinical judgment, or violations of the American Counseling Association Code of Ethics (American Counseling Association [ACA], 2014a; Brockhouse et al., 2011; Foreman, 2018; Masson, 2009; Maguire & Byrne, 2017). Brend et al. (2020) reported that 29% of mental health professionals serving the IPV client population met diagnostic criteria for PTSD, and asserted the importance of addressing this occupational risk. PTSD or VT can lead to clinical impairment, which threatens not only the quality of the counseling relationship and services provided but also the ethical nature of the relationship (ACA, 2014b; Foreman, 2018; Lawson & Myers, 2011). Clinician impairment can lead to decreased therapeutic quality and potential harm to clients (Lawson, 2007).

There is a wealth of literature regarding the personal and professional factors associated with VT development. However, I perceived a gap regarding the potentially predictive relationship between VT, wellness, and resiliency among CMHCs serving IPV survivors. Increased knowledge and understanding of this relationship may inform clinical counseling practice and professional development, counselor educators, and clinical supervisors by supplementing existing literature and professional practice with unique information regarding VT development and mitigation.

Purpose

VT can have detrimental personal and professional consequences on the lives of those impacted. The purpose of the current quantitative study was to examine for a statistically significant predictive relationship between wellness level and resiliency level (predictor variables) and VT level (outcome variable) among IPV CMHCs. Increased

knowledge about VT among IPV counselors may supplement healthy and sustainable training, education, supervision, and professional development for these mental health professionals. The current study extended existing VT and wellness literature by examining the potential role resiliency plays in VT development among IPV professionals. Further understanding of the role of resiliency and wellness in VT development may assist in ameliorating the adverse personal and professional implications of this occupational side effect. Increased knowledge and understanding of these variables may also inform clinical supervision, counseling practice, and counselor education in the prevention and intervention of VT. An increased understanding of VT may also assist in promoting quality, ethical counseling services for IPV survivors.

Research questions and hypotheses

Research question: Is there a significant predictive relationship between VT level, wellness level, and resiliency level among IPV CHMCs?

H_o1: There is no statistically significant predictive relationship between outcome variable VT level and predictor variable wellness level among IPV CMHCs as measured by an anonymous self-report survey.

H_a1: There is a statistically significant predictive relationship between the outcome variable VT level and predictor variable wellness level among IPV CMHCS as measured by an anonymous self-report survey.

H_o2: There is no statistically significant predictive relationship between outcome variable VT level and predictor variable resiliency level among IPV CMHCs as measured by an anonymous self-report survey.

H_a2: There is a statistically significant predictive relationship between outcome variable VT level and predictor variable resiliency level among IPV CMHCs as measured by an anonymous self-report survey.

H_o3: There is no statistically significant prediction of VT level by wellness level and resiliency level among IPV CMHCs as measured by an anonymous self-report survey.

H_a3: There is a statistically significant prediction of VT level by wellness level and resiliency level among IPV CMHCs as measured by an anonymous self-report survey.

Theoretical framework

The theoretical concepts of this study were based on the constructivist self-development theory (CSDT). CSDT integrates tenets of various theories including social learning, cognitive, and psychoanalytic theories, partnered with aspects of interpersonal psychology (McCann & Pearlman, 1990). CSDT asserts that the perceptions of counselors are molded and adjusted by the clinical experiences they are exposed to (Foreman, 2018; McCann & Pearlman, 1990). A detailed explanation of CSDT is provided in chapter 2.

CSDT was applicable to the current study by providing a foundation upon which VT could be understood. The traumatic client content counselors are exposed to can challenge and alter their perceptions, often leading to VT (McCann & Pearlman, 1990). CSDT asserts that with each exposure, traumatizing client content can be integrated into the emotional and cognitive schema of the mental health professional (Foreman, 2018;

McCann & Pearlman, 1990). CSDT offered a foundation for understanding VT development. Further, wellness and resiliency are developmentally, emotionally, and cognitively based reactive behaviors that can develop over time within mental health counselors as they are exposed to the traumatic experiences of their clients (Maguire & Byrne, 2017; Masson, 2019; McCann & Pearlman, 1990).

The research question for the current study focused on the use of a multiple regression analysis to examine the predictive relationship between wellness level, resiliency level, and VT levels among IPV counselors. This question was posed using the foundation of CSDT, specifically the assumption that IPV counselors would report some level of VT after having integrated traumatic material into their cognitive and emotional schemas.

Nature of the study

The current study was a quantitative survey study in which participant web-based survey responses were collected and analyzed for a statistically significant predictive relationship between identified variables. At the time of data collection, the selected variables had not been numerically examined among the identified population, leading to the selection of the quantitative design. Three variables were selected for examination within the current study. Participant VT level (outcome variable) reflected the subjective numerical value of VT among IPV CMHCs as measured using an anonymous computer-based Vicarious Trauma Scale (VTS). Participant wellness levels and resiliency levels (predictor variables) reflected the subjective numerical values as measured using the

anonymous computer-based Brief Resilience Scale (BRS) and the Helping Professionals Wellness Discrepancy Scale (HPWDS).

The participants targeted for the study were CMHCs providing clinical counseling services to survivors of IPV. Target participants were professionals with a clinical caseload comprised of only those clients with a presenting concern of IPV. A quantitative multiple regression analysis was conducted using the SPSS statistical analysis program to evaluate for the presence and nature of a statistically significant predictive relationship between VT level, wellness level, and resiliency level among IPV CMHCs.

Primary survey data were collected anonymously and directly from CMHCs who treat IPV survivors. Four separate web-based surveys were administered electronically to collect the data via the Survey Monkey website. The data were collected and stored confidentially to protect the identities of the participants. The four surveys that were administered included the HPWDS to assess wellness, the VTS to assess VT, the BRS to assess resiliency, and a study-specific demographic questionnaire.

The HPWDS is a self-report tool developed to quantitatively assess and measure wellness levels based on individual wellness, life choices, and risks (Blount & Lambie, 2018). The VTS is a self-report tool used to quantitatively assess and measure the perceived subjective levels of VT among professionals exposed to traumatized clients (Vrklevski & Franklin, 2008a). The BRS is a self-report tool developed to quantitatively assess and measure the ability to recover from stressful experiences (Smith et al., 2008). The final assessment was a study-specific demographic questionnaire used to collect

personally and professionally oriented participant information such as gender, age, length of time in the profession, highest level of education obtained, and state licensure status.

Definitions

In the current study, there were numerous terms with overlapping conceptualizations used to describe the adverse impact of trauma work, including secondary traumatic stress (STS), compassion fatigue, burnout, and VT. Many of these terms have varying definitions, some of which have been used differently and interchangeably throughout the literature. STS has been compared to and used interchangeably with VT throughout the literature (Arvay, 2001). I used the following definition of the outcome variable VT: Vicarious trauma is the emotional and psychological result mental health professionals experience after being exposed to traumatic client content (Foreman, 2018; McCann & Pearlman, 1990).

There were two separate constructs examined as predictor variables within the current study: wellness and resilience. Wellness is a holistic, integrated way of life in which each aspect of the human being is progressing toward optimum functioning (Myers & Sweeney, 2004). Wellness practices can increase and develop over time as the individual attends to each aspect of themselves. For the current study, the *wellness* term was defined as follows: Wellness is the pursuit of balanced, optimum health and wellbeing within each area of life (Myers & Sweeney, 2004). Resiliency has been referred to as a process, a developmental personality trait, an outcome, and an interaction in which many factors align to promote a successful outcome to adversity (Greinacher et al., 2019; Masson, 2019). In the current study, the term *resiliency* was defined as follows:

a complex interaction between social, cultural, and personal factors that promote a successful outcome to adversity (Greinacher et al., 2019; Masson, 2019).

The population of interest for the current study was CMHCs serving clients seeking support for IPV. IPV refers to any act of physical, emotional, psychological violence, including any act of threat, coercion, intimidation, or deprivation of liberty (CDC, 2018). Examples of IPV relevant to the current study included any instance of sexual assault, childhood sexual abuse, domestic/relationship violence, stalking, cyberstalking, and human trafficking. For the purposes of the current study, CMHC was used to describe "graduate-level mental health service providers, trained to work with individuals, families, and groups in treating mental, behavioral, and emotional problems and disorders" (ACA, 2020, Careers section). The target participants consisted of postgraduate counselors who possess a master's or doctoral degree in one of the following areas: (a) addiction counseling, (b) career counseling, (c) clinical mental health or community agency counseling, (d) marriage, couple and family counseling, (e) school counseling, (f) student affairs and college counseling, (g) gerontological counseling, and (h) counselor education and supervision (ACA, 2020).

Assumptions

Several assumptions were made in the current study. I assumed that participants would accurately comprehend all prompts included in each survey and respond to the best of their ability. I also assumed that participants would complete all self-report surveys honestly and in entirety. Next, I assumed that study participation would be voluntary and free of participant-based bias. Lastly, I assumed that the IPV CMHCs who

participated in the study would be representative of other IPV CMHCs allowing for limited generalization of findings.

A major content-based assumption for the current study was related to the CSDT. I assumed that the CSDT framework would be an appropriate selection as the foundation of the study. The CSDT asserts that with increased trauma exposure there will be increased VT (McCann & Pearlman, 1990). Regarding the variables selected for the study, I assumed that the target population of IPV CMHCs would report VT levels, wellness practice levels, and resiliency levels honestly and accurately. I also assumed that each scale would accurately measure the identified construct.

Scope and delimitations

The current study addressed the impact IPV can have on not only survivors but also supportive professionals. I examined VT and factors potentially related to VT, including wellness and resiliency levels, among IPV mental health professionals. The scope of the study was selected based on personal interest, professional development, continuing education interest, and lack of literature on the subject matter. As a CMHC and supervisor serving the IPV population, I have observed that VT is a common topic of conversation, warranting up-to-date and evidence-based research. Existing VT literature addressed professional disciplines such as graduate-level educated, volunteer level, medical, legal, and mental health professionals across varying types of trauma (emotional trauma, traumatic grief and loss, physical/medically based trauma, accidental trauma, and IPV trauma). The gap in the literature determined the scope of the study by offering an opportunity for me to examine IPV CMHC data. The results from the study may promote

not only the education, practice, supervision, and quality of life for IPV counselors but also the quality of counseling services provided to IPV survivors.

Potential participants included CMHCs whose caseloads consisted of IPV survivors. I excluded counselors in training, those serving other client populations, or professionals helping clients from other service disciplines such as first responders, medical personnel, or those in other mental health professions such as psychology, psychiatry, social work, human services, or volunteer professionals. I also excluded counselors who serve a variety of clients outside of the IPV population. The CSDT foundation was implemented to provide a foundation for examining the connection between caseload composition (only IPV) and potential VT levels. Because of the specificity of the target population and caseload composition, the findings are generalizable to only those professionals. Data collection was conducted via internet-based communications, which may have excluded those with limited computer access or skills.

Limitations

The specificity of the participants (IPV CMHCs) limited the generalizability of the findings. The participant sample was a self-selected convenience sample of IPV CMHCs. The multiple regression analysis indicated a predictive relationship, not a causal relationship. Social desirability may have been a limitation for the current study because all data collection was performed in a self-report format. Participants may have responded to study prompts in a socially desirable or favorable manner. There may also have been a selection limitation in that participants who self-selected may have been

predisposed to characteristics such as previous trauma, resiliency, or wellness, which could have predisposed them to VT levels. There may also have been an instrumentation limitation in that the self-report surveys selected for the study may not have been consistent over time and may not have accurately measured the intended constructs.

A potential limitation associated with the internal validity of the study involved the outcome variable, VT. There are many terms with overlapping conceptualizations that attempt to describe the adverse impact of trauma work on professionals: STS, burnout, VT, and compassion fatigue. One strategy to address this potential limitation was to clearly define and clarify the term VT for study participants to ensure operationalization and clarity. In addition to the operationalization of the VT term, another limitation associated with the outcome variable was the accurate collection of participant data. VT can threaten the ethical nature of clinical work provided and can lead to psychological disruption, specifically PTSD symptoms (Maguire & Byrne, 2017). Due to the sensitive nature of this variable, participants may not have accurately reported their lived experiences with this construct (see Foreman, 2018). To address this limitation, I ensured the anonymity of the survey data and provided all participants with complimentary psychoeducational materials including VT prevention, intervention, and recovery strategies, as well as resiliency building and wellness strategies to assist in the amelioration of VT (see Appendix D).

Additional potential limitations involved the data collection portion of the study. The successful collection of primary data from the desired number of target participants posed a challenge. Specifically, securing the participation of only those CMHCs serving

IPV clients was a time-consuming challenge. Additionally, the completion of four separate surveys in entirety was also a challenge. This study included the administration of four separate online surveys: three variable-specific surveys on VT, wellness, and resiliency, as well as one demographic survey, which required increased time and effort from participants. To address these potential limitations, participants were offered complimentary psychoeducational materials for their time and effort.

Potential limitations associated with the external validity of the study included the generalizability of the findings. Namely, the specificity of the professional discipline (CMHC) limited the generalizability of findings beyond the target population. Only counseling professionals such as CMHCs, counselor educators, and clinical supervisors may benefit from the findings. Further, the specificity of the caseload composition (IPV) limited the generalizability of findings to those involved in the care of IPV trauma.

I am a clinical supervisor providing residency-level clinician supervision to CMHCs serving only IPV clientele. I solicited anonymous participation from various IPV service agencies using listservs and email recruitment. I excluded the IPV service agency where I currently provide clinical supervision services avoid any potential biases or ethical complications. Members of this agency were asked not to participate given the exclusion criteria of the informed consent document.

A further consideration for research bias included the target participants. Targeting CMHCs serving only IPV clients likely impacted the reported VT levels (see McCann & Pearlman, 1990). There may have also been a history bias present in the current study for participants. Given the potential influence of the #MeToo movement,

IPV trauma exposure outside of occupational settings may have increased, which could have impacted VT levels among participants. The #MeToo movement began in 2006 and has gained mainstream traction in recent years with increased reports of IPV (such as occupationally based sexual harassment) and highlighted instances of IPV within the mainstream media, bringing the issue to the forefront of many social, political, personal, and occupationally based interactions for many, possibly including IPV CMHCs (Rai & Pathak, 2019). The potentially increased exposure to IPV content associated with the #MeToo movement, combined with the traumatic content present within an IPV caseload, could have altered the VT data.

Significance

The current study provided additional quantitative findings to the existing library of literature regarding the personal and professional factors associated with VT development among professionals. The personal variables that were quantitatively examined included resiliency level and wellness level. The professional factors examined included professional discipline (CMHC) and caseload composition (IPV) clients only. The current study provided an original contribution to existing VT literature by providing a quantitative examination of VT within these personal and professional conditions. The current study provided an examination of VT within the CMHC profession as a separate mental health discipline, lending additional profession-specific information for counselors, clinical supervisors, and counselor educators regarding VT. The current study also contributed to an ongoing empirical examination of the impact personal wellness practices can have on professional development and functioning within the context of

VT. Lastly, the current study addressed the potential impact personal resiliency levels can have on VT.

The results of this study contributed to existing literature and knowledge of factors associated with VT development, including how it can be effectively addressed. The findings of this study may be practically applied across the counseling, counselor education, and supervision professions. With increased knowledge and understanding of how resiliency and wellness influence the VT level, counselors may work to combat VT and promote ethical practice and quality services for IPV survivors. Leaders in the counseling profession, such as clinical supervisors and counselor educators, may integrate knowledge from the study into their work to promote the dissemination of VT knowledge to counselors at varying stages of development. Counselor educators can disseminate the preventative value of this VT knowledge to counselors in training, recipients of consultation services, and collegial interaction. Clinical supervisors may apply this knowledge to a wide range of counselors across developmental levels such as postgraduate, prelicensure, postlicensure, or consultation capacities.

The positive social change implications of this study include academic, professional development, and occupational benefits, and findings may influence the clients and community members struggling with IPV-related trauma. IPV is an important social problem with far-reaching and lasting consequences including VT, which threatens the overall quality and ethical nature of the counseling relationship (Maguire & Byrne, 2017). This study provided valuable, original information to mitigate the impact of VT on

the counseling relationship and on the community. Healthier counselors may result in healthier, more effective counseling and healthier clients and communities.

Summary

The current study was designed to address a relevant and important gap in the social sciences literature regarding VT. The study addressed personal and professional factors associated with VT development among clinical mental health counselors. Using study findings, clinical mental health counselors, clinical supervisors, and counselor educators may enrich their practice and better serve the IPV client population. The following section provides an in-depth examination of the current literature regarding the selected variables of wellness, VT, and resiliency.

Chapter 2: Literature review

IPV is an important social problem that can adversely impact not only the primary victims of violence but also the professionals involved in the trauma intervention and recovery process. IPV counselors are at an increased risk of integrating traumatic client content into their psychological schemas, as well as personal and professional areas of functioning (Branson et al., 2013; Choi, 2011; Sodeke-Gregson et al., 2013). The purpose of the current study was to quantitatively examine the numerical relationship between the predictor variables (wellness level and resiliency level) and the outcome variable (VT level) among CMHCs serving IPV clients. Increased knowledge of VT among IPV counselors may assist in supplementing healthy and sustainable professional development and functioning for these professionals, as well as promote effective and ethical counseling services for IPV survivors.

Researchers have explored many facets of VT including aspects of development, intervention, and recovery among professionals exposed to traumatic client content (Foreman, 2018; Hensel et al., 2015; Lawson, 2007; McCann & Pearlman, 1990; Molnar et al., 2017; Saakvitne & Pearlman, 1995). Major themes in the literature included the positive and negative impact of VT across personal and professional areas of functioning (Ben-Porat, 2015; Brend et al., 2010; Brockhouse et al., 2011; Dunkley & Whelan, 2006; Hernanadez et al., 2010; Iqbal, 2015; Saakvitne & Pearlman, 1995; Sodeke-Gregson et al., 2013; Sprang et al., 2007; Trippany et al., 2004). If left unaddressed, VT can lead to significant personal and professional disruption, with consequences stretching as far as the efficacy of counseling services, the integrity of the counseling relationship, and the

mental health of the professionals (Branson et al., 2013; Brend et al., 2020; Figley, 1995; Foreman, 2018; Lawson, 2007; McCann & Pearlman, 1990). Counselors-in-training and across various areas of development, clinical supervisors, counselor educators, and clients may benefit from an increased understanding of factors associated with VT. The current study addressed personal and professional factors associated with VT development among CMHCs. The impact of personal wellness practices and personal resiliency levels was examined, along with VT levels among CMHCs with caseloads composed only of IPV survivors.

Chapter 2 includes an examination of existing literature and knowledge available on the variables selected for the current study. The literature review addresses VT, wellness, and resilience, the theoretical basis of the study (CSDT), and IPV/trauma-based services. I review not only the existing understanding of these variables but also the necessity for further understanding of these factors within the context of the current study.

Literature search strategy

There is extensive literature across methodologies, variables, participants, and theoretical orientations regarding the subject of VT (Foreman, 2018; Hensel et al., 2015; Lawson, 2007; Molnar et al., 2017). The current review of the literature was focused on studies related to wellness, resilience, VT, and the CSDT orientation among mental health professionals providing IPV/trauma-based services. Electronic databases were accessed and explored via the Walden University library to gather a foundation of knowledge and an understanding of up-to-date research. Walden University's online

databases were searched in the winter and spring of 2020 using the following search parameters: Library, databases a-z, Academic Search Complete, choose databases, Psych info, ERIC, Socindex, and Medline. Once the search filters were added, the following search terms were entered and explored: *vicarious trauma*, *vicarious trauma scale*, *self-care*, *wellness*, *resiliency*, *resilience*, *vicarious trauma* and *wellness*, *vicarious trauma* and *resiliency*, *counselor vicarious trauma*, *counselor wellness*, *counselor resiliency*, *interpersonal violence counseling*, *interpersonal violence counseling* and *wellness*, *interpersonal violence counseling* and *vicarious trauma*, *interpersonal violence counseling*, and *resiliency*. The scope of the relevant literature spanned the years 1952 to 2020 and included peer-reviewed empirical research that addressed the identified variables, including qualitative, quantitative, and mixed-methods studies, individual case studies, focus groups, pilot studies, and meta-analyses across varying populations of focus.

There were limited studies that addressed the personal variable of resilience within the context of VT. Several researchers examined and discussed vicarious resilience; however, resilience alone was not featured often within the review of the literature. The lack of available information on this variable increased my interest and the necessity of the current study to explore the possible role resilience plays in VT development, mitigation, or recovery among IPV mental health counselors.

Theoretical foundation

CSDT was developed by McCann and Pearlman (1990) to provide a context for understanding the psychological impact that exposure to traumatic client content can

have on professionals. CSDT is an eclectic approach to understanding human behaviors based on tenets of various psychological approaches including social, cognitive, psychoanalytic, and interpersonal theories (McCann & Pearlman, 1990). CSDT asserts that throughout the developmental process a person's reality and perception are formulated based on experiences (Williams et al., 2012). CSDT postulates that exposure to traumatic client material contributes to the reality and perception of the professional and can alter/recreate their cognitive interpretation of themselves, their clients, and the world in which they personally and professionally function, resulting in VT (Pearlman & Saakvitne & Pearlman, 1995). CSDT also asserts that through empathetic engagement, the mental health professional can begin to absorb the emotional trauma responses of the client, such as feeling unsafe in the world. CSDT has been consistently included as a foundation for conceptualizing how trauma impacts a person throughout the VT literature (Branson et al., 2013; Dunkley & Whelan, 2006; Halevi & Idisis, 2018; Hernandez et al., 2010; Iqbal, 2015; Pearlman & MacIan, 1998; Trippany et al., 2004). CSDT was the foundation of understanding and conceptualization of VT for the current study. CSDT provided a foundation for the central assumption that CMHCs with caseloads consisting of solely IPV trauma cases will report VT. The following section outlines the existing literature addressing each variable selected for the current study.

Literature review related to key variables and/or concepts

The review of the literature includes an examination of the existing research involving the variables selected for the current study. The outcome variable selected for the study, VT, was examined in conjunction with the two predictor variables, wellness

and resiliency levels, among IPV CMHCs. The review of the literature on VT is presented within the context of the personal and professional impact of VT and personal and professional factors associated with VT development.

