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Trauma Informed Care and Secondary Traumatic Stress Experienced by Counselors in Community Mental Health

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This is to certify that the doctoral dissertation by

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has been found to be complete and satisfactory in all respects,
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the review committee have been made.

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Abstract

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MA, Texas State University, 2014

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Dissertation Submitted in Partial Fulfillment

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Doctor of Philosophy

Counselor Education and Supervision

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Abstract

Secondary traumatic stress (STS) is prevalent in counselors working with clients with trauma. Clients seeking services in community mental health (CMH) settings often have a higher prevalence of traumatic experiences and are unable to access services outside of CMH settings. Counselors working in these settings also generally face high caseloads, less pay, and often less experience in the field. Trauma informed care (TIC) has been shown to increase positive outcomes for clients and counselors providing services to clients. This quantitative survey study focused on the relationship between counselor attitudes related toward TIC and the severity of STS experienced by counselors. Lazarus and Folkman's theory of transactional stress and Harris and Fallot's creating cultures of TIC were the theoretical and conceptual frameworks. The relationship between counselor attitudes related toward TIC, the independent variable, was measured by the ARTIC-45 Scale and the severity of STS experienced by counselors in CMH, the dependent variable, was measured by the STS Scale (STSS). Data from these measures were analyzed using a multiple regression to better understand the relationship between the seven subscales of the ARTIC-45 and total score from the STSS. A statistically significant correlation was identified between the STSS and one subscale of the ARTIC-45, self-efficacy at work. As respondents' ARTIC-45 score increased in self-efficacy at work, their STSS score decreased, meaning they were reporting fewer symptoms and a lower severity of STS symptoms. The results of this study can be used to advocate for TIC implementation in CMH settings to increase the wellness of counselors serving clients that find services in this setting vital to their mental health and well-being.

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Dedication

I would like to dedicate this work to a few very important people in my life. The first being my mother. She raised me as a single parent that always did what she needed to do to make sure we had what we needed. This included getting her GED when I was very young, earning her bachelor's degree when I was in elementary school, and her master's degree when I was in high school. She continues to champion me, encourage me with unwavering support, and love me. Thank you, Mom, for blazing the trail.

I would also like to acknowledge my daughter Ayla Rain Hernandez. She has brought a love and a light to my life beyond measure. She has journeyed with me as I completed each step of this program. I started this program when she was just two years old, and she used to fall asleep next to my desk during late night homework sessions. I hope she remembers this experience as I remember my experience of watching my mom reach her goals. I hope she feels empowered and truly understands her value and the power she has to achieve her dreams, whatever they may be, now and in the future. Ayla, I love you and want to say thank you for being such an amazing daughter and a wonderful light in my life.

Last, but definitely not least, I would like to acknowledge my wonderful husband, Joe. There is absolutely no way I could have accomplished this goal without him. He is the reason I began this journey when I did as he knew it was a dream of mine and he encouraged me. When I first began, we lived in an RV with our two-year-old daughter and two dogs. I used to work on homework on a work laptop in our bedroom while he rocked our daughter to sleep. He has been by my side every single step of the way.

Wiping my tears, giving the best hugs, and a listening ear when I needed it, compassion, and grace as I struggled, and support I cannot begin to put into words. Joe, I love you and thank you for everything. WE did it!!

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I would like to acknowledge my dissertation chair, Dr. Mark D. Stauffer, and my committee member, Dr. Rebecca Cowan. I appreciate your guidance and support as I completed each step of this lengthy process. I have truly grown as a learner, researcher, and advocate as I have progressed through this process with your help. Thank you.

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Chapter 1: Introduction to the Study

Numerous studies have examined the positive impacts of implementing trauma informed care (TIC) practices in differing settings. These positive impacts include health and wellness benefits for counselors as well as increased benefits for clients (Goddard et al., 2020). Secondary traumatic stress (STS) has also been studied in various settings, including the correlation between STS and burnout leading to a decrease in the quality of services clients receive, decreased health and wellness of counselors, and a higher likelihood that a counselor may leave the profession (Christian-Brandt et al., 2020). In this study, the relationship between TIC and STS was examined to better understand how counselor perspectives on TIC could decrease STS severity among counselors working in a community mental health agency setting. In Chapter 1, I provide the theoretical and conceptual frameworks used to structure the study as well as the research questions, purpose, and nature of the study. Lastly, I will describe the significance as well as the limitations and delimitations of this study.

Background

The impact of TIC has been studied in a variety of settings, including schools, medical settings, and mental health settings. Research has shown that the implementation of TIC promotes positive effects for clients and for helping professionals, including counselors and therapists (Goddard et al., 2020). In a study of 90 government workers and nonprofit professionals, researchers found that TIC implementation and training increased personal awareness of symptoms of burnout and compassion fatigue (Damian et al., 2017). Burnout is a type of stress syndrome that impacts an individual's energy

level, leads to higher levels of depersonalization, and decreases feelings of personal accomplishment (Cordes & Dougherty, 1993; Maslach & Jackson, 1981). Compassion fatigue is defined as the emotional exhaustion of working with people over time who are hurting or in pain and feeling motivated to remedy the source of their pain (Figley, 1995). When counselors have a better understanding of burnout and are more self-aware of the symptoms, they are more likely to engage in interventions that may increase their wellness and decrease levels of burnout (Damian et al., 2017). Furthermore, a study on pediatricians working with child abuse survivors showed a decrease in provider burnout and an increase in feelings of hope in the work setting and meaning in work when TIC was implemented (Passmore et al., 2020). In another study, results supported the positive impacts of TIC implementation as workers in settings with a TIC focus showed decreased cortisol levels (Schmid et al., 2020).

Researchers in the helping profession have studied STS in a variety of settings. STS occurs when an individual experiences a trauma response after being exposed to the traumatic experiences or the trauma of another person or persons (Passmore et al., 2020). Counselors may encounter STS as they sit with clients and listen to their clients share their traumatic experiences. STS is a leading factor contributing to burnout for many in the helping profession (Christian-Brandt et al., 2020). Counselor burnout can have negative consequences including but not limited to decreased counselor wellness and a decrease in the quality of care provided by the counselor if intervention does not occur (Kim et al., 2018). Therefore, decreasing the overall severity of STS in counselors by using TIC practices could have numerous positive effects for counselors and their clients.

Problem Statement

Burnout and STS are linked to negative outcomes for counselors and the clients they serve (Kim et al., 2018). Burnout has been shown to increase rates of turnover while decreasing counselor wellness and the quality of services provided by these professionals (Kim et al., 2018). One primary cause of burnout among counselors is STS, which occurs when counselors are exposed to the trauma of their clients as they listen to the traumatic events and experiences their clients have endured (Passmore, et al., 2020). STS typically occurs after a one-time exposure to another person's trauma, but counselors may have repeated opportunities to have these one-time secondary traumatic experiences. As these experiences mount and overlap, a counselor's symptoms in response to being exposed to the traumatic experiences of others can contribute to or cause burnout (Kim et al., 2018).

Implementation of TIC includes numerous benefits for clinicians and the clients they serve (Goddard, 2020). Counselors' cortisol levels decreased when TIC was written into workplace culture including policies and procedures (Schmid et al., 2020). In another study TIC approaches were found to decrease levels of aggression toward staff exhibited by the children in their care (Schmid et al., 2020). Students have also experienced increased positive outcomes and an increase in teacher longevity in the education field when TIC was implemented by teachers in their school and used in classrooms (Christian-Brandt et al., 2020). TIC is also effective for foster parents and their foster children. Foster parents reported feeling better prepared to effectively redirect the behaviors of their foster children when they learned and implemented trauma-informed approaches (Lotty et al., 2020). Foster children also experienced an increase in positive

outcomes when TIC was implemented in their foster home (Lotty et al., 2020).

With mounting literature and statistically significant results showing the efficacy of TIC in many aspects, TIC still has not been written into policy and procedure in every mental health setting across all economic and geographical landscapes as a general baseline practice (Im et al., 2021; Isobel, 2021). Community mental health settings are often underfunded, and staff are overwhelmed with the amount of work they are required to complete by funders and to meet community needs (Segal et al., 2002). These stressors and lack of funding could lead to many of these settings not implementing TIC and benefiting from the positive outcomes that TIC utilization can bring. Barriers to including TIC in programming include time constraints in community mental health settings as well as lack of professional curriculum in graduate school that educates those working to become counselors on the pervasiveness of trauma and how TIC can mitigate the impact of trauma in many ways (Courtois & Gold, 2009; Palfrey et al., 2019).

