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Job Stress, Anxiety, and Depression in Mental Health Professionals: An Examination of Experienced Vicarious Trauma and Gender Differences

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Walden University
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Abstract

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MA, the University of Texas at Brownsville, 2012

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Mental health professionals are susceptible to an increased risk of job stress, anxiety, and depression based on the very nature of their work. The study was quantitative, focusing on profile analysis. A two-way MANOVA was performed utilizing the independent variables of gender and vicarious trauma, and three dependent variables of job stress, anxiety, and depression. The population size was 88 mental health professionals with a Bachelor's degree or higher who work in the behavioral health field, directly servicing clients in the capacity of supervision, case management, social work, counseling, or therapy. Participants completed four self-reported questionnaires: General Work Stress Scale (GWS), Beck Anxiety Inventory (BAI), Beck Depression Inventory-II (BDI-II), and the Trauma and Attachment Belief Scale (TABS). The results of the study indicated that there was no statistical significance of the interaction term of gender and vicarious trauma with respect to the GWS ($F = 0.572$, $p = .45$), BAI ($F = 0.268$, $p = 0.60$), or BDI-II ($F = 1.270$, $p = .26$). The results indicated there was no statistical significance in gender with respect to the GWS scale, BAI, or the BDI-II ($F = 0.895$, $p = .347$) ($F = 2.870$, $p = 0.094$) ($F = 0.134$, $p = 0.715$). In addition, the results did indicate there was a statistical significance in vicarious trauma with respect to the GWS ($F = 9.79$, $p = 0.002$), BAI ($F = 18.98$, $p = 0.000$), and BDI-II score ($F = 38.2$, $p < .01$). The study outcomes may contribute to positive social change, assisting in the development, promotion, and facilitation of awareness training, educational workshops, organizational support systems, and gender-sensitive interventions for mental health professionals.

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Dedication

"Desire is the starting point of all achievement, not a hope, not a wish, but a keen pulsating desire which transcends everything". Napoleon Hill

This dissertation is dedicated to the family and friends who have supported and encouraged me throughout the arduous process of acquiring my greatest educational aspirations. I'd like to especially dedicate it to my reason, rock, and my everything. To my mother, Gloria, for her unconditional love and for instilling in me the strength, dedication, and resilience to go the distance and reach for the stars. My son, Joseph Nathaniel, for his never-ending faith in me, and for his love, support, and encouragement. The dissertation journey was a long and challenging process; through the difficult days (which were many), they stood by me, encouraged me, and never once doubted me. I am beyond blessed to have been afforded these opportunities and the fortitude to acquire one of my biggest accomplishments.

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Chapter 1: Introduction to the Study

Introduction

Mental health professionals (MHP) serve a vast array of diverse clients to help them work through crises, emotional disturbances, manage mental health disorders, deal with trauma, and cope with loss amid a multitude of other clinical responsibilities. Job stress, anxiety, and depression impact the clinical services that MHP implement and can have detrimental effects on personal, interpersonal, and professional responsibilities and proficiencies. The current study examined job stress, anxiety, and depression among mental health professionals and the impact that experienced vicarious trauma and gender differences have on the levels of the identified factors. The literature indicates that additional research is needed concerning vicarious trauma (VT) for numerous reasons such as inconsistencies in research, potential professional and personal dangers of unaddressed VT, and to access positive benefits for clinicians, agencies, clients, and the community (Branson, 2019).

Gender is another study variable that has been consistency linked with the development of vicarious trauma. While some studies found that females were more susceptible to experience and report vicarious trauma (Baum, 2016), Osofsky et al. (2008) proposed that there is an association between vulnerability and males being less likely to endorse symptoms of fear of being seen as weak. The examination of these variables contributes to positive social change amongst mental health professionals working with victims of trauma and increases the efficacy of interventions and overall community well-being. This chapter provides the background of the topic of study,

problem statement, the purpose of the study, research questions and hypothesis, theoretical framework, definitions, assumptions, the scope of delimitations, limitations, and significance.

Background

Vicarious trauma in mental health professionals stems from exposure to victims of trauma and recurring attendance to their client's painful and often graphic accounts of abuse, torture, and violence amid other traumatic events they have endured. This repeated exposure has fallen under several stress responses such as burnout, compassion fatigue, and secondary traumatic stress (Baum, 2016). Vicarious trauma, however, is marked mainly by cognitive changes in meanings, beliefs, schemas, and adaptations associated with a multitude of triggers that may result in adverse effects such as anxiety and depression (Baum, 2016). Gender differences in vulnerability to life stressors such as job stress, anxiety, and depression are based on individual beliefs, culture, values, identified social norms, and universal societal expectancies (Salk et al., 2017). There are limited research findings on the impact that gender has on mental health professionals following repeated exposure to trauma, which led to experiencing vicarious trauma, further establishing the need for further exploration. Recognition of how vicarious trauma and gender differences influence levels of job stress, anxiety, and depression that mental health professionals experience is necessary to begin addressing the associated implications that affect the mental health providers and communities at large. The following articles, studies, and analyses serve to acknowledge the work that has been

completed on identified facets of the study, which further supports the rationale for the completed research.

Fleury et al., (2018) sought to acquire a deeper understanding of factors contributing to mental health professionals' job satisfaction following the implementation of mental health reforms that have a demonstrated sharp impact on professional practices that improve quality and continuity of care. As opposed to job satisfaction, professionals who experience job dissatisfaction tend to have negative outlooks toward clients, provide inadequate service, and demonstrate high turnover rates, which in turn affect service continuity, gaps in service, and weaken the support for client mental health recovery. The results of the study indicate and confirm that job satisfaction among MH professionals is strongly related to team processes. They suggest mental health managers place emphasis on assessing and improving team support, interprofessional collaboration, reducing team conflict, and strong supervisory support that promotes job satisfaction, commitment, and stable management in mental health teams (Fleury et al., 2018). Notably, Molnar et al. (2017) provided a review of a research agenda to address occupational vicarious trauma, and results demonstrate that without collaborative responses from researchers, policymakers, and organizations, first responders, mental health practitioners and other professionals in the helping field are left vulnerable to vicarious trauma and secondary traumatic stress.

Shamoon et al. (2017) postulated that anxiety has been identified as a common factor among therapists, further positing that therapist anxiety, specifically anxiety triggered by difficult and activating clients in therapeutic practice, signifies challenges to

efficacious therapy. Therapist anxiety can result in detrimental outcomes that include, but are not limited to, countertransference, projection, emotional disengagement, compassion fatigue, demoralization, hesitation, and reactivity toward clients. Shamoon et al. (2017) hypothesized that therapist anxiety management, which is when therapists actively navigate their internal states through self-awareness and ongoing introspection, will eliminate the possibility of inadequate services that may result in breaking client alliances and additional deleterious effects. Shamoon et al. (2017) reports that a therapist-client alliance is a central component needed for positive change. The concept of therapist affect management provides an opportunity to include self-of-the-therapist knowledge in the common factor's conversation, and can remain attuned to what happens to their feelings as they do this work. The authors further suggest a stronger emphasis on therapist anxiety management in training and ongoing practice.

A meta-analysis completed by Salk et al. (2017) of 65 and 95 articles on depression and depression symptoms, with corresponding national data sets of over 90 different nations, postulates that depression is a global health priority accounting for 10% of nonfatal disease burden worldwide. The study further indicates that this burden falls disproportionately on women and girls. Salk et al. (2017) reports that analysis results indicate a major difference in depression symptoms and the gender gap in diagnosis as symptoms peak in adolescence and stabilize in adulthood. The meta-analysis indicates that the difference in magnitude should not exclude exploration of depression in men as it should not be overlooked (Salk, et al., 2017). There are limited findings on the developmental and evolving patterns of depression beyond adolescence and into

adulthood as authors posit that it has been largely neglected, empirically indicating the need for further extant research and comprehension (Salk et al., 2017).

The expectation that mental health professionals working with victims of trauma and immersed in repeated exposure to suffering, loss, and tragedy not be impacted by these factors is both unrealistic and irrational. Mental health professionals must be aware, cognizant, and acknowledge the potentially deleterious effects inherent in the profession (Molnar et al., 2017). Experienced vicarious trauma and gender are important factors that affect mental health professionals' levels of job stress, anxiety, and depression requiring exploration based on the modest research and literature. Ashley-Binge and Cousins (2020) called for more research into what organizations are doing to address vicarious trauma, highlighting the need to educate managers on the signs of vicarious trauma and completing preventative checks to better respond to the needs of the social work workforce. In addition, Salk et al. (2017) report that only eight of 310 articles (2.6 percent) from the mainstream social work journals that specifically focused on research examined gender inequality, with only 1.5 percent (n ¼ 6) of mainstream social work articles, explicitly apply a theoretical frame to include gender structure, inequality, gender, and power. The limited research and published findings associated with vicarious trauma and gender differences in mental health professionals demonstrate the need for exploration of the realistic implications and consequences. Understanding the facets of job stress, anxiety and depression identified as health priorities may prompt emphasis on management, training and the personal, community and organizational application of mediating interventions.

Problem Statement

The current study focused on the significance of job stress, anxiety, and depression among mental health professionals, and the examination of how experienced vicarious trauma and gender differences impact the associated factors. Trauma is an event or set of events experienced by an individual perceived to be physically or emotionally harmful, menacing, or overwhelming, thus triggering long-term, harmful effects to an individual's physical, social or emotional wellbeing (Foreman, 2018). The literature indicates that 94% of clients seeking mental health services in centers report some form of trauma, denoting the likelihood that counselors will be exposed to repeated trauma, as well as the elevated possibility of experiencing vicarious trauma (Foreman, 2018). The identified specific components of vicarious trauma affect therapists as they experience psychological distress and symptoms that include, but are not limited to, irritability, anger, fatigue, emotional hardening, cynicism, and seclusion (Baum & Moyal, 2020). Foreman (2018) conducted a pilot study on the content analysis of vicarious trauma and wellness. He found that only nine articles were published on vicarious traumatization across three counseling journals between 1994 and 2014, which establishes the need for further exploration (Foreman, 2018).

Gender differences in the response to distress following indirect exposure, psychological effects, and susceptibility are essential components to assess because emotional impact influences mental health professionals' capacity to care and provide suitable and efficacious treatment. According to Yalcin and Tek (2021), emotional processes have been identified to be the most important administrators of human

behavior. Further, gender differences may significantly impact job stress, anxiety, and depression, which requires further exploration and recognition in order to address the possible implications it may have on the client, therapist, and community. Gaps in the literature indicate that the issue of gender is generally ignored in studies associated with secondary traumatization, a term used interchangeably with vicarious trauma, denoting the need to assess the gender differences in vulnerability, predisposition, and associated implications (Baum, 2016).

Mental health professionals have an increased risk and vulnerability to experiencing job stress, anxiety, and depression based on the very nature of the work, which triggers emotional responses and internal safeguards that may be emotionally, physically, and intellectually challenging (Ju-Hyun et al., 2020). Increased job stress impacts a therapist's personal perception of one's capacity and achievement, hindering treatment services and further contributing to socioeconomic loss. An example of this is observed when women are subjected to strong gender role expectations that exist in the workplace, creating a challenge as women struggle to compete with male counterparts while maintaining traditional gender role ideals (Li et al., 2018). Anxiety is identified as one of the most common psychological disorders. Thus, it is important that we understand what contributes to increased levels of anxiety so that we may create the opportunity for a healthy and balanced life. The literature indicates that unmanaged anxiety among therapists challenges their ability to implement effective therapeutic interventions because as they are grappling to manage their own emotions, they may rupture the therapeutic alliance and flow of therapy in the process which may result in

deleterious effects **(**Shamoon et al., 2017). Depressive symptoms experienced by therapists affect the therapeutic process and relationship amid therapist and client as therapists attempt to mediate personal symptoms of anhedonia, insecurity, inescapability, and general unpleasantness (Ratcliffe, 2015). The implications associated with unresolved job stress, anxiety, and depression amongst therapists can have detrimental outcomes for the client, therapist, and community as therapeutic needs go unmet, further limiting the opportunity for resolution. These results indicated the need to identify how experienced vicarious trauma and gender differences impact these levels to assess the negative connotations of specified factors and efficacious intercessions for specified populations.

Purpose of the Study

The quantitative study examined job stress, anxiety, and depression amid mental health professionals, and the impact that experienced vicarious trauma and gender differences have on the levels of the identified factors. Vicarious trauma has been placed under an umbrella of overlapping stress responses of repeated exposure to trauma survivors with designated specifiers that include, but are not limited to, distinct cognitive changes, interpretation in meanings, individual beliefs, and alterations of personal schemas among men and women (Baum, 2016). Components of vicarious trauma impact mental health professionals' psychological need for trust, safety, control, esteem, and intimacy that have been identified to motivate internal behavior and affect perception of the self, others, and their world (Foreman, 2018). While the term has been used interchangeably with terms such as burnout, compassion fatigue, and secondary traumatic

stress, the identified distinct cognitive changes require recognition as implications of these effects have demonstrated to have deleterious outcomes for the mental health professionals and clients. Gender roles and stereotypes initiate powerful gender role expectancies that influence how professionals deal with stressors in the workplace, life's common and complex disparities, and collective anxieties of daily living. While traditional sex-role divisions have been substantially reformed, the literature shows that women face a double dilemma. Strong situational cues clearly associated with gender role imply that women be both the breadwinner and homemaker as opposed to male's sole role of breadwinner. This inequality required assessment for the implementation of support systems to mediate challenges, as current research alludes that 40% of American men and women in the workforce still endorse customary gender role ideals (Li et al., 2018). The examination of professionals' adaptations to the specific restrictions and or opportunities that are afforded based on experienced vicarious trauma and gender expectations provides an opportunity to implement suitable interventions to identify risk and protective factors. Shamoon et al. (2017) suggested scholarship and research of emotional states such as sadness, depression, and anxiety among therapist required future observation.

The study addresses the research questions and helps fill the gaps in the literature. The aim is to contribute to the knowledge base on the impact that experienced vicarious trauma and gender differences have on mental health professionals' levels of job stress, anxiety, and depression.

Research Questions and Hypothesis

RQ1: What is the impact of vicarious trauma and gender on a linear combination of job stress, anxiety, and depression among mental health professionals?

*H*01: Vicarious trauma and gender will not impact job stress, anxiety and depression among mental health professionals.

*H*a1: Vicarious trauma and gender will impact job stress, anxiety and depression among mental health professionals.

RQ2: Are there significant gender differences between job stress, anxiety, and depression among mental health professionals?

*H*01: Gender differences will not impact job stress, anxiety, and depression among mental health professionals.

*H*a2: Gender differences will impact job stress, anxiety, and depression among mental health professionals.

RQ3: What is the impact of vicarious trauma on job stress, anxiety, and depression among mental health professionals?

*H*01: Vicarious trauma will not impact job stress, anxiety, and depression among mental health professionals.

*H*a2: Vicarious trauma will impact job stress, anxiety, and depression among mental health professionals.

Theoretical Framework

The theoretical framework outlining my study is the constructivist self-development theory that was developed in 1992 by Dr. Lisa McCann and Dr. Anne

Pearlman. The researchers wanted to answer questions regarding why some survivors of trauma are devastated by their victimization, and others demonstrate the capacity to resolve issues and return to well-being. This theory is established from a constructivist view, indicating a distinctive history is what shapes an individual's experience of traumatic events and outlines how they will adapt to the trauma (Pearlman, 1992), This theoretical framework affords an "understanding of the unique inner experience of trauma survivors that accounts for individual differences in the posttraumatic state and provides a heuristic framework for assessment and intervention" (Pearlman, 1992 p. 190). A more extensive explanation of the purpose, rationale, and integration of the chosen theoretical framework will be provided in Chapter 2.

Nature of the Study

The research design is a quantitative design incorporating inferential statistical analysis. The goal was to assess the impact that vicarious trauma and gender may have on job stress, anxiety, and depression among mental health professionals. The statistical analysis utilized was the Two-Way Multivariate analysis of variance (MANOVA), Independent t-test, and Tukey HSD test, with vicarious trauma and gender as the independent variables, and job stress, anxiety, and depression as dependent variables.