Vicarious trauma

Saakvitne and Pearlman (1995) conducted a scholarly exploration of VT, which has since been expanded across many variables, populations, and methodologies. Researchers have explored personal and professional factors associated with VT development, prevention, treatment, and recovery, as well as important ramifications of this occupational hazard. There has been a wide range of studies focused on the impact of trauma work on professionals, including the positive impact such as post-traumatic growth, compassion satisfaction, occupational satisfaction, altruism, and vicarious resilience (Brend et al., 2020; Brockhouse et al., 2011; Hernanadez et al., 2010; Sodeke-Gregson et al., 2013;), as well as the negative impact such as VT (Ben-Porat, 2015; Brend et al., 2020; Dunkley & Whelan, 2006; Iqbal, 2015; Pearlman & Saakvitne, 1995; Sprang et al., 2007; Trippany et al., 2004). The adverse impact of working with survivors of trauma has been studied within the context of countertransference since as early as the 1950s (M. B. Cohen, 1952). Since then, there have been numerous terms with overlapping themes of conceptualization used to describe the adverse impact of trauma work, including VT, STS, compassion fatigue, and burnout (Brend et al., 2020; Bride et al., 2007; Figley, 1995; Hensel et al., 2015). Arvay (2001) conducted a review of numerous studies that indicated that STS and VT are the same construct and result in marked shifts within the professional partnered with the development of trauma

symptoms. In 2013 the American Psychiatric Association acknowledged the adverse impact of professional exposure to traumatic content within the diagnostic criteria of the PTSD diagnosis. This affirmed the impact trauma work can have on professionals vicariously exposed to client trauma, and clarified the symptoms associated with this occupational hazard. The independent or outcome variable selected for the current study was the VT level. Subjective numerical data regarding the VT level were collected from participants using the VTS.

Personal and professional impact of VT

Many studies have been conducted to explore the impact of VT on professionals with results ranging from personal symptoms such as the development of VT and PTSD symptoms to professional disruption, including impairment and career change (Branson et al., 2013; Brend et al., 2020; Figley, 1995; McCann & Pearlman, 1990). Brend et al. (2020) conducted a review of 13 empirical studies between 2000 and 2015 that explored the impact of IPV work among human services professionals (HSPs). The review addressed a variety of qualitative, quantitative, and mixed-methods studies across HSPs who offered psychological services to survivors and perpetrators of IPV. The results of the review supported existing data regarding the adverse impact of IPV work, promoted the positive impact of occupational social support, and highlighted the potential for post-traumatic growth among professionals. The review also summarized personal and professional factors that may contribute to VT development including social isolation, avoidance or minimization of emotional responses, wellness and self-care strategies, occupationally based social support, trauma-informed clinical supervision, and adequate

VT training. The review indicated a balance of challenges and rewards associated with IPV work among HSP participants. The review highlighted the potentially positive influence of personal and professional factors among HSPs functioning within the context of VT development, specifically self-care and wellness practices. In addition to VT, Brady et al. (1999) examined the additional impact trauma work can have on personal functioning, including spirituality. This quantitative study addressed the responses of female psychotherapists who treat sexual abuse survivors. Results indicated that participants who treated more trauma cases experienced increased spiritual disruption as well as VT.

Molnar et al. (2017) continued the investigation into the impact of VT by conducting a review of existing literature focused on the occupational factors associated with VT development. From a preventative public health perspective, the review illuminated the personal and professional impact VT has across numerous disciplines. The review focused on the community and occupationally based responsibility of VT development, and on the personal responsibility professionals have to proactively respond and prepare for VT. The review resulted in a concise plan of action to address VT as an occupational hazard impacting professionals across disciplines. This review also illuminated the adverse impact of VT across multiple disciplines and substantiated the need for continued research and understanding of this construct.

Personal and Professional Factors Associated With VT Development

The literature included a rich exploration of variables associated with VT development including those of a personal and professional nature. Personal factors that

were correlated to VT in the literature included personality variables such as emotional style, personal coping/wellness style and skills, personal history of trauma, and differentiation of self (Branson et al., 2003; Foreman, 2018; Halevi & Idisis, 2018; Marmar et al., 1996; Saakvitne & Pearlman, 1995). Occupationally based factors associated with VT included caseload composition, length of time in the profession, discipline, organizational factors, presence and quality of supportive, trauma-informed clinical supervision, and opportunity for occupationally based socialization/support (Brend, et al., 2020; Bell et al., 2003; Brady et al., 1999; Catanese, 2010; Choi, 2011; Cunningham, 2003; Finklestein et al., 2015; Hensel et al., 2015; Neuman & Gamble, 1995; Saakvitne & Pearlman, 1995; McCann & Pearlman, 1990; Sprang et al., 2007).

Personal trauma history. Among the personally based factors associated with VT development, several studies addressed the influence personal trauma history may have on VT development among professionals (Branson et al., 2003; Cunningham, 2004; Dunkley & Whelan, 2006; Hernandez et al., 2010; Slattery & Goodman, 2009; Soeke-Gregson et al., 2013; McCann & Pearlman, 1990; Maquire & Byrne, 2016). Branson et al. (2011) conducted a quantitative study of STS and behavioral health clinicians that included an examination of both personal and professional factors. Upon the foundation of the CDST, the study focused on behavioral health clinicians specializing in substance abuse treatment. The findings indicated the detrimental personal impact VT can have among behavioral health clinicians, including VT symptoms and decreased sexual desire. The results suggested that personal sexual trauma history and the professionally oriented factor of length of time in the profession could be associated with increased VT.

Cunningham (2003) conducted a quantitative examination of social workers exposed to varying types of trauma, years of experience, and a personal history of trauma. The findings suggested that those with increased exposure to human-induced trauma and a personal history of trauma experienced increased levels of VT. Treatment providers serving survivors of naturally occurring traumas (such as cancer) experienced lower levels of VT, which was explained by increased levels of resilience. Butler et al. (2016) examined not only the history of trauma but also the relationship between adverse childhood experiences and STS levels among social work professionals. The results of this quantitative study suggested that adverse childhood experiences were associated with STS levels.

Caseload composition (IPV and trauma-based counseling). Throughout the literature, caseload composition, trauma saturation, or trauma ratio was identified as a factor associated with VT development across mental health disciplines, with types of trauma including exposure to accidents, natural disaster, disease, death, and IPV-based trauma (Bell et al., 2003; Brend et al., 2020; Choi, 2011; Cunningham, 2003; Dunkley & Whelan, 2006; Finklestein et al., 2015; Hensel et al., 2015; Neuman & Gamble, 1995; Saakvitne & Pearlman, 1995; Sprang et al., 2007). The current study addressed only CMHCs who provide counseling services to IPV survivors.

Hensel et al. (2015) conducted a meta-analysis of 38 studies that addressed the risk factors of STS among professionals who provide therapeutically based services to trauma survivors. The review suggested that quality occupationally based support including supervision and occupational social support can mitigate the impact of VT. The

analysis also suggested that caseload composition, specifically the ratio of trauma cases to nontrauma cases, could be a professional factor associated with the development of an adverse response. Bell (2003) suggested that a diversified caseload can assist in preventing or mitigating the development of VT among mental health professionals. Brend et al. (2020) conducted a review of 13 empirical studies to examine the impact of IPV work on HSPs. Consistent with existing literature, the review indicated that those who treat only IPV trauma described their work as predominantly challenging.

Further support for caseload diversity was provided by a quantitative study conducted by Choi (2011), which examined the STS levels among social workers who provide IPV services. The results indicate that 29% of those HSPs providing IPV services met diagnostic criteria for PTSD. Sodeke-Gregson et al. (2013) conducted a quantitative study that examined both the positive and negative impact IPV mental health workers can have on professionals. Specifically, this study examined the prevalence of compassion satisfaction, burnout, and STS among IPV mental health professionals. The results further supported existing literature indicating an average CS and burnout levels and indicated an increased risk of STS. These results suggest that those with increased STS are at an increased risk for burnout as well.

Makadia et al. (2015) conducted a study examining the wellbeing of clinical psychologists in training who have encountered 1-2 trauma cases (described as mostly sexual trauma) within 6 months. The results indicated a lack of psychological distress and a lack of STS among this population. Slattery and Goodman (2009) also examined IPV specifically, by conducting an examination of workplace factors and STS levels among

domestic violence advocates exposed to only IPV-based trauma. The results of the study suggest that quality and trauma-informed supervision partnered with the support of colleagues assisted in the amelioration of VT among participants. Maquire & Byrne (2016) quantitatively examined the VT levels and personality traits between mental health professionals and lawyers who are exposed to traumatic client content. The results indicated that although both groups reported VT, those with training and education in the mental health discipline displayed lower levels of VT when compared to those trained in a different profession.

In addition to IPV-based trauma, the literature also includes an examination of other/non-specified types of vicarious trauma exposure. Finkletsin et al. (2015) conducted a quantitative study examining PTSD, VT, and professional supports for mental health professionals residing in an area with high levels of war-related trauma/attacks. The results indicate that those working in such areas reported increased levels of both PTSD and VT when compared to other professionals residing out of the area with increased incidents of trauma.

Professional discipline. In addition to caseload dynamics, several studies have examined the length of time professionals have been in their discipline, (professionals in school/training, postgraduate, licensed, ranging from 0-25 years in the profession) as well as the impact of trauma work across varying disciplines (healthcare, mental health or human services professionals, first responders, members of the legal system, and volunteers serving the public in a variety of settings) as factors associated with VT (Cunningham, 2003; Dunkley & Whelan, 2006; McCann & Pearlman, 1990; Neuman &

Gamble, 1995). Ben-Porat and Itzhaky (2009) conducted a mixed-methods examination of both the positive and adverse experiences of social workers serving IPV families and non-IPV families. The study also examined STS, VT, and growth as well as personal areas of functioning that were impacted. The results indicated no differences between two groups- as all participants indicated average levels of STS, with the non-IPV group, indicated increased levels of growth.

As opposed to the type of discipline, Neuman and Gamble (1995) examined the length of time in discipline. Specifically, Neuman and Gamble (1995) explored the impact of working with adult survivors of childhood sexual abuse among developing psychotherapists. The results of this study suggest that trauma work can have an adverse impact on new, developing therapists. The study suggests further that with increased wellness and support these adverse influences can be mitigated. Ben-Porat (2015) also examined time in the profession, as well as the type of discipline (domestic violence workers and social services workers), and post-traumatic growth among professionals. The results aligned with existing studies, indicating vicarious post-traumatic growth among both groups, with increased levels of growth among social service professionals when compared to domestic violence workers. The author suggests that these findings could be related to the nature and scope of trauma professionals are exposed to. The results also indicate increased levels of distress among professionals who were working in the discipline longer, regardless of the type of discipline.

Klien Riggenbach-Hays et al. (2018) conducted a pilot study to investigate the quality of life, CS, and CF among healthcare professionals. The participants consisted of

healthcare professionals from an inpatient palliative care department and neonatal care providers exposed to medical-based trauma. Participants completed a resiliency-based self-care education program to promote the implementation of ongoing self-care among professionals. Results suggest that self-care practices and self-care education can promote CS and reduce burnout among professionals. The results did not indicate a change in the level of STS between scores obtained before and after the training sessions.

Organizational factors. Many studies have implicated the importance of organizational factors in the prevention and amelioration of VT (Bell et al., 2003; Dunkley & Whelan, 2006; Grant & Kinman, 2014; Hernanadez et al., 2010; Slattery & Goodman, 2009; Soedeke-Gregson et al., 2013; McCann & Pearlman, 1990; Trippany et al., 2004). Throughout the literature, there has been a consistent acknowledgment of the positive impact quality, open, and trauma-informed clinical supervision can have on VT development among professionals **(**Bell et al., 2003; Finklestein et al., 2015; Hernandez et al., 2010; McCann & Pearlman, 1990; Salston & Figley, 2003; Slattery & Goodman, 2009; Sodeke-Gregson et al, 2013; Trippany et al.,2004). Bell et al. (2003) conducted a review of literature focused on VT and burnout among social workers which highlighted various organizational factors associated with the adverse consequences of trauma work. Specifically, the review indicated factors such as supportive group processing opportunities, quality supervision, VT education, and workload may prevent VT. The review also highlighted the impact personal factors such as self-care and wellness practices could have on the mitigation of VT. Slatterty and Goodman (2009) quantitatively examined factors associated with the emotional and psychological

wellbeing, STS specifically among domestic violence advocates working in a variety of settings. Consistent with existing literature, these findings also illuminated decreased STS levels among those participants who reported access to occupationally based supervision and peer support. Data also echoed existing literature regarding individual survivor status being associated with increased STS levels.

The current study has expanded upon the existing VT literature by providing quantitative data on the VT levels among a specific group of mental health professionals: CMHCs, who provide psychological support to specific group survivors from a specific type of trauma: only IPV trauma clients. This specific discipline partnered with this specific specialization has yet to be quantitatively explored along with the variables of wellness and resiliency.

Wellness

In addition to the VT level, the current study also examined two predictor variables, wellness, and resiliency. The following section contains a review the literature examining wellness. Throughout the literature, many studies have examined wellness practices across varying methodologies, variables, and participants within the context of VT development, prevention, and recovery (Bell, 2003; Catanese, 2010; Dunkley & Whelan, 2006; Gregson et al., 2013; Hernandez et al., 2010; Iqbal, 2015; Neuman & Gamble, 1995; Rothschild, 2006; Salston & Figley, 2003; Soedeke- Tripppany et al., 2004). Wellness theory has been conceptualized as a way of life, a strengths-based approach to counseling, and to clinical supervision which purports optimum balanced functioning within every area of life (Foreman, 2018; Myers & Sweeney, 2004). The

current study quantitatively explored wellness practices among CMHCs serving the IPV trauma survivor population using the Helping Professionals Wellness Discrepancy Scale (HPWDS).

Mitigating impact of wellness

Wellness strategies can promote the balanced wellbeing of professionals while deterring the development of VT (Foreman, 2018; Lawson & Myers, 2009). McCann and Pearlman (1990) indicated the importance of maintaining a balance between personal and professional areas of functioning when they initiated the discussion of VT. Building upon these results, Harrison and Westwood (2009) conducted a qualitative study to explore protective practices among mental health therapists who self-identified as doing well for more than 10 years. There were central protective themes indicated within-participant practices that deterred VT development including increased holistic wellness and self-care practices. Participants of the study highlighted a specific need for personal and professional balanced wellness to effectively combat VT. Similarly, Williams et al. (2012) quantitatively examined the effect of personal and professional factors on VT development including personal trauma history, personal wellness practices, the supervisory working alliance, and organizational factors. Using CSDT as a framework, this study examined if the identified variables contribute to VT development among mental health professionals. Consistent with existing literature, the results from this survey study indicated that wellness practices can have a substantial mediating effect on VT levels among professionals, further encouraging the pursuit of regular wellness practices among professionals.

Wellness and trauma work

Hensel et al. (2015) conducted a meta-analysis of 38 articles in which the risk factors of STS among professionals exposed vicariously to trauma were examined. The analysis yielded a total of 17 STS risk factors among the professionals, most notably caseload composition/ratio of trauma cases, and an indication of personal trauma history. The mitigating factors revealed to suggest that both occupational and personal wellness factors were associated with decreased VT levels, specifically personal and occupationally based supportive processing.

Foreman (2018) conducted a quantitative study to examine the impact of personal wellness practices on VT levels among licensed mental health professionals exposed to traumatic content. The results further supported existing data regarding the mitigating impact of wellness on VT levels, as well as suggested that length of time in profession and caseload dynamic could influence the scores. Specifically, the data suggested that those professionals exposed to trauma who engaged in increased wellness practices reported lower levels of VT. Similar to Foreman (2018), Bishop and Schmidt (2011) examined only IPV workers. Specifically, Bishop and Schmidt (2011) conducted a mixed-methods study within which 52 IPV transitional home advocates were asked to discuss their perceptions around VT and coping within a self-report survey and focus group formats. Some participants reported feelings of stress, fear, VT, and perceived increased threat of developing VT due to the IPV clientele. The results indicated that effective self-care and wellness strategies can assist in ameliorating the effects of VT and IPV work. The results also indicated the need for increased occupationally based

education, support, and attention to VT among staff. Further conclusions included the personal responsibility of professionals to seek out education, support, and to engage in ongoing wellness/self-care practices which include specific attention to clear boundaries and balance between personal and professional functioning. Kulkarni et al. (2013) conducted a quantitative research study that also focused on IPV service providers which indicated that personal restorative wellness and self-care strategies helped mitigate the impact of VT, burnout, and promoting compassion satisfaction. Participants also indicated that professional self-care strategies such as attention to client resilience helped mitigate the stress of VT.

The current study has expanded upon the existing wellness literature by providing quantitative data on the wellness levels among a specific group of mental health professionals. Specifically, CMHCs who provide psychological support to a specific group of survivors from a specific type of trauma: only IPV trauma clients. This specific discipline with this specific specialization has yet to be quantitatively explored along with an examination of the variables of VT level and resiliency.

Resilience

The current literature suggests that resiliency is a central professional competency among health care and mental health professionals, with increased levels associated with personal, organizational, and client-based benefits (Dunkley & Whelan, 2006; Grant & Kinman, 2014; Hernandez et al., 2010). Factors such as increased wellness, compassion satisfaction, social support, occupational social support, and trauma-informed supervision can assist in promoting resilience among professionals (Branson et al., 2013; Clark, 2009,

Kinman & Grant, 2017; Radey & Figley, 2007). The literature reflects the personal and professional benefits of increased resiliency among mental health professionals (Fisk & Dionisi, 2010). Increased levels of resiliency among mental health professionals could deter the development of VT, promote wellbeing, and contribute to quality clinical outcomes (Finklestein et al, 2015; Kinman & Grant, 2017). Those who are more resilient often have a more optimistic perspective, have reduced stress both of which can assist in mitigating the impact of VT (Catanese, 2010). The current study has quantitatively explored resiliency levels among CMHCs serving the IPV trauma survivor population using The Brief Resilience Scale (BRS).

Mitigating impact of resilience

Dekel (2016) completed an autobiographical essay within which various personal and professional experiences that have contributed to her overall level of trauma resilience are described. The author is a scholar and social worker who has been personally and professionally exposed to trauma, and who has reframed experiences to promote resiliency among other professionals. Within the essay the author illuminates the impact of individual factors (such as differentiation of self via increased boundaries within various areas of functioning), existential aspects of trauma, and well as social and community factors associated with resiliency. The conclusions of the essay assert similar suggestions found throughout this review, that there are personal and professional aspects of functioning that can mitigate the impact of trauma work. The author suggests specifically that personal and professional steps be taken to promote resiliency and enhance coping with trauma exposure.

Similarly, Kinman and Grant (2017) provide a unique discussion of the importance of resiliency as a mitigation tool, and how it can be developed among professionals. This quantitative study examined organizationally based interventions that could assist in resiliency development among novice level mental health professionals. The authors assumed an organizational perspective in their brief multi-modal intervention study which examined the impact of resiliency training among novice mental health professionals. The results of the study suggest that with an increased understanding of resiliency, mental health professionals reported increased psychological wellbeing. The authors also assert that with increased resiliency comes increased wellbeing and quality of professional practice among social workers. The results also suggest that resiliency training be integrated into the training and education of mental health professionals. Howlett and Collins (2014) continued the examination of both personal and organizational responsibility for addressing VT among professionals exposed vicariously to traumatic content. This qualitative study sought an increased understanding of the perceived risks of VT development among crisis intervention volunteers serving those impacted by trauma. The results of this study suggest that both personal and professional factors together can bolster one's resilience against VT development. Specifically, the authors suggest that in addition to organizationally based VT education and support, balanced self-care within the occupational and personal areas of functioning could assist in mitigating the impact of VT.

Resilience and trauma work

MacKay (2017) qualitatively examined the role of differentiation of self in the development of resilience among mental health professionals serving trauma survivors. Using a case study within the context of the family systems foundation, the author asserts the personal responsibility professionals have to increase self-care and resilience when treating trauma survivors. Specifically, with increased differentiation of self the mental health professional has an increased sense of self, ability to adapt, and efficient coping skills within stressful circumstances. With increased differentiation of self, the mental health professional has effective personal and professional boundaries, and resiliency when treating traumatized clients. The study suggests that protection from STS, VT, and burnout begins with personal efforts by the professional to enhance differentiation of self thus improve resiliency. Similarly, Bell et al. (2003) conducted a qualitative study to examine specific organizational factors associated with VT among counselors. Participants shared levels of stress associated with IPV work, indicating that resilience assisted with effective coping. Participant responses further indicated that effective social and familial support partnered with supervisory and occupational support, as well as a spiritual calling or motivation further assisted in promoting resilience against VT development.

Greinacher et al. (2019) quantitatively examined VT, psychological distress, and resilience among emergency care professionals who provide services survivors, witnesses, bystanders, and family members, who are involved in accidents and trauma. The writers defined resilience as a complex interdependent process through which

individuals successfully adapt to adversity, involving aspects of psychological, biological, social, and cultural factors. Specific factors of resiliency which were examined among participants included: social support, frequency of case discussions, length of time in the role, sense of coherence, mindfulness, attachment behavior, and the levels of personality functioning. The participants in the study included first responders such as volunteers, policemen, firemen, search and rescue personnel, and paramedic teams all of which offer an array of response interventions including psychosocial and psychological support, medical support, and accompaniment. The study examined responses from this specific participant pool compared to norm samples from the general population. The quantitative data for each variable was examined within the context of trauma exposure of any kind, as opposed to a specific type of trauma exposure, such as IPV. Due to the nature of their work, the participant pool is at increased risk for developing PTSD, and VT. The study revealed that those first responders with increased resiliency factors reported lower levels of VT and psychological distress. This population reported lower levels of occupationally oriented distress when compared to other professionals such as mental health therapists. The results suggest that increased resiliency can assist in mitigating VT symptoms.

Like Greinacher et al. (2019), Maguire and Byrne (2017) conducted a quantitative study examining how VT impacts professionals with different disciplinary specialties. Specifically examining levels of depression, anxiety, and stress, personality traits, and VT levels among lawyers and mental health professionals. The results indicated that those professionals in the mental health discipline better managed exposure to trauma

when compared to lawyers. The participants in law indicated increased levels of psychological distress including depression, anxiety, and stress as well as increased VT. The data indicated that personality traits such as resiliency can deter VT development among professionals. The overall results of the study indicated that regardless of discipline, vicarious exposure to trauma resulted in some level of distress or vicarious trauma, warranting further research on the topic.

Masson (2019) examined resiliency within the context of a self-care strategy used to combat VT. This mixed-methods study was conducted to highlight the impact of increased resiliency on VT levels among social workers. In addition to resiliency, the author also included the concepts of post-traumatic growth as well as the role that both organizations and individuals have in addressing VT. Obrien and Haaga (2015) explored the influence of empathy in the development of adverse reactions to traumatic content among counselors in training at varying levels of development. The results of the study suggest that further exploration into the role of counselor resiliency level could illuminate important information about the occupational challenges associated with trauma work as well as adjusting clinical training to address resiliency skill-building.

The current study has expanded upon the existing resiliency literature by providing quantitative data on the resiliency levels among a specific group of mental health professionals: CMHCs, who provide psychological support to specific group survivors from a specific type of trauma: only IPV trauma clients. This specific discipline with this specific specialization has yet to be quantitatively explored along with the variables of wellness and VT levels.