After reviewing the literature, I found no studies that investigate the effect of counselor attitude toward TIC and the severity of STS experienced by counselors working with clients in community mental health settings. In this study, I investigated the impact of counselor attitude toward TIC on the severity of STS among licensed professional counselors (LPCs), licensed professional counselor associates (LPC-Associates), licensed marriage and family therapists (LMFTs), and licensed marriage and family associates (LMFT-Associates). My research promotes positive social change because it provides additional research to support decision makers funding and implementation of TIC. The findings of this study can be used to advocate for further

implementation and funding for use of TIC specifically in community mental health settings, that often serve populations that have been historically marginalized and oppressed (Alegria et al., 2022). These populations often struggle with decreased accessibility to quality mental health services outside of community mental health (Thornicroft, 2021). Further, community mental health can be the first place of employment postgraduation for counselors, and the first 2 years of postgraduate, supervised clinical experience often promote the most professional growth a counselor will experience throughout their career (Kimbel & Levitt, 2017). Increasing TIC in these spaces may promote the health and wellness of counselors, that could lead to better outcomes for counselors who are new to the field and the clients they serve.

Purpose of the Study

The purpose of this quantitative study was to better understand the potential relationship between counselor attitudes related to TIC, as measured by the Attitudes Related to Trauma-Informed Care (ARTIC)-45 Scale (2021), and the severity of STS, as measured by the STS Scale or STSS (Bride et al., 2004), among counselors providing therapeutic services in a community mental setting. The intention of this study was to promote positive social change by increasing knowledge related to increased health and wellness of counselors. Increased health and wellness of counselors includes less burnout, compassion fatigue, and premature departure from the profession, and this may lead to better outcomes for clients as well (Plath & Fickling, 2020). My research adds to the literature in support of TIC by investigating the relationship between the counselor's attitude toward TIC in their work setting, the independent variable, and the severity of

STS, the dependent variable, among counselors working in a community mental health setting.

Research Question

RQ 1: Is there a statistically significant relationship between counselor attitude toward TIC, as measured by the seven subscales of the ARTIC-45 Scale, and the severity of STS, as measured by the STSS, among counselors working in community mental health settings?

$H_0$1: There is no statistically significant relationship between counselor attitude toward TIC, as measured by the seven subscales of the ARTIC-45 Scale, and the severity of STS as measured by STSS among counselors working in community mental health settings.

H_a1: There is a statistically significant negative correlation between counselor attitude toward TIC, as measured by the seven subscales of the ARTIC-45 Scale, and the severity of STS as measured by the STSS among counselors working in community mental health settings.

Framework

Theoretical Framework

The theoretical framework for this study is Lazarus and Folkman's theory of transactional stress. Lazarus and Folkman (1984) posited that an individual's stress response and level of stress are the result of the individual's transaction with their environment. This theory was organized with workplace stress at the forefront and the perception of the individual guiding the type of response (Lazarus & Folkman, 1984).

This theory states that it is the individual's reaction to a stressor or their perception of the stressor that leads to the consequences experienced by the individual experiencing that stressor. This is important for my research as I looked at the counselors' self-reports of and attitudes toward the different domains of TIC as assessed by the ARTIC-45 Scale. This theoretical framework was not used in creating the ARTIC-45 Scale, but it closely aligns with the focus of the assessment being self-report of stressors and attitudes related to TIC. My hypothesis was that a potential relationship exists between a counselor's attitude toward TIC and the severity of STS. As counselors self-report more supportive attitudes toward TIC their self-reported severity of STS will be decreased. In essence, it is not the only the stressor that is causing the STS but also the individual's experiences and perception of that stressor along with their attitude toward the domains of the ARTIC-45 Scale, which include underlying causes of problem behavior and symptoms, responses to problem behavior and symptoms (could include coping strategies or lack thereof), empathy and control, self-efficacy at work, and reactions to work (Baker et al., 2021; Lazarus & Folkman, 1984).

Conceptual Framework

The conceptual framework for this study is Creating Cultures of TIC (CCTIC) developed by Harris and Fallot (2001). Harris and Fallot developed this framework at Community Connections in Washington D.C. after 15 years of experience in the field observing how trauma is very broad and impacts many life domains, the impact of trauma is often deep and life-shaping, violent trauma is often self-perpetuating, trauma is insidious and preys, particularly on the more vulnerable among us, trauma affects the

way people approach potentially helpful relationships, trauma has often occurred in the service context itself, and trauma affects staff members as well as consumers in human service programs (Harris & Fallot, 2001). This framework also outlines five core values that must be implemented in human service programs to create trauma-informed workplace culture: safety, trustworthiness, choice, collaboration, and empowerment (Harris & Fallot, 2001). This theory posits that workplace environment can be triggering and impact the performance of a direct service staff member (Harris & Fallot, 2001). Using this theoretical perspective and applying it to my dissertation topic, I expected my independent variable, counselor attitude toward TIC, as measured by the ARTIC-45 Scale, to influence my dependent variable, the severity of STS, as measured by the STSS, among counselors working in a community mental health setting. This framework is useful to define what TIC implementation includes and the assessment being utilized measures these constructs. My research findings support the applicability of this theory as well.

Nature of the Study

I used a quantitative, correlational research design to study the relationship between the independent variable, counselors' attitude toward TIC in their community mental health work setting as measured by the ARTIC-45 Scale and the dependent variable, severity of STS among counselors employed in a community mental health setting as measured by the STSS. I used a cross-sectional survey research design to analyze data collected from these assessments at one specific point in time. The population I studied was counselors (LPC, LPC-Associates, LMFT, LMFT-Associates)

working in community mental health settings.

Data was collected using anonymous online services on the Survey Monkey platform. I conducted an a priori power analysis to determine the appropriate sample size needed to achieve sufficient statistical power and to increase the generalizability of my research. I used SPSS to facilitate statistical analyses of the data collected. Data analysis methods included correlational statistics to study the relationship between variables and multiple regression statistics were used to study the relationships between the subscales of the ARTIC-45 Scale and the STSS.

Definitions

In this section I provide definitions of the various constructs, terms, and variables that were used in this study.

Burnout: Burnout is defined as overall exhaustion due to repeated exposure to problems and stress related to work (Guseva Canu et al., 2021).

Community mental health: Community mental health refers to mental health care facilities and agencies that are community-based and services are offered at a discounted rate or free of charge. Community mental health facilities and agencies are often funded through state, federal, or charity-based grants and contracts.

Compassion fatigue: Compassion fatigue is the overall exhaustion mentally and physically that results from caring for others in various capacities (Figley, 2002).

Counselor: Counselors are professionals in the field of counseling that hold a license to practice and provide mental health care to clients. This could include LPCs, LPC-Associates, LMFTs, and LMFT-Associates.

Counselor wellness: Counselor wellness refers to a state of being that promotes a counselor's full potential (Neswald-Potter et al., 2013).

Culturally responsive trauma informed care (TIC): Culturally responsive TIC refers to an approach to service delivery that includes, "the importance of context, recognizes transgenerational vulnerabilities, and promotes equity and the utilization of cultural humility in order to lessen the multilayered disparities in service accessibility experienced by minoritized communities" (Meléndez Guevara et al., 2021, p. 325).

Organizational culture/Climate: Organizational culture and organization climate are terms used interchangeably and refer to the understood expectations within in a work setting which include the company or employer's values and accepted or promoted behavioral norms (Glisson, 2015).

Secondary traumatic stress (STS): STS refers to "Reactions resembling posttraumatic stress… resulting from indirect exposure to trauma" (Cieslak et al., 2013, p. 918). Vicarious trauma (VT) is used synonymously with STS, but they are two separate constructs. The symptomology of these two constructs is similar; however secondary traumatic stress is usually brought on suddenly by exposure to the traumatic experiences of others while VT is a gradual and cumulative effect of having ongoing exposure to the traumatic experiences of others (Bride et al., 2004; Kounenou et al., 2023).

Trauma-informed care (TIC): TIC is defined as the

> shift in human service, health, education, and related sectors toward organizational cultures that understand the prevalence and impact of trauma,

> recognize the signs and symptoms of trauma in system-users and staff, and respond by changing policies, practices, and procedures to ameliorate rather than exacerbate the effects of ACEs and trauma. (Baker et al., 2021, p. 506)

Trauma-informed practice: Trauma informed practice refers to a counselor's knowledge of trauma and the impacts of trauma to include trauma diagnoses and considerations for therapeutic strategies to mitigate the challenges a trauma survivor might be experiencing as they seek and participate in therapeutic services (Szczygiel, 2018).