The variables were measured upon respondents' completion of questionnaires (Trauma and Attachment Belief Scale, Occupational Stress Indicator and General Wellbeing Questionnaire, the Beck Anxiety Inventory and the Beck Depression

Inventory) available on online Qualtrics survey software. Once data were collected, the Two-Way MANOVA was performed via SPSS.

Definition of Key Terms

Anxiety: Kazdin (2000) defined anxiety as an emotion characterized by feelings of tension, worried thoughts, and anticipation of future threat that result in altered physiological and psychological states.

Depression: The American Psychiatric Association (2013) defined depression as persistently depressed mood or loss of interest in pleasure with symptoms that include, but are not limited to, changes from previous functioning: lack of energy, thoughts of death or suicide, sleep disturbances, changes in appetite, feelings of guilt, and worthlessness, poor concentration, and difficulty making decisions.

Gender: Defined as either male or female for the purpose of this study.

Job stress: BRUIN (2006) defined job stress as "an uncomfortable state of psychological tension that results from an appraisal that the perceived demands of the workplace exceed the individual's perceived resources to successfully meet the demands."

Vicarious trauma: Maguire and Byrne (2017) defined vicarious trauma as the painful psychological effects that come as a result of a professional's exposure and engagement with traumatic material, and the integration of that material into one's cognitive schemas, thus disrupting beliefs about trust, safety, control, esteem, and intimacy.

Assumptions

In this study, the following assumptions were made. One assumption is that all the participants in the study will be honest in their responses to items on the four self-report surveys they were asked to complete. Another assumption is that all of the participants will be honest in answering questions associated with the criteria required to be a participant of the study (mental health professional), as defined for the purposes of the study. A third assumption is that all of the participants will be honest in their responses indicating the direct service of clients. The final assumption is that in the context of this study's participant responses were honest responses that demonstrated the significance and contributed to outcome meaningfulness.

Scope and Delimitations

The study examined how experienced vicarious trauma and gender impact mental health professionals' levels of job stress, anxiety, and depression. For the purpose of this study, mental health professionals were identified as individuals with a bachelor's degree or higher that work in the behavioral health field and directly service clients in the capacities of supervision, case management, social work, counseling, or therapy in outpatient settings. This population was chosen based on the essential services they provide, and the implications of the research outcomes that may promote positive social change in the field of mental health services. Internal threats assessed included selection bias and reactive arrangement. Interventions to address the bias and reactive arrangement include the assessment of equivalency in groups, with close attention to all variables and the minimization of socially desirable responses. External threats for assessment include

population validity and ecological validity. Interventions implemented to minimize these threats included assessing the number of participants required and increasing the population for a better selection pool. In addition, it was important to ensure that the research was not over-generalizing the conclusions and comparisons to existing comprehensive literature so that the results can be placed in a realistic context (Onwuegbuzie, 2000).

Limitations

Some possible challenges, limitations, and barriers in completing this study may be participants' reluctancy to complete surveys, as the questions may cause them to feel emotional distress and trigger memories that may hinder their ability to accurately complete the questionnaire. An additional barrier may be that participants who have experienced these symptoms may choose not to share their trauma and opt out of the study, resulting in limited participants.

Significance

Vicarious trauma amid mental health professionals working with trauma victims is a phenomenon that places them in settings where there is increased susceptibility to experiencing changes in personal, professional, physical, and emotional functioning. The repeated exposure may lead clinicians to question their self-identity, effectiveness, and personal safety. According to a study completed by Foreman (2018), the projected prevalence rate of vicarious trauma amid counselors is 45.9%, with negative effects that include, but are not limited to, rigid beliefs, cynicism, anxiety, depression, and impairment of professional functioning. In addition, quantitative and qualitative studies,

as well as clinical self-reports on mental health professionals who provide services to traumatized clients, show equivalent patterns of intrusion, avoidance, and hyperarousal that characterize their clients' PTSD, which further demonstrates the vulnerability and need for mediation (Baum, 2016). Gender differences amid mental health professionals have been demonstrated to influence response, reaction, and adaptation to repeated exposure of traumatic events as they are said to have intrusive thoughts, image recollection, and physiological reactivity to the reminders. Yalçin and Tek (2021) found that males and females experience physical and mental changes, adhere to the sociocultural structure, social role, and status assigned to them, resulting in higher scores of anxiety in males, and higher scores of guilt in females. These findings indicate that gender differences impact how male and female perceive and experience job stress, anxiety, and depression; however, the literature review demonstrates the study of gender differences is limited. Baum (2016) suggested that the reluctance to generalize from small studies on gender vulnerability is appropriate; however, it highlights the need for a systematic examination of gender vulnerability to assess who is most vulnerable in the workplace and under what conditions. The expansion of the collective knowledge base associated with how experienced vicarious trauma and gender differences impacts mental health professionals' levels of job stress, anxiety and depression affords theoretical and practical importance. On a theoretical level, the outcomes contribute to a better understanding of gender differences and similarities. Whereas on a practical level, the importance lies in the fact that clinicians of both genders engage with traumatized individuals in the course of their work (Baum, 2016). The knowledge gained may be used

in designing and implementing support systems, training, and gender-sensitive interventions with mental health professionals. These interventions, whether preventive or after the fact, may serve to prevent and decrease experiences of vicarious trauma resulting in positive social change.

Summary

Mental health professionals play such an important role in ensuring the mental well-being of community members and community wellness; therefore, it is important that they receive the support needed to maintain personal, interpersonal, and professional efficacy. The background of this chapter emphasizes how experienced vicarious trauma and gender differences affect levels of job stress, anxiety, and depression that mental health professionals may experience. It further denotes the necessity to address the associated implications affecting the mental health providers and communities at large. The significance of this chapter highlights how outcomes may be used in designing and implementing support systems, training, and gender-sensitive interventions that may serve to prevent and decrease experiences of vicarious trauma, resulting in positive social change. Chapter 2 will provide a thorough review of the theoretical foundation and an extensive literature review of the key variables and concepts of the study.

Chapter 2: Literature Review

Introduction

The role of a mental health professional is comprised of, but not limited to, providing services to individuals that struggle with life's increased daily stressors, suffer from mental health disorders, and experience unexpected emotional crises, with the hope that overall mental health will improve and stabilize. Mental health professionals have an increased risk and vulnerability of experiencing job stress, anxiety, and depression, as the very nature of the work triggers emotional responses and internal safeguards that may be emotionally, physically, and intellectually challenging (Ju-Hyun et al., 2020). Thus, experienced vicarious trauma and gender differences impact an individual's mental, physical, physiological, and psychological responses to the repetitious indirect exposure. This causes a strain on interpersonal relationships with clients, peers, and loved ones, as well as their view of the self, in personal and professional settings. The empirical literature indicates that vicarious trauma symptoms may be manifested in a multitude of ways throughout a helping professional's system, as observed in physical, emotional, and behavioral symptoms, work-related issues, interpersonal problems, as well as professional efficacy (Middleton & Potter 2015). Vicarious trauma and gender differences may further increase levels of job stress, anxiety, and depression, resulting in occupational ambiguity, professional dissatisfaction, high turnover, unmanaged anxiety, high rates of depression, and decreased quality of services, leading to negative connotations of the profession. Hernandez-Wolfe et al. (2015) suggested that a sophisticated understanding of how these factors influence the helping professionals and

their clients in personal and social contexts may inspire a conscious exploration and bring new meaning in their work.

The purpose of this study was to examine the prevalence and significance of job stress, anxiety, and depression among mental health professionals and evaluate whether these symptoms increase or decrease based on an individual's experience of vicarious trauma and gender differences. Job stress, anxiety, and depression have been recognized as occupational hazards, commonplace psychological diseases, and health disparities that are acknowledged globally and are at an advanced state of concern (Briley et al., 2021; Middleton & Potter, 2015; Yalcin & Tek, 2021). The serious implications associated with these symptoms indicate the need for further for exploration. This chapter's content will consist of the literature and search strategies utilized, the scope of the literature, the terms and years searched, and seminal literature incorporated based on theoretical assumptions and relevance to the topic. The theoretical framework on which the study was based will be presented, an analysis of the theoretical implications of past and present research will be assessed, and information building on the existing theory will be reviewed for applicability. An extensive literature review of the phenomena, constructs of interest, applied research, and inferences based on outcomes will be established. The summary and conclusions of overall synthesized information will be also presented for reflection, discussion, and assessment of limitations, as well as the identified need for continued research on mediation interventions.

Literature Search Strategy

The literature search included the following databases and search engines: ProQuest Central, ProQuest Dissertations & Theses Global, Psychology Database Combines Search, PsychInfo, PsycArticles, Thoreau Multi-Database, Google Scholar, and Z-Library. The key search terms and combinations utilized were *job stress, anxiety, depression, vicarious trauma and therapists/clinicians / mental health professionals and depression, anxiety, job stress among therapists/clinicians / mental health professionals, gender differences in mental health professionals, gender differences in therapists / clinicians / counselors, gender and vicarious trauma in mental health professionals, gender and job stress, gender differences in the workplace, gender and anxiety, gender and depression, gender differences in mental health professionals, mental health professionals who experience depression, gender inequality, social-structural theory and or gender inequality, social-structure theory,* and *gender inequality*. The scope of the literature review included an appraisal of books, encyclopedias, peer-reviewed journals, and meta-analysis review from publications starting in 2015 up to date. The seminal literature that was incorporated was based on the theoretical framework from which the study is being presented, as well as articles that date back to 1992 when the constructivist self-development theory was developed by Lisa McCann Ph.D. and Laurie Anne Pearlman Ph.D. In cases where there was minimal literature presented on constructs of interest, synonymous terms were integrated and appraised for the interpretation of relevant inferences.

Theoretical Foundation

The theoretical framework for this study is the constructivist self-development theory that was developed in 1992 by Dr. Lisa McCann and Dr. Anne Pearlman. In 1986, Lisa McCann and Laurie Pearlman founded the Traumatic Stress Institute to promote recognition and add to the knowledge base of psychological trauma and treatment. The constructivist self-development theory was developed out of Dr. McCann and Dr. Pearlman's interest in answering questions associated with trauma survivors and their feelings and perceptions of victimization, its psychological impact, and perseverance. The aim was to understand the differentiation amid response patterns, taking into consideration the individual's personal history of trauma, characteristics of the traumatic experience, the world of people, and the inner world of the survivor. McCann and Pearlman spent several years developing the theory, which would provide some explanation of the diverse trauma response patterns and distinct psychological repercussions. According to McCann and Pearlman (1992), this theoretical framework will afford an "understanding of the unique inner experience of trauma survivors that accounts for individual differences in the posttraumatic state and provides a heuristic framework for assessment and intervention" (p. 190).

Constructivist self-development theory has a framework that blends object relations, self-psychology, and social cognition theories and integrates the contributions of the literature on traumatic stress, constructivist, developmental as well as additional cognitive theories (McCann & Pearlman, 1992). The fundamental construct of constructivist self-development theory is the concept of schemata and or schemas, which

are individual beliefs, expectancies, and assumptions of the self, others, and the world. Cognitive schemas are derived from Piaget's (1971) work on cognitive development, which denotes that schemas serve as mental frameworks that mature with life experiences, are reshaped with new information, and further filter individuals' perceptions of the world (Buchanan et al., 2016). This demonstrates that as individuals experience new perceived events of trauma, initial schemas are modified based on the new information presented; then, world view and adaptation to trauma are transformed. A major premise of the constructivist self-development theory is that individuals have an inherent ability to construct personal realities based on interaction with their environment, which then results in the conscious/unconscious creation of their respective representational model of the world (McCann & Pearlman 2015). Perception and assessment of the self and the surrounding world have significant inferences on physical, physiological, social, emotional, and psychological responses to trauma. The behaviors serve as instinctual reactions that fit the individuals' need and desire to remain safe and protected in their world. The constructivist self-development theory postulates that psychological needs are shaped by individual experience and motivate behaviors, specifying several aspects of the self that are impacted by trauma. Saakvitine (1995) identified these aspects as an individual's worldview, self-capacities, ego resources, psychological needs, cognitive schemas, and memory.

The response to trauma is thus a unique and multifaceted process in which personal subjective meanings are assigned to the event based on the development of cognitive schemas and how the events are experienced and perceived, with consideration

of specified aspects of the self. Therefore, it is important to note that trauma is determined by the individual and not by the event. According to constructivist self-development theory, vicarious trauma experienced by mental health professionals is when an individual's inner experience is negatively altered. In the process of demonstrating empathic attunement to another's traumatic accounts of suffering and distress, mental health professionals are affected in various ways, dependent on personality, defensive styles, and available resources (Buchanan et al., 2016).

The literature and research-based analysis of the constructivist self-development theory incorporated in previous research applications is assessed here in three studies that include an exploratory factor analysis completed in 2016, a meta-analysis of 38 studies completed in 2017, and a confirmatory factor analysis completed in 2018. The exploratory factor analysis was completed on the Trauma and Attachment Belief Scale (TABS), which was identified and created based on the constructivist self-development theory. Buchanan et al., (2016) sought to assess levels of cognitive schema disruption in partners of military service members based on their exposure to secondary trauma associated with partner deployment. In order to identify the main concerns that are exclusive to service members areas of personal cognitive schemas researchers utilized the TABS scale. Buchanan et al., (2016) postulated that the TABS was developed to assess the psychological impact that traumatic events have on an individual's cognitive schemas of the self and psychological needs. The constructivist self-development theory identified these psychological needs as safety, trust, esteem, intimacy, and control. The results of the study indicate that the TABS had strong internal consistency and support the

utilization of the instrument with partners of the service members, further denoting that the information acquired may assist in identifying and implementing evidence-based therapeutic interventions. The introduction of instrumentation developed based on the constructivist self-development theory, as well as guided understanding of presented key schemas and outcomes that afford interventions to address vicarious trauma, demonstrates the relevance of this review for the current study.

The meta-analysis of 38 studies completed in 2017 is a review of the existing research and the development of a research agenda to address vicarious trauma and secondary traumatic stress in the workplace (Molnar et al., 2017). The authors establish that professionals working in the fields of trauma are vulnerable to experiencing vicarious trauma and the negative impacts, which are considered an occupational challenge. The aim of the study was to address the dilemma and create an agenda of four organized steps associated with the public health approach to address vicarious trauma and secondary traumatic stress. Molnar et al., (2017) presented four steps outlining a public health approach, which included a definition of the problem, identification of risk factors, the development of interventions, and observation of policies over time. The researchers identified vulnerable professionals that include, but are not limited to, victims' assistance, mental health professionals, and emergency medical services due to their exposure to mass casualty events and painful and horrendous experiences daily. The researchers began by defining the problem and measuring the prevalence, incorporating instruments that measure vicarious trauma, secondary traumatic stress, and compassion fatigue, which are terms that have been utilized interchangeably. The Secondary Traumatic Stress Scale

(STSS), which is designated to tap on specific secondary trauma symptoms; the Compassion Fatigue Self-Test (CFST), which was founded on clinical experience assessed both compassion fatigue and job burnout; and the Trauma and Attachment Belief Scale, which was developed on the premise of constructivist self-development theory, are all used to assess long-term impact that trauma has on an individual's beliefs about the self, others, and relationships (Molnar et al., 2017). The outcomes indicate that the prevalence rate differentiates based on the profession, such as helping professionals, first responders, social workers, mental health professionals, and victims' services providers. They advise that we should err on the side of caution as some professionals may be reluctant to share due to stigma, confidentiality and job safety.