Summary and conclusions

Although there is a wealth of information about VT across varying methodologies, theoretical perspectives, and variables, one major theme emerged from the current review, factors associated with VT development are of the personal or professional nature. Many studies have highlighted the potentially positive impact of trauma work for professionals including compassion satisfaction, vicarious resilience, and altruism. Many studies have also illuminated the adverse impact trauma work can have on the personal and professional functioning of professionals including STS, VT, burnout, and CF. Throughout the literature many professional factors have been considered and determined associated with VT including: (a) trauma-informed, open, or supportive clinical supervision, (b) organizational support, (c) organizational social/peer support, (d) VT specific training, (e) composition of caseload, (f) type of and level of engagement with trauma, (g) professional discipline and length of time in the profession, and (h) and education and training needs/adjustments. There has also been consideration of personal factors associated with VT including: (a) holistic self-care/wellness practices, (b) personal history of trauma, (c) coping skills, (d) differentiation of self, (e) spirituality, (f) sense of altruism, (g) sense of spiritually driven calling or motivation, (h) resilience, (i) boundaries, (j) social and familial support (k) emotional/empathetic engagement.

There has yet to be a quantitative exploration of the variables of wellness, resiliency, and VT level among IPV clinical mental health counselors. The existing literature and knowledge base have been extended by offering a quantitative summary of these variables. The current study has examined both personal and professional areas of

life within the context of VT development. Specifically, the current study examined for a quantitative predictive relationship between two predictor variables (wellness practices and resiliency levels) and the outcome variable (VT) among CMHCs serving IPV survivors. The information from this study can supplement the existing knowledge base for not only counselors across varying developmental levels but clinical supervisors and counselor educators as well.

Within the next chapter, the methodology has been described including the research design and rationale for using quantitative analysis to examine participant wellness levels, resiliency levels, and VT levels.

Chapter 3: Research method

The purpose of the current quantitative study was to examine whether VT level can be predicted based on the wellness level and resiliency level of IPV CMHCs. Chapter 3 provides aspects of the research methodology. The target population, recruitment, sampling, data collection procedures, instrumentation, threats to validity, and ethical considerations are explained.

Research design and rationale

I used a quantitative approach and a web-based survey design to examine the identified variables. Anonymous survey responses were collected and analyzed to determine whether there was a statistically significant predictive relationship among the identified variables. I used quantitative data from self-report survey instruments to examine the predictive relationship among VT (outcome variable) and wellness and resilience levels (predictor variables). The study targeted existing groups of IPV CMHCs for voluntary participation. IPV CMHCs were asked to complete four self-report measures including three variable-focused instruments and a study-specific demographic questionnaire.

The self-report survey methodology was selected for the study because this data collection strategy was the most advantageous for the quality of the study, the participants, and me. The survey methodology allows for increased efficiency, privacy, number of potential participants reached, and economic efficiency (Creswell & Creswell, 2018). The survey methodology allowed me to access not only an increased quantity of potential participants but also a wider range of IPV CMHCs across geographic locations,

IPV associations, and IPV agencies. Increased sample size associated with the administration of the survey data collection method allowed for increased representation of IPV CMHCs. Increased representation meant increased generalizability of the findings to IPV CMHCs.

Methodology

Population

The target population of interest for the study included a sample of postgraduate-level CMHCs who provide clinical counseling services to survivors of IPV. There was no time frame placed on how long the CMHCs had seen IPV clients; however, participants were asked to indicate how long they had served the IPV population. The inclusion criteria for the study stipulated that target participants were CMHCs (pre- or post licensure) with a clinical caseload consisting solely of clients with a presenting concern of IPV. Solicitation for participation in the study included a clear operationalization of the terms IPV and CMHC. The target recruitment population size was intentionally well above the target sample size.

Sampling and sampling procedures

Potential participants for the study were chosen using a nonprobability purposive sampling strategy in which respondents were selected based on targeted, common characteristics relevant to the identified constructs of interest (see Burkholder et al., 2016). The nonprobability purposive sampling strategy aligned with the web-based quantitative research design and methodology. The purposive sampling method allowed for consideration of IPV CMHCs, facilitating the collection of the data necessary for the

study. The target sample of respondents included only CMHCs who serve IPV survivors. This sample of respondents was targeted for participation due to similar shared characteristics such as IPV caseload and comparable educational and training backgrounds.

The sample for the study was generated using a nonprobability purposive sampling strategy. Although this strategy can be time-consuming and labor-intensive for researchers, it was the most appropriate for the current study given the variables selected for examination (see Burkholder et al., 2016). Further, the nonprobability purposive sampling strategy allowed for increased validity or generalizability of results to the IPV CMHC population.

The sampling procedures for the current study involved online/electronic-based formats of correspondence. Sample recruitment took place using an array of state and national professional associations and agency-based public contact information. Potential participants were invited to voluntarily join the study via email correspondence. Potential participants were targeted based on place of employment or membership in a professional counseling organization using the published contact information. solicitation/recruitment and reminder emails were sent to the published agency/organization email address (See Appendices A and B)

The sampling frame consisted of CMHCs who provide clinical counseling services to clients seeking support for IPV. Clear, operationalized definitions of IPV (caseload composition) and CMHC (professional discipline) were provided to all potential respondents as inclusion criteria for voluntary study participation. Potential

participants included only those postgraduate-level mental health services providers who were formally trained to provide clinical counseling services to individuals, families, couples, and groups in treating mental, behavioral, and emotional disorders (ACA, 2020). IPV client services include only those clinical counseling services offered to clients presenting to counseling to address issues associated with any act of physical, emotional, or psychological violence, including any threat, coercion, intimidation, or deprivation of liberty (CDC, 2018). Those professionals contacted for participation who did not meet these criteria were asked not to complete the surveys.

Exclusion criteria were also clearly articulated to potential participants. These criteria included any professional discipline outside of CMHC and any caseload composition outside of clients addressing IPV within the session. An additional exclusion criterion was association with the YWCA-South Hampton Roads, Virginia, an IPV service agency. Due to my close affiliation with the agency and supervision of IPV CMHCs currently serving IPV clientele, this agency was excluded from participation solicitations. The exclusion and inclusion criterion were noted within the informed consent/initial participation solicitation correspondence.

Sample size

An a priori power analysis was conducted to determine the appropriate minimum sample size for the study. The power analysis is used to calculate an appropriate sample size for quantitative studies to mitigate the potential risk of error within the data analysis process (Frankfort-Nachmias & Leon-Guerrero, 2018). A statistical power analysis software program for the social and behavioral sciences was used to account for the

presence and magnitude of the probability of statistical significance among variables, while also accounting for the margin of error. The G*Power software Version 3.1.9.7 was used with the following parameters: (a) linear multiple regression statistical test, (b) an alpha of .05, (c) a medium effect size of 0.15, (d) a 95% confidence interval, and (e) two predictor variables (see Faul et al., 2007). The effect size is a statistical figure that measures the strength of the relationship between identified variables; as effect size increases, the difference between the variables increases (J. Cohen, 1988; Frankfort-Nachmias & Leon-Guerrero, 2018).

The alpha level is a statistical significance criterion that indicates the probability of a false positive or that the null hypothesis will be rejected (Frankfort-Nachmias & Leon-Guerrero, 2018). The alpha level for the a priori power analysis for the current study was.05. The effect size represents the quantitative magnitude of the difference between identified variables (Frankfort-Nachmias & Leon-Guerrero, 2018). In the G*Power software parameters for a linear multiple regression *F* test, the effect size was set to 0.15, which is considered a medium effect size (see J. Cohen, 1988). A medium effect size of 0.15 was an appropriate selection for multiple regression analysis (see J. Cohen, 1988). The confidence interval is a range of values that may or may not contain the mean of the population (Frankfort-Nachmias & Leon-Guerrero, 2018). A 95% confidence level indicates a 95% probability that the interval will contain the accurate value of the population mean (Frankfort-Nachmias & Leon-Guerrero, 2018). Using these parameters within the G*Power software, I calculated a minimum sample size of 107 participants.

Procedures for recruitment, participation, and data collection

A minimum of 107 CMHCs were recruited using an electronic communication format. The target population for this study consisted of any postgraduate CMHC who provides IPV trauma counseling services. There were three electronically based study solicitation platforms used for the study: the Walden University participant pool, direct email contact, and direct social media contact. All study participation recruitment correspondence included the same content and varied in format depending on the platform of communication. For potential participants contacted via email, a second and then a final reminder message was sent in pursuit of maximum response rate after the initial solicitation contact (see Appendices B and C).

Initially, the Commonwealth of Virginia was targeted for participation due to my residence and knowledge of available IPV resources including IPV-specific counseling services. Participant solicitation efforts were then expanded beyond Virginia to include other local, state, and nationally based associations, agencies, businesses, universities, and organizations based on publicly published contact information. Targeted participant recruitment was based on publicly published information regarding services provided, including indication of IPV caseload composition or CMHC professional discipline. Additionally, social media study recruitment targeted agencies, associations, businesses, or individuals who publicly indicated IPV services were provided, or CMHC status. Also, the Walden University participant pool was used, allowing the informed consent, recruitment email, survey access information, and complimentary psychoeducational materials to be posted on university research boards for voluntary student access. This

sampling procedure allowed for a wide participant pool from which a representative minimum sample of 107 IPV CMHCs was drawn.

The data collection for this study was conducted using the Survey Monkey website, which facilitates confidential, secure, internet-based data collection (SurveyMonkey, 2020). Three web-based self-administered surveys were included in the study to address each variable of examination: VT, wellness, and resiliency. In addition to these variable-specific web-based self-administered surveys, a study-specific demographic questionnaire was administered to all participants (see Appendices F, I, L, and M). Potential participants were provided with the same recruitment content (electronic informed consent, study-specific information, invitation to participate, request to share with other potential participants, psychoeducational materials, and survey access) in varying formats depending on the method of recruitment.

Electronic study solicitation correspondence included an overview of the study, operationalized terms vital to the study, an electronic copy of the informed consent document, and a link to the Survey Monkey website to initiate the surveys (see Appendix D). Primary web-based self-administered survey data were collected from the CMHCs who treat IPV survivors. A total of four separate anonymous web-based surveys were administered electronically to collect the data via the Survey Monkey website. The Survey Monkey website offers convenient, private, and confidential survey access for participants (SurveyMonkey, 2020). After collection, the data were stored in my password-protected laptop and locked briefcase. The surveys that were administered

included the HPWDS to assess wellness, the VTS, the BRS, and the study-specific demographic questionnaire (see Appendices F, I , L, and M).

All participants were offered complimentary psychoeducational materials regarding VT, resilience, and wellness practices. These materials were offered as an expression of gratitude for time and participation in the study (dee Appendix D).

Instrumentation and operationalization of constructs

The data collection portion of the study involved the administration of three variable-specific instruments and a study-specific demographic questionnaire. This section includes a summary of the instruments selected to examine the variables in the study. This section also includes the appropriateness of each instrument for use in the study, as well as published applications to varying populations, and a discussion of relevant validity and reliability values associated with each.

The VTS

The VTS was developed by Vrklevski and Franklin (2008a) to examine subjective levels of VT among solicitors. The self-report instrument includes eight items rated on a 7-point Likert scale with response options ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). Total response scores can range from 8 to 56, with the lower scores indicating lower levels of VT. Vrklevski and Franklin (2008a) defined *solicitors* to include professionals who are indirectly emotionally and visually exposed to traumatic material, including physicians, nurses, first responders, legal professionals, and therapists. Vrklevski and Franklin (2008a) defined *VT* as profound alterations to aspects of both personal and professional identity across various areas of functioning.

The VTS was an appropriate instrument for the current study because the instrument measures VT in a quantitative self-report format designed for professionals exposed indirectly to trauma. The instrument has demonstrated good reliability among criminal lawyers (Cronbach's $\alpha = .88$), among social workers (Cronbach's $\alpha = .77$), and among lawyers and mental health professionals (Cronbach's $\alpha = .84$; Aparicio et al., 2013; Maguire & Byrne, 2017; Vrklevski & Franklin, 2008b). Permission to use this instrument was granted for educational purposes without the need for specific written permission from the authors (see Appendix E).

The BRS

The BRS is a quantitative self-report instrument developed by Smith et al. (2008) to assess a person's ability to recover from stress. The assessment consists of six items related to resiliency constructs scored on a 5-point Likert scale with response options ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Total response scores can range from 6 to 30, with lower scores indicating lower levels of resilience. Each of the six items assesses a participant's perception of their ability to recover from stress. Smith et al. defined *resilience* as the ability to recover following stressful circumstances.

The BRS was an appropriate scale to include in the current study to assess participant resiliency, as this instrument quantitatively examined self-reported resiliency levels among study participants. The scale has been used to assess resilience among the general population, undergraduate students, elderly, parents of children with disabilities or developmental disorders, HIV-positive individuals, parents of children with cancer or critical illness, those with increased levels of anxiety and stress, and oncology patients

(Rodriguez et al., 2016; Smith et al., 2008; Windle et al., 2011). When compared to other resiliency scales, the BRS appears to measure only resiliency as opposed to factors that could contribute to resiliency. Specifically, other resiliency scales examine factors associated with resilience, including protective factors, personal characteristics (such as optimism), and one's adaptability (Rodriguez et al., 2016; Windle et al., 2011). The BRS scale demonstrates good construct validity internal consistency as well as test-retest reliability, with an $\alpha = .93$). Permission to utilize this instrument was requested and granted via email from author Dr. Bruce Smith (see Appendices G, H, and I).

The HPWDS

The HPWDS was originally developed in 2018 by Blount and Lambie to gather self-report data regarding wellness among helping professionals. Specifically, the HPWDS was designed to assess any discrepancy between perceived wellness and aspirational wellness among helping professionals. The HPWDS quantitatively examines wellness across the following domains: professional and personal development activities, religion and spirituality, leisure activities, burnout, and helping professional optimism. The HPWDS is the longest of the assessments included within the current study with a total of 22 items. Each assessment item is rated on a 5-point verbal frequency scale with response options ranging from 1= (0-2 times within a week) to 5 = (12 or more times within a week). Total response scores range from values of 1 to 110, with the lower scores indicating lower levels of wellness. The response sections are separated into areas of current function (how often do you?) and areas of ideal functioning (how often do you

want to?). Authors define wellness as physical, mental, and social wellbeing not merely in the absence of disease, highlighting that wellness is not the absence of disease.

The HPWDS was an appropriate scale for the current study to assess wellness among participants, as the assessment quantitatively examined wellness in a self-report format. Further, the HPWDS was designed for administration to the population of helping professionals, including counselors specifically. The authors defined *helping professionals* as those practicing professionals within the discipline of counseling, psychology, social work, and counselors in training. In contrast to other wellness inventories, the HPWDS assesses current wellness and ideal wellness, providing participants with insight building information and potential areas in which wellness practices could be improved. The HPWDS demonstrates strong internal consistency reliability, (Cronbach's $\alpha = .869$). Permission to utilize this instrument was requested and granted via email from author Dr. Ashley Blount Bruce Smith (see Appendices J, K, and L).

Demographic questionnaire

The demographic questionnaire was designed for this study to collect descriptive information from the participants. The demographic questionnaire included open and closed-ended questions, as well as those requiring scaled responses. Demographic questions posed to participants included those of both a personal and professional nature including: age, gender, number of years in the profession, and current licensure/credentialing status (See Appendix M). The demographic survey was included with the confidential web-based surveys administered via Survey Monkey website.

Threats to validity

The current study examined the predictive relationship between the identified variables. The quality of the study and applicability of the results was impacted by the external and internal validity associated with the study. Considerations for threats to both internal and external validity of the current study have been examined within this section.

External validity

Threats to the external validity of a research study can involve the researcher incorrectly assuming or generalizing information based upon the results generated from a study (Frankfort-Nachmias & Leon-Guerrero, 2010). The current study examined specific variables among a specific population, greatly limiting the generalizability of the data. The limited sample and subsequently decreased generalizability of the study results limit the applicability of the data to other populations or circumstances. Expanding the parameters, adjusting the methodology or variables within future research endeavors could assist in increasing the generalizability of the data from the current study. An additional threat to the external validity of the current study was participant reactivity to the assessment. Specifically, participants could have been susceptible to social desirability bias, and purposefully altered survey responses to emulate a desired performance/characteristic (Frankfort-Nachmias & Leon-Guerrero, 2010). Social desirability may have occured to appease the researcher or for participants to make themselves appear better (Frankfort-Nachmias & Leon-Guerrero, 2010).

Internal validity

Threats to the internal validity of a research study involve the researcher's ability to develop conclusions regarding participants based on the results of the study (Frankfort-Nachmias & Leon-Guerrero, 2010). A potential threat to the internal validity of the current study was history. Specifically, the potential influence of the recent #MeToo movement on how participants complete the VT assessment. Along with increased awareness, advocacy, justice, and controversy, the #MeToo movement has also brought increased exposure to IPV content for members of the public, including CMHCs. This increased IPV content could have potentially influenced IPV CMHCs, as they may be exposed to IPV content outside of the boundaries of occupational duties. The #MeToo movement could threaten the internal validity of the current study by potentially impacting the amount and extent of IPV content participants could be exposed to. One strategy to address this potential threat was to pose a question in the demographic questionnaire regarding if #MeToo movement IPV exposure has impacted participants.

An additional potential threat to the internal validity of the current study involves the dependent variable, VT. Specifically, many terms or concepts describe the adverse impact trauma work can have on professionals including STS, burnout, VT, and compassion fatigue. One strategy to address this potential threat was to operationalize the term for participants. An additional potential threat to the internal validity of the current study was to construct validity. This threat involves the quality of the selected instruments-if each assessment effectively explores the construct it intends to.

Another potential threat to the internal validity of the current study was the process of completing the assessments, or testing. Specifically, if participants completed any of the three existing measures before study participation, the previous experience may have altered how they completed the current study (Frankfort-Nachmias & Leon-Guerrero, 2010). Another potential threat to the internal validity of the study could have been participant selection. Participants selected for the study could have certain characteristics that predispose them to particular outcomes (Frankfort-Nachmias & Leon-Guerrero, 2010). Specifically, due to the nature of the occupation, helping professionals can be susceptible to higher levels of VT, or of becoming unwell, which could be reflected in the scores reported within the study (Blount & Lambie, 2018; Lambie, 2007; Lawson, 2007; Lawson & Myers, 2011; Puig et al., 2012).

A final threat to the internal validity of the current study was instrumentation-based threats. The internal validity of a study can be strengthened by selecting instruments that demonstrate strong internal content validity, specifically that selected assessments effectively measure what they are intended to measure (Frankfort-Nachmias & Leon-Guerrero, 2010). The three variable-specific assessments selected for the current study each demonstrate sufficient content validity and effectively measure the identified constructs of focus.

Ethical considerations and procedures

Upon the approval of the current research study proposal, (approval code: 09-25-20-0579858) the Walden University Institutional Review Board [IRB] application was initiated. Upon receipt of IRB ethical approval, the data collection portion of the study

was being initiated. Potential ethical considerations made within the current study have been explored within this section.

Recruitment materials

All recruitment procedures within the current study were executed to ensure the privacy of potential participants throughout the study. Recruitment materials for the current study were limited to internet-based contact including all efforts posted within social media, email, and Walden University participant pool. The participant solicitation and recruitment process were done so confidentially, no participant names or contact information was used/shared or published throughout the study. Participant solicitation and recruitment emails were sent from a password-protected email account, with all recipients being blind copied into the dissemination list. An ongoing list of participant recruitment efforts and outcomes was maintained within a password-protected laptop computer accessed only by the principal author of the study.

Data collection process

The data collection process for the current study included the following steps: a) dissemination of recruitment correspondence to connect with potential study participants, b) completion of informed consent, c) data collection begins. Each step of the data collection process was done to promote the privacy and confidentiality of all potential participants, and their responses. Each step has been discussed herein in further detail.

Dissemination of recruitment correspondence

All recruitment correspondence was extended electronically via three separate communication platforms: author password-protected email, author password-protected

social media, and Walden University participant pool. The agency/contact's name and email address of each potential email-based invitation recipient was maintained confidential. All social media and Walden University-based recruitment was posted publicly allowing potential respondents to voluntarily access information if interested/eligible to participate. All recruitment correspondence included the same contain but varied in format dependent upon communication platform. Each recruitment correspondence included: an electronic copy of the informed consent form, basic information about the nature, purpose, potential benefits, and risks associated with study participation, as well as inclusion criteria and procedural guidance regarding survey completion procedures, survey access, invitation to participate, request for dissemination to any other potentially eligible participants, and complimentary psychoeducational materials.

Completion of informed consent

The informed consent document was included as the recruitment correspondence page. In the interest of securing the anonymity of the participants and encouraging participation, the study recruitment document included the following statement: *By clicking the survey access link below (labeled link to survey) I acknowledge sufficient understanding of the study described above and provide consent to participate in the study* (. This statement allowed for confidential data collection and storage free from the documentation featuring participant names.

Data collection and treatment

Following the successful recruitment and completion of informed consent, the data collection process began. The current web-based survey research study utilized self-report instruments for the data collection process via the Survey Monkey website. This data collection strategy limited any direct between author and with the study participants. All surveys used were self-administered web-based documents that were accessed, completed, and stored within an online setting. Survey Monkey is a website which hosts and provides survey access to research participants in a confidential, and HIPAA-compliant format (Survey Monkey, 2020). The use of the Survey Monkey website assisted in promoting the anonymity of the participants. Upon completion of the surveys, the data was downloaded from the website to the researcher's password-protected laptop for data analysis purposes. All data analysis was conducted using IBM SPSS software (version 25) on the locked and secured laptop computer with several layers of confidentiality supported security including passcodes, a locked external flash drive, and a physical lock for the bag in which the laptop is stored (IBM SPSS Statistics, 2020). The data was then statistically analyzed. Each participant was assigned an identification number for survey responses to prepare for anonymous data analysis. Data collected within the study was viewed by only the researcher and dissertation committee members. Data collected throughout the study has been maintained and stored within the password-protected laptop of the researcher for 5 years, at which point it will be permanently deleted from the computer.

Data collected from the demographic questionnaire such as age, gender, ethnicity, nature of IPV caseload, etc. is featured within the results of the study in such a manner that participants cannot be identified. Specifically, these participant details are not included with any identifying information such as email contact information, location of workplace, or affiliation with association, or organization. Further, the figures for each of these details are reported as a numerical group total or percentage as opposed to individual responses. For example, the total number of respondents (100%) could be broken down into 50% licensed, and 50% non-licensed CMHCs. This reporting format further protects the identities of participants.

The recruitment correspondence included complimentary psychoeducational materials. These materials provided participants/potential participants with information about VT prevention, intervention, and recovery, as well as information about building resiliency, and wellness practices. Should any participants need guidance information or support regarding any of the variables included in the study, the information was readily and privately available for them.

Ethical Considerations

Specific ethical considerations for the current study have been explained within the next section. The ACA Ethical Code purports the beneficence, confidentiality, justice, and rights of each potential study participant are promoted and maintained throughout a research study (ACA), 2014; Groves et al., 2009). A specific potential ethical concern associated with the current study involved general potential risks associated with participation. Participation in the study exposed respondents to increased awareness of

VT. Study involvement and completion of survey questionnaires could have increased participant awareness of VT, the impact of VT, VT symptoms they may have been experiencing, as well as increased awareness of the potentially adverse impact IPV counseling may have on them. If participants experienced any disruption because of participation, complimentary psychoeducational materials for all participants were provided electronically and confidentiality. The psychoeducational materials included information regarding VT, wellness, and resilience to support the participants if needed.