Vicarious trauma: Vicarious trauma is defined as

> the indirect trauma that may occur to people working with traumatized clients, such as health professionals, and includes nightmares, phobic thoughts, images that suddenly appear in the mind, suspicion of others' intentions, decreased empathy, and on a professional level, a loss of efficiency in providing therapeutic services while professional satisfaction decreases. (Kounenou et al., 2023, p. 1)

Assumptions

Assumptions I had, as I prepared to conduct this study, included being able to recruit participants who are representative of the profession that would provide data that can be generalizable. I recruited participants in varying geographic locations to capture data from rural and urban settings. I targeted counselors working in community mental health settings including those working primarily with children and families and others working in settings that serve adults.

Another assumption of this study is that participants who voluntarily agreed to

complete the surveys did so thoroughly and honestly. I assumed that they would be able to answer the questions truthfully without fear of any type of repercussion from their work setting, as these surveys were anonymous. Studies have shown that participants may respond in more socially accepted ways when completing surveys using various methods (Kreuter et al., 2008). For this study, I used a web-based survey collection method, which has been shown to provide the most accurate self-report data to minimize the occurrence of participants responding based on what is more socially desirable instead of basing responses on facts (Dillman et al., 2009).

Scope and Delimitations

The scope of this study was limited to the effect of TIC, as measured by the ARTIC-45 Scale, on the severity of STS, as measured by the STSS, on counselors working in community mental health agencies. The decision to focus on community mental health agencies was based on the higher prevalence of trauma for clients seeking services in community mental health settings and the need for advocacy to increase TIC in these settings to meet the needs of a population that is historically oppressed and marginalized (Muzik et al., 2013). Inclusionary criteria for participants included (a) LPCs, LPC-Associates, LMFTs, or LMFT-Associates (b) working in a community mental health agency. Individuals with a social work license or any other credential were excluded from this study. Also, individuals working in any site other than a community mental health agency (private practice, for-profit counseling centers, schools, etc.) were excluded.

Limitations

One challenge encountered was getting potential participants to complete the online surveys and engage in the study. I studied STS, and those who are suffering from this issue may be less inclined to take on an additional task like completing a voluntary study due to the symptoms of STS that include decreased job satisfaction, headaches, fatigue, and higher rates of depression (Alavi et al., 2022). I ensured that I clearly communicated the value of my research and the possible benefits that my findings may have to the field in the hopes that this increased investment by potential participants.

Another challenge I encountered was a lack of diversity between the types of licensures present in the participants. I included four types of licensures: LPCs, LPC-Associates, LMFTs, and LMFT-Associates. I did not have a strategy in place to ensure an equal representation of each licensure type in the survey respondents. The participant pool ended up being more heavily represented for one licensure type over others. I discuss this further in the Limitations section in Chapter 5 and include the impact on the generalizability of my research study results.

Another challenge and possible opportunity for this study was that participants may be under increased stress due to the aftereffects of the COVID-19 pandemic and associated experiences of navigating the pandemic. This may have provided more insight into the benefits of TIC and the impact of TIC implementation on STS, but the findings may not be as applicable as the country continues to recover from the pandemic.

Significance

Community mental health settings often provide services to vulnerable

populations including those living in poverty (Alegria et al., 2022). Often the clients seeking services in these settings would not be able to receive mental health services elsewhere due to financial strain, transportation issues, and lack of accessibility to other resources. Further, clients served in this setting may have endured some form of childhood maltreatment if not multiple complex traumatic experiences (Kealy & Lee, 2018). Cusack et al. (2004) conducted a study in South Carolina investigating the prevalence of trauma in individuals seeking services in a community mental health setting. Results indicated that 91% of the 505 participants in the study had experienced at least one traumatic event and of this 91%, or 460 participants, the average number of traumatic events experienced was 4.7 (Cusack et al., 2004). Research using the adverse childhood experiences (ACE) assessment showed that individuals with these types of experiences are vulnerable to multiple negative health outcomes if they are unable to get treatment and therapy to process these experiences (Felitti et al., 1998). Other results have indicated similar numbers of ACEs with associated negative health outcomes but a higher prevalence of social barriers making it more challenging to get mental health services after a traumatic experience (Prokosch et al., 2022).

Understanding the vulnerability of this population promotes the need for effective, quality mental health services that are accessible. An increase in counselor health and wellness would increase the quality of services received (Plath & Fickling, 2022). The findings of my study can be used to advocate for additional funding to implement TIC in community mental health settings to increase positive outcomes for clients served in this setting. Additionally, the findings of this study could be used to

advocate for widespread TIC implementation in community mental health settings to decrease the severity of STS leading to a decrease in the negative consequences of STS including burnout and a premature departure from the counseling field. Counselors are personally impacted by the effects of STS, which can lead to burnout and, ultimately, a premature exit from the counseling profession (Robino, 2019). Counselors often dedicate their lives, including multiple years of specialized and supervised training to enter the counseling profession, and it can be devastating for them to leave the profession due to burnout and STS. Counselors that exit the counseling profession prematurely also take with them an abundance of knowledge and expertise that could have been used to help clients and the community.

Summary

TIC positively impacts counselors and clients in many ways. In this study I examined the relationship between TIC implementation and the severity of STS in counselors working in a community mental health agency setting. In this chapter, I provided the background, problem statement, purpose of the study, as well as the conceptual and theoretical frameworks. I also highlighted the research questions and discussed the limitations and delimitations of the study. In Chapter 2, I provide a thorough review of the literature in each of the content areas.

Chapter 2: Literature Review

Burnout has been studied numerous times as it is linked to many negative outcomes for counselors and the clients in their care (Kim et al., 2018). Negative outcomes experienced by counselors include low job satisfaction, a decrease in their ability to be effective counselors, and somatic symptoms such as fatigue (Kim et al., 2018). Burnout has been shown to increase rates of turnover while decreasing counselor wellness and the reported quality of services provided by counselors (Kim et al., 2018). One of the leading causes of burnout among counselors is STS, which occurs when counselors are repeatedly exposed to the traumatic experiences of their clients as their clients share these experiences while receiving services (Passmore et al., 2020). STS can be seen as an occupational hazard for counselors working with populations that are at an elevated risk for having experienced trauma (Bride, 2007).

TIC has become a catchphrase in recent years due to the mounting evidence showing that TIC principles promote positive outcomes for staff and clients in numerous settings (DeCandia et al., 2020). Cortisol levels were often dramatically decreased when TIC principles were adopted and implemented in a community health setting (Schmid et al., 2020). Teachers and students have also shared positive outcomes when their school implemented TIC (Christian-Brandy et al., 2020). Further, foster children and their foster parents experienced positive outcomes when the foster parents utilized a trauma-informed approach to parenting (Lotty et al., 2020). Some speculate that these positive outcomes could be attributed to a single TIC principle, but research has shown that all the TIC principles are equally important (Hales et al.,2017). Counselor attitude and buy-in

regarding TIC implementation and facilitation is also a vital facet of the efficacy of TIC practices (Small & Huser, 2019). My research could add to this body of knowledge and provide support for increasing the health and wellness of community mental health workers, promoting positive outcomes for their clients.

The purpose of this quantitative study was to investigate the potential relationship between counselor attitude related toward TIC, as measured by the ARTIC-45 Scale and the severity of STS, as measured by the STSS (Bride et al., 2004) among counselors working in community mental health settings. Better understanding the potential relationship between these variables further supports the implementation of TIC in spaces where counselors provide services to populations at risk for experiencing trauma to help mediate the negative consequences of STS experienced by counselors and the clients they serve. In this chapter, I provide a thorough review of the literature.

Literature Search Strategy

I began my literature search by utilizing the Walden University Library where I accessed various research article databases including APA PsycINFO, EBSCOhost, PsycARTICLES, and SAGE Journals. I searched peer-reviewed articles and found that most of the content I would later utilize was published in the last 10 years. There were numerous articles published within the last year. I searched the following key terms: *vicarious trauma, secondary trauma, compassion fatigue, trauma-informed care, secondary traumatic stress, community mental health, organizational culture, trauma-informed assessment, trauma-informed practice, culturally responsive trauma informed care,* and *stress*. In addition, I used the following Boolean search terms to ensure I was

capturing the breadth of the literature: *trauma-informed care* or *trauma-informed practice* or *trauma informed approach*; *burnout* or *burn-out* or *burn out* or *occupational stress* or *compassion fatigue*; *secondary trauma* or *compassion fatigue* or *vicarious trauma*; *counselor* or *therapist* or *psychotherapist*; and *organizational culture* or *company culture* or *corporate culture*. Finally, I searched for seminal works that predated the 5-year timeframe, which focused on Lazarus and Folkman's (1984) theory of transactional stress.