In one of the studies researchers assessed the prevalence of STS in internet Crimes Against Children personnel. The results indicated that prevalence varied based on the investigator's gender, extroversion, and neuroticism (Molnar et al., 2017). The researchers of the meta-analysis identified risk factors in the workplace also varied amid the professions, however, recognized caseload, caseload frequency, caseload ratio, and history of personal trauma as most common factors. The established prevalence and risk factors allowed the researchers to present the promotion of health and wellness through trauma treatment and interventions for professionals. Interventions included professional skills training as a preventative measure, psychoeducation to increase knowledge and skills development, and critical incident stress management to prevent posttraumatic stress (Molnar et al., 2017). This article further recognizes that organizations need to take a trauma-informed approach in assuming responsibility and being proactive in

addressing the impact of vicarious trauma through the implementation of policies, procedures, practices, and the promotion of programs. The basic goal of addressing vicarious trauma, acknowledging it as an occupational hazard, recognizing its prevalence and associated impacts as well as presented interventions for mediation establishes relevance and adds to the application of the study.

The confirmatory factor analysis (CFA) completed in 2018 was to analyze the psychometric properties of the Victim Trauma Scale (VTS) in order to confirm the findings of previous research associated with vicarious trauma (VT) and posttraumatic stress disorder (PTSD). Aparicio et al., 2013 examined vicarious trauma with social workers utilizing the VTS and claimed it to be a two factor construct both affective and cognitive. The CFA was completed by the researchers to confirm the findings and found that through the examination of the latent structure associated with vicarious trauma and the use of TABS vicarious trauma was unidimensional (Benuto et al., 2018). The researchers then wanted to see if a new population (victim's advocates) would be unique in their experience and understanding of vicarious trauma and completed an exploratory factor analysis (EFA) to assess which of the models fit best, the two-factor construct or the unidimensional construct. The findings support the use of TABS for the measurement of vicarious trauma created by Pearlman in 2003. Through the introduction and explanation of constructs of the study, the researchers presented an informed definition of vicarious trauma. They included the onset, presentation, and longevity of its effects that distinctly distinguishes it from other psychological sequelae professionals may experience such as compassion fatigue and secondary trauma (Benuto et al., 2018). The

very nature of the study constructs examined, theoretically based definitions and outcomes along with recommendations to improve the quality of care by mental health providers corroborates the relevance of this review for the study.

The rationale for choosing the constructivist self-development theory (CSDT) in this study was to acquire an understanding of how individuals differentiate in their response to traumatic events, and how they adapt and resume wellbeing. CSDT is established from a constructivist view demonstrating that personal schemas and a distinctive history are what shape an individual's experience of traumatic events and outline how they will adapt to the trauma. Schemas are a major concept in CSDT as they are the beliefs, expectations, and assumptions that individuals have of the self, others, and the world. They are templates that individuals develop through their experience, then use to organize information and future experience (McCann & Pearlman, 1992 p. 189). In this case, the self includes all aspects of the self, an individual's gender, race, and ethnicity, amid other social identities and status. In this study, the aim is to evaluate the significance of job stress, anxiety, and depression amid mental health professionals and examine how experienced vicarious trauma and gender either increase or decrease these factors. A holistic view of vicarious trauma and gender differences and how they may impact the identified variables may assist in the development and application of gender-sensitive training, supervision, and organizational support for mental health professionals. It may further serve to minimize the probability and decrease individualized symptomology. The term vicarious trauma was developed from the constructivist self-development theory and symbolizes detrimental changes in the manner that professionals

understand and interpret material, as a consequence of exposure to second-hand traumatic material (Benuto et al., 2018). Vicarious trauma as a construct driven by theory that highlights the gradual, veiled, and ongoing changes impacting the schemas of the mental health professionals may provide significant implications for understanding levels of job stress, anxiety, and depression. It is with this validation that the Traumatic and Attachment Brief Scale TABS has been chosen as one of the measurement instruments in this study to specifically assess the impact of vicarious trauma.

The TABS was developed in 2003 by the same authors who developed the constructivist self-development theory in 1992 Dr. Lisa McCann and Dr. Anne Pearlman and correspondently the theoretical framework for the current study. The TABS is the amended version of the Traumatic Stress Institute (TSI) Belief Scale that was modified as clinicians and researchers became more cognizant of the long-lasting psychological effects of trauma and the increased need to identify instruments that would measure trauma-specific symptoms (Pearlman, 2003). The TABS is a self-report with 84 items that ask participants to answer on a Likert scale between 1 and 6, with 1 being Disagree strongly and 6 being Agree strongly. It was developed to assess cognitive schemas associated with the five particular belief areas of safety, trust, esteem, intimacy, and control. The TABS has 7 interpretive T-Score ranges and are placed in categories of Extremely low (very little disruption), Very low, Low Average, Average, High Average, Very High, and Extremely High (substantial disruption). The TABS was also chosen based on its sensitivity to the psychological impacts that vicarious trauma has on its survivors as they may react more adversely to psychological tests. TABS avoids utilizing

terminology with disempowering labels or other terms that may make the trauma survivor feel alienated. The items do not center around the trauma symptoms, instead they focus on the beliefs about the people that may be due to the traumatic experiences (Pearlman, 2003). The constructivist self-development theory and associated instruments related to the study as they provided results specifically indicating how vicarious trauma impacts the identified dependent variables of job stress, anxiety and depression and build upon the literature of the existing theory. According to Pearlman (2003) the TABS outcomes suggest the possible presence of trauma history, detect psychological themes in trauma material, document improvement in treatment and propose appropriate focus for therapy with clients as needs shift with time.

Literature Review Related to Keywords and Concepts

Vicarious Trauma and Gender Differences

Vicarious trauma and gender differences impact mental health professionals' physical, physiological, emotional, and psychological responses to job stress, anxiety, and depression. This is a result of their work with clients as they help them manage emotional dysregulation, continuous distress, mental health disorders, pervasive traumatic experiences, and immediate crisis among a multitude of other unexpected obligations. Increased interest in the phenomena of vicarious trauma and its psychological impacts on mental health professionals has prompted additional recent research. The gaps in the literature indicate that the impact of vicarious trauma and gender on job stress, anxiety, and depression among mental health professionals has not been directly examined and is generally ignored. The purpose of this study was to help

fill the gaps in the literature and contribute to the knowledge base associated with experienced vicarious trauma and gender differences in mental health professionals' levels of job stress, anxiety, and depression.

Vicarious trauma, compassion fatigue, and secondary traumatic stress are some key statements, terms, and definitions inherent in the framework of the study. These terms are often synonymously utilized in research to describe overlapping stress responses of mental health professionals' repeated exposure to traumatic stressors and details of others' pain and suffering. Vicarious traumatization (VT) was described as the cumulative impact of learning about the details of clients' traumatic experiences on a professional, and specifically, the alterations in an individual's cognitive schemas and systems of meaning that may occur as a result (Pearlman & Saakvitne, 1995, Sprang et al., 2019). Compassion fatigue (CF) was labeled according to its association with feelings of helplessness, confusion, isolation, numbness or avoidance, as well as continued arousal in those who work with traumatized individuals. Secondary traumatic stress (STS) is defined as the emotional response that results when a person hears about the firsthand trauma experiences of another. Unlike vicarious trauma, STS is not specific to mental health professionals, rather it indicates that anyone who closely interacts with a trauma survivor may experience it (Jimenez et al., 2021). Although the terms have been used interchangeably it is important to note that vicarious trauma's prominent symptoms include cognitive changes, in meanings, beliefs, schemas, and adaptations associated with a multitude of triggers that may result in adverse effects such as anxiety and depression (Baum 2016). The distinctive cognitive changes require acknowledgment as

repercussions of these effects have demonstrated to have deleterious outcomes for the mental health professionals and clients.

Gender Differences in Job Stress

The social-structural theory suggests that a society's division of labor by gender determines and impacts all other psychological gender differences (Salk et al., 2017). Gender differences, divisions, roles, and expectations are perceived at various if not all levels in society and predominantly in the workplace. Gender inequality in top corporate jobs is an additional issue that has been at the forefront of the global agenda along with concerns about social support for career women that have been placed on the global stage (Fernandez & Ferreira 2021, Li et al., 2018). These differences can be seen primarily in the gender pay gap, organizational hierarchies and employment opportunity, occupational gender role expectations, and cultural/societal assigned gender norms in the workplace. The gender gap is referred to as the realization that females earn less than males in all and any profession around the world and is "often interpreted in the literature as the extent of employer discrimination" (Fernandez & Ferreira 2021 p. 382). Organizational hierarchies and employment opportunity demonstrate the inequality and privileges that are afforded to men in terms of access and opportunity. Men stereotypically control official positions of greater influence within organizations affording them greater authority and discretion. Women, in general, have a harder time finding and maintaining employment based on the very basic gender differences of sex. Their career trajectories are expected to differ based on opportunity, capacity, and ability as well as any existing constraints associated with the position. Occupational gender role expectations along with cultural and societal

assigned gender norms place women in a double dilemma as they are required to meet the daily work requirements, per se quota, while at the same time maintaining the household responsibilities, and attending to the nurturing of the children. Women are expected to meet the needs of their husbands and children regardless of the work schedule they maintain as this is part of the cultural and societal norms placed upon the role of the women (Li et al., 2018). This further leaves women in a more vulnerable state of getting into problems at work because they are tending to familial needs during work hours as well as the possibility of family conflicts and vice versa. Men on the other hand are seen as the providers and breadwinners, therefore as long as they maintain employment and pay the bills, they are said to have met gender, social and cultural norms. The gender role expectations model proposes that there exist role expectations for women to be more invested in the home and for men to be more devoted to work. Compared to men, women are more challenged to keep family interference from work because women are socially cued to give priority to family (Li et al., 2018). The socially defined and differentiated expectations of child care and household chores along with the unequal weight assigned to often jobs of the same characteristics may significantly contribute to women's perceived levels of satisfaction. In order to assess how this inequality accurately impacts women in the workplace, we must hear them out, for only then can we see it from their point of view.

Vicarious Trauma and Anxiety

Vicarious Trauma (VT) can be described as a process of alteration that mental health professionals experience, that is continuous, and develops over time due to the

recurrent exposure and attunement to the trauma of others (Comerchero 2015). VT is considered a transformation that is the product of the transmission of traumatic stress resulting in symptoms that include but are not limited to anxiety, depression, intrusive thoughts and feelings, emotional numbing and flooding, and personal vulnerability. Mental health professionals often bear the burden of dealing with increased trauma in the workplace as some clients may present with a severe history of trauma that requires additional and specific interventions that can be mentally and physically draining. This can cause the adverse symptoms to be intensified and impact the individual, further triggering other mental health-related issues that can impact personal and professional responsibilities. It is therefore important that mental health professionals that work in this particular profession be aware of any pre-existing concerns that may impact or cause serious impairment. Organizations and supervisors should also be aware and provide employers with this information as a preventative measure. Risk factors for vicarious trauma that informs mental health professionals of possible susceptibility include pre-existing anxiety, mood disorders, personal trauma history and maladaptive coping skills (Comerchero 2015).

According to the American Psychiatric Association (2013) anxiety is defined by an individual's anticipation of a future threat that is associated with muscle tension and vigilance in preparation for future danger with the inclusion of cautious and avoidant behaviors. The symptoms of anxiety include but are not limited to excessive worry, apprehensive expectations, restlessness, fatigue, irritability, muscle tension, and sleep disturbances (APA, 2013). Anxiety is considered to be one of the most common mental

health disorders and psychological diseases and is presented as an advanced state of concern. As mental health professionals, this should be a red flag indicating the need for an understanding of what exactly is the cause, or causes and what may be triggering and contributing to these increasing statistics. The extent to which mental health professionals experience anxiety and whether it is impacted by an individual's experience with vicarious trauma is a topic that has not been examined and minimal literature expands on the issue. It is therefore crucial that we attempt to assess how vicarious trauma impact levels of anxiety.

Gender Differences in Anxiety

According to Lauve-Moon at al., (2020) gender operates as one of the highest inequitable divisions in society and transcends all fields of social work practice, education, and research. Gender differences and issues play a central role in the therapeutic process as individuals assert their identity along with the aspirations associated with the assigned gender, cultural restrictions, and barriers which presents itself as the cause of the distress. Hernandez-Wolfe et al., (2015) suggested that cultural transitions are often difficult and may be exacerbated by perceived and experienced oppressions due to ethnicity, class, and gender, which generates additional hardships and adversities to overcome. Universal social expectations of male and female response to daily complexities and trauma may confine individuals' actual/genuine reaction as they attempt to conform to societal norms. (Christiansen, 2015) posits that gender-roles such as these are likely to affect sex differences in anxiety (Christiansen, 2015).

Anxiety disorders have been identified as the most predominant group of psychiatric disorders with established documentation indicating females more likely than males to develop anxiety within the lifetime and past years (Christiansen, 2015). Females are continually found to be more susceptible than males to experience anxiety and generally diagnosed with most anxiety disorders. The pervasiveness of anxiety amongst females has persisted independently of the changes that have been made in the diagnostic criteria. Females remain more likely to be diagnosed with anxiety to include agoraphobia (AG), panic disorder (PD), separation anxiety (SA), specific phobia (SP), social anxiety disorder (SAD), generalized anxiety disorder (GAD), obsessive-compulsive disorder (OCD), as well as acute and posttraumatic stress disorder (ASD and PTSD) (Christiansen, 2015). Gender roles impact sex differences in anxiety as males tend to align with masculine identity resulting in the underreporting of symptoms and reporting bias. Since childhood males have been taught to confront fear as opposed to females that avoid fearful situations therefore consequently females tend to report more symptoms of anxiety as opposed to their counterparts. In addition, gender differences in the division of work and socioeconomic status further leave females more susceptible to experience anxiety due to the environmental stressors that include sexual harassment, sexual abuse, domestic abuse and male superior relationship stressors.

Despite the extensively reported sex differences, prevalence, severity and gender implications associated anxiety disorders, sex differences in anxiety have been generally neglected. Christiansen (2015) indicates that in search of sex/gender and anxiety disorder

published research between 2011 through 2015 between 0 and 5 articles were identified addressing unique anxiety disorders.

The limited research and literature associated amid gender differences, gender and anxiety demonstrates the need to further assess the implications and outcomes. This will improve mental health amid men and women and can contribute to the designation and development of gender-specific mental health services. According to Stiawa et al., (2020) in order to centralize gender in research, we must first begin pursuing research questions that examine gendered systems and causal sexist outcomes commonly associated with almost every major social issue of the 21st century.

Vicarious Trauma and Depression

Mental health professionals are witnesses to testaments that are unique and incomparable as to render them incomprehensible to those who were not there (Hernandez- Wolf et al., 2015). The repeated exposure to these types of traumatic disclosures goes to show how mental health professionals can be psychologically impacted as they demonstrate a genuine and empathic clinical approach to the clients they serve. To be truly attuned and demonstrate empathy professionals must have the capacity to be aware, cognizant, understanding, and vicariously see the world from the point of view of the client and feel their distress. This according to the scientific literature is what contributes to vicarious traumatization as they demonstrate reactions to others' accounts of traumatic events (Hernandez- Wolf et al., 2015). Branson (2019) described vicarious trauma as the phenomenon of clinicians being physically, cognitively, emotionally, mentally, socially, and/or spiritually affected by bearing witness to others'

trauma. Emotional symptoms include feelings of grief, irritability, frequent distraction, changes in mood or sense of humor; Behavioral symptoms include isolation, change in eating and sleeping patterns as well as am increased alcohol or substance consumption; Physiological symptoms consist of frequent headaches, unexplained rashes, ulcers, and heartburn; Cognitive symptoms may be observed in the form of cynicism, negativity, and problems with concentration and memory; Spiritual symptoms can result in loss of hope, decreased sense of purpose and disconnection from others (Jimenez et al., 2021). These effects may increase the likelihood that mental health professionals will experience increased levels of depression and further hinder the therapeutic process resulting in psychological distress of the therapist, and poor quality of services / care for the client.