An additional ethical consideration for the current study involved the potential impairment that can be associated with VT (Foreman, 2018; Lawson, 2011). Specifically, the ACA Code of Ethics stipulates that clinician impairment or threat to the client's well-being is to be addressed (ACA), 2014). Moderate to high levels of VT could be an indication of clinician impairment or a potential threat to sound clinical judgment, either of which could adversely impact clients (Foreman, 2018; Lawson, 2011). VTS results which indicated moderate to high levels of VT were potential ethical concerns for the clients receiving services from these clinicians, as well as for the clinicians themselves. However, participant responses were not linked to their name and were anonymous. Because of this potential risk, every study participant was given psychoeducational materials to address VT or any potential feelings of distress resulting from study participation. The informed consent document for this study not only informs each respondent of this potential risk, also included this information to support each participant should VT levels be a concern.

Summary

The current study used a quantitative research design, and a web-based survey research methodology. Throughout this chapter, a summary of methodological details and considerations has been provided. Participant survey responses were collected and analyzed in search of the statistically significant predictive relationship between VT, wellness, and resilience. The current study recruited existing groups of IPV CMHCs for voluntary participation. IPV CMHCs were asked to engage in a total of 4 self-report measures, including 3 separate variable-focused instruments and a demographic questionnaire. Participants were given complimentary psychoeducational materials regarding VT, wellness, and resilience.

Chapter 4: Results

The purpose of the current web-based survey study was to quantitatively examine the relationship between predictor variables (resiliency levels and wellness levels) and the outcome variable (VT level) among CMHCs. The sample for the study included CMHCs who provide counseling services to survivors of IPV. The research question addressed within the study was the following: Is there a significant predictive relationship between VT level, wellness level, and resiliency level among IPV CHMCs?

The alternative and null hypotheses posed:

H_o1: There is no statistically significant predictive relationship between outcome variable VT level and predictor variable wellness level among IPV CMHCs as measured by an anonymous self-report survey.

H_a1: There is a statistically significant predictive relationship between the outcome variable VT level and predictor variable wellness level among IPV CMHCS as measured by an anonymous self-report survey.

H_o2: There is no statistically significant predictive relationship between outcome variable VT level and predictor variable resiliency level among IPV CMHCs as measured by an anonymous self-report survey.

H_a2: There is a statistically significant predictive relationship between outcome variable VT level and predictor variable resiliency level among IPV CMHCs as measured by an anonymous self-report survey.

H_o3: There is no statistically significant prediction of VT level by wellness level and resiliency level among IPV CMHCs as measured by an anonymous self-report survey.

H_a3: There is a statistically significant prediction of VT level by wellness level and resiliency level among IPV CMHCs as measured by an anonymous self-report survey.

Chapter 4 includes an examination of the data collected, the results generated, and a summary of the findings. Details of the data collection process are provided, including a summary of participants targeted for solicitation, the data collection time frame, and variations from the proposed data collection plan. The chapter also includes descriptions of the sample within the context of demographics and representation of the target population. Lastly, Chapter 4 includes the findings of the statistical analyses performed to answer the research question and address each hypothesis.

Data collection

The target population for the study included postgraduate CMHCs who provide counseling services to IPV survivors. A nonprobability purposive sampling strategy was used to recruit the target sample of 107 participants for the study. Potential respondents were contacted via (a) Walden University participant pool; (b) email correspondence; and (c) social media messages, emails, or posts via Facebook. All participant solicitation was done using the Walden University IRB-approved informed consent document, which was disseminated with accompanying complimentary psychoeducational materials and reminder emails (see Appendices B, C, and D). Participant solicitation took place until

the target number of survey responses (107) was obtained to ensure an adequate number of usable responses.

In addition to the Walden University participant pool, study solicitation targeted professional counseling organizations, associations, agencies, private or group counseling practices, businesses, or universities within which counselors may provide IPV counseling services. Each correspondence included the IRB-approved informed consent, link to the survey, complimentary psychoeducational materials, invitation for participation, and a request to share the study information with anyone who may be eligible to participate (see Appendices B, C, and D). A total of 7,222 email addresses, Facebook pages, and messenger recipients received the invitation to engage in the study (see Table 1). It is unknown how many email messages were forwarded or how many social media posts may have been shared or viewed by other potential participants. All respondents who agreed to participate in the study completed a total of four survey questionnaires within the Survey Monkey website. The surveys included the VTS, the BRS, the HPWDS, and a study-specific demographic questionnaire. All survey data were collected and stored within the Survey Monkey website.

Members of statewide counseling/clinical counseling associations were contacted via association websites, publicly published contact information, and Facebook homepages for all U.S. states. For example, the Virginia Counseling Association regional/chapter representatives/members were contacted via publicly published email addresses and public Facebook pages. Social media-based contact was made via publicly published Facebook pages for professional associations as well as clinical counseling-

based contact pages. Potential participants were contacted via Facebook messenger, email address publicly published within Facebook pages, or by posting approved study solicitation on the page. CMHCs providing IPV counseling services in private or group practice settings were targeted via publicly published contact information including Facebook pages or email addresses.

Table 1

Potential participant and type of solicitation effort

Name of potential participant	Type of solicitation
American Mental Health Counseling Association	Publicly published email-based contact Social Media Based contact for all available states across the United States
Virginia Counseling Association	Publicly published email-based contact Social media-based contact for all available chapters
Licensed Professional Counselor Association of Northern Virginia	Publicly published email-based contact
American Art therapy Association	Publicly published email-based contact
National Institute of Health	Publicly published email-based contact
University-based counseling offices and title IX coordinators within the northern and southeastern regions of Virginia, as well as the title IX coordinator listserv	Publicly published email-based contact
Counselor Educators and Supervisors (CES): Association of Counselor Educators and Supervisors (ACES), VA-ACES, Western ACES, the Counselor Education and Supervision Network listserv.	Publicly published email-based contact Social media based contact

Name of potential participant	Type of solicitation
Counseling Today, Professional Counseling Connections, Become a More Effective Therapist, a Training Resource Group for Mental Health Professionals, Counseling and Therapy Connections, Trauma Competent Clinicians.	Social media based contact
Virginia Sexual and Domestic Violence Action Alliance	Publicly published email-based contact
The Somatic Experiencing Trauma Institute	Publicly published email-based contact
The National Human Trafficking Hotline	Publicly published email-based contact
www.211.org	Publicly published email-based contact
Court Appointed Special Advocate Norfolk Virginia office	Publicly published email-based contact
The Rape, Abuse, and Incest National Network (RAINN) 24/7 Hotline, and all agencies listed on the publicly published RAINN partner agency directory	Publicly published email-based contact
Virginia Department of Social Services	Publicly published email-based contact
Norfolk Virginia Community Services Board	Publicly published email-based contact
Norfolk, and Newport News Human Services	Publicly published email-based contact
Virginia Department of Victim Services (victim-centered programming)	Publicly published email-based contact
The North American Clinical Trauma Professionals (CTP) public access registry featuring the direct email addresses of all those registered as:	Publicly published email-based contact

Name of potential participant	Type of solicitation
Clinical Trauma Professionals (CTP), Certified Clinical Trauma Professionals (CCTP-levels I and II)	Publicly published email-based contact
Certified Family Trauma Professional Certification (CFTP)	Publicly published email-based contact
Certified Child and Adolescent Trauma IPV clinicians within private or group practices University-based counseling offices, Women's Center offices, Health Services offices, and Title IX offices for public/state universities in the Commonwealth of Virginia	

Alterations in recruitment and data collection procedures

The data collection process varied from the original plan viand required three IRB-approved changes of procedure, including the addition of the Walden University participant pool. The solicitation process was initiated on October 29, 2020, among IPV-specific state and national professional associations and IPV-based agencies/practitioners as planned. However, following low response rates, requests for change in procedures were made to increase the range of targeted recruitment efforts.

The initial request for a change in procedures was for expansion of the existing email-based recruitment to include the following: (a) recruitment efforts outside of the state of Virginia, (b) state and national coalitions against domestic violence, c) relevant professionally oriented social media groups, (d) state and national victim compensation services, (e) state and national victim assistance services, (f) relevant interpersonal

violence contacts listed within www.211.org, (g) state and national sexual assault response teams, (h) state and national emergency shelters (domestic and relationship violence), (i) and department of criminal justice victim services grant recipients. The second requested change in procedures was for expansion of existing email-based recruitment efforts to include mental health counselors across places of employment using the relevant publicly posted personnel contact information (e.g., any public, private, state, and/or national agency, university, association, and/or organization). The third and final change in procedures request was for the alteration of wording used in the existing IRB-approved informed consent/recruitment email used to solicit study participation. Specifically, any recruitment email recipient was invited to forward the request to any other potential participant.

Additionally, study solicitation efforts were expanded to include the use of the Walden University participant pool. In congruence with the Walden University participant pool requirements, the informed consent document and complementary psychoeducational materials were altered to accommodate the formatting needs of the participant pool platform. The presentation of the study information, informed consent, and psychoeducational materials varied from originally planned, and were no longer included as an email but rather were included as a single document within the Survey Monkey website. The content and wording remained consistent with existing IRB-approved documents.

Participant solicitation and data collection began October 29, 2020, and continued until the desired number of responses was achieved on February 1, 2021. A total of 168

respondents completed the surveys with an average completion rate of 92%. Incomplete surveys and those completed by ineligible participants were removed from the study, leaving a total of 119 participants. This sample size was adequate considering the power analyses that indicated a sample size of 107 would have sufficient power.

Baseline descriptive and demographic characteristics of the sample

Participants were asked to complete a study-specific demographic questionnaire including both personally and professionally oriented questions relevant to the study. The sample consisted of 119 CMHCs throughout the United States who provide IPV counseling services. The frequency and percentage of participants' responses to the personally oriented demographic questions addressing gender, age, ethnicity, relationship status, and religion are included in Tables 2 and 3. Respondents were also asked to indicate their current personal IPV status. In response to the question "have you, a friend, family member, or loved one (non-client relationship) ever been a victim/survivor of IPV?" 75 (63.0%) of the sample indicated "yes," 25 (21.0%) indicated "no," and 19 (16.0%) indicated a preference not to reply.

Table 2

Participant personal demographic data: Gender and age

	Frequency	Percentage
Which gender identity do you most closely identify with?		
Female	96	80.7%
Gender variant/nonconforming	1	0.8%
Male	20	16.8%
Other (please specify)	1	0.8%
Transgender male	1	0.8%
Transgender female	0	0.0%
What is your age?		
25–34 years	33	27.7%
35–44 years	35	29.4%
45–54 years	22	18.5%
55 years or older	29	24.4%

A total of 97 participants (80.7%) identified as female, and 35 (29.4%) of the sample reported as being within the age range of 35–44 years. A total of 72 (60.5%) reported White ethnicity, 85 (71.4%) indicated being Engaged/Married, and 55 (46.2%) indicated a Christian religious affiliation (see Table 3). The gender and age range of the sample appeared to be consistent with national statistics provided for counselors within the United States. The U.S. Department of Labor (2019) indicated that there were 283,540 counselors employed across the substance abuse, behavioral disorder, and mental health occupations. I was not able to locate statistics that described the demographics of U.S. CMHCs. However, based on the available information regarding U.S. counselors, it appears that most counselors are White females with an average age of 41.3 years (National Mental Health Services Survey (N-MHSS), 2019). Considering this

information, the study sample appeared to represent the larger population of counselors across the United States in terms of age and gender.

Table 3

Participant personal demographic data: Ethnicity, relationship status, and religion

	Frequency	Percentage
How would you describe your ethnicity?		
African American or Black	35	29.4%
Asian	2	1.7%
Caucasian/White	72	60.5%
Hispanic/Latina/Latino	5	4.2%
Native American/American Indian or Alaska Native	1	0.8%
What is your current relationship status?		
Co-habitating/domestic partnership	7	5.9%
Dating	3	2.5%
Divorced	7	5.9%
Engaged/married	85	71.4%
Other (please specify)	1	0.8%
Prefer not to answer	1	0.8%
Separated	4	3.4%
Single (never married)	10	8.4%
What is your current religious/spiritual affiliation if any?		
Agnostic	8	6.7%
Atheist	6	5.0%
Buddhist	1	0.8%
Christian	55	46.2%
Jewish	3	2.5%
Other (please specify)	14	11.8%

Results

In this section, the data analysis process is described including a summary of the data cleaning process, the complete descriptive statistics of the sample, and an evaluation of the statistical assumptions appropriate to the linear multiple regression statistical test.

Using linear multiple regression analysis, the current study quantitatively explored the predictive statistical relationship between wellness levels, resiliency levels, and VT levels among IPV CMHCs. The results of the multiple linear regression analyses conducted and study findings are included here.

Data cleaning

The initial portion of the data analysis process included downloading the raw data from the Survey Monkey website, uploading it into Microsoft Excel, and then into the SPSS (Version 25) statistical analysis software. After download, the data collected from the 168 total participants were reviewed and cleaned within Microsoft Excel for any incomplete responses or any ineligible participants. Ineligible participants included those who indicated they were outside of the professional discipline of clinical counseling. For example, social workers, psychologists, and schoolteachers were removed from the sample. Incomplete responses included those surveys which were not completed in their entirety or where questions were not responded to. This lowered the total eligible participant responses and sample size down to n=119. The final cleaned and coded Excel spreadsheet including participant responses for each scale was then transferred into SPSS (Version 25) for analysis. The next step of the data analysis process was to convert the raw scores into standardized z-scores using the SPSS (Version 25) software.

After this conversion, the next step was to examine the dataset for outliers, those scores which significantly varied from most of the scores throughout the dataset (Frankfort-Nachmias & Leon-Guerrero, 2018). For this study, an *outlier* was defined as a value at least 3 standard deviations above or below the mean value. Graphic

representations of the data, specifically boxplots, were generated to examine the presence of outliers within each variable of the data set (see Figure 1). Outliers were determined within the resilience level variable (BRS) and the VT level variable (VTS). The mean and standard deviation scores were generated and examined for each variable (see Table 3). The mean score and standard deviation for the resilience level variable (BRS) with the outliers included was (*M*) = .000, (*SD*) =1.00, and without the outlier, scores included, (*M*) =.000, (*SD*) = 1.000. The mean score and standard deviation for the VT level variable (VTS) with the outliers included was (*M*) = .000, (*SD*) =1.00, and without the outlier, scores included, (*M*) =.000, (*SD*) = 1.000. With no changes to these descriptives with and without the outlier values, the outliers were removed from each of these variables.

Figure 1

Boxplots of study variables

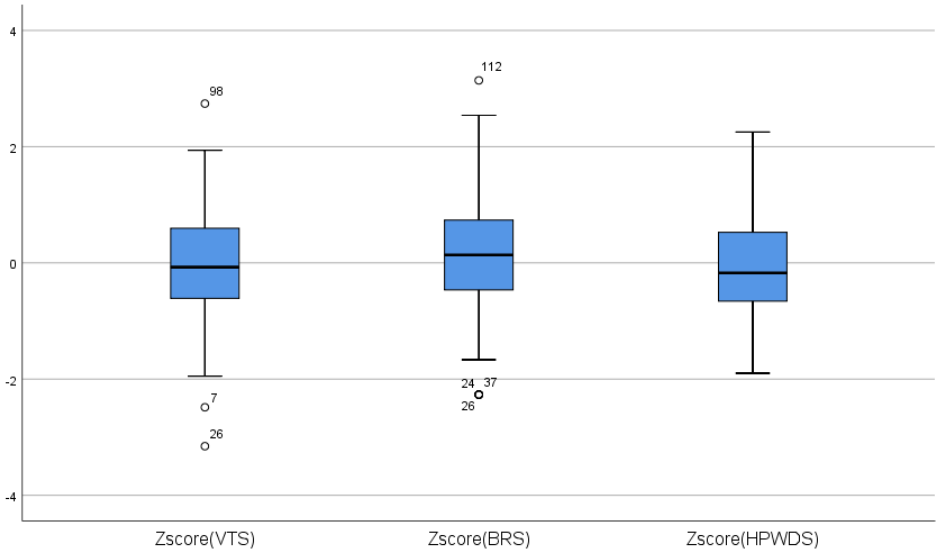


Table 4

Descriptive statistics for each study variable

	N	Minimum	Maximum	Mean	Std. Deviation
VTS	119	-3.15522	2.74083	.0000000	1.00000000
BRS	119	-2.26699	3.14047	.0000000	1.00000000
HPWDS	119	-1.89873	2.25135	.0000000	1.00000000

Statistical assumptions

A linear multiple regression statistical analysis was conducted for this study to determine the presence of a predictive relationship between the identified variables. In addition to ensuring the variables selected are of the appropriate continuous level of measure, there are six assumptions of the multiple regression analysis which must be satisfied including a) linear relationship, b) multivariate normality, c) little or no multicollinearity, d) homoscedasticity, e) independence of error, and f) there are no influential cases causing bias. The multiple regression analysis includes the examination of two or more continuous level predictive variables (wellness and resiliency levels), and a single continuous level outcome variable (VT; Creswell & Creswell, 2018). The next step in the data analysis process was to test the assumptions for the multiple regression statistical test.

Linear relationship. The assumption of a linear relationship between predictor variables and the outcome variable ensures that any relationship detected will be an accurate representation of the true relationship (Frankfort-Nachmias & Leon-Guererro, 2018). The assumption of a linear relationship was tested by examination of graphic representations of the variable data, specifically, a matrix scatterplot generated within

SPSS (Version 25; see Figure 2). After examination of the matrix scatterplot, the predictor and outcome variables appear to have somewhat of a linear relationship, which satisfies this statistical assumption. The assumption of linearity was also tested by examination of a scatterplot visual representation of the standardized residual values and the standardized predicted values, (see Figure 3; Frankfort-Nachmias and Leon-Guerrero, 2018). The scatterplot depicts residual scores spread positively and negatively with a seemingly random pattern, also satisfying the assumption of linearity.

Figure 2

Scatterplot matrix of study variables

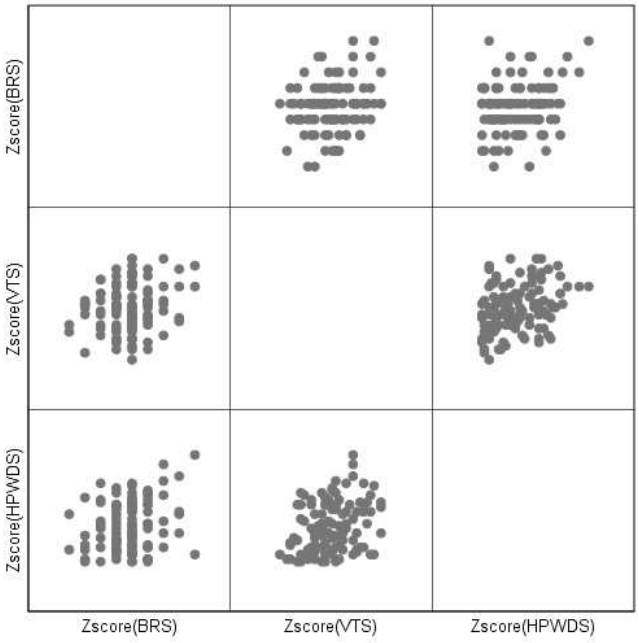
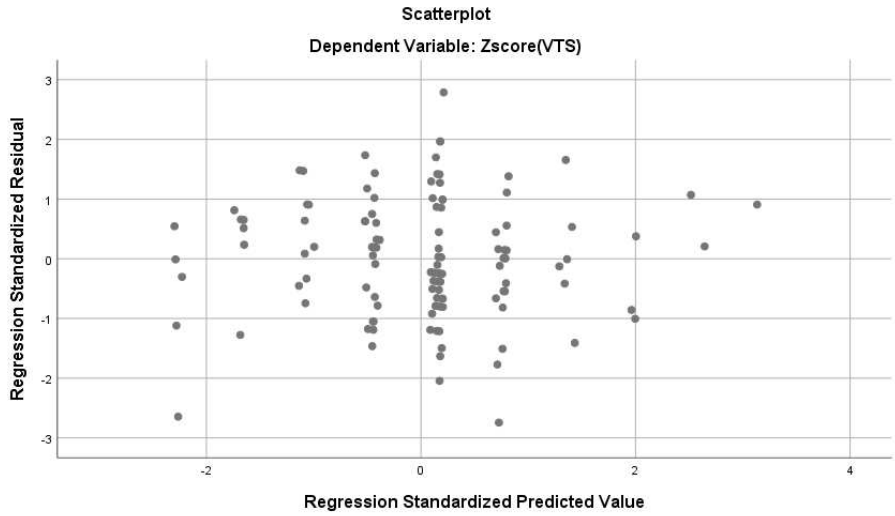


Figure 3

Scatterplot of residual and predictor values



Multivariate normality. The assumption of normality indicates that the data is normally distributed (Frankfort-Nachmias & Leon-Guerrero, 2018). This assumption was tested using the SPSS (Version 25) software, specifically, a frequency distribution was generated within a histogram and probability-plots, (P-Plots), to depict the data. The graphic representation of each variable appeared to be normally distributed (see Figures 4,5, 6, and 7). The assumption of normality was also tested by examination of the skewness and kurtosis values for each variable (see Table 5). These values indicate a normal distribution within the range of -1 and 1, where a value of 0 indicates a normal distribution (Frankfort-Nachmias & Leon-Guerrero, 2018). Skewness values for VT were (-.059), and kurtosis was (.317), both of which indicate that the data for VT did not include any significant skewness or kurtosis and were normally distributed. Skewness values for resiliency were (.121) and kurtosis was (.969), falling within the range of

normality (-1 and 1). The skewness values for wellness were (.468), and kurtosis was (-.602), both of which did not indicate any significant skewness or kurtosis and were normally distributed. Each of the variables appeared to satisfy the statistical assumption of normality.

Table 5

Multivariate normality values: Skewness and kurtosis values

	VTS	BRS	HPWDS
Skewness	-.059	.121	.468
Kurtosis	.317	.969	-.602

Little or no multicollinearity. The assumption of multicollinearity indicates that each of the predictor variables (resiliency and wellness levels) is independent of one another (Frankfort-Nachmias & Leon-Guerrero, 2018). This assumption can be tested by generating a Pearson correlation, by examining the collinearity statistics within SPSS (Version 25), or by examining the predictor variable scores. The correlation values were low for each of the predictor variables, BRS (.257), and HPWDS (.008) both of which fall below 0.7 indicating little or no multicollinearity, satisfying this statistical assumption. Correlation coefficients of 1 or -1 indicate collinearity (Frankfort-Nachmias & Leon-Guerrero, 2018). The tolerance score of (.996) and variance inflation factor (VIF) scores of 1.004 for both predictor variables, also indicate little to no multicollinearity. A tolerance value less than 0.2, indicates a potential violation of this assumption (Frankfort-Nachmias & Leon-Guerrero, 2018). A VIF value less than 10, and an average VIF for all variables not greater than 1.0 indicate satisfaction of this assumption (Frankfort-Nachmias & Leon-Guerrero, 2018).