Theoretical Framework

The theoretical framework for this study is Lazarus and Folkman's (1984) transactional model of stress and coping. In this section I describe the foundation and development of this theory along with my rationale for using this theory as the foundation of this study.

Foundation and Development of the Transactional Model of Stress and Coping

Lazarus and Folkman (1984) challenged the mainstream idea at the time that stress was generally caused by an environmental factor that then impacted the mind and body in a linear fashion. Lazarus and Folkman created the transactional model of stress and coping to add that the mind and body impacted each other and the environment as well. Lazarus and Folkman stated that the mind's perception of the threat and the availability of assets to address the threat and ultimately cope with the stressor are all key variables that contribute to the impact that stressor has on the individual. Lazarus and Folkman used the term *psychological stress* to describe the experience of an individual that perceives a threat as needing more internal and external resources to cope with the

stressor than they are presently able to muster. The individual appraises the situation and takes inventory of their resources, and psychological stress occurs when they perceive a deficit between these two constructs.

Lazarus and Folkman (1984) also distinguished between life events and daily hassles as potential sources of stress. Life events include all expected or unexpected events that the individual may or may not have control over, but they cause change and often stress in the individual's life. There are also daily hassles, which are common events that may be stressful, and often the stress incurred by these everyday happenings builds over time and may lead to negative consequences physically, psychologically, and socially. Lazarus and Folkman discuss the significance and meaning of these events as major predictors of the level of stress and associated consequences unique to everyone. This theory posits that the more severe the individual perceives the experience to be or the more of a deficit they perceive existing between the resources needed and the resources available to process the stressor the more they will be negatively impacted by said event while also perceiving a higher level of stress resulting from the event.

Rationale for Use of the Transactional Model of Stress

The transactional model of stress posits that an individual's stress response and stress level are the result of their interaction with and perception of their environment (Lazarus & Folkman, 1984). This theory states that it is the individual's reaction to a stressor or their perception of the stressor that led to the consequence experienced by the individual experiencing that stressor (Lazarus & Folkman, 1984). For my research this was important as I looked at the therapists' attitudes toward the different domains of

trauma-informed care. My hypothesis was that as their attitude favors TIC implementation their experience of STS will be decreased. In essence it was not the stressor that was causing the STS but the individual's experience and perception of that stressor along with their perception of and attitude toward the domains of the ARTIC-45 Scale, which includes underlying causes of problem behavior and symptoms, responses to problem behavior and symptoms, empathy and control, self-efficacy at work, and reactions to work (Baker et al., 2021; Lazarus & Folkman, 1984).

Conceptual Framework

The conceptual frame for this study was Harris and Fallot's (2001) CCTIC. Harris and Fallot developed this theory after 15 years of observing how trauma impacts individuals and how TIC can decrease the negative impacts of trauma. This theory includes eight propositions: trauma is pervasive, the impact of trauma is very broad and impacts many life domains, the impact of trauma is often deep and life-shaping, violent trauma is often self-perpetuating, trauma is insidious and preys particularly on the more vulnerable among us, trauma affects the way people approach potentially helpful relationships, trauma has often occurred in the service context itself, and trauma affects staff members as well as consumers in human service programs. This theory also outlines five core values for human service programs to create a trauma-informed workplace culture: safety, trustworthiness, choice, collaboration, and empowerment. It is important for individuals to feel safe, otherwise the therapeutic process and therapeutic relationship building will be stunted. This is also true from a staff and agency perspective as staff cannot provide services and their jobs to the best of their abilities if they do not feel both

physically and emotionally safe in their work environment. Trustworthiness includes clarity and consistency in service goals, and outcomes, as well as the overall mission, vision, and core values of the organization. The core values and foundations of the agency must align with the policies and day-to-day practices of the agency and all staff, including leadership, to foster a trauma-informed workplace and therapeutic environment. The importance of choice and collaboration are discussed relative to client experience as they are engaged in services and therapeutic interventions. This value also informs best practices when understanding staff experience as they need a sense of choice, ownership, and a sense of control over their work experience and the services they provide. The core value of empowerment includes staff having a voice in programming decisions and an avenue to advocate for staff needs as needed and appropriate.

Trauma Informed Care

TIC refers to policies, procedures, and general ways of relating and working with humans that is respectful and responsive to their lifelong experiences including any type of trauma (Harris & Fallot, 2001). Trauma refers to a single experience or multiple experiences that overpower an individual's ability to cope with the incoming stressor, which may lead to numerous symptoms that can be long lasting (Esaki & Larkin, 2013). Trauma is not limited to experiences in childhood, although current research suggests that trauma experienced earlier can increase the negative impact on the brain, brain development, severity, and duration of symptoms experienced as a result of the trauma (Esaki & Larkin, 2013).

TIC is also a perspective to view human behavior as more than the presentation and specific behaviors, but more so the need behind an individual's behavior regardless of their adaptive or maladaptive strategies to get that need or those needs met (Harris & Fallot, 2001). Systems that provide mental health services often address presenting concerns without better understanding those concerns as manifestations of the individuals experiencing trauma (Harris & Fallot, 2001). With this deeper understanding of behavior and the need behind behavior, interventions and relational strategies can be deployed that are more effective and appropriate given everyone's history and current need (Purvis et al., 2013).

TIC in a mental health treatment setting includes educating staff about the pervasiveness of trauma in populations seeking mental health services and designing programming in such a way as to work with vulnerabilities that may be present in the client population due to trauma (Harris & Fallot, 2001). Programming must be tailored to populations that have experienced trauma to increase participation and engagement in mental health services for this population (Harris & Fallot, 2001). TIC has been shown to promote positive outcomes for clients in numerous settings including foster care and adoption, residential treatment facilities, schools, and workplace settings (Christian-Brandy et al., 2020; Hiles Howard et al., 2015; Purvis et al., 2013). Positive outcomes for clients and staff can be behavioral and physiological. Schmid et al. (2020) found that the cortisol levels of staff working in a mental health setting decreased when their work setting implemented trauma informed practices. This means that TIC can also be measured physiologically as more is understood about the impacts of trauma on the body

and how TIC can mitigate the symptoms experienced by those that have a trauma history.

TIC can be useful and supportive to all individuals and particularly those with a trauma history including ACEs (Esaki & Larkin, 2013). For instance, social service providers tend to have more ACEs than the overall population on average (Esaki & Larkin, 2013). More individuals who have experienced trauma seek out helping profession careers because the result of trauma can often be a feeling of helplessness or lack of control, and by helping others therapeutically process and heal from their trauma, the helpers can feel a sense of control and experience healing as well (Hiles Howard et al., 2015). However, service providers with a trauma history may be more susceptible to experiencing STS, and associated symptoms, as they provide services to individuals that may be retelling their traumatic experiences as a part of the therapeutic process (Hiles Howard et al., 2015). Thus, when an agency or organization implements TIC, it will not only help the clients seeking services experience more positive outcomes but also the population of service providers helping these clients with therapeutic interventions and support (Esaki & Larkin, 2013). Direct service professionals like counselors and social workers are at an increased risk for experiencing STS, but staff in more indirect roles can still experience STS (Hiles Howard et al., 2015). This is further reasoning to support implementing TIC at all levels of an agency because everyone has the potential to experience positive outcomes from these practices (Hiles Howard et al., 2015).

Current literature focusing on TIC is mostly focused on outward-based initiatives. More is being understood about the pervasiveness of trauma and how to use trauma-informed practices with clients and those being cared for by staff. There is not as much

literature on more inwardly based trauma informed initiatives, but there seems to be a shift in this direction. Harris and Fallot (2001) are known as pioneers in the work of TIC, and they include inward strategies in their field of study. Harris and Fallot created a set of assessments, called CCTIC, to provide insight into TIC practices at the staff and administration levels of an agency. These assessments include a program self-assessment, a program self-assessment scale, and an implementation form. These tools can be used by agencies to better understand their level of TIC implementation, areas of strengths, and challenges within their program that provide opportunities for further growth in the implementation of trauma informed practices. Harris and Fallot's research is based on the premise that trauma is pervasive, it is much more common than many individuals understand, and that trauma can permeate every aspect of human experience. Trauma-informed approaches are vital to increase positive outcomes for clients and for staff as well. Harris and Fallot include the following core values of TIC: empowerment, choice, collaboration, trustworthiness, and safety.