Depression is characterized by symptoms that include but are not limited to depressed mood, loss of interest, feeling sad, empty and hopeless, diminished interest in activities of pleasure, insomnia, and hypersomnia. In a meta-analysis by the American Psychiatric Association (2013) of 65 articles of depression and 95 articles of depression symptoms, with corresponding national data sets of 90 distinctive nations postulated that Depression has been identified as a global health priority that accounts for 10% of non-fatal diseases burden worldwide with disproportionate numbers for girls and women. The results of this meta-analysis expose the reality associated with the prevalence of depression and the possible impact that it can have on mental health professionals. The limited literature on vicarious trauma and gender differences impact on mental health professionals' levels of experienced and reported depression demonstrates the significant need for further exploration as it has been identified as a global health priority and health

disparity. Salk et al., (2017) suggested that the gender-based differences in rates of depression, high suicide rates among men, and male-specific help-seeking behavior establishes that there is a strong need for further research as well as the need to develop gender-specific services tailored to men with depression. The question presented here is how these rates of depression experienced by mental health professionals can be impacted by experienced vicarious trauma a topic that has limited examination published, yet may serve to provide a wealth of knowledge and prompt action in interventions.

The scarcity of literature correlating vicarious trauma specifically with depression and depression symptoms may be due to the fact that vicarious trauma has been placed under an umbrella of overlapping emotional stress responses such as secondary traumatic stress (STS), compassion fatigue (CF) and burnout. Molnar et al., (2017) reported notable challenges in portraying the accurate prevalence of vicarious trauma due to variability of how the constructs of the interchangeable terms are defined and operationalized in research methodologies. In a study to explain and predict vicarious trauma amongst therapists, researchers incorporated the Bowen's Family Systems Theory with specific reference to the phenomenon of "differentiation of self". According to Halevi and Idisis (2018) the concept of the differentiation of self is referred to as the therapist's ability to sustain an emotional balance amid the sense of self and sense of togetherness with others. This indicates that therapists must have the capacity to engage in an emotionally intimate relationship without losing their sense of self. The balance allows the therapist to acquire a healthy ego identity while affording reciprocated and rewarding interpersonal relationships. It is suggested that violations of this balance has had significant

psychological and physiological implications amongst therapists. Halevi and Idisis (2018) reported that since the development of the theory studies have made connections between the differentiation of self and depression, emotional stress and anxiety.

A study to examine the frequency of reported secondary traumatic events /stress and the effects of psychological well-being and work ability in nurses indicated that although this population is more suspectable to acquiring vicarious trauma, data is scarce. Bock et al., (2020) found that nurses from different specialties reporting secondary traumatic symptoms reported higher depression and anxiety, further postulating that those who developed STS (25.3%) not only displayed depression and anxiety but also experienced greater job strain and work ability. Research on STS further demonstrates that it is a recurrent condition across nursing specialties, with prevalence ranging between 35% and 60% (Beck, 2011). The interchangeably utilized terminology accompanying vicarious trauma and symptom commonalities along with identified connections to depression and anxiety among therapists merit recognition and appraisal. Educational, professional and personal awareness amongst therapists and policy makers associated with vicarious trauma will afford the implementation of personal and organizational interventions. Finklestein et al., (2015) suggested that specialized training, debriefing, supervision, and peer support may be helpful in safeguarding the effects of vicarious trauma.

Gender Differences and Depression

Sociological and social structural theories provide an outline for understanding the relationship between gender inequity. They indicate that gender differences are a

consequence of individuals' adaptations to the specific limitations on or opportunities based on the gender in society. Salk et al., (2017) postulated that sociological approaches to mental health highlight the role of poverty, violence, and gender inequality as factors that contribute to the gender difference in depression as they illustrate that a recent estimate of the global 12-month prevalence of major depressive disorder shows women percentages as 5.8% as opposed to men at 3.5%. The gender difference in depression denotes a major health disproportion as women are believed to experience depression twice as much as men (Salk et al., 2017). The gender differences associated with gender roles, assigned expectations, and social/cultural norms further contribute to the elevated numbers of females being diagnosed with depression and ambivalent numbers associated with male diagnosed depression. Men are less likely to report depression because it goes against gender roles and assigned expectations that men are the strong ones, need to take care of the women, and therefore cannot express these concerns as they may be seen as weak. It is for this reason that we see lower numbers of men being diagnosed based on their reluctance to admit to feeling depressed or seeking help as it goes against their gender norms (Salk et al., 2017). Cultural norms also play a big role in men seeking help for depression or any mental health issues as many times cultural norms do not believe or accept these issues as an actual illness and expect men to deal with these concerns within themselves. According to Stiawa et al., (2020) there have been a number of qualitative studies that provide evidence that men see depression as being incompatible with the male expected gender role and rather align it with female attributes of weakness.

The literature associated with men who have depression indicates that they are subject to discriminating attitudes and stigmatization. Depression diverges from the ideal of the projected hegemonic masculinity and the assumption of "doing gender" which has been described as individuals acting unconsciously in accordance with the perceptions of gender (Stiawa et al., 2020). The concept of depression among men demonstrates that men usually experience externalized symptoms that include aggression and substance abuse that further decreases the likelihood that men will seek help. The practicality is that men have higher suicide rates than women which demonstrates the discordant relationship amid men's low rates of diagnosed depression and high male suicide rates. These disparities indicate a need to examine how gender affects depression so that we may develop and implement gender-specific services and tailor the interventions and treatment to address the barriers men experience and endure when it comes to mental health. The gaps in the literature show that there is little to no research on the magnitude of gender differences in depression symptoms and the developmental patterns of gender differences beyond adolescence have been largely neglected empirically (Salk et al., 2017).

Summary and Conclusions

It is evident that vicarious trauma and gender differences may impact and influence mental health professionals' experience and levels of job stress, anxiety, and depression based on the very nature of the profession and repeated exposure to the mental health distress of the clientele serviced. Vicarious trauma and gender differences demonstrate to impact mental health professionals' levels of job stress as the literature

indicated the need for more research on the actual rates of vicarious trauma amid social workers and research into the effectiveness of strategies implemented to ameliorate the negative outcomes. Vicarious trauma and gender differences associated with the anxiety experienced by mental health professionals is a topic that has not been examined. Minimal literature has presented possible interventions or treatment despite the fact that it has been identified as the most common disorder among psychological diseases and known as an advanced state of concern (Yalcin & Tek 2021). This shows the need and relevance that the study has on the limited knowledge based associated with this highly recognized disorder.

Chapter 3: Research Method

Introduction

The goal of this quantitative study was to examine job stress, anxiety, and depression amid mental health professionals and the impact that experienced vicarious trauma and gender differences have on the levels of the identified factors. The expansion of the collective knowledge base that was acquired from research affords theoretical and practical importance, further contributing to the designation and implementation of support systems, training, and gender-sensitive interventions with mental health professionals. This chapter will present the research design and rationale for selection, assumptions, and in-depth segments of methodology. The selection of population, recruitment procedures, instrumentation, operationalization of constructs, plan for data analysis, and ethical considerations will be presented. In conclusion, the chapter will further identify and elucidate any resource constraints associated with design choice and threats for internal/external validity, and or construct / statistical conclusion validity.

Research Design and Rationale

The research design chosen was a quantitative study that focused on correlation. A correlational study is the examination of the relationships between variables without the control or manipulation of the variables. The main premise of the correlational study was to identify variables that have a relationship to the degree in which a change in one variable will cause a change in the other variable.

The two-way MANOVA is considered an extension of the two-way ANOVA and is utilized when there are situations incorporating two or more dependent variables with

the aim of understanding if there is an interaction amongst the two independent variables and two or more collective dependent variables (Laerd Statistics, 2016). In this study, the scores were the three dependent variables job stress, anxiety, and depression; the group comparisons were made utilizing the independent variables of gender and vicarious trauma. The two-way MANOVA was the appropriate statistical test because it considered the interaction between independent variables gender and vicarious trauma on the three dependent variables job stress, anxiety, and depression. In terms of interaction, the goal was to assess if males and females that demonstrate vicarious trauma scores are more likely to have increased job stress, anxiety, and depression. The design choice was consistent with research designs needed to advance knowledge in the discipline as outcomes reflected whether there was an interaction effect amid mental health professionals' levels of job stress, anxiety, and depression taking into account experienced vicarious trauma and gender.

A quantitative study was chosen for this research as quantitative research has been connected to an advanced understanding and enhanced sophistication in statistical analysis (Hackett, 2018). Quantitative research is collected through the measurement of different aspects, and data is analyzed through different numerical comparisons, affording the interpretation of statistical means that has been recognized as scientifically objective. In this study, questionnaires were utilized with Likert scales for measurement of participant responses before being into categories in order to be interpreted through statistical means for specific outcomes. In a search of the Journal of Consumer

Psychology and a similarly high number of consumer-based studies, quantitative research demonstrated to be predominantly employed for investigative purposes (Hackett, 2018).

Methodology

Participants

Population. The population selected for the study were individuals with a bachelor's degree or higher that work in the behavioral health field, directly servicing clients in the capacity of supervision, case management, social work, counseling, or therapy in out-patient settings.

Sampling Method. The sampling method utilized was non-probability convenient sampling that is comprised of selecting participants that are conveniently available and interested in participation via online platforms. This sampling strategy was chosen based on accessibility, population size, and timeframe. The sample size calculation is based on the two-way MANOVA test statistic and was performed using the G-Power software. A sample of at least 42 participants will be collected, assuming an effect size of 0.2 using the Pillal V statistic, alpha of 0.05, a power of 80%, three dependents, two independents, and at least three groupings in each combination of the independent variables. All descriptive statistics were used to summarize interval data, such as the mean and standard deviation. Percentages and frequencies were used to summate nominal and ordinal variables.

Procedures for Recruitment Participation and Data Collection

The procedure for recruitment, participation, and data collection utilized electronic communication. Participants were solicited via email announcement to mental

health organizations in the United States and posting on various social media sites requesting voluntary participation as well as advising them what the study goals are and what it will entail. The demographic information collected included participant age, education, and gender. The participants were provided with an informed consent form indicating participation expectations, background information, confidentiality, description of the study and voluntary status. The informed consent was constructed into the online survey platform, and once participants indicated agreement to participate, they were prompted to complete the four self-report questionnaires. The data collected were acquired using the online survey tool Qualtrics, which is utilized to create, send and examine surveys. Study participant data were not gathered, and information was stored on a password-protected computer. Once participants completed and submitted the four self-report questionnaires, they were not required to complete any additional information.

Instrumentation and Operationalization of Constructs

The published instruments that were utilized to gather the data consisted of the General Work Stress Scale, Beck Anxiety Inventory, Beck Depression Inventory II, and the Trauma and Attachment Belief Scale. In this section, the instruments will be presented, including notes on identified developers and publication, appropriateness for the study, reliability and validity values relevant for the use of this study. The procedure for permission requests of instruments from developers will be explicated.

The General Work Stress Scale is a measure of subjectively experienced stress in the workplace that was developed by authors Gideon P. De Bruin and Nicola Taylor in 2005. The scale consists of nine items with a five-point Likert-type response that

typically yields Cronbach alpha coefficients of .90. In a study completed by Bruin (2006), the authors examined the dimensionality of the General Work Stress Scale, with overall results stipulating support of the construct validity and describing the GWSS as a subjective measure of experienced work stress. This instrument is appropriate for the present study as it affords participants the opportunity to identify how stressed they are at work with diverse people. These individuals include correctional officers who have been identified to experience a significant amount of role conflict and ambiguity, along with threat perceptions based on the physical conditions of employment conditions. Permission was requested from developers via a formal permission request sent from the researchers' personal email indicating the purpose and rationale for the study, instrumentation utilization, and possible implications.

The Beck Anxiety Inventory (BAI) is a 21-item self-report measure of general anxiety that is used to assess the intensity of physical and cognitive anxiety symptoms. The BAI was developed by psychiatrist Aaron Beck and colleagues in 1988. The BAI is a published scale that has been demonstrated to provide reliable and validated measures. Each of the items is rated based on a 3-point scale with 0-7 indicating Minimal levels of anxiety, 8-15 Mild anxiety, 16-25 Moderate anxiety, and 26-63 Severe Anxiety (Stark 2021). The BAI is utilized in clinical settings where psychological and neurological tests can be administered as a single instrument to measure anxiety if that is the concern being presented, or administered in collaboration with other psychological instruments to complete full psychological examinations. In a study done by Senol-Durak et al. (2006) to assess the development of the Work Stress Scale with correctional officers, the BAI

was used in collaboration with the Beck Depression Inventory (BDI), Beck Hopelessness Scale (BHS), and Multidimensional Scale of Perceived social support (MSPSS). The authors indicate that the BAI is a reliable and validated measure that demonstrates reliability and validity coefficients equivalent to its original values.

The Beck Depression Inventory (BDI-II) is one of the most widely utilized psychometric tests to assess the severity of depression in individuals between the ages of 13-80. The self-report questionnaire was revised in 1996 in response to the modified criterion for depression in the American Psychological Associations' publication of the DSM-IV. The authors implemented asking individuals to respond to questions based on a two-week time frame as opposed to the one-week time frame used in the BDI (Beck et al., 1996). The BDI-II has 21 questions, with each symptom of depression scored on a scale of 0 for minimal to 3 for severe, with the highest score being 63 and the lowest score being 0.

Scoring for levels of depression are as follows: 0-10 These ups and downs are considered normal; 11-16 Mild mood disturbance; 17-20 Borderline clinical depression; 21-30 Moderate depression; 31-40 Severe depression; and anything over 40 is described as Extreme depression. In a two-part study to investigate the criterion validity and test-retest reliability of the BDI-II, researchers utilized separate samples of university students receiving services at the counseling centers; they found evidence of the BDI-II criterion validity and short-term test-retest reliability in university students (Beck et al., 2002). The BDI-II is also utilized in clinical settings where psychological and neurological tests can be administered as a single instrument to measure depression if that is the concern being

presented, or administered in collaboration with other psychological instruments to complete full psychological examinations.

The Trauma and Attachment Belief Scale (TABS) is to assess the psychological impacts of traumatic events on cognitive schemas regarding beliefs about self and others in relation to the five aforementioned psychological needs (safety, trust, esteem, intimacy, and control) based on Constructivist Self Development Theory (Buchanan et al., 2016). The TABS instrument was formally known as the Traumatic Stress Institute Belief Scale and was developed by Dr. Laurie Anne Pearlman in 2003. Initially, it was normed for adults 17 years and older; however, it has now been modified to suit adolescents. The scale was created based on the increasing, long-lasting psychological effects of traumatic life experiences that clinicians and researchers were encountering in practice prompting the need for trauma-specific instruments. According to Pearlman (2003), a range of trauma-specific instruments are needed because the effects of traumatic life experiences are so pervasive and complex that it effects the victim's entire psychology. The individual psychology includes, but is not limited to, defenses, coping styles, ego resources, psychological needs, worldview, identity and spirituality. The TABS has been incorporated to measure the effects of traumatic life experiences in a vast array of populations that include, but are not limited to, survivors of abuse, therapists, battered women, paramedics, social workers, and criminal law solicitors. Although the TABS was originally designed to assess for the effects of primary trauma, several studies have utilized the TABS to assess for the effects of secondary trauma among therapists, social workers, criminal law solicitors, and others (Pearlman, 2003). Construct validity of

the TABS was supported through measurement of concurrent validity between the TABS and the Trauma Symptom Inventory (TSI), in which all TABS subscales were significantly correlated with TSI trauma symptom scales. Pearlman (2003) reported internal consistency estimates of .96 for the total TABS score. This instrument adds to the knowledge of the topic as the developers are the creators of the theoretical framework of said dissertation; thus, they are inclined to understand how the inner experiences of trauma survivors will impact future psychological states.

Independent Variables

Vicarious trauma is defined as the painful psychological effects that come as a result of a professional's exposure and engagement with traumatic material and the integration of that material into one's cognitive schemas, disrupting beliefs about trust, safety, control, esteem, and intimacy (Maguire & Byrne, 2017). This independent variable is ordinal and will be measured utilizing the Trauma and Attachment and Belief Scale which consists of seven levels. The levels are as follows extremely low ($\leq$29), very low (30-39), low average (40-44), average (45-55), high average (56-59), very high (60-69), and extremely high ($\geq$70). The scaled scores will be derived from the survey tool as a summation of the items within the survey. The variable of gender is defined as male and female. This independent variable is nominal and contains two levels, male and female, and was calculated based on the individual response of 1 male and 2 female.