Homoscedasticity. Homoscedasticity is an assumption that the variance within the predictor and outcome variables is constant throughout the sample (Frankfort-Nachmias & Leon-Guerrero, 2018). This assumption is tested by an examination of graphic representations of standardized residuals and standardized predicted values, specifically a scatterplot, (see Figure 2). The spread of the data points appeared seemingly random with no values exceeding the limitations of 3 or -3 on the graph, indicating the satisfaction of this assumption.

Independence of error. The assumption of independence of error assumes that there is no autocorrelation, or that any errors within the data were not due to participant influence upon one another (Frankfort-Nachmias & Leon-Guerrero, 2018). This assumption was tested using the Durbin-Watson test which was generated within SPSS (Version 25; see Table 4). The Durbin-Watson values range from 0 to 4, with no autocorrelation falling within the range of 1.5 and 2.5 (Frankfort-Nachmias & Leon-Guerrero, 2018). The Durbin Watson value for this study was 1.75, indicating there was independence of residuals, no autocorrelation, and satisfaction of this statistical assumption.

Figure 4

Multivariate normality histogram

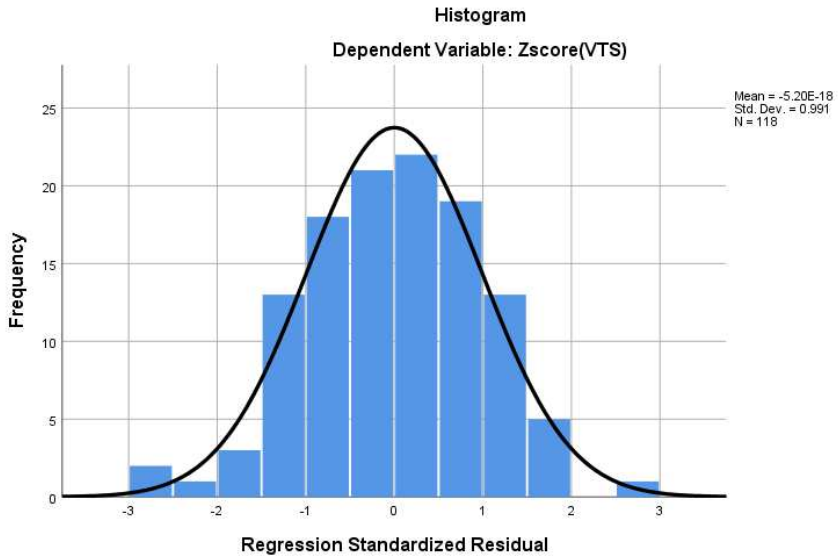


Figure 5

Scatterplot of vicarious trauma level

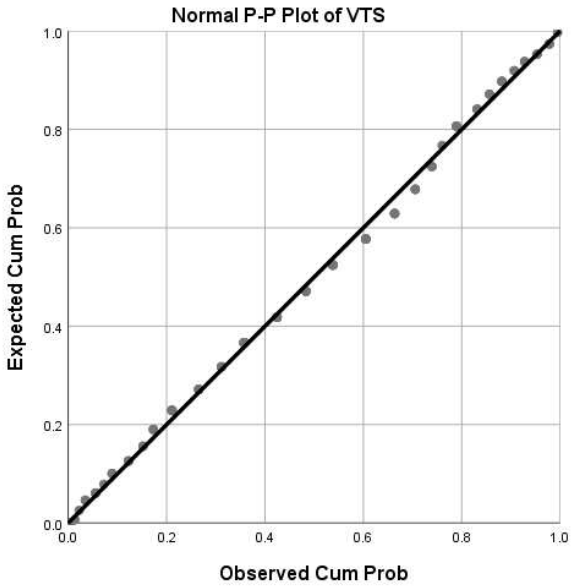


Figure 6

Scatterplot of resiliency level

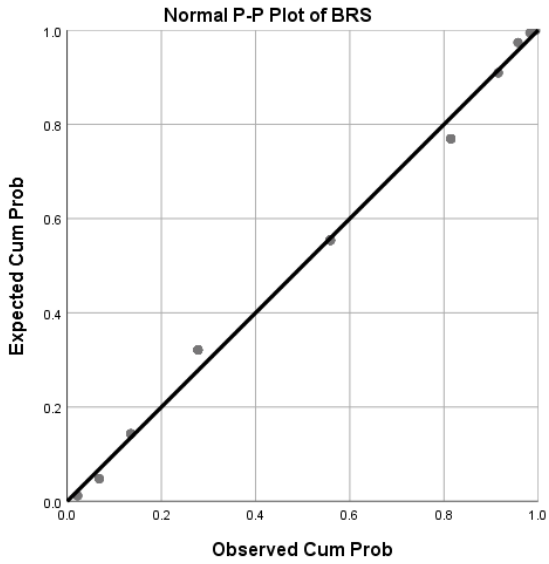


Figure 7

Scatterplot of wellness level

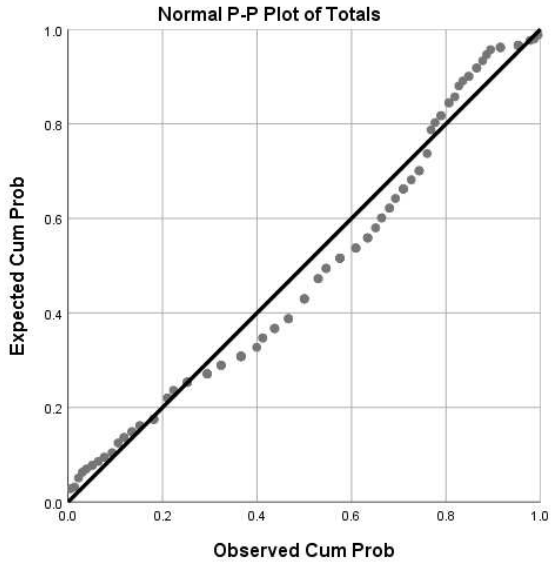


Figure 8

Model summary independence of error test

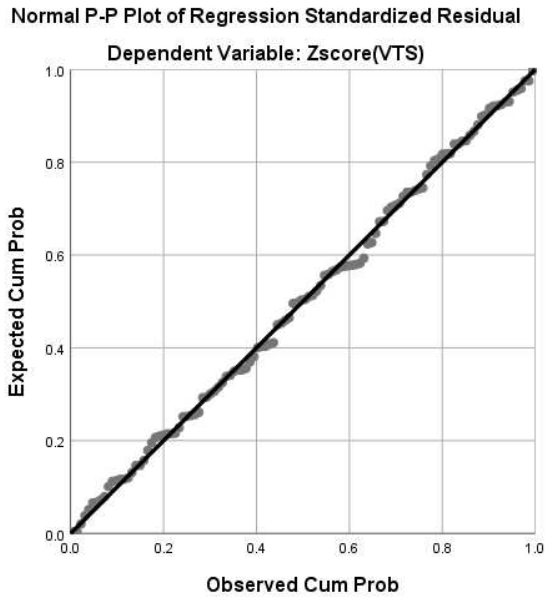


Table 6

Model summary independence of error test

Model	*R*	*R* Square	Adjusted *R* Square	Std. Error	Durbin-Watson
1	.258[a]	.066	.050	.96886108	1.751

a. Predictors: (Constant), Zscore (HPWDS), Zscore(BRS)

b. Dependent Variable: Zscore (VTS)

No influential cases biasing the data. The final assumption of the multiple regression analysis assumes that there are no influential data points that could bias the model or result in a less representative result (Frankfort-Nachmias & Leon-Guerrero, 2018). This assumption was tested by conducting Cook's distance test. Any Cook's distance value above 1 indicates an influential case, which could bias the model. The

Cook's distance test revealed a maximum value of (.140) and a minimum value of (.000), with no values above 1, satisfying this assumption.

Statistical analysis

Demographic information. The study-specific demographic questionnaire included personally and professionally-oriented questions ranging from participant age and relationship status to the caseload composition and length of time in the profession. The demographic survey report indicated that the sample for this study appeared to adequately represent the general population of counselors across the United States across the variables of gender and age. The personally oriented demographics are presented in Tables 2 and 3. The professionally-oriented demographics were as follows. Regarding employment, most respondents 97 (81.51%) were employed full time, and 42 (35.3%) have been in the CHMC profession for 6-8 years (see Tables 7 and 8). When asked about their work with the IPV population, 85 (71.4%) participants indicated they have been working with this population for 24 or more months (see Table 9).

Table 7

Participant employment status

	Frequency	Percentage
Employed part-time (up to 34 hours per week)	13	10.93%
Full-time employment (35+ hours per week)	*97*	81.51%
Other (please specify)	*6*	5.04%
Retired	*2*	1.68%
Unemployed and currently seeking work	*1*	.84%

Table 8

Years employed as a clinical mental health counselor (CMHC)

	Frequency	Percentage
0-2 years	9	7.6%
3-5 years	15	12.6%
6-8 years	42	35.3%
9-11 years	14	11.8%
12 or more years	39	32.7%

Table 9

Length of time working with the IPV population

	Frequency	Percentage
1-6 months	9	7.56%
12-18 months	6	5.04%
18-24 months	12	10.15%
6-12 months	7	5.88%
24 or more months	85	71.43%

Eligible study participants included post-graduate CMHCs. The academic and professional details of these participants were also explored. Overall, most participants 108 (90.8%) held a master's degree, with 57 (47.9%) indicating graduation from a CACREP program (see Tables 10 and 11). The demographic survey report also explored participant's current licensure status, were of the 48 respondents who indicated status, 38 (52.1%) indicated holding current licensure (see Table 12).

Table 10

Highest level of education/degree completed

	Frequency	Cumulative percentage
Doctorate (e.g. PhD, EdD)	11	9.2%
Master's degree (e.g. MA, MS, Med)	108	90.8%

Table 11

Council for the Accreditation of Counseling and Related Educational Programs (CACREP) accredited program graduate indication

	Frequency	Cumulative percentage
No	38	52.1%
Yes	57	47.9%

Table 12

Current licensure status

	Frequency	Cumulative Percentage
Active	39	52.1%
Expired	1	.8%
None	8	6.7%

Clinical supervision services were also explored among respondents. Overall, of those 107 who replied, most respondents 79 (66.4%) indicated that they were not receiving clinical supervision at the time of survey completion (see Table 13). Of the 83 who indicated, 20 (16.8%) respondents indicated the supervision was from a Board Approved Clinical Supervisor (see Table 14). Study participants were also asked if the clinical supervision they received was considered Trauma-Informed Supervision (TIS). Lastly, the demographic survey report indicated that of the 82 participants who responded to the item, 46 (38.7%) respondents reported that TIS was not applicable to them (see Table 15).

Table 13

Receipt of current clinical supervision

	Frequency	Cumulative percentage
N/A	13	12.15%
No	79	73.83%
Yes	15	14.02%

Table 14

Receipt of clinical supervision from a board approved clinical supervisor (BACS)

	Frequency	Cumulative percentage
N/A	53	74.8%
No	10	8.4%
Yes	20	16.8%

Table 15

Receipt of trauma informed clinical supervision

	Frequency	Cumulative percentage
N/A	46	38.7%
No	11	9.2%
Yes	25	21.0%

Study respondents were asked additional questions regarding environmental factors relevant to the variables examined within the study. Most participants, 68 (57.1%) indicated that they process traumatic client material with colleagues (see Table 16). Finally, study participants were asked if IPV exposure associated with the #MeToo movement has impacted them. Of the 92 respondents, 25 (42.9%) indicated that increased #MeToo IPV exposures have impacted them (see Table 17).

Table 16

Whether participants debrief/process traumatic case content with colleagues

	Frequency	Cumulative percentage
No	25	42.9%
Yes	68	57.1%

Table 17

Whether IPV exposure associated with the #MeToo *movement has been impactful*

	Frequency	Cumulative percentage
N/A	15	12.6%
NO	31	26.1%
Other	1	.8%
Yes	47	39.5%

Scoring responses on instruments. Measures of central tendency were calculated for each of the variables examined for the study using the SPSS (Version 25) software. The mean, median, mode, range of the scores, standard deviation, highest and lowest score for each variable were examined for this study (see Tables 18,19, and 20). Participant response information for each scale is as follows.

The first predictor variable reviewed was wellness. The HPWDS was used to measure participant wellness levels. This scale required respondents to indicate perceived and aspirational wellness levels across 22 items covering varying domains of wellness. Due to formatting limitations within the survey distribution website, each of the 22 items was separated into 2 questions. Respondents indicated wellness across a total of 44 questions, 22 questions examined perceived areas of current wellness functioning (how often do you?) and 22 questions examined areas of aspirational levels of wellness functioning (how often do you want to?). Each of these 44 assessment items was rated on a 5-point Likert scale with response options ranging from 1= (0-2 times within a week) to

5 = (12 or more times within a week). The response scores range from values of 1 to 110, with the lower scores indicating lower levels of wellness. The mean wellness score for the sample was 62.27 (with a standard deviation of 18.49). The median score was 59.00 and the mode was (*Mo*= 53.00). The scores were evenly distributed, platykurtic, (-.602), and were not skewed (.468). The range was 27.00 -104.00. Based on these results, it appears that study participants reported a moderate level of wellness, (see Table 18).

Table 18

Statistics for the HPWDS

	HPWDS
Mean	62.27
Median	59.00
Std. Deviation	18.49
Minimum	27.00
Maximum	104.00
Range	77.00
Skewness	.468
Kurtosis	-.602

The second predictor variable reviewed was resiliency. The BRS was used to measure participant resiliency level. Participants rated their resiliency levels within 6 questions on a 5-point Likert scale with response options ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Possible scores range from 6 to 30, with lower scores indicating lower levels of resilience. The mean score for the sample was 17.77 (with a standard deviation of 1.66). The median score was 18.00 and the mode was (*Mo*= 18.00). The range was 14.00- 23.00. The scores were evenly distributed, mesokurtic (.969), and were not skewed (.121). The higher the BRS score, the higher the resiliency level. Based

on these results it appears that study participants were experiencing moderate levels of resiliency at the time of assessment (see Table 19).

Table 19

Statistics for the BRS

	BRS
Mean	17.77
Median	18.00
Std. Deviation	1.66
Minimum	14.00
Maximum	23.00
Range	9.00
Skewness	.121
Kurtosis	.969

The final variable for the study, the outcome variable VT level was measured using the VTS. Respondents indicated vicarious trauma levels within eight questions on a 7-point Likert scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). Possible scores ranged from a minimum value of 8 to a maximum value of 56, with higher scores indicating higher levels of VT. The mean score for the sample was 34.55 (with a standard deviation of 7.46). The median score was 34.00 and the mode was (*Mo*= 33.00). The range was 11.00 -55.00. The scores were evenly distributed, platykurtic (.317), and were not skewed (-.059) The higher the VTS score, the higher the VT level. Based on these results it appears that study participants were experiencing moderate levels of VT at the time of assessment, (see Table 20).

Table 20

Statistics for the VTS

	VTS
Mean	.0000000
Median	-.0731940
Std. Deviation	1.00000000
Minimum	-3.15522
Maximum	2.74083
Range	5.89606
Skewness	-.059
Kurtosis	.317

Regression analysis. The next step of the data analysis portion of the study was to conduct the linear regression statistical test to answer the research question posed, and to test the hypotheses for the study. The research question for the study was: Is there a significant predictive relationship between VT level, wellness level, and resiliency level among IPV CHMCs. The multiple linear regression was conducted to predict VT level based on wellness level and resiliency level. An alpha level of .05 was used as the significance level throughout these analyses. The results of the multiple linear regression model were not significant, F (2, 115) = 4.088), p = .922, R^2 = .066. The multiple linear regression effect size was calculated using *Cohen's* f^2 which is the equation typically used for this statistical test (Frankfort-Nachmias & Leon-Guerrero, 2018). The effect size calculated for the current linear regression model is f^2 = .071, which is considered a small effect size. A small effect size (.071) accounts for 2% of the variance.

H_o1. There is a statistically significant predictive relationship between the outcome variable VT level and predictor variable wellness level among IPV CMHCs measured by an anonymous self-report survey.

H_a1. There is no statistically significant predictive relationship between outcome variable VT level and predictor variable wellness level among IPV CMHCs measured by an anonymous self-report survey.

Research hypothesis 1 stated that VT levels among IPV CMHCs who serve the IPV population could be predicted by wellness levels. The results of the regression analysis indicated that wellness did not significantly predict VT level. Based on these results, I failed to reject the null hypothesis 1 (see Table 21).

H_o2. There is no statistically significant predictive relationship between outcome variable VT level and predictor variable resiliency among IPV CMHCs measured by an anonymous self-report survey.

H_a2. There is a statistically significant predictive relationship between outcome variable VT level and predictor variable resiliency among IPV CMHCs measured by an anonymous self-report survey.

Research hypothesis 2 stated that VT levels among IPV CMHCs who serve the IPV population could be predicted by resiliency levels. The results of the linear regression analysis indicated that resiliency did significantly predict VT level. Based on these results, I rejected the null hypothesis 2 (see Table 21).

H_o3. There is no statistically significant prediction of VT level by wellness level and resiliency level among IPV CMHCs measured by an anonymous self-report survey.

H_a3. There is a statistically significant prediction of VT level by wellness level and resiliency level among IPV CMHCs measured by an anonymous self-report survey.

Research hypothesis 3 stated that there is a statistically significant prediction of VT level by wellness level and resiliency level among IPV CMHCs measured by an anonymous self-report survey. The multiple regression analysis suggested that participant resiliency level was a significant predictor of VT level, but wellness level was not, (see Table 21). Based on these results, I failed to reject null hypothesis 3.

Table 21

Linear multiple regression analysis

Model	Unstandardized B	Coefficients Std. Error	Standardized Coefficients Beta	*t*	Sig.
(Constant)	-.009	.089		-.098	.922
BRS	.260	.091	.259	2.858	.005
HPWDS	-.009	.091	-.010	-.106	.916

R^2= .066 R^2 $_{Adjusted}$ =.050

Summary

The purpose of this study was to determine the quantitative predictive relationship between predictor variables resiliency levels and wellness levels, and the dependent variable, vicarious trauma level among CMHCs serving the IPV client population. A multiple linear regression analysis was conducted to determine if the combination of predictor variables predicted VT levels among IPV CMHCs. The regression analysis indicated that the combination of wellness and resiliency together did not significantly predict VT levels among CMHCs serving the IPV client population. These analyses suggest that there are other variables not included within the current study that contribute to VT levels among CMHCs serving the IPV population.

The next chapter includes further interpretation of the findings listed here within the context of relevant existing literature regarding VT. Chapter 5 also includes a

discussion of the limitations of the current study including the areas of validity, reliability, generalizability, and trustworthiness of the results. Lastly, chapter 5 includes a discussion of recommendations for further exploration, as well as the implications of this new data within the counseling education profession.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this quantitative study was to examine for a statistically significant predictive relationship between wellness level, resiliency level, and VT level among IPV CMHCs. VT can have damaging personal and professional consequences on the lives of those impacted (Foreman, 2018; Maguire & Byrne, 2017). Increased knowledge and information about VT may supplement training, education, supervision, and professional development for these mental health professionals. The potential positive social change implications of the current study may include not only providing counselor educators, clinical supervisors, and IPV CMHCs with VT information, but also enriching the counseling services provided to IPV survivors.

A total of 119 CMHCs serving only IPV clients were recruited across the United States for participation in the current quantitative web-based survey study. A multiple regression analysis was conducted to examine for a predictive relationship between wellness levels, resiliency levels, and VT levels among participants. The results of this study indicated that resiliency levels among professionals predict VT levels, but wellness levels do not.

The following chapter includes a description of these findings within the context of the existing VT literature. The results are discussed within the context of existing personal and professional factors associated with VT, including wellness, resiliency, caseload composition, and professional discipline. Next, the findings are examined within the context of the CSDT theoretical framework used for the study. Limitations to the

validity and reliability of the study are then discussed, followed by recommendations for further study. Finally, general and positive social change implications are explored.

Interpretation of findings

The existing literature included a wide range of exploration on the personal and professional factors associated with the development of VT among mental health professionals. The current study extended this body of research by addressing the personal factors of wellness and resiliency and the professional factors of mental health discipline (only CMHCs) and caseload composition (only IPV clients). The results of the current study confirmed and contradicted existing findings regarding VT development. Resiliency level was a statistically significant predictor of VT among CMHCs serving IPV clients, supporting existing research.

Personal and professional factors associated with VT development

Existing literature addressed personally and professionally oriented factors associated with VT development across methodologies and analyses (Bell et al., 2003; Branson et al., 2003; Brady et al., 1999; Brend et al., 2020; Catanese, 2010; Choi, 2011; Cunningham, 2003; Foreman, 2018; Halevi & Idisis, 2018; Hensel et al., 2015; Marmar et al., 1996; Neuman & Gamble, 1995; McCann & Pearlman, 1990; Saakvitne & Pearlman, 1995; Sprang et al, 2007). The current study addressed both personally and professionally oriented factors in the development of VT. I used the HPWDS and the BRS to measure the personally oriented factors of wellness levels and resiliency levels. The professionally oriented factors of caseload composition and professional discipline were inclusion criteria for study participants. Participation was limited to CMHCs whose

counseling caseload consisted of only IPV clients. Professionals from other disciplines, such as psychology or social work, and those with diverse caseloads other than IPV clients were excluded from the study.

Personal factors

Wellness level. The personally oriented factor of wellness level was examined using the HPWDS. The response scores ranged from 1 to 110, with the lower scores indicating lower levels of wellness. The mean wellness score for the sample was 62.27 with a standard deviation of 18.49, indicating a moderate level of wellness at the time of assessment. These results suggested that wellness level did not significantly predict VT levels among IPV CMHCs. These findings contradicted existing research regarding the mitigating influence wellness can have on VT development. Foreman (2018) examined the impact of wellness practices on VT levels among licensed mental health professionals. The results indicated that increased wellness practices were associated with decreased VT levels among participants. Williams et al. (2012) also examined the personal and professional factors associated with VT development among mental health professionals, including wellness practices. The results indicated that wellness practices had a significant mediating impact on VT levels among the sample of mental health professionals. Using a qualitative approach, Harrison and Westwood (2009) examined protective practices among mental health therapists who self-identified as doing well for more than 10 years. Contrary to the results of the current study, the qualitative interviews conducted revealed that holistic wellness and self-care practices were among the central protective factors identified.

The results of the current study further contradicted existing findings regarding the mitigating impact of wellness on VT development among mental health professionals with trauma-intensive caseloads (see Bishop & Schmidt, 2011; Foreman, 2018; Hensel et al., 2015; Kulkarni et al., 2013). Hensel et al. (2015) conducted a meta-analysis exploring the risk factors of STS across a range of professional disciplines exposed to varying levels of trauma. Among the mitigating factors included the wellness practices of the professionals sampled. Using a mixed-methods approach, Bishop and Schmidt (2011) examined only those professionals who serve IPV survivors. The results of the self-report survey and focus group sessions indicated that wellness strategies assisted in mitigating the impact of the IPV work. The results of the current study also contradicted the findings of Kulkarni et al. (2013) whose research indicated the mitigating impact restorative wellness practices could have on VT and burnout among IPV service providers.