Other researchers and social service providers have continued this work and created additional assessments and implementation structures. Baker et al. (2016) created the ARTIC Scale to provide another assessment tool for organizations and agencies to better understand their level of trauma informed implementation based on the self-report data from their staff. Additional assessments and implementation structures will likely continue to be developed as more literature mounts regarding the pervasiveness of trauma and how it impacts client outcomes and the impact of trauma on staff. Researchers have since used this instrument to further understand additional areas impacted by counselor

attitudes toward TIC. For example, Chase and Post (2022) studied 409 play therapists and found that their attitudes related to TIC significantly impacted the likelihood they would invest time and energy into social advocacy opportunities and projects.

Agency, organization, and school staff face numerous challenges as they journey toward more trauma informed practices and policies. Many mental health agencies are steered by meeting service goals and metrics to appease funders and stakeholders to sustain programming. Oftentimes funders look to psychometrically based instruments to decide which initiatives to implement at the agency level and, until recently, there were few instruments that measure TIC that were evidence based or created using empirical methods (Baker et al., 2016). These types of instruments are also necessary to measure progress and meet benchmarks set by funders to continue support for programs while also ensuring effective practices for the clients being care for (Baker et al., 2016).

Another boundary faced by agency and organization staff that have the desire to implement TIC, is the lack of a centralized definition and structure of TIC (Baker et al., 2016). Instead, there is a plethora of different ideas regarding what TIC is, what the pillars or characteristics of TIC include, and what the structure of implementation looks like (Baker et al., 2016). Again, there are many ideas, but very few that have empirical data to justify the claims and values set forth by the creators of each model (Baker et al., 2016). Without a standardized definition, structure, assessment, and means to measure progress, agencies may find it difficult to acquire the necessary funds to make shifts in their programming, policies, and service to delivery to reflect more trauma informed approaches (Baker et al., 2016).

Another challenge in implementation of TIC in community mental health settings is that due to outward facing implementation strategies garnering most of the attention, many service organization leave implementation up to direct service staff (Guevara et al., 2021). Guevara et al. studied TIC implementation in schools and community mental health settings finding that buy in and investment from administration and upper management is a vital in successfully shift to trauma-informed approaches outwardly and inwardly (Guevara et al., 2021). The organization or agency needs to implement TIC from the top down (starting with leadership and moving to direct service staff), instead of bottom up, and inward to outward (including updating internal policy and procedure, treatment of staff, etc.), instead of only outward or client facing, for initiatives to be effective and sustainable long-term (Guevara et al., 2021). Administration and upper management generally have the ability and authority to make changes to agency policies to reflect a more trauma informed approach to include reasonable and ethical caseload numbers, benefits available to staff that provide mental and physical health and wellness support, and supportive, collaborative, connection-based relationships between staff members (Amateau et al., 2022).

Trauma Informed Practice

Trauma Informed Practice refers to the strategies and therapeutic interventions a counselor may utilize in response to their knowledge of the pervasiveness and impacts of trauma on the clients they serve (Szczygiel, 2018). Trauma informed practices may include a counselor seeking out more information about the impact of a specific type of trauma and how that trauma may impact or hinder the therapeutic process if not

approached with care and a trauma informed lens (Szczygiel, 2018). Trauma informed therapeutic practice may also include the counselor's knowledge of the neurological, physiological, and psychological impacts of trauma regardless of when the trauma occurred or the severity of the trauma (Szczygiel, 2018). Counselors with this knowledge may then proceed with a more holistic therapeutic approach to be mindful of these impacts and increase the effectiveness of the therapeutic interventions utilized (Szczygiel, 2018).

Culturally Responsive Trauma Informed Care

Culturally responsive TIC adds a layer of perspective and complexity from which to view the impact and context of trauma (Meléndez Guevara et al., 2021). This approach could include better understanding the impact of systemic oppression and racism that leads to increased risks of health disparities and exposure to traumatic experiences and the trauma of others (Meléndez Guevara et al., 2021). Culturally responsive TIC also includes being aware of aspects of an individual's culture that may increase their likelihood of having experienced more ACEs compared to the general population (Meléndez Guevara et al., 2021). Culturally responsive TIC also includes being aware of and understanding cultural values, norms, and strengths that can be utilized to promote positive therapeutic outcomes and decrease the impacts of trauma (Meléndez Guevara et al., 2021).

Trauma Informed Care Outside of Mental Health

TIC has been and continues to be implemented and studied in various settings outside of mental health services. Poldon et al. (2021) conducted a study including

interviews of 8 sexual abuse nurse examiners and the results indicated support for TIC in this setting as well. Nurses reported positive results, including developing safe nurse patient relationships and nurses reporting feeling like they did the right thing for their patients, when they understood the importance of the individual's experience, connection between the patient and nurse, and the client needing to have choice throughout services.

Del Jones et al. (2022) highlighted an organization utilizing TIC frameworks to develop an organization response for staff vaccine hesitancy in response to the COVID-19 pandemic. This organizational response included aspects of cultural humility in being aware of historical, race-based trauma, as well as other causes of fear and anxiety related to vaccination.

Consumer researchers are also starting to be more mindful of TIC and the implications in their realm of work (Crosby et al., 2023). Crosby et al. (2023), utilized a trauma informed approach to improve their qualitative data collecting approach as they interviewed consumers to get feedback on various products. The results of this study supported TIC as a path to creating a safer space for consumers so they may share more accurate and meaningful data for market research purposes (Crosby et al., 2023). This study highlighted the lack of consumer voice in terms of marginalized populations and how using a trauma-informed approach could provide more inclusivity in market research (Crosby et al., 2023).

Literature Review Related to Other Key Concepts

Community Mental Health

When John F. Kennedy signed the Community Mental Health Act in 1963,

centers for healthcare began to appear in communities across the country (Thornicroft, 2011). This act was intended to shift mental health care from formal institutions to community-based centers. This shift meant that those previously institutionalized for mental health diagnoses were now released and directed to get their mental health care in their community. This was challenging because these community-based centers were not funded enough to meet the needs of the community in this way. Initially, these centers were tasked with providing care for a wide array of mental health disorders including treatment and prevention. Having this wide range of concerns being addressed in these community-based centers was not sustainable and the centers began to narrow their focus while referring higher need community members to additional resources. In previous decades, the community mental health system has seen advancements in focusing more on recovery and less on institutionalization and the emergence of evidence-based practices. The intention of the community mental health system is to provide care and prevent further suffering by community members struggling with mental illness, their family members, workplaces, and the community they live in.

Despite advances over the decades, including additional funding and more accessibility to services, there continues to be deficits in terms of continuity of care, quality of care, accessibility for all community members, and equitable services (Thornicroft, 2011). There is a shortage of counselors and psychiatrists that will work in community mental health settings due to the low pay and stressful work conditions (Alegría et al., 2022). Many of these issues can be deduced to an emphasis on funding, appeasing stakeholders, and turning profits rather than a focus on overall community and

individual mental health care and addiction services as the system was initially designed for (Thornicroft, 2011). Community mental health funding has been an agenda for recent administrations with the most recent Biden administration including 1.6 billion dollars for community mental health in 2022, and 4.6 billion dollars in 2023 (Alegría et al., 2022; Latest Content, n.d.).

Counselors working in community mental health settings face numerous challenges. Oftentimes, counselors in this setting are asked to take on multiple roles increasing their workload exponentially while also being tasked with roles for that they are not adequately trained to perform (Li et al., 2022). Counselors working in community mental health often perceive that they are at an increased risk of violence because they work primarily with individuals experiencing a mental health diagnosis (Li et al., 2022). This perception could be influenced by stigma and bias toward those with mental health diagnoses coupled with previous personal negative experiences working in mental health and/or hearing others' negative experiences working with this population (Li et al., 2022). Either reasoning could lead to increased stress levels for counselors.

Racial disparities exist in community mental health care. Populations of color are more likely to need mental health care in a community mental health setting, yet this population is less likely to access this care due to several factors including mistrust in medical professionals stemming from a history of racism and discrimination in medical settings (Alegría et al., 2022). To truly decrease disparities using the community mental health model, the system will need to acknowledge and respond to individual, structural, and systemic factors that have historically increased disparities and inequities for

populations of color (Alegría et al., 2022).

Clients seeking services in a community mental health setting are more likely to have multiple traumatic experiences in their histories and less likely to be seeking services based on a one-time traumatic event like a car accident, crime, or natural disaster (Terr, 1991).

Regional Programs and Services

Counselors providing services in community mental health settings are likely to meet individuals with more severe trauma histories. Researchers in Philadelphia administered the Post Traumatic Diagnostic Scale to 10,260 individuals seeking services in community mental health settings and found that 58.2% of the participants met the criteria for PTSD that is significantly higher than the 8.3% reported in the general population (Pincus et al., 2022). Providing therapeutic services to this population results in counselors having daily exposure to the trauma of others, which could result in Secondary Traumatic Stress.