Dependent Variables

Job stress is defined as the as "an uncomfortable state of psychological tension that results from an appraisal that the perceived demands of the workplace exceed the

individual's perceived resources to successfully meet the demands" (BRUIN, 2006 p. 68). Job stress will be measured with the General Work Stress Scale. The instrument is a self-report questionnaire that has nine questions with a five-point Likert scale type of response format 1=Never, 2=Rarely, 3= Sometimes, 4= Often and 5= Always. This variable is interval and scaled scores were derived from the survey tool as a summation of the items within the survey.

Anxiety is defined as an emotion characterized by feelings of tension, worried thoughts, and anticipation of future threat that results in altered physiological and psychological states (Kazdin, 2000). Anxiety will be measured with the Beck Anxiety Inventory. The instrument is a self-report questionnaire with 21 questions with a four-point Likert scale type of response format with 0= Not at all, 1= Mildly, 2= Moderately, and 3=Severely. This variable is interval and scaled scores were derived from the survey tool as a summation of the items within the survey.

Depression is defined as persistently depressed mood or loss of interest in pleasure with symptoms that include but are not limited to changes from previous functioning: lack of energy, thoughts of death or suicide, sleep disturbances, changes in appetite, feelings of guilt, and worthlessness, poor concentration, and difficulty making decisions (American Psychiatric Association, 2013). Depression will be measured using the Beck Depression Inventory. The instrument is a self-report questionnaire with 21 questions with a four-point Likert scale type of response format of 0 to 3. In this inventory, the participant is required to choose which response accurately represents them

and responses for 0- to 3 change. This variable is interval and scaled scores and were derived from the survey tool as a summation of the items within the survey.

Data Analysis Plan

The software that was used for analysis is the IBM Statistical Package for the Social Sciences SPSS. It is a powerful software platform designed for data management and advanced and innovative analytics of complicated statistical data. The screening procedures appropriate for the study were to ensure that all surveys are complete in order to incorporate them into the study. Incomplete information for the independent and dependent variables compromises data analysis and therefore will not be included. Incomplete surveys were not utilized in the study.

Research Questions and Hypothesis

RQ1: What is the impact of vicarious trauma and gender on a linear combination of job stress, anxiety, and depression among mental health professionals?

*H*01: Vicarious trauma and gender will not impact job stress, anxiety and depression among mental health professionals.

*H*a1: Vicarious trauma and gender will impact job stress, anxiety and depression among mental health professionals.

The statistical test used to test the hypothesis is the Two-Way MANOVA as it allowed us to understand if there is an interaction between the two independent variables on the two or more combined independent variables (Laerd Statistics, 2016). The Two-Way MANOVA was used to detect statistically significant interactions of vicarious

trauma and gender given the three scores of job stress, anxiety, and depression. The secondary analysis was performed to further explore the research question.

The assumptions of the test are as follows: (1) two or more dependent variables, (2) two or more categorical independent variables, (3) independent observations per study participant (no participants in multiple levels within a variable), (4) No univariate or multivariate outliers, (5) more cases in each group than dependent variables, (6)Multivariate normality of the Shapiro Wilks test, (7) a linear relationship between each pair of dependent variables in relation to the independent factors, (8) No multicollinearity, and homogeneity of variance -covariance matrices. Any graphics, such as a line graph were used to show differences in scores with respect to the independent variables in the model.

RQ2: Are there significant gender differences between job stress, anxiety, and depression among mental health professionals?

*H*01: Gender differences will not impact job stress, anxiety, and depression among mental health professionals.

*H*a2: Gender differences will impact job stress, anxiety, and depression among mental health professionals.

The statistical test used to test the hypothesis the One-way MANOVA as it allowed us to understand if there is a relationship between the independent variable and two or more dependent variables (Laerd Statistics, 2016). The independent variable is gender.

The assumptions of the test are as follows: (1) two or more dependent variables, (2) one independent variable should be consisting of two or more categorical independent groups (3) independent observations per study participant (no participants in multiple levels within a variable), (4) must have adequate sample size (5) No univariate or multivariate outliers, (6) Multivariate normality of the Shapiro Wilks test, (7) a linear relationship between each pair of the dependent variables for each group of the independent variable**, (8)** homogeneity of variance-covariance matrices (9) no multicollinearity amongst the dependent variables (Laerd Statistics, 2016).

RQ3: What is the impact of vicarious trauma on job stress, anxiety, and depression among mental health professionals?

*H*01: Vicarious Trauma will not impact job stress, anxiety, and depression among mental health professionals.

*H*a2: Vicarious Trauma will impact job stress, anxiety, and depression among mental health professionals.

The statistical test used to test the hypothesis the One-way MANOVA as it allowed us to understand if there is a relationship between the independent variable and two or more dependent variables (Laerd Statistics, 2016). Vicarious trauma was a categorial variable.

The assumptions of the test are as follows: (1) two or more dependent variables, (2) one independent variable should be consisting of two or more categorical independent groups (3) independent observations per study participant (no participants in multiple levels within a variable), (4) must have adequate sample size (5) No univariate

or multivariate outliers, (6) Multivariate normality of the Shapiro Wilks test, (7) a linear relationship between each pair of the dependent variables for each group of the independent variable**,** (8) homogeneity of variance-covariance matrices (9) no multicollinearity amongst the dependent variables (Laerd Statistics, 2016).

Threats to Validity

The assessment of threats to internal and external validity in all types of research is essential as it serves to evaluate the trustworthiness and significance of research findings. They describe how the study was conducted indicating whether it was well disciplined and structured and how the outcomes can be applied in general or the generalizability of the outcomes. According to McKibben and Silvia (2016) validity is referred to as the degree in which the researchers' inferred assumptions of the data demonstrate actuality indicating that validity lies in researchers' interpretation of study results. This section will preview possible threats to internal and external validity based on the nature of the study as well as intervention recommendations.

In this study, some threats to internal validity may be selection bias and reactive arrangement. Onwuegbuzie (2000) postulates that threats to internal validity associated with selection bias occur when participants that are selected to participate in the study have group differences that are respective of cognitive, affective, personality, or demographic variables. These threats are most often seen in the data collection stage, which is when the groups have already been shaped and ordinarily due to non-randomization. The fact that it is significantly more difficult to conduct controlled randomized studies makes the selection of participants a frequent and common threat to

internal validity (Onwuegbuzie, 2000). Some interventions to address the bias include the assessment of equivalency in groups with close attention to all variables. Due to the nature of the research, participants were required to have a bachelor's degree or higher, that work in the behavioral health field, directly servicing clients in the capacity of supervision, case management, social work, counseling, or therapy in outpatient settings. Since my independent variables consist of vicarious trauma and gender, I tried to ensure to have relatively equal gender groups by sending the email invitation to mental health organizations and social media sites. Reactive arrangements and behavior bias to include socially desirable responses are other threats to internal validity that may present themselves in my study. These occur when individuals perceive that they are getting special or preferred attention, therefore tend to be more engaged and cite with the intervention condition (Onwuegbuzie, 2000). In this study, many of the identified individuals were asked to participate are therapists and counselors that may want to be seen and perceived in a socially desirable light. The research indicates that self-report measures are subject to socially desirable responses and that social desirability is specifically higher when participants are asked to appraise aspects of themselves (McKibben & Silvia, 2016). In this study, participants were asked to complete four self-report questionnaires with questions about aspects of themselves therefore it was important that I initiate interventions to detect and minimize socially desirable responses. Interventions explored were item separation, item ambiguity, and item neutrality. In item separation scores are obtained from multiple sources to reduce bias, item ambiguity requires specificity and item neutrality refers to neutralizing the items or forcing

participants to choose between items that are balanced for social desirability (McKibben & Silvia, 2016). In addition, all participant responses were anonymous.

Threats to external validity include population validity and ecological validity. Population validity refers to the extent to which findings are generalizable from the sample of individuals on which a study was conducted to the larger target population of individuals, as well as across different subpopulations within the larger target population (Onwuegbuzie, 2000 p. 30). Population validity like selection bias is a common external threat because random samples are very difficult to acquire based on time money resources and logistics. Interventions to minimize the threat are to assess the number of participants required and increase the population for a better selection pool. In addition, like selection bias interventions assess all groups with identified variables. Ecological validity is the extent to which the results of the research can be generalized across different settings, conditions, variables, and contexts and if findings from the study are independent of the setting or location (Onwuegbuzie, 2000). Ecological validity like selection bias and population validity is a common threat to external validity. Interventions in these cases were to ensure that researchers are not over-generalizing the conclusions and that comparisons are made to extant comprehensive literature so that the results were placed in a realistic context (Onwuegbuzie, 2000).

Ethical Considerations

All participants of the study were treated with dignity and respect, and were advised of the nature of the study, rationale, hypothesized outcomes, and implications. Participants were advised of Walden University Internal Review Board Requirements and

expectations, applications submitted, the process associated with acquiring approval, and applications of research findings. Participants were recruited voluntarily and advised of their rights to choose not to participate without any ambiguity of penalty or repercussions. Participants were provided with a formal informed consent that will ensure competence to understand and decide voluntariness, disclosure of information associated with the nature of the study, rationale, implications, and applicability. The informed consent was initiated via online platform and agreement to participate prompted the completion of research questionnaires. All demographic information provided by the participants remained confidential and data protection protocols were integrated into procedures of data collection and document risk analysis procedures.

Ethical concerns associated with the current study were minimal based on the fact that the participants were recruited to participate in the study on a voluntary basis with the understanding that at any phase of the study they may choose to no longer participate. An ethical concern that may arise is the completion of questionnaires that are associated with job stress, anxiety, depression, and vicarious trauma. Questionnaires may cause participants to feel emotional distress and trigger memories which may hinder their ability to accurately complete the study. Participants of the study were informed of their voluntary participation and that their decision to choose to end the study would not have any repercussions.

Summary

This study utilized was a quantitative design with a focus on correlation, utilizing the Two-Way MANOVA to identify the interaction amid the independent variables of

vicarious trauma and gender on the three dependent variables of job stress, anxiety, and depression. Research implications of the study may serve in the designing and implementing support systems, training, and gender-sensitive interventions with mental health professionals, whether preventive or after the fact that may prevent and decrease experiences of vicarious trauma resulting in positive social change. The chapter provides a synopsis of the research methodology to include identified population, sampling procedures, recruitment details, plans for data collection and analysis, instrumentation operationalization, and ethical considerations. Special considerations and distinct intercessions are presented to address threats to the legitimacy and validity of participant completion and research results. In chapter 4 descriptive statistics, statistical assumptions, and analysis findings will be presented as indicated in identified research question and hypothesis.

Chapter 4: Results

Introduction

The purpose of this quantitative correlational study was to examine the relationship between the independent variables (i.e., vicarious trauma and gender) on the three combined dependent variables (i.e., job stress, anxiety, and depression). The goal was to assess how both gender and vicarious trauma impact job stress, anxiety, and depression. The current chapter will present the following sections in detail: changes in research processes from the original proposal, research questions, hypotheses, data collection, data analysis, study results, and final summary.

Change of Mode to Original Study

Minor changes were made to the study's original processes and protocols based on the completed self-ethics checklist, requests, and recommendations of the university Internal Review Board (IRB). Changes were made in the recruitment processes, gathering of demographic data, the presented available community resources, and the process of sharing results in the informed consent. These changes were made to increase the participant pool by making the survey available to mental health professionals throughout the United States, in order to maintain anonymity, and clarify the minimal risks associated with participation in the study. The changes implemented further provided clarity of expectations, possible time frames entailed in the study, and ensured participants were able to make an informed decision with implied consent.

Changes in the recruitment process were made to expand the participant pool. Initially, it was proposed that participants would be solicited via email announcement to

members of the Texas Psychological Association, Tip of Texas Counseling Association, and the Cameron County Mental Health Task Force. In a review of the number of participants that would be sought out for the study, I decided to expand the recruitment pool to include posting the recruitment flyer on various social media sites and mental health organizations in the United States. This change allowed me the opportunity to send the recruitment flyer to various social media sites and place the flyer in several mental health clinics. Additional changes were made based on the request of the IRB as, given the sensitivity of the study, participation should remain anonymous, and no contact information or other identifying details could be gathered. Therefore, rather than electronically signing the consent form to indicate a willingness to participate in the study, participants were asked at the bottom of the informed consent if they wished to participate; if so, clicking yes was considered the implied consent.

Changes were made to the initial consent form regarding available community resources. The initial informed consent had a list of community resources available to participants that included four national hotlines for suicide and crisis. It was indicated by the IRB that by placing these resources in the form, it was indicating some psychological risks that would require interventions. It was clarified that the study could involve some risk of minor discomforts that can be encountered in daily life such as sharing sensitive emotional information associated with past and present employment experiences. It was further documented that the risks of the study are offset by the study benefits, and hotlines were subsequently removed from the informed consent. The final change made to the consent form was the clarification of how study results would be made available to

participants. It was initially indicated that participants would be emailed the results, however, to maintain anonymity, participants were advised that results will be shared on researchers' social media sites, social media sites used for recruitment, and would be made available in the published dissertation.

Research Questions and Hypothesis

Research Question 1 (RQ1)

What is the impact of vicarious trauma and gender on a linear combination of job stress, anxiety, and depression among mental health professionals?

*H*01: Vicarious trauma and gender will not impact job stress, anxiety, and depression among mental health professionals.

*H*a1: Vicarious trauma and gender will impact job stress, anxiety, and depression among mental health professionals.

Research Question 2 (RQ2)

Are there significant gender differences between job stress, anxiety, and depression among mental health professionals?

*H*01: Gender differences will not impact job stress, anxiety, and depression among mental health professionals.

*H*a2: Gender differences will impact job stress, anxiety, and depression among mental health professionals.

Research Question 3 (RQ3)

What is the impact of vicarious trauma on job stress, anxiety, and depression among mental health professionals?

*H*01: Vicarious Trauma will not impact job stress, anxiety, and depression among mental health professionals.

*H*a2: Vicarious Trauma will impact job stress, anxiety, and depression among mental health professionals.

Demographics

The sampling technique that was incorporated in the study was non-probability convenient sampling, which is comprised of selecting participants that are conveniently available and interested in participating. The sample size calculation was based on the two-way MANOVA test statistic and was performed using the G-Power software. A sample of at least 42 participants was needed, assuming an effect size of 0.2 using the Pillal V statistic, alpha of 0.05, a power of 80%, with three dependent variables, two independent variables, and at least three groupings in each combination of the independent variables. A prospective sample of 100 participants was sought to mitigate the risk of missing data. The recruitment flyer was placed on several social media sites and individually sent to potential participants directly. The email addresses were acquired through personal professional networking in my 15 years of tenure as a licensed professional counselor. Approval to launch the study and recruit participants from the IRB (11-17-22-0995134) was acquired on November 17, 2022. Recruitment of participants took place from November 17, 2022, through November 27, 2022, when the targeted number of participants needed was acquired. A total of 100 mental health professionals participated in the study and initiated the four self-report questionnaires. Sample demographics are displayed in Table 1.

Table 1

Participant Demographics

Parameter	Statistic
	n (%)
Gender	
Male	15 (17)
Female	73 (83)
Education	
Bachelors	22 (25)
Master's	56 (63.6)
Doctorate	10 (11.4)
Age	
Mean (SD)	39.5 (9.5)

Note: N = 100 participants. 88 participants completed survey.