Resiliency level. The personally oriented factor of resiliency level was examined using the BRS in the current study. Response scores ranged from 6 to 30, with lower scores indicating lower levels of resilience. The mean resiliency score for the sample was 17.77 with a standard deviation of 1.66, indicating moderate levels of resiliency at the time of assessment. These results indicated that resiliency levels significantly predicted VT levels among CMHCs. These findings supported existing knowledge regarding the relationship between resiliency and VT. Increased resiliency among mental health professionals can deter VT development (Bell et al., 2003; Greinacher et al., 2019; Kinman & Grant, 2017). Bell et al. (2003) conducted a qualitative examination of factors associated with VT development. Interview respondents indicated that resilience assisted

with effective VT coping. Kinman and Grant (2017) also highlighted the importance of resiliency and resiliency training as mitigating factors against VT development among novice mental health professionals. Greinacher et al. (2019) examined numerous factors related to VT development among first responders. Findings indicated that participants with increased resiliency had lower levels of VT.

The results of the current study extended existing findings that resiliency can mitigate VT among mental health professionals (Kinman & Grant, 2017). The results of the current study suggested that resilience can predict VT. Promotion of resiliency among professionals exposed to traumatic client content including those IPV CHMC may mitigate the impact of VT.

Professional factors

Caseload composition. Caseload composition of only IPV clients was an inclusion criterion for the current study; only respondents who serve IPV clients were able to participate. The sample for the current study consisted of 119 CMHCs serving only IPV clients. Caseload composition, trauma saturation, and trauma ratio were examined as contributing factors to VT development in the literature (Bell, 2003; Brend et al., 2020; Choi, 2011; Hensel et al., 2015). Bell (2003) found that a diversified caseload could assist in ameliorating or preventing VT development among professionals. In a review of 13 studies, Brend et al. (2020) found that the impact of IPV work among human services professionals who serve only IPV clients increased challenges associated with the work. Hensel et al. (2015) found that among 38 studies examined within a meta-analysis of STS risk factors among mental health professionals,

many indicated a diverse caseload composition could mitigate VT development. Choi (2011) found that social workers providing only IPV services experienced STS, and 29% met diagnostic criteria for PTSD.

The results of the current study extended the existing knowledge that caseload composition may be associated with VT development among professionals. Of the 119 CMHCs with IPV caseloads in the current study, the mean score on the VTS was 34.55, indicating a moderate level of VT across the sample. These results supported existing literature (Bell et al., 2003; Brend et al., 2020; Choi, 2011) that IPV caseload composition can contribute to VT development and extended those results to include the population of IPV CMHCs.

Professional discipline. The professional discipline of CMHC was an inclusion criterion for the current study. Professional discipline has been a factor noted throughout the VT literature, as the type of IPV exposure and treatment can vary across occupational titles and responsibilities (Cunningham, 2003; Dunkley & Whelan, 2006; Greinacher et al., 2018; Howlett & Collins, 2014; Iqbal, 2015; Maguire & Byrne, 2017). A first responder or nurse may have a different level and intensity of IPV exposure or engagement compared to lawyers or mental health professionals (Greinacher et al., 2019; Iqbal, 2015; Maguire & Byrne, 2017). The results of the current study contributed to the existing VT literature by addressing VT among CMHCs who are serving only IPV clients. Respondents who were not IPV CMHCs were removed from the sample.

The results of the current study extended the existing literature by providing information about VT within the context of IPV CMHCs. Of the 119 CHMCs included in

this study, moderate levels of VT were reported within the VTS (mean score of 34.55). These results supported the existing literature (see Greinacher et al., 2019; Iqbal, 2015; Maguire & Byrne, 2017) that professional discipline can impact VT development, and contributed to the understanding of VT among CMHCs.

Theoretical framework revisited

The current study was based on the eclectic CSDT model (see McCann & Pearlman, 1990), which provided a context for understanding the psychological impact traumatic client material can have on professionals. CSDT suggests that continued exposure to traumatic client material, partnered with the empathetic engagement of the counseling relationship, can adversely impact the worldview of the professional, resulting in VT (Pearlman & Saakvitne, 1995). The VT and wellness tenets of this model were supported and contraindicated in the current study.

CSDT provided the foundation for a central assumption in the current study that CMHCs serving only IPV survivors will report VT. VT was measured using the VTS. Possible scores on this assessment ranged from a minimum of 8 to a maximum of 56, with higher scores indicating higher levels of VT. The mean score for the sample was 34.55 with a standard deviation of 7.46, indicating moderate levels of VT across the sample of 119 IPV CMHCs. Within the context of the CSDT foundation and the caseload composition of eligible participants, the results of the study were anticipated. However, considering the increased exposure to traumatic client material, the CSDT would suggest higher levels of VT among this sample.

Current literature suggested that within the context of CSDT, wellness practices may mitigate the impact of VT among professionals (Williams et al., 2012). The results of the current study did not support this theme. The results of the multilinear regression analysis indicated that wellness did not significantly predict VT levels among IPV CMHCs, $p = .916$.

Limitations of study

The specific sample of 119 IPV CMHCs limited the generalizability of the results to this specific population. There may also have been a selection limitation. Participants who engaged in the study may have had predisposed characteristics such as VT, resiliency, or wellness, which could have altered their responses. Further, potential participants who chose not to respond may have been experiencing increased VT, which may have impacted their decision to complete the surveys. Additionally, despite the anonymity of the web-based surveys, there could have been a social desirability bias that could have threatened the generalizability of these results. Specifically, respondents may have been reluctant to accurately report their experiences across all variables due to fear of judgment. Further, social desirability bias not only could have impacted the reports made by participants but also could have prevented participation from those who chose not to respond. Although participants were offered psychoeducational materials and referrals to address symptoms, the adverse psychological impact of VT could have impacted accurate reporting among participants, as well as participation from potential respondents. Additionally, although VT was operationalized, comprehension or understanding of this construct was not verified before survey completion. Many words

are used interchangeably with VT, and participants may have mistaken VT for burnout, for example. This misuse of terms could have altered accurate reporting among participants.

In addition, there was history bias present for the study in two areas: the influence of the #MeToo movement on the experiences of the participants, and the timing of the COVID-19 pandemic. Regarding the #MeToo movement, participants may have experienced increased exposure to IPV content outside of the context of occupational settings. Of the 119 study respondents, 39.5% indicated that IPV exposure associated with the #MeToo movement had impacted them. In addition to the #MeToo movement, the unanticipated COVID-19 pandemic was occurring at the time of data collection. The global pandemic forced change for millions of people across many functional domains, and may have impacted resiliency levels, wellness practices, and VT levels among the study sample. This history bias could have impacted the data by altering not only participation overall but also the reports made across all variables included in the study.

Recommendations

Based on the results, there are several areas warranting further study. Future research focused on these variables could provide not only additional information and understanding but also confirmation of the findings from the current study. Recommendations for further study include replication of the current study with expansion of the parameters and adjustments to the methodology or variables.

A replication of the study following a resolution of the COVID-19 global pandemic is recommended. Once potential respondents resume typical functioning across

varying areas of life including most notably occupational and wellness-oriented functioning, it may alter the respondents, response rates, as well as content reported. Replication of the study with altered methodology could also further inform the topic, perhaps in the form of qualitative interviews, focus groups, or case studies to further explore VT development within the IPV counseling specialty. The qualitative methodology could further inform existing findings of not only the current study but the existing library of research as well. Further research could explore not only VT development within the IPV counseling specialty but perhaps an exploration of preventative or mitigating factors associated with VT as well.

Predictor variables

The predictor variables selected for the current study included wellness levels, as measured by the HPWDS, and resiliency levels as measured by the BRS. The results of the current study suggest that resiliency does predict VT at statistically significant levels. This result suggests that resiliency is associated VT development among professionals. Further exploration of this variable is suggested across varying methodologies, samples, and variables to increase knowledge and understanding of the specific role of resiliency in VT development. Specifically, future research could explore potential correlations or directional relationship between resilience and VT with consideration to other variables or methodologies. Perhaps increased knowledge, understanding, training, and professional development around resilience could further promote VT mitigation.

Surprisingly, the results of the current study suggest that wellness does not predict VT development among IPV CMHCs at statistically significant levels. These findings

indicate that there may be other factors that were not included in the current study which could contribute to VT levels. These findings invite further exploration into this variable across varying methodologies, instruments, samples, and variables. Further exploration into wellness levels could clarify the relationship between these two constructs.

Study-specific demographics questionnaire

The study-specific demographic survey posed various personally and professionally-oriented questions for participants. Although statistical analyses were not conducted to determine specific quantitative relationships for these questionnaire items, percentages were noted. Many of the items included in the survey-specific demographic survey were based upon factors noted in existing VT literature, such as length of time in the profession, and trauma informed supervisory relationship **(**Bell et al., 2003; Finklestein et al., 2015; Gregson et al., 2013; Hernandez et al., 2010; McCann & Pearlman, 1990; Salston & Figley, 2003; Slattery & Goodman, 2009; Sodeke- Trippany et al.,2004). Further research could be conducted to determine statistical relationships between questionnaire items and VT. The percentages of the demographic survey response were as follows. Each of these items provides areas warranting further exploration in the future within this population.

Relationship status and religion

The study-specific demographic survey included personally oriented questions for respondents, including those regarding current relationship status and religion. The pursuit of wellness includes many aspects of functioning, including interpersonal relationships and spirituality (Myers & Sweeney, 2004). The demographic survey report

indicated that overall, 79.8% of the sample indicated being involved in some type of relationship. Further research could be conducted to explore the possible role of interpersonal relationships on VT development and overall wellness functioning. Further, 61.3% of the sample indicated the endorsement of some type of religion. Further research could be conducted to explore the possible relationship between religion/no religion and VT development.

Personal trauma history

The study-specific demographic survey also included a question regarding personal IPV history. Personal IPV history has been noted within the literature as a personal factor associated with VT development among mental health professionals (Brandon et al., & Cunningham, 2003). Branson et al. (2011) conducted a study exploring the impact of personal IPV history on the development of VT among behavioral health clinicians. Cunningham (2003) also extended this perspective among social workers, where results suggested that personal experiences of IPV were quantitively associated with VT levels. The current study appears to support existing findings. In response to the question "have you, a friend, family member, or loved one (non-client relationship) ever been a victim/survivor of IPV?", 75 (63.0%) of the sample indicated yes. Considering 63.0% of the current sample consists of solely IPV CMHCs, additional research could be conducted to explore these variables further.

Years in the profession

The study-specific demographic survey also included professionally-oriented items based on factors included within existing VT literature. Specifically, previous

research has suggested associations between length of time in the profession and VT levels (Neuman & Gamble, 1995). Specifically, for the current study, 88.2% indicated being employed in the CMHC profession for between 6-8 years, with 81.51% indicating full-time (35+ hours per week) employment (see Table 8). Additionally, 71.4% of the current sample reported serving the IPV population for 24 or more months. Further research could be conducted to clarify this variable, could there be a relationship between inexperience and VT, or perhaps an extended amount of time within the IPV specialty.

Academic and credentialing details

Additional professionally-oriented items included within the study-specific demographic questionnaire included academic and credentialing details of the respondents. VT research has been conducted across varying professional disciplines including medical professionals, first responders, educators, and mental health professionals (Cunningham, 2003; Dunkley & Whelan, 2006; Neuman & Gamble, 1995; Pearlman & McCann, 1995). Studies have also been conducted to explore VT among various mental health disciplines including psychiatry, psychology, social work, counseling, and other volunteer and advocacy roles (Makadia et al., 2015; Maquire & Byrne, 2016; Slattery and Goodman, 2009). The current study explored VT within IPV CMHCs alone. Most participants 108 (90.8%) held a master's degree, with 57 (47.9%) indicating graduation from a CACREP program. The demographic survey report also explored participant's current licensure status, whereof the 48 respondents who indicated status, 38 (52.1%) indicated current licensure. These academic and credentialing details

contribute to the existing literature as well as pose opportunities for further exploration and understanding of how educational factors could influence VT development.

Occupational support details

Among the many professional factors associated with VT development, the role of occupational support, such as clinical supervision, and collegial interaction have been noted in the VT literature **(**Bell et al., 2003; Finklestein et al., 2015; Hernandez et al., 2010; McCann & Pearlman, 1990; Salston & Figley, 2003; Slattery & Goodman, 2009; Sodeke-Gregson et al, 2013; Trippany et al.,2004). The current study-specific demographic survey posed several questions regarding each of these factors. Each item included could be explored further to provide an increased understanding of factors possibly associated with VT development. Of those 107 who replied, most respondents 79 (66.4%) indicated that they were not receiving clinical supervision at the time of survey completion. Of the 83 who indicated, 20 (16.8%) respondents indicated the supervision was from a Board Approved Clinical Supervisor. Study participants were also asked if the clinical supervision they received was considered Trauma-Informed Supervision (TIS). Of the 82 participants who responded to the item, 46 (38.7%) respondents reported that TIS did not apply to them. Each of these demographic survey items could be explored further in future research endeavors. Examination of potential correlations present among these factors within the context of VT development could provide valuable information for IPV counselors, counselor educators, and clinical supervisors.

Various aspects of occupational setting have been examined throughout the VT literature including support of leadership as well as the ability for professionals to debrief traumatic content with colleagues. In addition to questions regarding supervisory support, study respondents were also asked about the support of colleagues. Specifically, 68% of respondents indicated that they debrief/process traumatic client content with colleagues. This could be an area of focus for further exploration across varying methodologies in pursuit of an increased understanding of VT development among professionals.

As reflected in the current library of literature, the development of VT appears to involve the combination of many different personal and professional factors. The current study contributed unique information to this collection by providing further understanding of the variables of resiliency and wellness across the professional discipline of CMHCs serving those with solely IPV caseloads. Further research is encouraged across varying methodologies, populations, and settings in pursuit of an increased understanding of VT.

Implications

The implications of the current study were discussed in Chapter 1. The results of the current study supplement the existing library of VT literature by providing increased knowledge and understanding of how wellness and resiliency influence VT among IPV CMHCs. The specificity of the sample for the current study lends valuable information for not only IPV CMHCs, but their counselor educators, clinical supervisors, and employers as well.

Positive social change implications

The positive social change implications of the current study can occur at the individual, organizational, and even societal levels. Specifically, these results can be practically applied across the counseling profession, among individual counselors, counselor educators, and clinical supervisors. With increased knowledge and understanding of the predictive relationship between VT, wellness, and resiliency, these individual counseling professionals can work to not only combat VT, but the potentially adverse personal and professional impact of VT as well. The results of this study can be stretched beyond the individual positive social change levels and extended to organizational or university-wide social change levels. Specifically, the leaders in the counseling profession, such as counselor educators, clinical supervisors, or consultants can integrate these results into their work to increase awareness around VT development among professionals. Counselors in training, supervisees, recipients of consultation services, and those engaged in collegial interaction can benefit from the increased understanding of VT. Lastly, and perhaps most importantly, the results of this study can affect positive social change among clients and community members struggling with IPV-related trauma.

General implications

With increased understanding of what can predict VT among professionals, counselors, counselor educators, and clinical supervisors can work to deter VT development. This study has contributed unique information to the existing library of literature which has explored the development of VT among professionals. Armed with

this information, members of the counseling profession can work to mitigate the impact VT can have on the counseling relationship, on the wellbeing of the counselor, and perhaps most importantly, the wellbeing of the client. Healthy counselors can provide more effective counseling services, generating healthier client outcomes-with healthier counselors, come healthier clients, and ultimately, healthier communities (Foreman, 2018; Hill, 2004; Lawson & Myers, 2011; Witmer & Young, 1996).

Conclusion

The purpose of the current quantitative research study was to gain an increased understanding of personal and professional factors that contribute to VT among professionals. Namely, resiliency and wellness were examined as predictive variables in VT development among IPC CMHCs. The results of the study were both surprising and anticipated. The results indicated that resiliency does play a significant role in the development of VT among IPV CMHCs. Surprisingly, the results also indicated that wellness did not predict VT at a statistically significant level. The findings of this study contribute unique information to the existing rich library of literature regarding VT development among professionals. Increased knowledge and understanding of VT can not only promote the health of counseling professionals, but most importantly the health, wellbeing, and ethical treatment of IPV survivors.

References

American Counseling Association. (2014a). *Code of ethics*.

American Counseling Association. (2020b). *Choosing a career in counseling*.

American Counseling Association. (2014c). *Vicarious trauma*.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental health disorders: DSM-5* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Aparicio, E., Michalopoulos, L. M., & Unick, G. J. (2013). An examination of the psychometric properties of the vicarious trauma scale in a sample of licensed social workers. *Health & Social Work*, *38*(4), 199–206. https://doi.org/10.1093/hsw/hlt017

Arvay, M. J. (2001). Secondary traumatic stress among trauma counsellors: What does the research say? *International Journal for the Advancement of Counselling*, *23*, 283–293. https://doi.org/10.1023/A:1014496419410

Bell, H. (2003). Strengths and secondary trauma in family violence work. *Social Work*, *48*, 513–522. https://doi.org/10.1093/sw/48.4.513

Bell, H., Kulkarni, S., & Dalton, L. (2003). Organizational prevention of vicarious trauma. *Families in Society: Journal of Contemporary Social Services*, *84*(4), 463–470. https://doi.org/10.1606/1044-3894.131

Ben-Porat, A. (2015). Vicarious post-traumatic growth: Domestic violence therapists versus social service department therapists in Israel. *Journal of Family Violence*, *30*, 923–933. https://doi.org/10.1007/s10896-015-9714-x

Ben-Porat, A., & Itzhaky, H. (2009). Implications of treating family violence for the therapist: Secondary traumatization, vicarious traumatization, and growth. *Journal of Family Violence*, *24*, 507–515. https://doi.org/10.1007/s10896-009-9249-0

Bishop, S., & Schmidt, G. (2011). Vicarious traumatization and transition house workers in remote, northern British Columbia communities. *Rural Society*, *21*, 65–73. https://doi.org/10.5172/rsj.2011.21.1.65

Blount, A. J., & Lambie, G. W. (2018). Development and factor structure of the helping professional wellness discrepancy scale. *Measurement & Evaluation in Counseling & Development*, *51*(2), 92–110. https://doi.org/10.1080/07481756.2017.1358060

Brady, J. L., Guy, J. D., Poelstra, P. L., & Brokaw, B. F. (1999). Vicarious traumatization, spirituality, and the treatment of sexual abuse survivors: A national survey of women psychotherapists. *Professional Psychology: Research and Practice*, *30*(4), 386–393. https://doi.org/10.1037/0735-7028.30.4.386

Branson, D. C., Weigand, D. A., & Keller, J. E. (2013). Vicarious trauma and decreased sexual desire: A hidden hazard of helping others. *Psychological Trauma-Theory Research Practice and Policy*, *6*(4), 398–403. https://doi.org/10.1037/a0033113

Brend, D. M., Krane, J., & Saunders, S. (2020). Exposure to trauma in intimate partner violence human service work: A scoping review. *Traumatology*, *26*(1), 127–136. https://doi.org/10.1037/trm0000199

Bride, B. E., Radey, M., & Figley, C. R. (2007). Measuring compassion fatigue. *Clinical*

Social Work Journal, *35*, 155–163. https://search-ebscohost-com.ezp.waldenulibrary.org/login.aspx?direct=true&db=edsovi&AN=edsovi.00001073.200735030.00002&site=eds-live&scope=site

Brockhouse, R., Msetfi, R. M., Cohen, K., & Joseph, S. (2011). Vicarious exposure to trauma and growth in therapists: The moderating effects of sense of coherence, organizational support, and empathy. *Journal of Traumatic Stress*, *24*(6), 735–742. https://doi.org/10.1002/jts.20704

Burkholder, G. J., Cox, K. A., & Crawford, L. M. (2016). *The scholar-practitioners guide to research design*. Laureate.

Catanese, S. A. (2010). Traumatized by association: The risk of working sex crimes. *Federal Probation*, *74(*2), 36–38. https://search-ebscohost-com.ezp.waldenulibrary.org/login.aspx?direct=true&db=tsh&AN=55064333&site=eds-live&scope=site

Centers for Disease Control and Prevention. (2014). *Prevalence and characteristics of sexual violence, stalking, and intimate partner violence victimization-National intimate partner and sexual violence survey, United States, 2011*. https://www.cdc.gov/mmwr/pdf/ss/ss6308.pdf

Centers for Disease Control and Prevention. (2015). National intimate partner and sexual violence survey (NISVS): 2015 Data brief. https://www.cdc.gov/violenceprevention/datasources/nisvs/summaryreports.html

Centers for Disease Control and Prevention. (2018). *National center for injury prevention and control, division of violence prevention: Intimate partner violence*.

https://www.cdc.gov/violenceprevention/intimatepartnerviolence/index.html

Choi, G. (2011). Secondary traumatic stress of service providers who practice with survivors of family or sexual violence: A national survey of social workers. *Smith College Studies in Social Work, 81*, 101–119. http://dx.doi.org/10.1080/00377317.2011.543044

Clark, P. (2009). Resiliency in the practicing marriage and family therapist. *Journal of Marital and Family Therapy, 35*, 231–247. http://dx.doi.org/ 10.1111/j.1752-0606.2009.00108.x

Cohen, M. B. (1952). Countertransference and anxiety. *Psychiatry: Journal for the Study of Interpersonal Processes, 15*, 231–243. http://dx.doi.org/10.1080/00332747.1952.11022877

Cohen, J. 1988. Statistical power analysis for the behavioral sciences. Lawrence Erlbaum Associates.

Creswell, J. W., Creswell, J. D. (2018). *Research design: Qualitative, quantitative, and mixed methods* (5th ed.). Sage.

Cunningham M. (2003). Impact of trauma work on social work clinicians: empirical findings. *Social Work, 48*(4), 451–459. https://doi-org.ezp.waldenulibrary.org/sw/48.4.451

Cunningham, M. (2004). Teaching social workers about trauma: Reducing the risks of vicarious traumatization in the classroom. *Journal of Social Work Education, 40*(2), 305–317. https://doi-org.ezp.waldenulibrary.org/10.1080/10437797.2004.10778495

Dunkley, J., & Whelan, T. (2006). Vicarious traumatization: current status and future directions. *British Journal of Guidance & Counselling, 34*(1), 107–116. https://doi-org.ezp.waldenulibrary.org/10.1080/03069880500483166

Faul, F., Erdfelder, E., Lang, A.-G., & Buchner, A. (2007). G*Power 3: A flexible statistical power analysis program for the social, behavioral, and biomedical sciences. *Behavior Research Methods*, *39*, 175-191. https://search-ebscohost-com.ezp.waldenulibrary.org/login.aspx?direct=true&db=edswss&AN=000248501300003&site=eds-live&scope=site.

Faul, F., Erdfelder, E., Buchner, A., & Lang, A.-G. (2009). Statistical power analyses using G*Power 3.1: Tests for correlation and regression analyses. *Behavior Research Methods*, *41*, 1149-1160. Doi: 10.3758/BRM.41.4.1149

Figley, C. R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder* (pp. 1–20). Brunner/Mazel.