In Texas, there are several programs set up to provide health and mental health care for citizens. One such program is the Department of Family Protective Services (DFPS) Prevention and Early Intervention (PEI) Program. This program is tasked with preventing and responding to child abuse and other negative outcomes for children to include child abuse, neglect, juvenile delinquency, runaway youth, and truancy (DFPS Prevention and Early Intervention, n.d.). Services within PEI are voluntary and free of charge for all families with children ages zero to eighteen years of age. Services include counseling, case management, youth skills groups, parenting classes, and support. PEI

does not provide services, but rather funds local entities with state dollars to provide these services to the communities they serve (DFPS Prevention and Early Intervention, n.d.). PEI also provides training, conferences, and networking opportunities for staff from each organization funded. PEI has an annual budget of 121 million dollars and this program reached over sixty thousand youth in 2022 as indicated in their last report (*Prevention and Early Intervention Outcomes Rider 20 Outcomes Report*, 2022). Additionally, this report indicated that 97 percent of youth engaged with this program remained safe from abuse or neglect and did not become involved with the juvenile justice system (*Prevention and Early Intervention Outcomes Rider 20 Outcomes Report*, 2022). This report includes 62 pages of data on client outcomes and overall community output, but there is no mention of any data on staff outcomes and overall wellness. Other states have similar programs and initiatives.

Secondary Traumatic Stress

The term Secondary Traumatic Stress (STS) became popular in the 1970s as research into the trauma response gained popularity as well (Figley, 1995). STS occurs when an individual experiences a trauma response by learning of the trauma of another person or people (Figley, 1995). Figley (1995) described STS as being, “natural, predictable, treatable, and preventable” (p. 4). Many counselors working in community mental health experience the effects of STS as they are repeatedly exposed to the trauma of the clients in their care as clients recount their traumatic experiences as a part of the therapeutic process.

Shoji et al., 2015) posited that while STS could lead to job burnout, health care

providers are also much more susceptible to the impact of STS if they are already feeling burned out in their current job role. This study provides support for the importance of workplace culture and counselor wellness in decreasing the impact of the cognitively, emotionally, and physically challenging work of providing therapy to populations that have experienced elevated levels of trauma. Additionally, if counselors are experiencing STS, they are more likely to harm the clients in their care that have already experienced trauma (Figley, 1995). Sutton et al. (2022) found that STS can significantly impact a counselor's ability to make effective clinical judgements and facilitate a helpful therapeutic relationship with clients.

The impact of STS is widespread and includes physical and psychological symptoms. These symptoms include headaches, fatigue, insomnia, relational issues, depression, anxiety, and an overall decrease in job satisfaction (Alavi et al., 2022). STS can have an impact on the organization the counselor is working for as well. These impacts include a higher rate of counselor absences and tardiness as well as a higher rate of turnover that impacts the organization, staff, and the individual counselor as well (Alavi et al., 2022). In addition, each of these structural impacts could cause a decrease in the overall quality of care provided to the clients served (Alavi et al., 2022).

Many researchers have focused their work on how to cope with STS and ways to mitigate the negative impacts of STS. Coping strategies for handling STS can be adaptive or maladaptive depending on each context in which the coping strategy is being used (Vukčević Marković & Živanović, 2022). For example, Vukčević Marković and Živanović developed a quantitative study using the COPE inventory that included 288

participants who were working with refugees and found that the most adaptive coping strategy for mitigating the impacts of STS is a counselor's robust support system including friends and family. Workplace social support was also shown to be supportive in decreasing the impact of STS. This includes supervisor support, support from the organization, and support from coworkers in the field along with the role of humor and positive reframing that also showed promise in helping individuals experiencing STS cope with their symptoms. If counselors can reframe or reinterpret situations with a positive perspective, they may experience fewer negative symptoms from the exposure to the traumatic experiences of others. All these aspects of coping with STS support the need for positive and supportive workplace culture and support of a work/life balance for staff interacting with clients that have elevated levels of reported trauma.

Burnout, vicarious trauma, and compassion fatigue are often used synonymously with STS, but these constructs have differing definitions. Compassion fatigue more so relates to the emotional exhaustion that may occur when an individual is working with clients that are in pain, physically or mentally, and they are sharing these experiences with the counselor (Figley, 1995). Burnout refers to the overall exhaustion which could include physical and mental exhaustion that may result from experiencing STS (Guseva Canu et al., 2021). VT is similar to STS in that the symptoms are similar, and the catalyst is being exposed to the traumatic experiences of others, however, STS typically has a sudden onset while vicarious trauma builds over time when a counselor is repeatedly exposed to the traumatic experiences of others (Bride et al., 2004; Kounenou et al., 2023).

Maladaptive Coping Strategies

There are also maladaptive strategies for coping with STS that can add to the negative impacts of STS and stress in general. Of those researched, avoidant strategies like using drugs, alcohol, or tobacco to cope with negative experiences were shown to positively impact the correlation between STS and the coping strategy (Vukčević Marković & Živanović, 2022). The more a counselor turns to these avoidant strategies, the more likely they are to have increased STS symptoms. Counselors who used passive coping strategies were also more likely to have increased STS symptoms (Vukčević Marković & Živanović, 2022). The use of both avoidant and passive coping strategies was shown to be predictive for symptoms of burnout, Post Traumatic Stress Disorder symptoms, distress, and depression as well as STS (Vukčević Marković & Živanović, 2022).

Post Traumatic Stress

Post Traumatic Stress (PTS) occurs when an individual has a traumatic experience and then experiences lasting effects to include insomnia, irritability, fatigue, headaches, and being easily startled (Miller et al., 2022). The symptoms of PTS mirror the symptoms of STS. The difference between these two constructs is that PTS occurs when an individual experiences a direct traumatic experience or threat of danger whereas STS is the result of indirect exposure to traumatic experiences of others (Miller et al., 2022). Counselors are at a higher risk for secondary exposure to trauma as they listen to the traumatic experiences and stories of their clients in the therapeutic setting (Miller et al., 2022).

Miller et al. (2022) measured the post-traumatic stress symptoms experienced by 31 counselors working with child abuse survivors in a community mental health setting and found that over 40% of counselors in this study reported a level of symptomology indicative of a Post Traumatic Stress Disorder (PTSD) diagnoses. This study further showed a positive correlation between two factors, counselors exhibiting experiential avoidance and difficulty with emotion regulation, and a higher prevalence of Post Traumatic Stress symptoms (PTSS; Miller et al., 2022).

Post-Traumatic Growth

The impact of trauma is typically explained as the negative symptoms experienced by individuals, but the consequences of an individual's traumatic experience can also be positive (Barnicot et al., 2023). The positive shifts and changes for individuals that have experienced on-going traumatic events includes increases in personal strength, increased life appreciation and satisfaction, reorganization of priorities, and a greater focus on interpersonal relationships. Barnicot et al. (2023) surveyed 854 staff members working in community mental health settings in the United Kingdom during the COVID-19 pandemic and they found that those who experienced post-traumatic growth had a lower risk of experiencing STS. However, they also found that staff working in community mental health settings were less likely to experience post-traumatic growth than their counterparts working in different settings.

Summary

Numerous studies have been conducted focusing on the efficacy of TIC in various settings and contexts. Most of the current literature focused on outward based strategies

for implementing TIC. The focus of this work has been on the clients, patients, or students being served. As the literature has provided ample support for TIC being an effective strategy for promoting positive outcomes the focus is now shifting to include the experience of staff providing services to the populations being served. While this shift results in new research and studies being conducted, there are many opportunities to fill gaps in this research. To address a noted gap in the research literature, I explored the relationship between counselor attitudes toward TIC and the severity of Secondary Traumatic Stress experienced by counselors working with clients in community mental health settings. In chapter three, I discuss the methodology I used to study this relationship and answer my research question.

Chapter 3: Research Method

TIC has been shown to have positive impacts on clients and counselors in a variety of settings (Goddard, 2020). Current research has mostly focused on positive outcomes for clients and how these outcomes positively impact counselors including job satisfaction and wellness (Damian et al., 2017; Goddard et al., 2020; Passmore et al., 2020; Schmid et al., 2020). The purpose of this study was to investigate the relationship between counselor attitude related toward TIC and the severity of STS experienced by counselors working with clients in community mental health settings. In this chapter, I outline the details of the methodology for this study. I discuss my reasoning behind choices in sampling procedures, measures utilized, data analyses methods. I also summarize the ethical considerations, including ethical procedures and any threats to validity.