Evaluation of Statistical Assumptions

Statistical Assumption for Research Question 1

The two-Way MANOVA requires a set of assumptions to be met. First, the dependent variable must be measured as either interval or ratio. In the current study, this assumption is met as the model has three interval dependent variables: General Work Stress (GWS) score, the Beck Anxiety Inventory (BAI), and the Beck Depression Inventory II (BDI-II). The second assumption is that there are two independent variables consisting of two or more categorical groups. The current study meets this assumption as the independent variables for the model (i.e., gender and vicarious trauma) are binomial variables. The third assumption is that each observation is independent in each group or between groups. As data are collected from each participant individually and only once, the assumption of independence of observations is met. An additional assumption was

that the sample population contain more cases in each group than the number of dependent variables. This assumption was met in the current data.

As there is one outlier per level of gender by vicarious trauma, the number of outliers is a violation of the assumption of multivariate normality. Since there were very few outliers, it was decided to preserve the target sample size. The linear relationship between each pair of dependent variables for each group of the independent variable was tested using scatter plots. The Normal Q-Q plots were found to be roughly linear for each dependent variable.

The Shapiro Wilk's test was used to detect normality in the dependent variables. Evidence of non-normality was found, as the Shapiro Wilk test was significant for BDI in males ($W = 0.80$, $p = .020$) and females ($W = 0.881$, $p = .004$) within the No Disruption level. Within the no disruption level, the Shapiro Wilk test was significant in the BDI-II for the males ($W = 0.788$, $p = .015$) and females ($W = .805$, $p < .001$). The significance of the Shapiro Wilks indicates a deviation from normality. The other levels of vicarious trauma, no disruption and gender, were not statistically significant, indicating normality in the scores.

The assumption of multicollinearity was met as the dependent variables were found to be moderately correlated with each other. GWS was moderately correlated with the BAI ($r = 0.56$, $p < .001$). BDI-II is moderately correlated with the General Works Stress score at ($r = 0.56$, $p < .001$). BDI-II was found to be moderately correlated with the BAI at ($r = 0.56$, $p < .001$).

The M Box test evaluates homogeneity of covariance matrices. Table 4 shows there was no statistical significance in the M Box test (p = .065) for the model containing an interaction term, gender, and vicarious trauma, indicating no violation of the assumption of homogeneity.

Table 2

Tests of Normality

	Vicarious Trauma * Gender		Kolmogorov-Smirnov[b]			Shapiro Wilks		
			Statistic	df	Sig.	Statistic	df	Sig.
GWS	Disruption	Male	0.265	6	0.2	0.869	6	0.221
		Female	0.131	45	0.05	0.964	45	0.168
BAI	Disruption	Male	0.177	6	0.2	0.93	6	0.579
		Female	0.115	45	0.169	0.952	45	0.059
BDI-II	Disruption	Male	0.205	6	0.2	0.91	6	0.435
		Female	0.08	45	0.2	0.978	45	0.555

p = .05

Table 3

Tests of Normality Pt. 2

	Vicarious Trauma * Gender		Kolmogorov-Smirnov[b]			Shapiro Wilks		
			Statistic	df	Sig.	Statistic	df	Sig.
GWS	No Disruption	Male	0.264	9	0.07	0.877	9	0.147
		Female	0.103	28	0.2	0.969	28	0.552
	No Disruption	Male	0.248	9	0.046	0.778	9	0.015*
		Female	0.146	28	0.013	0.805	28	0.000*
BDI-II	No Disruption	Male	0.248	9	0.118	0.8	9	0.020*
		Female	0.146	28	0.132	0.881	28	0.004*

p = .05

Table 4

Box's Test of Equality of Covariance Matrices

Box's M	**32.731**
F	1.551
df1	18
df2	1455.17
Sig.	0.065

Statistical Assumption for Research Question 2

The one-way MANOVA requires a set of assumptions to be met. First, the dependent variable must be measured as either interval or ratio. In the current study, the assumption is met as the model has three dependent interval variables: GWS score, BAI score, and BDI scores. The second assumption is that the independent variable consists of two or more categorical groups. The current study meets this assumption as the independent variable, gender is a binomial variable. The third assumption is that each observation is independent in each group or between groups and as previously stated, all observations were collected individually and one time only, therefore the assumption of independence of observations is met. As previously stated, an additional assumption for the MANOVA was that the sample population contain more cases in each group than the number of dependent variables. This assumption was met in the current data. No outliers were found in the group.

The Shapiro Wilk's test was used to detect normality in the dependent variables. Table 5, 6, and 7 show the Shapiro-Wilk tests for gender across study variables. The assumption of normality was met for all levels of gender, except for the BAI and BDI-II

(Male), respectively. Evidence of deviation from normality was found as the BDI-II score for the males was statistically significant ($W = 0.856$ $p = .021$), and deviation from normality was found in the BAI score for Males ($W = 0.915$, $p = .000$), as well as the BAI score for Females ($W = 0.86$, $p < .01$).

The linear relationship between each pair of dependent variables for each group of the independent was tested using a scatter plot. The Normal Q-Q plots were found to be roughly linear for each dependent variable. M Box test evaluates homogeneity of covariance matrices. Table 8 shows there was no statistical significance in the M Box test ($p = .28$) for the model which contained gender. The assumption of multicollinearity is met as the dependent variables are moderately correlated with each other. All study variables were found to be moderately correlated with each other ($r = 0.56$, $p < .001$).

Table 5

Tests of Normality Pt. 3

		Kolmogorov-Smirnov[b]			Shapiro Wilks		
	Gender	Statistic	df	Sig.	Statistic	df	Sig.
BDI-II	Female	0.091	73	0.2	0.975	73	0.147
BDI-II	Male	0.091	15	0.016	0.856	15	.021*
GWS	Male	.205	15	.092	.938	15	.362
GWS	Female	.091	73	.200	.975	73	.147
BAI	Female	0.245	15	.016	.856	73	.021*
BAI	Male	0.118	73	.013	.915	15	<.001*

Note: p = .05

Table 6

Box's Test of Equality of Covariance Matrices 2

Box's M	**8.17**
F	1.25
df1	6
df2	3592
Sig.	0.28

Statistical Assumption for Research Question 3

The One-Way MANOVA requires a set of assumptions to be met. First, the dependent variable must be measured as either interval or ratio. The current model meets this assumption as the model has three interval dependent variables: GWS score, BDI-II score, and BAI scores. The second assumption requires the independent variable to consist of two or more categorical groups. This assumption has been met as the independent variable, vicarious trauma, for the model is binomial. The third assumption is that each observation is independent in each group or between groups. As participants are only represented once in either vicarious group, the assumption of independence of observations was met. The sample population contains more cases in each group than the number of dependent variables. There are no outliers to consider in each group.

The Shapiro-Wilk's test was conducted to assess normality in the dependent variable. A review of the Shapiro Wilk's test for normality of the GWS (Table 7) showed no statistical significance was found in the disruption level ($W = 0.975$, $p = .342$), or the non-disruption level ($W = 0.962$, $p = 0.227$) indicating the assumption of normality was met. A Shapiro Wilk stub heading's test in the BAI (Table 10) indicated non-normality as

the statistical significance was found for the disruption level ($W = 0.946$, $p = .021$), and the non-disruption level ($W = 0.779$, $p < 0.001$). A Shapiro Wilk's test in the BDI-II (Table 7) showed a statistical significance was found in the disruption level ($W = 0.946$, $p = .021$) and the non-disruption level ($W = 0.779$, $p < .001$) indicating the assumption of normality was violated.

The linear relationship between each pair of dependent variables for each group of the independent variables was tested using a scatter plot. The Normal Q-Q plots were found to be roughly linear for each dependent variable. Further, the M Box test was conducted to evaluate the homogeneity of covariance matrices. No statistical significance was shown in the M Box test ($p = .07$) for all three dependent variables with respect to vicarious trauma, indicating the assumption of homogeneity of covariance matrices was met. The assumption of multicollinearity was met as the dependent variables were found to be moderately correlated with each other. The GWS score was found to be moderately correlated with the BAI ($r = 0.56$, $p < .001$). The BAI score was moderately correlated with the GWS score at ($r = .56$, $p < .001$). The BDI-II score was found to be moderately correlated with the BAI score ($r = 0.56$, $p < .001$).

Table 7

Tests of Normality

		Kolmogorov-Smirnov[b]			Shapiro Wilks		
	Vicarious Trauma	Statistic	df	Sig.	Statistic	df	Sig.
BDI-II	Disruption	0.077	51	0.2	0.946	51	.021*
BDI-II	No Disruption	0.153	37	0.028	0.779	37	<.001*
BAI	Disruption	0.112	51	0.151	0.946	51	.021*
BAI	No Disruption	0.193	37	0.001	0.779	37	<.001*
GWS	Disruption	0.108	51	0.198	0.975	51	0.342

GWS	No Disruption	0.105	37	0.2	0.962	37	0.227

Statistical Analysis Findings

To test RQ1 ("What is the impact of vicarious trauma and gender on a linear combination of job stress, anxiety, and depression among mental health professionals?"), a two-way MANOVA was conducted. The two-way MANOVA included vicarious trauma and gender with respect to the general work stress score, Beck Anxiety Inventory and Beck Depression Inventory Scores. The interaction term of gender and vicarious trauma was not a significant predictor of scores. There is no statistical significance of the interaction term with respect to the GWS (F = 0.572, p = .45), BAI (F = 0.268, p = 0.60), or BDI-II (F = 1.270, p = .26).

Table 8

Descriptive Statistics

	Vicarious Trauma	Gender	Mean	Std. Deviation	N
GWS	No Disruption	Male	18.22	9.00	9
		Female	18.57	5.58	28
		Total	18.49	6.43	37
	Disruption	Male	20.00	4.15	6
		Female	23.13	6.43	45
		Total	22.76	6.25	51
	Total	Male	18.93	7.29	15
		Female	21.38	6.47	73
		Total	20.97	6.64	88
BAI	No Disruption	Male	7.33	8.40	9
		Female	4.75	5.36	28
		Total	5.38	6.20	37
	Disruption	Male	16.83	12.70	6
		Female	11.98	7.80	45
		Total	12.55	8.50	51
	Total	Male	11.13	11.01	15
		Female	9.21	7.78	73
		Total	9.53	8.37	88
BDI-II	No Disruption	Male	3.67	4.42	9
		Female	5.04	4.69	28
		Total	4.70	4.60	37
	Disruption	Male	15.33	6.92	6
		Female	12.64	7.16	45
		Total	12.96	7.12	51
	Total	Male	8.33	7.95	15
		Female	9.73	7.31	73
		Total	9.49	7.40	88

Table 9

*Scores by Gender, Vicarious Trauma, and Gender*Vicarious Trauma*

Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	445.285[a]	3	148.428	3.676	0.015	0.116
	1272.837[b]	3	424.279	7.386	0	0.209
	1513.380[c]	3	504.46	13.06	0	0.318
Intercept	19029.05	1	19029.05	471.292	0	0.849
	4981.485	1	4981.485	86.723	0	0.508
	4007.676	1	4007.676	103.755	0	0.553
Vicarious Trauma	119.72	1	119.72	2.965	0.089	0.034
	833.502	1	833.502	14.511	0	0.147
	1106.718	1	1106.718	28.652	0	0.254
GENDER	36.126	1	36.126	0.895	0.347	0.011
	164.834	1	164.834	2.87	0.094	0.033
	5.189	1	5.189	0.134	0.715	0.002
Vicarious Trauma * GENDER	23.089	1	23.089	0.572	0.452	0.007
	15.379	1	15.379	0.268	0.606	0.003
	49.05	1	49.05	1.27	0.263	0.015

To test RQ2 (“Are there significant gender differences between job stress, anxiety, and depression among mental health professionals?”), a Two-way MANOVA was conducted. The two-way MANOVA included gender with respect to the general work stress, Beck anxiety inventory and Beck depression Inventory scores. The results of the two-way MANOVA indicate there is no statistical significance in gender with respect to the GWS scale, BAI, or the BDI-II (F = 0.895, p = .347) (F = 2.870, p = 0.094) (F = 0.134, p = 0.715). Gender was not a predictor for the model. Table 14 depicts the descriptive statistics for mean scores across genders. The mean scores were found to be similar across genders.

Table 10

Descriptive Statistics Pt. 2

	Gender	Mean	Std. Deviation	N
GWS	Male	18.93	7.29	15
	Female	21.38	6.47	73
BAI	Male	11.13	11.01	15
	Female	9.21	7.78	73
BDI-II	Male	8.33	7.95	15
	Female	9.73	7.31	73

To test RQ3 (“What is the impact of vicarious trauma on job stress, anxiety, and depression among mental health professionals?”) a two-way MANOVA was conducted. The two-way MANOVA included vicarious trauma with respect to the general work stress score, beck anxiety inventory, and beck depression inventory scores. Results from the Two-Way MANOVA indicated there is statistical significance in vicarious trauma with respect to the General Work Stress score ($F = 9.79$, $p = 0.002$), Beck Anxiety Inventory score ($F = 18.98$, $p = 0.000$), and the Beck Depression Inventory score ($F = 38.2$, $p < .01$). Descriptively, vicarious trauma levels of (disruption) showed higher scores for all three dependent outcomes, as evidenced in Figures A, B, and C.

Table 11

Descriptive Statistics Pt. 3

	Vicarious Trauma Y/N	Mean	Std. Deviation	N
GWS	0	18.49	6.43	37.00
	1	22.76	6.25	51.00
	Total	20.97	6.64	88.00
BAI	0	5.38	6.20	37.00
	1	12.55	8.50	51.00
	Total	9.53	8.37	88.00
BDI-II	0	4.70	4.60	37.00
	1	12.96	7.12	51.00
	Total	9.49	7.40	88.00

Figure 1

Estimated Marginal Means General Work Stress Score

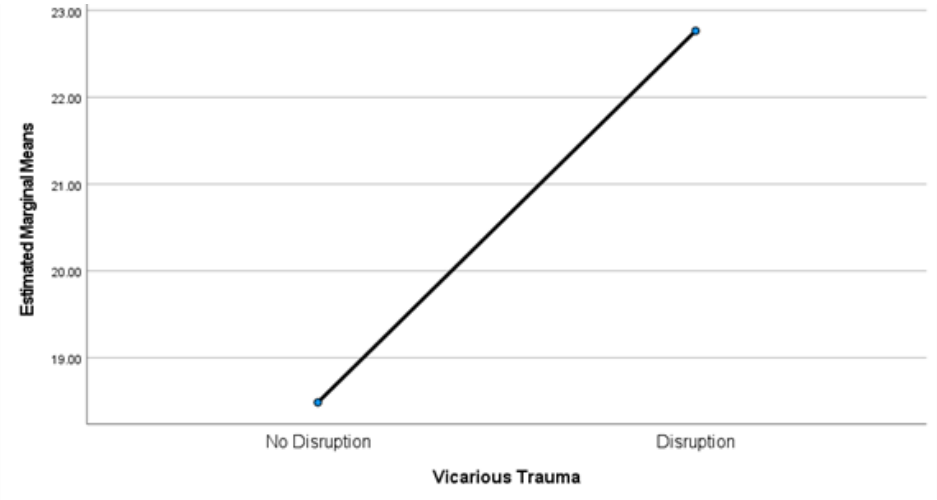
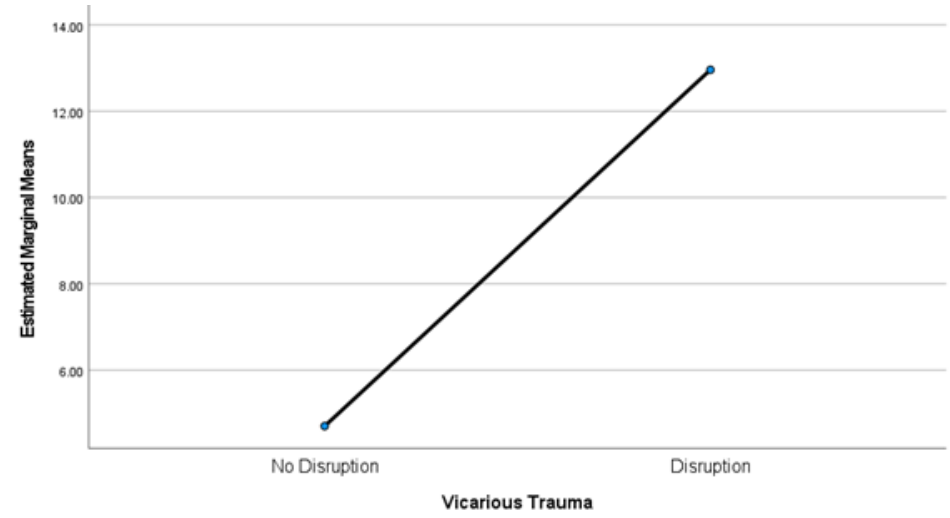


Figure 2

Estimated Marginal Means Beck Anxiety Score

Figure 3

Generated Marginal Means Beck Depression Score



Summary

The intention of the current study was to examine job stress, anxiety, and depression amongst mental health professionals and the impact that experienced vicarious trauma and gender differences would have on the levels of the identified factors. Further, the study aimed to examine whether gender and vicarious trauma individually had an impact on mental health professionals' levels of job stress, anxiety, and depression. The result of research question one indicates that the interaction term gender and vicarious trauma did not show statistical significance for job stress, anxiety, and depression. The interaction of vicarious trauma and gender was not statistically significant when predicting scores of job stress, anxiety, and depression. Furthermore, the results of research question two indicate that gender does not significantly affect job stress, anxiety, and depression. Finally, the results of question three indicate that experienced vicarious

trauma, having experienced a disruption of one of the five areas of psychological needs, significantly affects job stress, anxiety, and depression. Mental health professionals that had experienced vicarious trauma had higher scores on job stress, anxiety, and depression scales.