Fisk, G. and Dionisi, A. (2010). Building and sustaining resilience in organizational settings: The critical role of emotion regulation. *Emotions and Organizational Dynamism: Research on Emotion in Organizations, 6*, 167–88. doi:10.1108/s1746-9791(2010)0000006011

Finklestein, M., Stein, E., Greene, T., Bronstein, I., & Solomon, A. (2015). Posttraumatic stress disorder and vicarious trauma in mental health professionals. *Health & Social Work*, *40*(2), 26–31. doi:10.1093/hsw/hlv026

Foreman, T. (2018). Wellness, exposure to trauma, and vicarious traumatization: A pilot

study. *Journal of Mental Health Counseling*, *40*(2), 142-155. doi:10.17744/mehc.40.2.04

Frankfort-Nachmias, C., & Leon-Guerrero, A. (2018). Social statistics for a diverse society (8thed.). Sage Publications.

Grant, L. and Kinman, G. (2014) *Developing Resilience for Social Work Practice*: Palgrave Macmillan.

Greinacher, A., Nikendei, A., Kottke, R., Wiesbeck, J., Herzog, W., & Nikendei, C. (2019). Secondary traumatization, psychological stress, and resilience in psychosocial emergency care personnel. *International Journal of Environmental Research and Public Health, 16*(17). https://doi-org.ezp.waldenulibrary.org/10.3390/ijerph16173213

Groves, R. M., Fowler, F. J. Jr., Couper, M. P., Lepkowski, J. M., Singer, E., & Tourangeau, R. (2009). *Survey methodology* (2nd ed.). John Wiley & Sons.

Harrison, R. L., & Westwood, M. J. (2009). Preventing vicarious traumatization of mental health therapists: Identifying protective practices. *Psychotherapy: Theory, Research, Practice, Training*, *46*(2), 203-219. doi:10.1037/a0016081

Halevi, E., & Idisis, Y. (2018). Who helps the helper? Differentiation of self as an indicator for resisting vicarious traumatization. *Psychological Trauma: Theory, Research, Practice, and Policy, 10*(6), 698–705. https://doi-org.ezp.waldenulibrary.org/10.1037/tra0000318

Hayden, S. W., Williams, D. J., Canto, A. I., & Finklea, T. (2015). Shelter from the storm: addressing vicarious traumatization through Wellness-based clinical

supervision. *Professional Counselor*, *5*(4), 529-542. doi:10.15241/scwh.5.4.529

Hernández, P., Engstrom, D., & Gangsei, D. (2010). Exploring the impact of trauma on therapists: Vicarious resilience and related concepts in training. *Journal of Systemic Therapies, 29*(1), 67–83. https://doi-org.ezp.waldenulibrary.org/10.1521/jsyt.2010.29.1.67

Hensel, J. M., Ruiz, C., Finney, C., & Dewa, C. S. (2015). Meta-analysis of risk factors for secondary traumatic stress in therapeutic work with trauma victims. *Journal of Traumatic Stress*, *28*(2), 83-91. doi:10.1002/jts.21998

Hill, N. R. (2004). The challenges experienced by pretenured faculty members in counselor education: A Wellness perspective. *Counselor Education and Supervision, 44*, 135-14. DOI 10.1002/j.1556-6978.2004.tb01866.x.

Howlett, S. L., & Collins, A. (2014). Vicarious traumatization: risk and resilience among crisis support volunteers in a community organization. *South African Journal and Psychology*, *44*(2), 180–190. https://doiorg.ezp.waldenulibrary.org/10.1177/0081246314524387

IBM Corp. Released 2020. IBM SPSS Statistics for Windows, Version 25.0. Armonk, NY: IBM Corp.

Iqbal, A. (2015). The ethical considerations of counselling psychologists working with trauma: Is there a risk of vicarious traumatisation? *Counselling Psychology Review*, *30*(1), 44–51. https://eds-a-ebscohost-com.ezp.waldenulibrary.org/eds/pdfviewer/pdfviewer?vid=18&sid=10aaf24f-3dd5-42b3-b2bf-4a265d785852%40sessionmgr4006

Jones, C. T., & Branco, S. F. (2020). Trauma□informed supervision: Clinical supervision of substance use disorder counselors. *Journal of Addictions & Offender Counseling, 41*(1), 2–17. https://doi-org.ezp.waldenulibrary.org/10.1002/jaoc.12072

Kinman, G., & Grant, L. (2017). Building resilience in early-career social workers: Evaluating a multi-modal intervention. *British Journal of Social Work, 47*(7), 1979–1998. https://doi-org.ezp.waldenulibrary.org/10.1093/bjsw/bcw164

Klein, C.J., Riggenbach-Hays, J.J., Sollenberger, L.M., Harney, D.M., & McGarvey, J.S. (2018). Quality of life and compassion satisfaction in clinicians: A pilot intervention study for reducing compassion fatigue. *American Journal of Hospice & Pallative Medicine, 35*(6), 882-888. Doi: 10.1177/1049909117740848

Kulkarni, S., Bell, H., Hartman, J., & Herman-Smith, R. (2013). Exploring individual and organizational factors contributing to compassion satisfaction, secondary traumatic stress, and burnout in domestic violence service providers. *Journal of the Society for Social Work and Research, 4*, 114–130. http://dx.doi.org/10.5243/jsswr.2013.8

Lambie, G. W. (2007). The contribution of ego development level to burnout in school counselors: Implications for professional school counseling. *Journal of Counseling & Development, 85*, 82–88. https://doi.org/10.1002/j.15566678.2007.tb00447.x.

Lawson, G. (2007). Wellness and impairment: A national survey. *The Journal of Humanistic Counseling, Education and Development, 46*, 20-35.

https://doi.org/10.1002/j.2161-1939.2007.tb00023.x

Lawson, G., & Myers, J. E. (2011). Wellness, professional quality of life, and career-sustaining behaviors: What keeps us well? *Journal of Counseling and Development, 89,* 163-171. doi: 10.1002/j. 15 56-6678.2011,tb00074.x

MacKay, L. M. (2017). Differentiation of self: Enhancing therapist resilience when working with relational trauma. *Australian and New Zealand Journal of Family Therapy, 38*(4), 637–656. https://doi-org.ezp.waldenulibrary.org/10.1002/anzf.1276

Maguire, G. and Byrne, M.K. (2017) The law is not as blind as it seems: relative rates of vicarious trauma among lawyers and mental health professionals, *Psychiatry, Psychology and Law, 24*(2), 233-243, doi: 10.1080/13218719.2016.1220037

Makadia, R., Sabin-Farrell, R., & Turpin, G. (2017). Indirect exposure to client trauma and the impact on trainee clinical psychologists: Secondary traumatic stress or vicarious traumatization? *Clinical Psychology & Psychotherapy, 24*(5), 1059–1068. https://doi.org/10.1002/cpp.2068

Masson, F. (2019). Enhancing resilience as a self-care strategy in professionals who are vicariously exposed to trauma: A case study of social workers employed by the South African Police Service. *Journal of Human Behavior in the Social Environment*, *29*(1), 57–75. https://doi-org.ezp.waldenulibrary.org/10.1080/10911359.2018.1474159

Mayr, S., Buchner, A., Erdfelder, E., Faul, F. (2007). A short tutorial of GPower. *Tutorials in Quantitative Methods for Psychology. 3*(2), 51-59.

McCann. I. L, & Pearlman, I.A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress,3,*131-149. https://doi-org.ezp.waldenulibrary.org/10.1007/BF00975140

Molnar, B. E., Sprang, G., Killian, K. D., Gottfried, R., Emery, V., & Bride, B. E. (2017). Advancing science and practice for vicarious traumatization/secondary traumatic stress.*A research agenda. Traumatology, 23*(2), 129–142. https://doi.org/10.1037/trm0000122

Myers, J. E., & Sweeney, T. J. (2004). The indivisible self: An evidence-based model of wellness. *Journal of Individual Psychology, 60*(3), 234–245. https://search-ebscohost-com.ezp.waldenulibrary.org/login.aspx?direct=true&db=psyh&AN=2004-21594-004&site=eds-live&scope=site.

Myers, J. E., & Sweeney, T. J. (2008). Wellness counseling: The evidence base for practice. *Journal of Counseling & Development, 86*, 482–493. doi:10.1002/j.1556-6678.2008.tb00536.x

National Mental Health Services Survey (NMHSS). (2019). Data on mental health treatment facilities. https://www.samhsa.gov/data/sites/default/files/reports/rpt29388/NMHSS-2019/NMHSS-2019.pdf

Neumann, D. A., & Gamble, S. J. (1995). Issues in the professional development of psychotherapists: Countertransference and vicarious traumatization in the new

trauma therapist. *Psychotherapy: Theory, Research, Practice, Training, 32*(2), 341–347. https://doi-org.ezp.waldenulibrary.org/10.1037/0033-3204.32.2.341

O'Brien, J. L., & Haaga, D. A. F. (2015). Empathic accuracy and compassion fatigue among therapist trainees. *Professional Psychology: Research and Practice, 46*(6), 414–420. https://doi-org.ezp.waldenulibrary.org/10.1037/pro0000037

Pearlman, L.A. (1996). Trauma and the self: A theoretical and clinical perspective. *Journal of Emotional Abuse, 1*(1), 7-25. https://doi.org/10.1300/J135v01n01_02

Pearlman and Saakvitne, (1995). *Trauma and the Therapist: Countertransference and Vicarious Traumatization in psychotherapy with Incest Survivors*. W. W. Norton.

Puig, A., Baggs, A., Mixon, K., Park, Y.M., Kim, B.Y., & Lee, S.M. (2012). Relationship between job burnout and personal wellness in mental health professionals. *Journal of Employment Counseling, 49*,98–109.https://doi.org/10.1002/j.21611920.2012.00010.x.

Radey, M., & Figley, C. R. (2007). The social psychology of compassion. *Clinical Social Work Journal, 35*, 207–214. https://search-ebscohost-com.ezp.waldenulibrary.org/login.aspx?direct=true&db=swh&AN=56923&site=eds-live&scope=site. Acesso em: 18 maio. 2021.

Rai, S., & Pathak, M. K. (2019). MeToo Movement a reality or Myth? *Journal of Punjab Academy of Forensic Medicine & Toxicology, 19*(2), 190–191. https://doi-org.ezp.waldenulibrary.org/10.5958/0974-083X.2020.00042.4

Rodríguez-Rey, R., Alonso-Tapia, J., & Hernansaiz-Garrido, H. (2016). Reliability and validity of the brief resilience scale (BRS) Spanish version. *Psychological*

Assessment, 28(5), e101-e110. doi:10.1037/pas0000191

Rothschild, B. (2006). Help for the helper: The psychophysiology of compassion fatigue and vicarious trauma. W. W. Norton.

Saakvitne, K. W., & Pearlman, L. A. (1995). *Transforming the pain: A workbook on vicarious traumatization.* Norton.

Saakvitne, K. W., Tennen, H., & Affleck, G. (1998). Exploring thriving in the context of clinical trauma theory: Constructivist self-development theory. *Journal of Social Issues, 54*(2), 279–299. https://doi-org.ezp.waldenulibrary.org/10.1111/j.1540-4560.1998.tb01219.x

Sabin-Farrell, R., & Turpin, G. (2003). Vicarious traumatization: Implications for the mental health of health workers. *Clinical Psychology Review, 23*, 449-480. DOI: 10.1016/S0272-7358(03)00030-8,

Salston, M., & Figley, C. R. (2003). Secondary traumatic stress effects of working with survivors of criminal victimization. *Journal of Traumatic Stress, 16*(2), 167. https://doi-org.ezp.waldenulibrary.org/10.1023/A:1022899207206

Slattery, S. M., & Goodman, L. A. (2009). Secondary traumatic stress among domestic violence advocates: Workplace risk and protective factors. *Violence Against Women, 15*(11), 1358–1379. https://doi-org.ezp.waldenulibrary.org/10.1177/1077801209347469

Sommer, C. A. (2008). Vicarious traumatization, trauma-sensitive supervision, and counselor preparation. *Counselor Education & Supervision*, *48*(1), 61-71. DOI 10.1002/j.1556-6978.2008.tb00062.x.

Sodeke-Gregson, E. A., Holttum, S., & Billings, J. (2013). Compassion satisfaction, burnout, and secondary traumatic stress in U.K. therapists who work with adult trauma clients. *European Journal of Psychotraumatology, 4*, 21869. http://dx.doi.org/10.3402/ejpt.v4i0.21869

Smith, B. W., Dalen, J., Wiggins, K., Tooley, E., Christopher, P., & Bernard, J. (2008). The brief resilience scale: Assessing the ability to bounce back. *International Journal of Behavioral Medicine*, *15,* 194 – 200. DOI 10.1080/10705500802222972.

Sprang, G., Clark, J., & Whitt-Woosley, A. (2007). Compassion fatigue, compassion satisfaction, and burnout: Factors impacting a professional's quality of life. *Journal of Loss and Trauma, 12*, 259–280. DOI: 10.1080/15325020701238093

Sprang, G., Ford, J., Kerig, P., & Bride, B. (2018). Defining secondary traumatic stress and developing targeted assessments and interventions: Lessons learned from research and leading experts. *Traumatology.* Advance online publication. http://dx.doi.org/10.1037/trm0000180

SurveyMonkey (2020). https://www.surveymonkey.com/

Trippany, R. L., White Kress, V. E., & Wilcoxon, S. A. (2004). Preventing vicarious trauma: What counselors should know when working with trauma survivors. *Journal of Counseling & Development, 82*(1), 31–37. https://doi-org.ezp.waldenulibrary.org/10.1002/j.1556-6678.2004.tb00283.x

U.S. Department of Labor, Bureau of Labor Statistics. (2019). Occupational Employment Statistics: May 2019 National Occupational Employment and Wage Estimates

United States. https://www.bls.gov/oes/current/oes_nat.htm#21-0000

Williams, A., Helm, H., & Clemens, E. (2012). The effect of childhood trauma, personal wellness, supervisory working alliance and organizational factors on vicarious traumatization. *Journal of Mental Health Counseling, 34*, 133-153. Doi: 10.17744/mehc.34.2.j3l62k872325h583

Windle, G., Bennett, K. M., & Noyes, J. (2011). A methodological review of resilience measurement scales. *Health and Quality of Life Outcomes, 9*(1), 8-8. doi:10.1186/1477-7525-9-8

Witmer, J. M., & Young, M. E. (1996). Preventing counselor impairment: A wellness approach. *Journal of Humanistic Education and Development, 34*, 141-155. Doi: 10.1002/j.2164-4683.1996.tb00338.x.

Vrklevski, L. P., & Franklin, J. (2008a). Vicarious trauma scale. *PsycTESTS*. https://doi-org.ezp.waldenulibrary.org/Full text; 999903119_full_001.pdf

Vrklevski, L. P., & Franklin, J. (2008b). Vicarious trauma: The impact on solicitors of exposure to traumatic material. *Traumatology*, 14(1), 106–118. doi:10.1177/1534765607309961

Appendix A: Second Recruitment Email/Survey Reminder Email

Good Morning,

My name is Elizabeth Hunter, I am a doctoral candidate at Walden University attempting to complete a research study.

Several weeks ago emails were sent to you because your contact information was published as an interpersonal violence service agency/services provider, a clinical supervisor, and/or a trauma services provider.

I emailed you information and access to a research study regarding wellness, vicarious trauma, and resilience among clinical mental health counselors who provide clinical counseling services to survivors of interpersonal violence.

If you have already completed the surveys, please accept my sincere thanks and disregard this correspondence. If not, please do so as soon as possible, I have attached the original correspondence to this email for your reference. We are especially grateful for your help with this important research study.

Thank you for your consideration and participation in this research endeavor.

Attached: Original email/informed consent as per IRB guidance/professional courtesy

Appendix B: Final Survey Reminder Email

Good Morning,

My name is Elizabeth Hunter, I am a doctoral candidate attempting to complete a research study.

Several weeks ago emails were sent to you because your contact information was published as an interpersonal violence service agency/services provider, a clinical supervisor, and/or a trauma services provider.

I emailed you information and access to a research study regarding wellness, vicarious trauma, and resilience among clinical mental health counselors who provide clinical counseling services to survivors of interpersonal violence.

If you have already completed the surveys, please accept my sincere thanks and disregard this final notice for survey completion. If not, please do so as soon as possible, I have attached the original correspondence to this email for your reference We are especially grateful for your help with this important research study.

Thank you for your consideration and participation.

Best regards,
Ellizabeth Hunter
Elizabeth.hunter@waldenu.edu
Doctoral Candidate, Counselor Education and Supervision Program
Walden University

Attached: Original email/informed consent as per IRB guidance/professional courtesy

Appendix C: Complimentary Psychoeducational Materials

Thank you for participating in this important research study! In an expression of gratitude for your time and attention, please enjoy this complimentary psycho-educational, supportive material.

This handout will provide IPV professionals with the opportunity to learn more about and receive support for vicarious trauma (VT), including information about wellness practices and resiliency.

Vicarious Trauma

- This opportunity will include an exploration of:
    - What is VT, signs, symptoms, etc.
    - Personal and professional impact of VT
    - Etiology, contributing factors to VT development
    - Current, effective prevention and intervention strategies to address VT
    - Development of VT prevention plan

Sound Familiar???

- "I am so angry that this has happened to my clients, I get to support them, but know that the system will likely not yield a result for them, there will probably not be any justice for them. I'm angry all the time."
- "The #MeToo movement has just illuminated to everyone what I already know"
- "I keep a knife next to my bed now"
- "Sometimes if I am in a crowded place, like a bus stop, or movie theater line, I find myself recalling coping skills I shared with previous clients about this, then wonder, how many survivors are there in this room? Does her partner even know ?"
- "I have seen and heard first hand that protective orders, knives, defense classes, even guns, wont protect you against a perpetrator, and then they will just say you wanted it anyway."
- "When I was told I was having a girl, I was immediately filled with dread-I would have to protect her from this for her whole life- I was immediately envious of mothers of boys"
- "I purposely never go anywhere at night, or alone, or without my concealed carry at all times"

These are quotes that I have gleaned from IPV professionals, who have been impacted by the work that they do.

What is Vicarious Trauma (VT)?

Vicarious Trauma

- A form of compassion fatigue
- One case or cumulative cases can leave you traumatized

- Involves a transformation of the helper's inner experience, resulting from empathic engagement with clients' trauma material.
- A common side effect of working with interpersonal violence (IPV) survivors which can negatively impair the personal and professional functioning of the professional
- Often resembles the symptoms of Post-Traumatic Stress Disorder (PTSD)
- Is a NORMAL and anticipated reaction, and is not evidence of psychopathology in the professional or the client
- VT will look and feel different for each person

What is Vicarious Trauma (VT)?

- These symptoms are usually grouped into three broad categories:
  - *Intrusions:*
    - Flashbacks
    - Nightmares
    - intrusive thoughts
  - *Avoidance:*
    - situations
    - people or places that bring on the intrusions
  - *Hyperarousal:*
    - including hypervigilance
    - Sleeplessness
    - increased startle response ("jumpiness")

Signs and Symptoms of VT

Cognitive symptoms

- Minimization of your vicarious trauma
- Lowered self-esteem and increased self-doubt
- Trouble concentrating
- Confusion/disorientation
- Perfectionism
- Racing thoughts
- Loss of interest in previously enjoyed activities
- Repetitive images of the trauma
- Lack of meaning in life
- Thoughts of harming yourself or others

Social symptoms

- Withdrawal and isolation
- Loneliness
- Irritability and intolerance
- Distrust
- Projection of blame and rage
- Decreased interest in intimacy

    - Distrust
    - Change in parenting style (e.g., becoming overprotective)
- **Physical symptoms**
    - Panic symptoms – sweating, rapid heartbeat, difficulty breathing, dizziness
    - Gastrointestinal issues
    - Aches and pains
    - Weakened immune system
- **Emotional symptoms**
    - Helplessness and powerlessness
    - Survivor guilt
    - Numbness
    - Oversensitivity
    - Emotional unpredictability
    - Fear
    - Anxiety
    - Sadness and/or depression
- **Behavioral symptoms**
    - Nightmares
    - Appetite changes
    - Hypervigilance
    - Exaggerated startle response, "jumpiness"
    - Losing things
    - Clumsiness
    - Self-harm behaviors
    - Negative coping – smoking, drinking, acting out

Personal & Professional Impact of VT

Personal signs and symptoms:

- Physical, emotional, cognitive, social symptoms
- Ability to function is altered
- Impinges on boundaries
- Strain on relationships: familial and social
- Alteration of locus of control
- Alteration in worldview
- Alteration in spiritual or religious beliefs

Professional Signs and Symptoms:

- chronic absenteeism, moody
- High turn over
- Friction between employees, staff and management
- Changes in work relationships
- Inability for teams to work together well
- Desire among staff members to break organization rules

- Outbreaks of aggressive behaviors among staff
- Lack of flexibility, more rigidity
- increased negativity
- lack of vision toward the future
- inability of staff to belief that change impossible

VT Etiology

Why do some IPV service professionals develop VT, and others do not?

Professional Quality of Life:

- the quality one feels in relation to their work as a helper.
- Both the positive and negative aspects of doing your work influence your professional quality of life.
    - **Compassion Satisfaction:**
        - Some find it enriching and rewarding
        - Vicarious resiliency
        - Vicarious post-traumatic growth
    - **Compassion Fatigue:**
        - Some burn out
        - Some find it traumatizing (VT)
    - VT like- direct trauma, arises from an interaction between the person and the situation and is different for everyone

Compassion Satisfaction:

- The enjoyment and gratification that professional helpers feel when they are able to perform their work well
- typically feel that they are able to handle new protocols and technology as they emerge
- feel successful and happy with their work
- want to continue to engage in their work
- feel satisfied and invigorated by their job and from the act of helping itself.
- some helpers may experience enormous pleasure or contentment when the traumatized survivor or community they have worked with heals or is able to function better

Compassion Fatigue

- Burnout
    - Emotional exhaustion and withdrawal associated with increased workload, and institutional/organizational stress **NOT trauma related**
    - Organizational based stressors, such as deadlines, documentation, quotas of some kind
    - Burnout is a condition of feeling exhausted or worn out
    - Over time, professionals develop a sense of being ineffective- this becomes dominant and the clinician's sense of efficacy is challenged

Others develop Compassion fatigue in the form of VT, but why?