Research Design and Rationale

For this study, I used a quantitative research design with a survey methodology. This design is appropriate for this study because I sought to better understand the potential relationship between two variables: counselor attitude toward TIC and the severity of STS experienced by counselors in a community mental health setting. While attitude toward TIC may not adequately measure the level of TIC implementation in a specific agency, it may show how effective the implementation strategies are in the reflection of their staff's perception of TIC.

The independent variable in this study was counselor attitudes toward TIC, as measured by the ARTIC-45 Scale seven subscales. I decided to use counselor attitudes

related to TIC as an independent variable to determine if counselor perspective on TIC had an impact on their experienced level of STS. I chose to focus specifically on counselors working in community mental health settings because these counselors are more likely to encounter secondary trauma as they listen to the trauma histories of their clients (Muzik et al., 2013). I measured counselor attitude toward TIC with the ARTIC-45 Scale because this measure is the only measure that focuses on TIC implementation and has subsequent studies showing validity (Baker et al., 2016; Baker et al., 2021). This measure has been used numerous times in school settings as well as mental health settings (Bosk et al., 2020; MacLochlainn et al., 2022; Galvin et al., 2020). This method was easily accessible online, and researchers in university settings are allowed to use the measure for free for studies of up to 200 participants, making this measure cost effective as well. The dependent variable in this study was the severity of STS experienced by counselors (LPCs, LPC-Associates, LMFTs, and LMFT-Associates) working in community mental health settings, as measured by the STSS total score. The results of this study add to the literature in support of TIC utilization and implementation and, more specifically, the positive impact this work can have on counselors.

I utilized survey methodology by disseminating an online survey via Survey Monkey to counselors working in community health settings. I chose an online survey methodology to increase the reach of the study, convenience for participants, and an increase in anonymity experienced by potential participants of the study (Groves, 2009). This type of methodology also does not require as many resources as other types of methodologies, which is beneficial (Groves, 2009). Using a systematic approach like a

survey research method also increases the likelihood that the results will be generalizable to the population I intend to study (Groves, 2009).

Methodology

This study utilized a quantitative research design with a survey methodology to answer the research question: What is the relationship between counselor attitude toward trauma informed care, as measured by the ARTIC-45 Scale seven subscales, and the severity of STS, as measured by the STSS total score (little to no STS = 27 or less; mild STS = 28-37; moderate STS = 28-43; high STS = 44-48; severe STS = 49+), among counselors providing therapeutic services in community mental health settings? In this section I discuss the study population, sampling, and sampling procedures, procedures for recruitment, participation, and data collection.

Population

For this study I focused on counselors providing therapeutic services in community mental health settings. This included LPCs, LPC-Associates, LMFTs, and LMFT-Associates. I chose counselors working in community mental health because of the high prevalence of trauma in clients seeking services in this setting resulting in counselors being exposed to more secondary trauma in this setting (Muzik et al., 2013). Community mental health settings also see higher rates of counselor turnover (Adams et al., 2019; Bukach et al., 2017). Adams et al. (2019) studied 247 counselors in 28 community mental health agencies and found that the turnover rate in these agencies was 39%. Bukach et al. (2017) examined turnover in community mental health settings in Ohio by analyzing data from 42 randomly selected community mental health agencies

and found the turnover rate to be 26%. Clients seeking services in this setting are also characterized as being historically oppressed and marginalized while also experiencing higher rates of poverty decreasing choice in setting to receive therapeutic services (Muzik et al., 2013). For these reasons it is important to invest in counselor wellness to ensure those getting services in this setting are getting equitable, high-quality services.

I was open to including participants of all genders, races, ethnicities, and geographical locations and much of the diversity of the counseling profession was reflected in the study participants. The participants were limited to LPCs, LPC-Associates, LMFTs, and LMFT-Associates providing therapeutic services in community mental health settings. The community mental health settings could serve adults, children, or both, but there must be some level of TIC implementation or training present at the site. This study did not include a required minimum or maximum number of years working in the counseling field, but this information is documented in the demographics section of the survey.

Sampling and Sampling Procedures

My research participants included those who completed the survey. I used the G*Power statistic (Version 3.1.9.7) to identify the appropriate sample size for a regression analysis. The criteria I used for this statistic included power of $1 - \beta = .80$, medium effect size $f2(V)=0.15$, alpha level $\alpha = .05$. I used the medium effect size as this was noted as reasonable for this type of study and data analysis in the literature (Warner, 2013). The initial calculation resulted in a necessary sample size of 103 participants. After adding 20% to plan for the approximate response rate, the final required sample

size was 124 participants.

Procedures for Recruitment, Participation, and Data Collection (Primary Data)

I sent surveys out to counselors working in community mental health settings utilizing community partners that had agreed to share my survey with their employees. These community partners included several large community mental health organizations in Texas. I used the snowball sampling method by encouraging participants to send the survey link to others they know that fit the criteria to participate in the study. The survey email was sent weekly for three weeks to reach the participant total needed per the G*Power statistic.

The email sent included the SurveyMonkey link along with the informed consent. The informed consent informed the participants of the voluntary nature of this study along with a statement regarding the anonymity and confidentiality of their survey responses. Participants were also notified that the study was voluntary throughout the process, meaning they could decide to leave the study at any time, for any reason, without any kind of penalty. Lastly, I noted that their program or organization leadership would have access to the overall results of the study, but not their individual survey responses nor any identifiable information.

The SurveyMonkey link included the informed consent information and an option to proceed or leave the survey. If the participant decided to proceed, they were then asked to answer demographic questions (age, gender, race/ethnicity, geographic location, type of licensure held, number of years in the field, number of years at their current site, and number of hours of therapeutic services provided to clients per week), a question asking

if they currently work with clients in a community mental health setting, a question asking if their work setting has implemented any level of TIC, and if they are a licensed counselor or associate counselor. If they answered “no” to either of the last three questions they were taken to the end of the survey. If they answered “yes” to these questions they first took the ARTIC-45 Scale assessment followed by the STSS, which were both directly loaded into Survey Monkey. Upon completion of these items, they were taken to a page providing resources if they feel any type of stress or negative feelings associated with completing the survey. This page also included verbiage thanking them for their input and providing contact information should they have any questions or if they would like to inquire about the results of the study.

I chose to utilize SurveyMonkey due to the options the website provides, which included the ability to fully customize surveys to meet the needs of the study and collect the necessary data for the data analysis (SurveyMonkey, 2023). This platform also allowed the user to download the data to then analyze using more sophisticated data analysis software (SurveyMonkey, 2023). Lastly, this software was noted as being HIPAA compliant with several features that increase the safety and confidentiality of the data collected (SurveyMonkey, 2023). Once all the data was collected and the necessary participant total was reached, I ensured the data was de-identified, and then I entered the data into IBM SPSS Statistics Version 29 for data analysis. I ensured the data storage during each phase of the study, before, during, and after, was compliant with Walden’s Institutional Review Board (IRB) requirements. I shared the results with the participating organizations and any participants that requested the results.

Instruments

For this study I utilized a demographic survey and two valid and reliable instruments to gather the data needed for the data analyses to address the research questions. The first instrument I used was the ARTIC-45 Scale, which was used in several studies that reported high levels of reliability and consistency in measuring participants' perspectives on trauma-informed care (Baker et al., 2016; Blanton et al., 2022; MacLochlainn et al., 2022). The second instrument I chose for this study was the STSS. This instrument was widely used, also reporting high levels of consistency and reliability, to measure the symptoms experienced by helping professionals that have been exposed to the traumatic experiences and shared stories of the clients they provide services to (Bride & Kintzel, 2011; Duffy et al., 2015; Setti & Argentero, 2012). Additionally, I chose the ARTIC-45 Scale because it was free for students to utilize when conducting research, and I was given permission by the creators. I also chose the STSS because it was free for anyone to access and utilize.

ARTIC Scale

Baker et al. (2016) created the ARTIC Scale to measure perspective and understanding of TIC by professionals working in the school system, mental health professional roles, other human services settings, and any setting where staff interact with individuals that have experienced traumatic life events. This assessment was created in response to the barriers that exist when an organization is trying to implement TIC in their setting and the need for staff to invest and support such implementation (Metz et al., 2007). The assessment was based on a previous instrument called Risking Connection,

which measured attitude change but only in the context of the efficacy of TIC staff training (Brown et al., 2012).

The assessment has two focuses, schools and human services, and there are three survey lengths to choose from, 10-item, 35-item, and 45-item (Baker et al., 2016). The 10-item version only provides an overall score and does not include subscales (Baker et al., 2016). This version is only suggested for human services organization that are time limited or lack necessary resources for the 35 or 45-item versions (Baker et al., 2016). The 35-item version includes the overall score and scores for five of the possible seven subscales (Baker et al., 2016). This version is suggested for staff working in agencies that have not yet begun to implement TIC or if the staff member has limited knowledge of TIC (Baker et al., 2016). For the purposes of this study the 45-item human services focused assessment was used.