Chapter five will provide further elaboration on the purpose, nature, and findings of the current study. An interpretation of the analysis and findings will be provided that will demonstrate confirmation of the impacts associated with the independent variables on identified dependent variables. Limitations of the study will be further discussed, as will recommendations for future research and clinical implications. Chapter five will conclude with a demonstration of how the results of the study will inform and create opportunities to apply efficacious interventions and contribute to social change.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this quantitative study was to examine the impact that experienced vicarious trauma and gender have on mental health professionals stub heading' levels of job stress, anxiety, and depression. The aim was to further evaluate how the independent variables individually impacted the three identified dependent variables of job stress, anxiety, and depression. The theoretical framework outlining the study was the Constructivist Self Development Theory (CSDT) that was developed in 1992 by Dr. Lisa McCann and Dr. Anne Pearlman. The theory indicates that an individual's distinctive history is what structures their experience of traumatic events, ultimately outlining how they adapt to trauma. Pearlman (1992) posits that understanding the inner experience of trauma survivors and how it accounts for the individual differences in the post-traumatic state affords a heuristic framework for appraisal and intervention. The theory further demonstrates relevance in this study as its premise assesses the long-term impact that trauma has on an individual's belief about the self, others, and relationships (Molner et al., 2017). The literature reveals that this framework has been incorporated to inform on the impacts of vicarious trauma. In an article on vicarious trauma in clinicians, the author utilized the CSDT to demonstrate how vicarious trauma is observed to be a disruption of human development, adaptation, and specific needs (Quitangon, 2019). The goal is to utilize the knowledge gained from the outcomes to provide awareness and education that can contribute to designing and implementing support systems, training, and gender-sensitive interventions with mental health professionals.

In order to examine the impact that experienced vicarious trauma and gender have on mental health professionals' identified levels of job stress, anxiety, and depression utilized a two-way MANOVA. This afforded me the opportunity to identify if there was an interaction between the two independent variables, and the individual impact of experienced vicarious trauma and gender amid mental health professionals' levels of job stress, anxiety, and depression. These quantitative research designs were appropriate for the present study, as they have been paralleled with providing an enhanced understanding in order to advance the knowledge in the identified discipline (Hackett, 2018). The results of the study indicated that I will be failing to reject the null hypothesis for research question one, *H*01: Vicarious trauma and gender will not impact job stress, anxiety, and depression among mental health professionals. The statistical analysis for research question number one indicated the interaction term of gender and vicarious trauma was not a significant predictor of scores. There was no statistical significance of the interaction term with respect to the GWS, BAI, and BDI-II.

I failed to reject the null hypothesis for research question two, *H*01: Gender differences will not impact job stress, anxiety, and depression among mental health professionals. The statistical analysis for research question number two indicates there was no statistical significance in gender with respect to GWS, BAI, and BDI-II scores.

I will be rejecting the null hypothesis for research question three, *H*01: Vicarious Trauma will not impact job stress, anxiety, and depression among mental health professionals. The statistical analysis for research question three indicates there is statistical significance in vicarious trauma with respect to the GWS, BAI, and BDI-II

scores. Descriptively, vicarious trauma levels of (disruption) showed higher scores for all three dependent outcomes. This demonstrates that mental health professionals who had experienced vicarious trauma (disruption of one of the five psychological areas of need) had elevated scores in all the three dependent variables of job stress, anxiety, and depression.

Interpretation of the Findings

The goal of the study was to examine the impact of experienced vicarious trauma and gender differences among mental health professionals to increase the understanding and knowledge base of the effects and implications. The results further afford an opportunity to inform mental health professionals of the significant findings and contribute to the education and designation of mediating and preventative interventions. The outcomes confirm and extend the knowledge in the discipline, as well as reiterate the need for continued research based on the elevated possibility that mental health professionals have of experiencing vicarious trauma (Foreman, 2018).

Research questions one and two indicate that there is no statistical significance in gender with respect to job stress, anxiety, and depression, The underrepresentation of male participants in this study may be associated with the lack of research on vicarious trauma and gender. This extends the peer-reviewed gaps found in the literature, indicating a scarcity of research on the identified variables. The literature describes gender as being generally ignored in studies associated with secondary trauma. Synonymous with vicarious trauma, secondary trauma falls under a number of stress-related responses and is a term utilized interchangeably. Baum (2016) posits that the limited published findings

on secondary trauma demonstrates the need to assess gender differences in vulnerability, disposition, and the associated implications. The literature review further denotes that gender differences account for the likelihood that males will seek mental health services, or disclose feelings that go against the different social role expectations that society has assigned to males and females (Yak & Telcin, 2021). Therefore, based on the literature review and distinct cognitive changes and implications associated with vicarious trauma among mental health professionals, the gender inequality must be recognized and addressed.

The outcomes of research question three indicate that vicarious trauma had a statistically significant impact on mental health professionals' levels of job stress, anxiety, and depression. This confirms the findings that vicarious trauma in the workplace is considered an occupational challenge/hazard and threat to mental health professionals that provide services to traumatized and violence-exposed clientele (Middleton & Potter, 2015). The outcomes further extend the knowledge as experienced vicarious trauma is a predictor of increased levels of job stress for mental health professionals. Harvey (2015) posits that interpreters who bear witness to trauma have an extremely high likelihood, if not the inevitability, of experiencing vicarious trauma as a result of their empathic engagement and attunement to another stub heading's suffering. The literature reports that between 46 and 80 percent of therapists working with sex offenders identified vicarious trauma, compassion fatigue and secondary traumatic stress as the most named effects of their professional experience (Baum & Moyal, 2020).

Middleton and Potter (2015) postulate that findings from Structural Equation Modeling analyses revealed a significant relationship amid vicarious traumatization and child welfare professionals' intent to leave employment based on the stressful and unpredictable work environment. Job stress has been described as an ailment causing individual physical, psychological, suffering, and dysfunction impacting an individual's capacity to respond to needs and live up to personal expectations (De Sio et al., 2018). Despite the presented implications that vicarious trauma has on job stress, the literature indicates that minimal research has been done to explore workforce-related outcomes and the consequences associated with quality, uniformity, and stability of services (Middleton & Potter, 2015). The presented study and statistically significant outcomes should serve to inform and educate organizations and employers about the impacts and need for mediating interventions.

The research outcomes indicating that vicarious trauma has a statistically significant impact on mental health professional's levels of job stress, anxiety and depression corroborates the literature review as far as the impacts of vicarious trauma. Comerchero (2015) posits that vicarious trauma is thought to be a transformation based on the transmission of traumatic stress causing symptoms of anxiety, depression, emotional numbing, and personal vulnerability. The outcomes of the study expand the knowledge as results demonstrate that experienced vicarious trauma is a predictor of anxiety among mental health professionals. The presented significance informs mental health professionals working with victims of trauma on the concerns that may impact and cause serious impairments in personal and professional functioning.

Shamoon et al., (2017) identified anxiety as a common factor among therapists and posited that anxiety elicited by difficult and activating clients poses challenges to implementing effective therapy. Although the study results contribute to the knowledge, the topic of experienced vicarious trauma and anxiety among mental health professionals requires continued review and research based on the minimal existing literature. The APA (2013) has identified anxiety as the most common mental health disorder and physiological disease, further considering it an advanced state of concern and denoting the importance of recognizing the implications and incorporating preventative measures.

This study results further confirm the findings in the literature review denoting the roles and responsibilities that mental health professionals working with victims of trauma take on. The reality is that in the process of demonstrating genuine and empathic attunement to their clients they must be cognizant, understanding, and vicariously see the world from the client's point of view. They are witness to testaments that are unique, rendering them incomprehensible to those who were not there and increasing the likelihood of experiencing increased levels of depression (Hernandez-Wolf et al., 2015). The results of the study inform the discipline, however, more research and studies are needed Salk et al., (2017) identified depression as a global health priority accounting for 10% of nan-fatal diseases worldwide. A meta-analysis indicates that there are limited findings on the development and evolving patterns of depression, positing that the topic has been largely neglected (Salk et al., 2017). This further serves to demonstrate the need to acquire understanding and knowledge that may prompt action and the application of intercessions.

Limitations of the Study

The identified limitations in this study are associated with the gathering of limited demographics. Although the gender of participants in this study demonstrates to have a gender inequality with 83% being female and 17% being male it is important to note that the therapy field in general has an unequal ratio among genders. According to the literature, the psychology profession in many western nations is female-dominated (Ned et al. 2020; Seidler et al 2022). In 2019 gender statistics reveal that females make up 74% of the profession compared to that of males being 25% in the United States (Unknown, 2022). The limitations of a study may present themselves in the choice of design and execution impacting the validity and applicability. It is important that researchers demonstrate transparency and recognize the limitations associated with their studies as it contributes to trustworthiness, validity, and reliability. Alvarez et al., (2021) posited that recognizing and discussing the important limitations of a study and their impact on the implications and interpretations of the findings characterize the central part of scientific discourse. The discussion of the limitations further serves to inform the scientific community and provides future researchers the opportunity to address the limitations and enhance the research findings.

The gathering of limited demographics posed to be another limitation of the study. Participants were asked to provide their age, educational level (bachelor, master's, or doctorate), and gender. Since the study was made available to mental health professionals throughout the United States, I am unable to determine what states the participants are from, and if there was an area that represents the majority of the

participants. I did not gather their race and ethnicity or occupation, which are all factors that may impact whether males or females experience symptoms of vicarious trauma in the workplace or in the community. These identified variables require further research in order to add to the literature on vicarious trauma amid mental health professionals and inform the discipline. This limitation may also impact participation and questionnaire responses. This makes it difficult to conclude if the research outcome is generalizable to mental health professionals working with victims of trauma throughout the United States.

Recommendations

The rationale, background, literature review, outcomes, and limitations of the present study validate and establish the need for continued research on gender and vicarious trauma among mental health professionals. Gender disparities in research on vicarious trauma, exploration of training and support systems in the workplace, and psychoeducation on vicarious trauma, anxiety, and depression are essential themes for consideration. It is recommended that research on vicarious trauma and gender be thoroughly completed based on the gender disparities identified and demonstrated in the research on job stress, anxiety, and depression. Gaps in the literature indicate that the impacts of vicarious trauma and gender on job stress, anxiety, and depression have been generally ignored. Stiawa et al., (2020) indicated that the discordant relationship between men's low rates of diagnosed depression and high male suicide rates reveals the need for enhanced assessment and detection. It is unclear how male mental health professionals are impacted by experienced vicarious trauma. Therefore, it is recommended that a replication of the present study be completed with a population sample size that

demonstrates gender equality. It is recommended that employers explore improved training and support systems in the workplace to mediate and prevent vicarious trauma. Identified as an occupational challenge and hazard causing physical, psychological, suffering, and dysfunction, substantiates the need for personal and organizational approaches and interventions, Middleton and Potter (2015) suggested the assessment of supervisor and peer support, new employee training curricula, and education to enhance awareness and identification of the negative indicators of vicarious trauma. Consequently, future researchers that replicate the present study should acquire demographics of the occupation of participants to identify high-risk employment. It is further recommended that mental health employees be provided with psychoeducation on vicarious trauma and its significant impact on levels of job stress, anxiety and depression. A study to acquire an understanding of the symptoms of vicarious trauma revealed that 45.9 percent of practicing clinicians experienced numerous symptoms of vicarious trauma and suggested a need for educational training as well as workshops that would increase awareness and decrease associated symptoms (Lainer and Carney, 2019).

Implications for Social Change

The findings of the present study afford many implications for social change that will have a positive impact on mental health professionals, clients, organizations, and communities at large. The knowledge acquired will assist in designing and implementing training, educational workshops, support systems, and gender-sensitive interventions with mental health professionals. The development of enhanced training curriculums with hands-on workshops, specifically addressing the negative connotations accompanying

vicarious trauma will increase awareness and knowledge of preventative measures. The knowledge and implementation of efficacious preventative interventions will increase the psychological well-being of the clinician and in turn enrich therapeutic services for the clients in the community. The development of formal training for organizational leaders on the causes and dynamics of vicarious trauma will create supervisory and peer support systems in the workplace. Employers' implementation of mandated self-care strategies to minimize and manage the negative effects will increase job satisfaction, decrease turnovers, and positively impact employment rates for the community. The review, identification, and creation of gender-sensitive interventions for mental health professionals will assist in meeting the unique individual psychological and physiological needs shaped by their socially defined gender. These interventions, whether preventive or implemented after the fact may serve to prevent and decrease experiences of vicarious trauma resulting in positive social change.

Conclusion

True and genuine immurement in the therapeutic alliance with trauma survivors comes with and is accompanied by vicariously experiencing the feelings, emotions, fears, and psychological distress of the client. This contributes to the extremely high likelihood, if not the inevitability of mental health professionals experiencing symptoms of vicarious trauma. These symptoms change a mental health professional's personal schema, alter the worldview, and effects the adaptation to trauma. These impacts inherently hinder the ability to provide effective therapeutic interventions resulting in poor quality of services and care for the client. Preparing and safeguarding the internal states through self-

awareness, preventative knowledge, and training on the identified impacts of vicarious trauma will mediate and possibly prevent the experience. Therefore, as agents of social change, it is our responsibility to share the results of the study and promote the implementation of the identified efficacious mediating and preventative interventions.

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Appendix A: Informed Consent Form

CONSENT FORM

You are invited to take part in a research study about how experienced vicarious trauma and gender impact mental health professionals' levels of job stress, anxiety, and depression. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study is seeking 100 volunteers who have a bachelor's degree or higher that work in the behavioral health field, directly servicing clients in the capacity of supervision, case management, social work, counseling, or therapy in outpatient settings.

This study is being conducted by a researcher named Irma Perez, who is a Ph.D. Clinical Psychology student at Walden University.

Study Purpose:

The purpose of this study is to examine job stress, anxiety, and depression among mental health professionals and the impact that experienced vicarious trauma and gender differences have on the levels of the identified factors.

Procedures:

This study will involve you completing the following questionnaires and will take an estimated 50 minutes.:

Complete the General Work Stress Scale – Self-report questionnaire

Complete the Beck Anxiety Inventory - Self-report questionnaire

Complete the Beck Depression Inventory-II - Self-report questionnaire

Complete the Trauma Attachment Belief Scale - Self-report questionnaire

Here are some sample questions:

· Does work make you so stressed that you wished you had a different job? Never / Rarely / /Sometime / often / Always

· Numbness or Tingling: Not at all / Mildly / Moderately / Severely

· 0- I do not feel sad / 1- I feel sad / 2- I am sad all the time and I can't snap out of it / 3- I am so sad and unhappy that I can't stand it.