VT Etiology: Professional Factors

- Type of profession

- Type and level of interaction
- Environmental or organizational circumstances
- Supervisory influences
- Dynamics of caseload
- Length of time within the profession
- Training and expectations of profession
- Isolation
- Burnout
- The confidential nature of trauma work
- The difficulty forming therapeutic relationships with people whose ability to trust has been diminished by betrayal or abuse
- Systems problems in organizations and institutions
- Negative social attitudes toward trauma victims
- Logistic/organizational circumstances of office setting
- Lack of collegial support, interaction, and consultation
- Lack of trauma informed leadership, supervision and overall organizational functioning

VT Etiology: Personal factors

- preoccupation with thoughts about those they have tried to help
- The nature of the traumatic stressor and the trauma story
- Helpers feeling overwhelmed
- characteristics of the trauma survivor client
- demographic characteristics of the therapist or helper and how closely do they match or differ from those of the client
- the personal beliefs, ideological systems, and preconceptions of the therapist relevant to the situation and issues presented by the client
- the therapist's theoretical orientation and assumptions about life-cycle development and personality
- defensive styles and mechanisms are used by the therapist
- What motivated the therapist to work with trauma survivors?
- Amount of training and professional experience has the therapist had regarding trauma
- Admitting the impact the work may have on you
- unique life experiences, cultures, family and psychosocial histories, religious or spiritual orientations, and personalities.
- Wellness practices
- Personal trauma history or experiences and current resolution/treatment of those experiences
- Levels of resiliency
- Coping skills to address challenge and distress
- Current life circumstances

- Work-life balance
- Social support
- Spiritual or religious beliefs
- Ability to assess or enhance well being
- Ability to care for oneself
- Awareness of signs and symptoms
- Knowledge of what to do
- Lack of energy to engage in self care
- becoming strongly focused and concerned with the suffering of the client

So, now what?

- Wellness
- Resiliency
- Vicarious Resilience
- Vicarious Post -traumatic growth
- Trauma Stewardship
- Your plan

VT Prevention and Intervention: Wellness

- Wellness is a strengths-based philosophy of life, counseling, supervision, and vital VT defense
- a way of life oriented toward optimal health and well-being, in which body, mind, and spirit are integrated by the individual to live life more fully within the human and natural community.
- Ideally, it is the optimum state of health and well-being that each individual is capable of achieving.

VT Prevention and Intervention: Resilience

- For VT, the standard self-care prescription doesn't seem to work as well
- In short, a yoga class will not address the core beliefs that have been adversely changed by the VT
    - Yoga will help address the symptoms of VT, but will not address the core issues

VT Prevention and Intervention: Resilience

- The American Psychological Association defined *resiliency* as:

"the process of adapting well in the face of adversity, trauma, tragedy, threats, or even significant sources of stress — such as family and relationship problems, serious health problems, or workplace and financial stressors."

- APA suggested further that resiliency is the ability to "bounce back from difficult experiences"
- Resiliency is a protective factor which may help insulate service providers and practitioners against burnout

VT Prevention and Intervention: Resilience

- Factors associated with Resiliency development
    - Ongoing self-assessment

- Self-awareness is a protective factor against VT and burnout
- Identify problematic behaviors
- Educate yourself
- Selfcare/Wellness
- Protective factors

Development of your own prescriptive plan

- Wellness leads to resiliency
- Intentionality with each practice
- Mindfulness
- Trauma informed supervision

VT Prevention and Intervention: Vicarious Resilience (VR)

- Just as professionals can vicariously experience the trauma, we can experience the resilience
- VR focuses on the positive outcomes and provides skill improvement for professionals to reframe and cope with negative events in the process
- An understanding of how to effectively prevent or deal with the negative effects of trauma work
- Trauma practitioners also frequently have the opportunity to bear witness to the enormous resilience possessed by many survivors, although not all clinicians draw this out of their clients or focus on the positive.

VT Prevention and Intervention: Vicarious Resilience (VR)

- **Factors associated with VR development**
  - Increased experience of personal trauma
  - Increased peer relational quality
  - Perceived organizational support
  - Compassion Satisfaction
  - Ability to focus on positive aspects of work
  - unconditionally supportive social networks that include those outside the family
  - personal characteristics
  - and psychotherapeutic interventions that focus on building on the strengths
  - fostering sense of personal control
  - promotion and development of authentic relationships
  - Focus on how they got here/ the strength and courage that brought them here

VT Prevention and Intervention: Vicarious Resilience (VR)

- **Factors associated with VR development**
  - Promoting opportunities and contexts for professionals to explore vicarious resilience may serve to enhance their experience of it and allow them to find new meaning related to their work.

  - Including the concept of vicarious resilience in training and supervision sessions can help support trauma professionals to take better care of themselves.
  - more use of social diversion
  - Detachment
  - connection to compassion satisfaction factors
  - Strong occupational and personal support
  - task-oriented coping
  - greater perceived family support

VT Prevention and Intervention: Vicarious Post Traumatic Growth

- Post-traumatic growth is
  - An adaptive process
  - a significant **positive** psychological change that occurs as an outcome of an individual experiencing trauma
  - a result of the cognitive effort to redefine beliefs shattered by trauma and to rebuild one's assumptions about oneself, others, and the world
  - detracts from a singular view of the worst to attending to the positive that can occur from the situation.
  - Can co-occur with PTSD and VT

VT Prevention and Intervention: Trauma Stewardship

- Trauma stewardship reminds professionals to never forget that it is a gift to accompany survivors on their path to healing from trauma and also of their responsibility to take care of themselves and cultivate their capacity to serve
- Trauma stewards are called upon to uphold the highest standards of professionalism, integrity, and ethics at all times in their work with survivors who have entrusted them to safeguard their deeply painful and personal stories and their lives.

Bottom line: integration

- VT Prevention and Intervention: Trauma Stewardship
  - can be transformed into meaningful growth and healing when a quality of presence is cultivated and maintained even in the face of great suffering.
  - Trauma stewardship guides trauma clinicians to build a long-term approach to remain healthy so they can continue to work with trauma survivors, an approach that is intentional and grounded in mindfulness.
- Develop your own personalized VT prevention/intervention/recovery plan
  - Realistic, one that you will actually implement
  - Workplace strategies
  - Personal strategies
  - Overall functioning

Remember:

- VT is a normal response to the work that you do

- If unaddressed, VT can inflict significant personal and professional damage, and even impact your clients.
- VT can be prevented and recovered from
- You are such an important and vital part of every IPV client's journey to health Thank you!

Appendix D: Survey Usage: The Vicarious Trauma Scale

Vicarious Trauma Scale PsycTESTS

Citation: Vrklevski, L. P., & Franklin, J. (2008). Vicarious Trauma Scale [Database record]. Retrieved from PsycTESTS. doi: https://dx.doi.org/10.1037/t03119-000

Instrument Type: Rating Scale

Test Format: 7-point Likert-type scale, ranging from 1 (*strongly disagree*) to 7 (*strongly agree*).

Source: Vrklevski, Lila Petar, & Franklin, John (2008). Vicarious trauma: The impact on solicitors of exposure to traumatic material. Traumatology, Vol 14(1), 106-118. doi: https://dx.doi.org/10.1177/1534765607309961, © 2008 by SAGE Publications.

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Appendix E: The Vicarious Trauma Scale

Vicarious Trauma Scale

1. Strongly disagree
2. Disagree
3. Slightly disagree
4. Neither agree nor disagree
5. Slightly agree
6. Agree
7. Strongly agree

Please read the following statements and indicate on a scale of 1 (strongly disagree) to 7 (strongly agree) how much you agree with them.

1. My job involves exposure to distressing material and experiences.
2. My job involves exposure to traumatized or distressed clients.
3. I find myself distressed by listening to my clients' stories and situations.
4. I find it difficult to deal with the content of my work.
5. I find myself thinking about distressing material at home.
6. Sometimes I feel helpless to assist my clients in the way I would like.
7. Sometimes I feel overwhelmed by the workload involved in my job.
8. It is hard to stay positive and optimistic given some of the things I encounter in my work.

Source: Vrklevski, Lila Petar, & Franklin, John (2008). Vicarious trauma: The impact on solicitors of exposure to traumatic material. Traumatology, Vol 14(1), 106-118. doi: https://dx.doi.org/10.1177/1534765607309961, © 2008 by SAGE Publications.

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Appendix F: Survey Usage Request: The Brief Resilience Scale

May 25, 2020

Permissions Editor/Author

Dear Mr./Dr. Smith, B.W.
Smith, Bruce W., University of New Mexico,
Department of Psychology Albuquerque,
New Mexico, United States, 87131-1161

Contact information: bwsmith@unm.edu

My name is Elizabeth Hunter, I am a doctoral student from Walden University School of Counselor Education and Supervision. I am writing my quantitative dissertation tentatively entitled *The Relationship between Wellness, Resilience, and Vicarious Trauma among Interpersonal Violence Counselors* under the direction of my dissertation committee chair by Dr. Shelli Friess.

I would like your permission to use The Brief Resilience Scale in my research study. I see that permissions are to be secured via publisher/author. I would like to use an electronic version of your survey under the following conditions:

- I will use this survey for only my research study and will not sell or use it with any compensated or curriculum development activities.
- I will include the copyright statement/Source indication on all copies of the instrument.
- I will send my research study and copy of the reports, articles, and the like that make use of the survey data promptly to your attention.

I plan to begin the data collection portion of my research study as early as the Fall 2020 term (August – November 2020).

If these are acceptable terms and conditions, please indicate so by signing one copy of this letter and returning it to me either through postal mail or email.

Signature:

_____

The Brief Resilience Scale Author

Smith, Bruce W. (2008). The Brief Resilience Scale: Assessing the ability to bounce back. International Journal of Behavioral Medicine, 15(3), 194-200. doi: 10.1080/10705500802222972 PsycINFO Record: 2008-12748-006

Appendix G: Survey Usage Permission Granted: The Brief Resilience Scale

Bruce Smith <bws0513@gmail.com>
Mon 5/25/2020 10:42 PM
To: Elizabeth Hunter

Smith BW - BRS Original Validation Article.pdf
94 KB

5 Cantero-Garcia M - BRS Adapting for Specific Stressors.pdf
364 KB

3 Smith BW - BRS Predicting Outcomes.pdf
118 KB

2 Smith BW - BRS Instructions, Items, Scoring, & Cut-offs.pdf
389 KB

4 Rodriguez-Rey R - BRS Spanish Version Validation.pdf
224 KB

5 attachments (1 MB)Download all Save all to OneDrive - Laureate Education - ACAD

Hi Elizabeth,
Thanks for your interest in the Brief Resilience Scale. You are welcome to use it free of charge and for as much as you like.

I have attached (1) our original validation article, (2) a file with the instructions, items, scoring, and suggested cut-offs for high and low resilience, (3) an article on the relationship between the BRS and various outcomes, (4) an article showing how the BRS can be adapted for specific stressors, and (5) an article on the validated Spanish translation of the BRS.
As far as we know, there are also many other translations of the BRS including German, Dutch, Italian, Chinese, Japanese, Turkish, Finnish, Croatian, and Serbian translations. Also, there is also now a large number of articles reporting results when examining the BRS as a predictor, outcome, and/or mediator of other variables, intervention studies showing that it often increases during interventions, and also how much of the BRS scores may be accounted for by genetics (10% or so). You can generally find these articles by searching google scholar using the keywords “brief resilience scale bruce smith.”
Please let me know what you learn from using the scale if you can. I wish you the best in your work!
Warm Regards,
Bruce

Appendix H: The Brief Resilience Scale

Please indicate the extent to which you agree with each of the following statements by using the following scale:

1=strongly disagree
2=disagree
3=neutral
4=agree
5=strongly agree

1. I tend to bounce back quickly after hard times
2. I have a hard time making it through stressful events
3. It does not take me long to recover from a stressful event
4. It is hard for me to snap back when something bad happens
5. I usually come through difficult times with little trouble
6. I tend to take a long time to get over set-backs in my life

Smith, Bruce W., Dalen, Jeanne, Wiggins, Kathryn, Tooley, Erin, Christopher, Paulette and Bernard, Jennifer(2008)'The Brief Resilience Scale: Assessing the Ability to Bounce Back',International Journal of Behavioral Medicine,15:3,194 — 200

Appendix I: Survey Usage Request: The Helping Professionals Wellness Discrepancy Scale

June 15, 2020

Attn: Helping Professionals Wellness Discrepancy Scale Author

Dear Dr. Blount,

Contact information:
Blount, Ashley J.,
Department of Counseling, University of Nebraska Omaha
6001 Dodge Street Omaha, Nebraska,
The United States, 68182
ashleyjwindt@gmail.com
ablount@unomaha.edu

My name is Elizabeth Hunter, I am a doctoral student from Walden University School of Counselor Education and Supervision. I am writing my quantitative dissertation tentatively entitled *The Relationship between Wellness, Resilience, and Vicarious Trauma among Interpersonal Violence Counselors* under the direction of my dissertation committee chair by Dr. Shelli Friess.

I would like your permission to use The Helping Professionals Wellness Discrepancy Scale in my research study. I see that permissions are to be secured via publisher/author. I would like to use an electronic version of your survey under the following conditions:

- I will use this survey for only my research study and will not sell or use it with any compensated or curriculum development activities.
- I will include the copyright statement/Source indication on all copies of the instrument.
- I will send my research study and copy of the reports, articles, and the like that make use of the survey data promptly to your attention.

I plan to begin the data collection portion of my research study as early as the Fall 2020 term (August – November 2020).

If these are acceptable terms and conditions, please indicate your permission in writing in response to this email, or sign and return this email. Thank you in advance for your consideration.

Signature:

_____

The Helping Professionals Wellness Discrepancy Scale Author

Source: Blount, Ashley J. (2018). Development and factor structure of the **Helping Professional Wellness Discrepancy Scale**. Measurement and Evaluation in Counseling and Development, 51(2), 92-110. doi: 10.1080/07481756.2017.1358060
PsycINFO Record: 2018-14859-003

Appendix J: Survey Usage Permission Granted: The Helping Professionals Wellness Discrepancy Scale

From: Ashley Blount <ablount@unomaha.edu>
Sent: Tuesday, June 16, 2020 12:13 PM
To: Elizabeth Hunter <elizabeth.hunter@waldenu.edu>
Subject: Re: Survey Usage Request: The Helping Professionals Wellness Discrepancy Scale

Elizabeth,

You may absolutely use my scale. I will get you a copy of the assessment and the updated manual in a bit.

I look forward to seeing and learning more about your work.

AJB

Ashley J. Blount, Ph.D., NCC
Assistant Professor, Department of Counseling
College of Education
Roskens Hall 101E
University of Nebraska - Omaha
Telephone: 402-554-3648
Email: ablount@unomaha.edu
From: Elizabeth Hunter <elizabeth.hunter@waldenu.edu>
Sent: Tuesday, June 16, 2020 9:50 AM
To: Ashley Blount <ablount@unomaha.edu>
Subject: Survey Usage Request: The Helping Professionals Wellness Discrepancy Scale

Appendix K: The Helping Professionals Wellness Discrepancy Scale

Figure 9

The Helping Professionals Wellness Discrepancy Scale Page 1

Helping Professional Wellness Discrepancy Scale (HPWDS) Please review the following items and report (circle) how often you ***do*** and how often you ***want to*** engage in the activities or experience the feelings per week.	**How often do you?**					**How often do you want to?**				
	0 – 2 times	**3 – 5 times**	**6 – 8 times**	**9 – 11 times**	**12 or more times**	**0 – 2 times**	**3 – 5 times**	**6 – 8 times**	**9 – 11 times**	**12 or more times**
	↓	↓	↓	↓	↓	↓	↓	↓	↓	↓
1. Partake in activities to further your knowledge as a helping professional	**1**	**2**	**3**	**4**	**5**	**1**	**2**	**3**	**4**	**5**
2. Feel like you are making a difference as a helping professional	1	2	3	4	5	1	2	3	4	5
3. Immerse yourself in leisure activity/activities with which you participate	**1**	**2**	**3**	**4**	**5**	**1**	**2**	**3**	**4**	**5**
4. Have religious or spiritual beliefs that you feel are sustaining	1	2	3	4	5	1	2	3	4	5
5. Experience exhaustion because of your work as a helping professional	**1**	**2**	**3**	**4**	**5**	**1**	**2**	**3**	**4**	**5**
6. Partake in activities to further your knowledge in an area of your choice	1	2	3	4	5	1	2	3	4	5
7. Believe that your contributions as a helping professional matter	**1**	**2**	**3**	**4**	**5**	**1**	**2**	**3**	**4**	**5**
8. Engage in free-time/leisure activity (i.e., time spent away from work or chores)	1	2	3	4	5	1	2	3	4	5
9. Engage in prayer (e.g., praying)	**1**	**2**	**3**	**4**	**5**	**1**	**2**	**3**	**4**	**5**
10. Believe that your contributions as a helping professional matter	1	2	3	4	5	1	2	3	4	5
11. Take the initiative to learn about new research in the helping professions	**1**	**2**	**3**	**4**	**5**	**1**	**2**	**3**	**4**	**5**
12. Experience optimism about client's futures	1	2	3	4	5	1	2	3	4	5
13. Partake in enjoyable activities (i.e., things you enjoy doing)	**1**	**2**	**3**	**4**	**5**	**1**	**2**	**3**	**4**	**5**

Figure 10

The Helping Professionals Wellness Discrepancy Scale Page 2

Helping Professional Wellness Discrepancy Scale (HPWDS) Please review the following items and report (circle) how often you ***do*** and how often you ***want to*** engage in the activities or experience the feelings per week.	**How often do you?**					**How often do you want to?**				
	0 – 2 times	**3 – 5 times**	**6 – 8 times**	**9 – 11 times**	**12 or more times**	**0 – 2 times**	**3 – 5 times**	**6 – 8 times**	**9 – 11 times**	**12 or more times**
	↓	↓	↓	↓	↓	↓	↓	↓	↓	↓
1. Experience satisfaction with your spiritual or religious activity	**1**	**2**	**3**	**4**	**5**	**1**	**2**	**3**	**4**	**5**
2. Experience optimism about client's futures	1	2	3	4	5	1	2	3	4	5
3. Engage in activities to advance your knowledge (e.g., reading, writing)	**1**	**2**	**3**	**4**	**5**	**1**	**2**	**3**	**4**	**5**
4. Experience satisfaction in your life	1	2	3	4	5	1	2	3	4	5
5. Find time to relax	**1**	**2**	**3**	**4**	**5**	**1**	**2**	**3**	**4**	**5**
6. Meditate with a focus on a higher power or spiritual entity	1	2	3	4	5	1	2	3	4	5
7. Take time to advance your professional development (i.e., attend conferences or seminars)	**1**	**2**	**3**	**4**	**5**	**1**	**2**	**3**	**4**	**5**
8. Experience happiness	1	2	3	4	5	1	2	3	4	5
9. Experience optimism about your future	**1**	**2**	**3**	**4**	**5**	**1**	**2**	**3**	**4**	**5**

Source: Blount, Ashley J. (2018). Development and factor structure of the **Helping Professional Wellness Discrepancy Scale**. Measurement and Evaluation in Counseling and Development, 51(2), 92-110. doi: 10.1080/07481756.2017.1358060
PsycINFO Record: 2018-14859-00

Appendix L: Study-Specific Demographics Questionnaire

Which gender identity do you most closely identify with?

- Female
- Male
- Transgender Female
- Transgender Male
- Gender Variant/Non-Conforming
- Other/Not listed (please indicate)

  _____
- Prefer not to answer

What is your Age?

- 18-24 years old
- 25-34 years old
- 35-44 years old
- 45-54 years old
- 55 years or older

What is your current relationship status?

- Single (never married)
- Dating
- Cohabitating/domestic partnership
- Engaged/Married
- Separated
- Divorced
- Widowed
- Other (please indicate)

  _____
- Prefer not to answer

How would you describe your ethnicity?

- African American or Black
- Asian
- Caucasian/White
- Hispanic/Latina/Latino
- Native American/American Indian or Alaska Native
- Native Hawaiian or Other Pacific Islander
- Other (please indicate)

  _____

What is your current religious/spiritual affiliation if any?

Atheist
Agnostic
Buddhist
Christian
Hindu
Jewish
Other (please indicate)

_____

Prefer not to answer

Have you, a friend, a family member, or loved one (non-client relationship) ever been a victim/survivor of IPV?

Yes
No
Other (please indicate)

_____

Prefer not to reply

How many hours per 7-day week do you engage in self-care activities (1 week= 168 hours)?

0-7 hours
8-24 hours
25-72 hours
73-96 hours
97- 120 hours
121- 144 hours
145-168 hours

What is your current employment status?

Full-time employment (35+ hours per week)
Employed part-time (up to 34 hours per week)
Unemployed and currently seeking work
Unemployed and not currently seeking work
Unable to work/disabled
Retired
Student
Other (please indicate)

_____

How many years have you been working as a Clinical Mental Health Counselor (CMHC)?

0-2 years
3-5 years
6-8 years
9-11 years
12 or more years (please indicate)
_____

How long have you been working with the Interpersonal Violence (IPV) population?
1-6 months
6-12 months
12-18 months
18-24 months
24 or more months (please indicate):
_____

What is the highest level of education/degree completed?
Master's degree (e.g. MA, MS, Med) in:
_____
Doctorate (e.g. PhD, EdD) in:
_____
Other:
_____

Did you graduate from a CACREP accredited program?
Yes
No

What current license or certifications do you hold if any?
(please list and indicate status below)
_____
_____

None
Active
Suspended
Expired

As a CMHC, what is the age range of the primary population you serve?
Infants (0-2 years of age)
Children (3-9 years of age)
Preadolescent (10-12 years of age)
Adolescent (13-17 years of age)
Early adult (18-30 years of age)

Middle Adult (31-55 years of age)
Older Adult (56-70 years of age)
Senior Adult (71+ years of age)

As an IPV CMHC please indicate the caseload dynamics you encounter most often:

Sexual assault: to include acquaintance rape, stranger rape, familial rape/incest as an adult/molestation
Emotional/psychological abuse
Verbal abuse
Physical abuse
Stalking
Cyber-Stalking
Sex trafficking
Adult survivor of childhood sexual abuse
Other (please indicate):_____

As an IPV CMHC please indicate your occupational setting:

Non-profit agency
Private practice
State or government agency (e.g. Community Services Board, Department of Veteran Affairs etc.)
Hospital/residential facility
Distance based treatment (tele-mental health)
Other (please indicate)

_____

As a CMHC do you currently receive clinical supervision?
**Clinical Supervision: an intervention in which a senior counselor works with a novice counselor to enhance professional development, including dissemination of knowledge, clinical skill development, and client welfare monitoring (Bernard & Goodyear, 2019).*

Yes
No
N/A

If yes, please indicate how often?

_____

If yes, from a Board Approved Clinical Supervisor (BACS)?

Yes
No

N/A

If yes, would you consider this Trauma-Informed Supervision (TIS)?
**TIS is a model of clinical supervision in which the clinical supervisor possess knowledge related to VT and integrates trauma-based psychoeducation and skills to promote best practices for client care, and for supervisee, trauma-informed practice (TIP) development (Jones & Branco, 2020).*

Yes
No
N/A

As a CMHC do you debrief /process traumatic case content with colleagues?

Yes
No

Has IPV exposure associated with the #MeToo movement impacted you?
**The* #MeToo *movement began in 2016 and has continued to gain traction today with increased reports of IPV within the mainstream media. The movement has highlighted instances of IPV bringing the important social issue to the forefront of social, political, personal, and occupationally based interaction for many.*

Yes
No
N/A
Other (please indicate)

_____