· I believe I am safe: Strongly Disagree / Disagree / Disagree somewhat / Agree Somewhat / Agree / Agree Strongly

Voluntary Nature of the Study:

This research is voluntary in nature and you may agree or not agree to participate.

If you decide to join the study now, you can still change your mind later without consequence. You may stop at any time.

Risks and Benefits of Being in the Study:

Being in this study could involve some risk of minor discomforts that can be encountered in daily life such as sharing sensitive information. The questions associated with the instruments may trigger emotional reactions and distress. If at any time during the completion of the questionnaires you feel psychological distress you may call - 988 national hotline for suicide and crisis, 741741 National Text

Hotline for Crisis, NAMI National Hotline 1-800-950-NAMI and 888-628-9454 National Linea De Prevention de Suicido. With these protections in place, this study will pose minimal risk to your wellbeing.

This study offers no direct benefits to individual volunteers. The knowledge gained may be used in designing and implementing support systems, training, and gender-sensitive interventions with mental health professionals. These interventions, whether preventive or after the fact may serve to prevent and decrease experiences of vicarious trauma resulting in positive social change. Results will be shared on researchers' social media site, social media sites used for recruitment, and will be available in the published dissertation.

Payment:

There will be no monetary reimbursement or incentives for participation in this study.

Privacy:

The researcher is required to protect your privacy. Your identity will be kept anonymous. The researcher will not use your personal information for any purposes outside of this research project. If the researcher were to share this dataset with another researcher in the future, the dataset would contain no identifiers so this would not involve another round of

obtaining informed consent. Data will be kept secure in a password-protected computer with data encryption. Data will be kept for a period of at least 5 years, as required by the university.

Contacts and Questions:

You can ask questions of the researcher by contacting me via email at [redacted]. If you want to talk privately about your rights as a participant or any negative parts of the study, you can call Walden University's Research Participant Advocate at [redacted]. Walden University's approval number for this study is 11-17-22-0995134. will enter approval number here. It expires on November 16, 2023.

You might wish to retain this consent form for your records. You may ask Walden University for a copy at any time using the contact info above.

If you feel you understand the study and wish to volunteer, please indicate your consent by clicking Next and completing the four self-report questionnaires

Appendix B: Instruments and Permissions

General Work Stress Scale

Gideon P. de Bruin & Nicola Taylor
University of Johannesburg
2005

INSTRUCTIONS

The purpose of the following questions is to examine how stressed you are at work. Please respond to the following questions by making a cross [x] over the number that best indicates your answer.

		Never	Rarely	Sometimes	Often	Always
1.	Does work make you so stressed that you wish you had a different job?	1	2	3	4	5
2.	Do you get so stressed at work that you want to quit?	1	2	3	4	5
3.	Do you worry about having to wake up and go to work in the morning?	1	2	3	4	5
4.	Do you find it difficult to sleep at night because you worry about your work?	1	2	3	4	5
5.	Do you get so stressed at work that you forget to do important tasks?	1	2	3	4	5
6.	Does work make you so stressed that you find it hard to concentrate on your tasks?	1	2	3	4	5
7.	Do you spend a lot of time worrying about your work?	1	2	3	4	5
8.	Do you feel like you cannot cope with your work anymore?	1	2	3	4	5
9.	Does work make you so stressed that you lose your temper?	1	2	3	4	5

I

Permission to utilize the General Work Stress Scale

BAI®

NAME _____ DATE _____

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by each symptom during the PAST WEEK, INCLUDING TODAY, by placing an X in the corresponding space in the column next to each symptom.

	NOT AT ALL	MILDLY It did not bother me much.	MODERATELY It was very unpleasant, but I could stand it.	SEVERELY I could barely stand it.
1. Numbness or tingling.				
2. Feeling hot.				
3. Wobbliness in legs.				
4. Unable to relax.				
5. Fear of the worst happening.				
6. Dizzy or lightheaded.				
7. Heart pounding or racing.				
8. Unsteady.				
9. Terrified.				
10. Nervous.				
11. Feelings of choking.				
12. Hands trembling.				
13. Shaky.				
14. Fear of losing control.				
15. Difficulty breathing.				
16. Fear of dying.				
17. Scared.				
18. Indigestion or discomfort in abdomen.				
19. Faint.				
20. Face flushed.				
21. Sweating (not due to heat).				

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P.O. Box 599700 San Antonio, TX 78259 800.627.7271 www.PsychCorp.com

PsychCorp

Beck's Depression Inventory

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

1.

0 I do not feel sad.

1 I feel sad

2 I am sad all the time and I can't snap out of it.

3 I am so sad and unhappy that I can't stand it.

2.

0 I am not particularly discouraged about the future.

1 I feel discouraged about the future.

2 I feel I have nothing to look forward to.

3 I feel the future is hopeless and that things cannot improve.

3.

0 I do not feel like a failure.

1 I feel I have failed more than the average person.

2 As I look back on my life, all I can see is a lot of failures.

3 I feel I am a complete failure as a person.

4.

0 I get as much satisfaction out of things as I used to.

1 I don't enjoy things the way I used to.

2 I don't get real satisfaction out of anything anymore.

3 I am dissatisfied or bored with everything.

5.

0 I don't feel particularly guilty

1 I feel guilty a good part of the time.

2 I feel quite guilty most of the time.

3 I feel guilty all of the time.

6.

0 I don't feel I am being punished.

1 I feel I may be punished.

2 I expect to be punished.

3 I feel I am being punished.

7.

0 I don't feel disappointed in myself.

1 I am disappointed in myself.

2 I am disgusted with myself.

3 I hate myself.

8.

0 I don't feel I am any worse than anybody else.

1 I am critical of myself for my weaknesses or mistakes.

2 I blame myself all the time for my faults.

3 I blame myself for everything bad that happens.

9.

0 I don't have any thoughts of killing myself.

1 I have thoughts of killing myself, but I would not carry them out.

2 I would like to kill myself.

3 I would kill myself if I had the chance.

10.

0 I don't cry any more than usual.

1 I cry more now than I used to.

2 I cry all the time now.

3 I used to be able to cry, but now I can't cry even though I want to.

11.

0 I am no more irritated by things than I ever was.

1 I am slightly more irritated now than usual.

2 I am quite annoyed or irritated a good deal of the time.

3 I feel irritated all the time.

12.

0 I have not lost interest in other people.

1 I am less interested in other people than I used to be.

2 I have lost most of my interest in other people.

3 I have lost all of my interest in other people.

13.

0 I make decisions about as well as I ever could.

1 I put off making decisions more than I used to.

2 I have greater difficulty in making decisions more than I used to.

3 I can't make decisions at all anymore.

14.

0 I don't feel that I look any worse than I used to.

1 I am worried that I am looking old or unattractive.

2 I feel there are permanent changes in my appearance that make me look unattractive

3 I believe that I look ugly.

15.

0 I can work about as well as before.

1 It takes an extra effort to get started at doing something.

2 I have to push myself very hard to do anything.

3 I can't do any work at all.

16.

0 I can sleep as well as usual.

1 I don't sleep as well as I used to.

2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.

3 I wake up several hours earlier than I used to and cannot get back to sleep.

17.

0 I don't get more tired than usual.

1 I get tired more easily than I used to.

2 I get tired from doing almost anything.

3 I am too tired to do anything.

18.

0 My appetite is no worse than usual.

1 My appetite is not as good as it used to be.

2 My appetite is much worse now.

3 I have no appetite at all anymore.

19.

0 I haven't lost much weight, if any, lately.

1 I have lost more than five pounds.

2 I have lost more than ten pounds.

3 I have lost more than fifteen pounds.

20.

0 I am no more worried about my health than usual.

1 I am worried about physical problems like aches, pains, upset stomach, or constipation.

2 I am very worried about physical problems and it's hard to think of much else.

3 I am so worried about my physical problems that I cannot think of anything else.

21.

0 I have not noticed any recent change in my interest in sex.

1 I am less interested in sex than I used to be.

2 I have almost no interest in sex.

3 I have lost interest in sex completely.

Permission for Beck Anxiety Inventory and Beck Depression Inventory

MASTER LICENSE AGREEMENT Contract No. LSR - 544333 This Master License Agreement ("Master Agreement") by and between NCS Pearson, Inc., a Minnesota corporation, with its corporate offices located at [redacted] and its affiliates (hereinafter referred to individually and collectively as "Pearson") and Irma Perez, an individual, having an address at [redacted] ("Licensee"), is entered into as of the date of last signature ("Effective Date").

IN WITNESS WHEREOF, the parties have agreed and executed this Master Agreement as of the date of last signature below.

IRMA PEREZ	**NCS PEARSON, INC.**
Signature: Irma Perez (Sep 24, 2022 02:41 CDT)	Signature: randy trask (Sep 25, 2022 16:54 MDT)
Name: Irma Perez	Name: Randall T. Trask
Title: Doctoral Intern	Title: Senior Vice President
Date: 09/24/2022	Date: 09/25/2022

Trauma Attachment Belief Scale

BELIEF SCALE

Autoscore™ Form

Laurie Anne Pearlman, Ph.D.

Published by
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Directions

This questionnaire is used to learn how individuals view themselves and others. As people differ from one another in many ways, there are no right or wrong answers. Please circle the number next to each item which you feel most clearly matches your own beliefs about yourself and your world. Try to complete every item. Use the following response scale.

1 = Disagree Strongly
2 = Disagree
3 = Disagree Somewhat
4 = Agree Somewhat
5 = Agree
6 = Agree Strongly

If you want to change your answer, cross it out with an X, and circle the number for your new answer.

PLEASE PRESS HARD WHEN MARKING YOUR RESPONSES.

Education (highest grade level completed): _____

Age: ____ Gender: ☐ Male ☐ Female

1 = Disagree Strongly	2 = Disagree	3 = Disagree Somewhat	4 = Agree Somewhat	5 = Agree	6 = Agree Strongly

1. I believe I am safe.	1	2	3	4	5	6
2. You can't trust anyone.	1	2	3	4	5	6
3. I don't fell like I deserve much.	1	2	3	4	5	6
4. Even when I am with friends and family, I don't feel like I belong.	1	2	3	4	5	6
5. I can't be myself around people.	1	2	3	4	5	6
6. I never think anyone is safe from danger.	1	2	3	4	5	6
7. I can trust my own judgement.	1	2	3	4	5	6
8. People are wonderful.	1	2	3	4	5	6
9. When my feelings are hurt, I can make myself feel better.	1	2	3	4	5	6
10. I am uncomfortable when someone else is the leader.	1	2	3	4	5	6
11. I feel like people are hurting me all the time.	1	2	3	4	5	6
12. If I need them, people will come through me.	1	2	3	4	5	6
13. I have bad feelings about myself.	1	2	3	4	5	6
14. Some of my happiest times are with other people.	1	2	3	4	5	6
15. I feel like I can't control myself.	1	2	3	4	5	6
16. I could do serious damage to someone.	1	2	3	4	5	6
17. When I am alone, I don't feel safe.	1	2	3	4	5	6
18. Most people ruin what they care about.	1	2	3	4	5	6
19. I don't trust my instincts.	1	2	3	4	5	6
20. I feel close to lots of people.	1	2	3	4	5	6
21. I feel good about myself most days.	1	2	3	4	5	6
22. My friends don't listen to my opinion.	1	2	3	4	5	6
23. I feel hollow inside when I am alone.	1	2	3	4	5	6
24. I can't stop worrying about others' safety.	1	2	3	4	5	6
25. I wish I didn't have feelings.	1	2	3	4	5	6
26. Trusting people is not smart.	1	2	3	4	5	6
27. I would never hurt myself.	1	2	3	4	5	6
28. I often think the worst of others.	1	2	3	4	5	6
29. I can control whether I harm others.	1	2	3	4	5	6
30. I'm not worth much.	1	2	3	4	5	6
31. I don't believe what people tell me.	1	2	3	4	5	6
32. The world is dangerous.	1	2	3	4	5	6
33. I am often in conflicts with other people.	1	2	3	4	5	6
34. I have a hard time making decisions.	1	2	3	4	5	6
35. I feel cut off from people.	1	2	3	4	5	6
36. I feel jealous of people who are always in control.	1	2	3	4	5	6
37. The important people in my life are in danger.	1	2	3	4	5	6
38. I can keep myself safe.	1	2	3	4	5	6
39. People are no good.	1	2	3	4	5	6
40. I keep busy to avoid my feelings.	1	2	3	4	5	6
41. People shouldn't trust their friends.	1	2	3	4	5	6
42. I deserve to have good things happen to me.	1	2	3	4	5	6

Continue on back

43. I worry about what other people will do to me. 1 2 3 4 5 6
44. I like people. 1 2 3 4 5 6
45. I must be in control of myself. 1 2 3 4 5 6
46. I feel helpless around adults. 1 2 3 4 5 6
47. Even if I think about hurting myself, I won't do it. 1 2 3 4 5 6
48. I don't feel much love from anyone. 1 2 3 4 5 6

1 = Disagree Strongly 2 = Disagree 3 = Disagree Somewhat 4 = Agree Somewhat 5 = Agree 6 = Agree Strongly

50. String people don't need to ask for help. 1 2 3 4 5 6
51. I am a good person. 1 2 3 4 5 6
52. People don't keep their promises. 1 2 3 4 5 6
53. I hate to be alone. 1 2 3 4 5 6
54. I feel threatened by others. 1 2 3 4 5 6
55. When I am with people, I feel alone. 1 2 3 4 5 6
56. I have problems with self-control. 1 2 3 4 5 6
57. The world is full of people with mental problems. 1 2 3 4 5 6
58. I can make good decisions. 1 2 3 4 5 6
59. I often feel people are trying to control me. 1 2 3 4 5 6
60. I am afraid of what I might do to myself. 1 2 3 4 5 6
61. People who trust others are stupid. 1 2 3 4 5 6
62. I am my own best friend. 1 2 3 4 5 6
63. When people I love aren't with me, I believe they are in danger. 1 2 3 4 5 6
64. Bad things happen to me because I am a bad person. 1 2 3 4 5 6
65. I feel safe when I am alone. 1 2 3 4 5 6
66. To feel okay I need to be in charge. 1 2 3 4 5 6
67. I often doubt myself. 1 2 3 4 5 6
68. Most people are good at heart. 1 2 3 4 5 6
69. I feel bad about myself when I need help. 1 2 3 4 5 6
70. My friends are there when I need them. 1 2 3 4 5 6
71. I believe that someone is going to hurt me. 1 2 3 4 5 6
72. I do things that put other people in danger. 1 2 3 4 5 6
73. There is an evil force inside of me. 1 2 3 4 5 6
74. No one really knows me. 1 2 3 4 5 6
75. When I am alone, it's as if there's no one there, not even me. 1 2 3 4 5 6
76. I don't respect the people I know best. 1 2 3 4 5 6
77. I can usually figure out what's going on with people. 1 2 3 4 5 6
78. I can't do good work unless I am the leader. 1 2 3 4 5 6
79. I can't relax. 1 2 3 4 5 6
80. I have physically hurt people. 1 2 3 4 5 6
81. I am afraid I will harm myself. 1 2 3 4 5 6
82. I feel left out everywhere. 1 2 3 4 5 6
83. If people really knew me, they wouldn't like me. 1 2 3 4 5 6
84. I look forward to time I spend alone. 1 2 3 4 5 6

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Date: August 8, 2022

Principal Investigator's name and title: Irma Perez M.Ed, MS, LPC, Doctoral Candidate

Name of the Assessment: Trauma and Attachment Belief Scale (TABS)

Permitted number of uses: 100 Total Uses

Description of the study:

"Job Stress, Anxiety, and Depression in Mental Health Professionals: An Examination of Experienced Vicarious Trauma and Gender Differences."

References terms dated 29July'22.

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Method of administration:

Administration and scoring via a secure, password-protected, online environment.

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