There are seven subscales that were analyzed in relation to the total score of the STSS. There are five core and two supplementary subscales, and the subscales include: "underlying causes of problem behavior and symptoms, the impact of trauma, responses to problem behavior and symptoms, on-the-job behavior, self-efficacy and work, personal support of trauma-informed care, and system-wide support for trauma-informed care" (Baker et al., 2016). This version is recommended for staff that have some knowledge of TIC and their work setting has at least begun the process of implementing TIC. When participants are completing the instrument, they are given two opposite statements, one in favor of TIC and one unfavorable to TIC. Participants are given a 7-point, bipolar Likert-scale to measure their agreement or disagreement with the opposite statements. An

example of two opposite statements to consider in this assessment include: “the clients were raised this way, so there is not much I can do about it now” and “the clients were raised this way, so they don’t yet know how to do what I am asking them to do.” This assessment is scored based on mean scores instead of total scores. Each subscale produces a mean, and then a total mean score is calculated, with a higher mean being more in favor of TIC.

To validate this measure, Baker et al. (2016) researchers disseminated the survey in different forms (45-item and 35-item questionnaires) for two settings (schools and human service settings) to 760 staff employed in these settings. These findings support the validity and reliability of the measure. They used a confirmatory-factor analysis, which resulted in support for the assessment structure. This study also provided support for the internal consistency of the measure and 6-month test-retest reliability, specifically for the 35-item and 45-item measures. They reported that that the ARTIC Scale had differing levels of internal consistency. The 45-item measure had excellent internal consistency with Cronbach’s alpha of $\alpha = .9$, the 35-item measure results were $\alpha = .91$, and the 10-item measure results were $\alpha = .82$.

This instrument has been utilized and documented numerous times in studies in various settings with different intentions. Black et al. (2022) utilized the ARTIC Scale, 35-item, human services focused assessment to study the impact of TIC initiatives and training within the organization. This assessment supported this study in providing a measure to compare baseline data on staff attitudes toward TIC and then a comparison measure after initiatives and training programs were in place (Black et al., 2022). Another

study focused on the attitudes toward TIC for play therapists and how this impacted their investment in social advocacy (Chase & Post, 2022). In this study, they also utilized the 35-item, human services focused ARTIC Scale. Study results indicated a positive relationship between ACEs, ARTIC, and cultural humility (Chase & Post, 2022).

I chose this instrument because it can be completed online increasing anonymity and confidentiality for participants. It is brief with the creators estimating ten to twelve minutes to complete the 45-item measure (Baker et al., 2016). I also chose this instrument because it is easily accessible through an application process and provided for free for students conducting research with 200 participants or less. I submitted an application and was approved to use this instrument for this study.

Secondary Traumatic Stress Scale

Bride et al., (2004) created the Secondary Traumatic Stress Scale (STSS) to measure the severity of trauma related symptoms resulting from an individual's exposure to the traumatic experiences of others. Exposure to the traumatic experiences of others could include hearing clients' stories and experiences in a therapeutic setting (Bride et al., 2004). This assessment was created using the PTSD diagnostic criteria from the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders, with each of the 17 assessment items coinciding with a symptom of Post Traumatic Stress Disorder as listed in the DSM-IV-TR (Bride et al., 2004).

This 17-item assessment measures three subscales that include Intrusion (items 2, 3, 6, 10, ,13), Avoidance (items 1, 5, 7, 9, 12, 14, 17), and Arousal (items 4, 8, 11, 15, 16) symptoms using a five choice Likert-scale format (Bride et al., 2004). When participants

complete this assessment, they are instructed to read 17 statements and indicate how frequently that specific statement has been true for them in the previous 7 days (Bride et al., 2004). Utilizing the five choice Likert-scale, participants can choose 1 = never to 5 = very often (Bride et al., 2004). The assessment includes five items that measure the subscale of Intrusion, seven items that measure Avoidance, and five items that measure Arousal (Bride et al., 2004). Sample assessment statements to consider using the Likert-scale include:

1. I felt emotionally numb.
2. My heart started pounding when I thought about my work with clients.
3. It seemed as if I was relieving the trauma(s) experienced by my client(s).
4. I had trouble sleeping.

This assessment is scored by adding up the subscales scores separately first and then adding them all together for a grand total score (Bride et al., 2004). The higher the total assessment score, the more frequently the participant is experiencing the symptoms of Secondary Traumatic Stress (Bride et al., 2004). Bride (2007) established three strategies for scoring this assessment. The first method is described as the algorithm method, which states that if a participant scores a three or higher (occasionally, often, or very often) on one or more of the items in the Intrusion subscale, three items or more in the Avoidance subscale, and two items or more on the Arousal subscale then that participant meets the diagnostic criteria for Post Traumatic Stress Disorder due to Secondary Traumatic Stress (Bride, 2007). The second method noted by Bride (2007) is to use the cutoff score of 38 to classify results as meaning a participant has Post

Traumatic Stress Disorder caused by Secondary Traumatic Stress if their score is 38 or higher, and they do not if they have a score lower than 38 (Bride, 2007). The third and most widely used scoring method is to compare a participant's total score to the normative data from the validation study (Bride, 2007). Utilizing this method means if a participant's score is lower than 28 the result is "little or no Secondary Traumatic Stress," if their score is between 28 and 37 the result is "mild Secondary Traumatic Stress," if their score is between 38 to 43 the result is "moderate Secondary Traumatic Stress," if their score is between 44 to 48 the result is "high Secondary Traumatic Stress," and if their score is 49 or higher the result is "severe Secondary Traumatic Stress" (Bride, 2007).

Bride et al. (2004) found this measure to be both reliable and valid. Bride et al. studied 294 social workers in a southeastern state in the United States utilizing the Secondary Traumatic Stress Scale and reported that the Secondary Traumatic Stress Scale overall had good internal consistency with a reported Cronbach's alpha of $\alpha = .93$ (Bride et al., 2004). Additionally, statistics for each subscale were reported as follows: Intrusion $\alpha = .80$, Avoidance $\alpha = .87$, and Arousal $\alpha = .83$. Bride et al. also tested the convergent and discriminant validity of this instrument, and both claims are supported. Researchers noted that the correlation between frequency and extent were mildly statistically significant with the explanation being that if a counselor is exposed to the trauma of others, it is not automatically true that they will or have experienced trauma symptoms. Some counselors may be exposed to the trauma of their clients and be unaffected by the experience due to the way their brain responded to the stressor. Bride et

al. also used structural equation modeling with the hypothesis that all responses to the Secondary Traumatic Stress Scale could be understood utilizing the three subscales (Avoidance, Intrusion, Arousal) and found support for this claim as well.

This instrument has been widely used in several settings, contexts, and with different helping professionals from diverse backgrounds and geographic locations. The Secondary Traumatic Stress scale has also been adapted to include additional languages including Japanese, Chinese, French, and Italian (Kitano et al., 2021; He et al., 2022; Jacobs et al., 2019; Setti & Argentero, 2013).

Devilly et al. (2009) utilized the Secondary Traumatic Stress Scale in their study focusing on vicarious trauma, secondary traumatic stress, burnout, and workplace culture. This study included 152 mental health professionals working with clients in Australia (Devilly et al., 2009). The results of this study supported the need for healthy workplace conditions to decrease Secondary Traumatic Stress experienced by mental health professionals (Devilly et al., 2009). Devilly et al. (2009) found this measure to be valid and reliable as well. Researchers noted a limitation of the measure being that it is difficult to decipher between Secondary Traumatic Stress and burnout (Devilly et al., 2009).

I asked study participants to complete this assessment thinking about the last seven days working with clients which is in accordance with the STSS validated assessment measure instructions (Bride et al., 2004). I chose this assessment because it is brief, can be administered online in a survey format increasing anonymity and confidentiality, and this assessment is accessible and free to use. There is not a requirement for written permission from the creator of this instrument to use it as a part

of a research study.

Demographic Questionnaire

I created and utilized a demographic questionnaire. This section included questions regarding age, gender, race/ethnicity, geographic location (rural or urban), type of licensure held (Licensed Professional Counselor, Licensed Professional Counselor-Associate, Licensed Marriage and Family Therapist, or Licensed Marriage and Family Therapist-Associate), number of years working in the counseling field, number of years at their current site, and number of hours of therapeutic services provided to clients per week. There were additional questions asking if they currently work with clients in a community mental health setting and if that site has at least some level of TIC implementation. The purpose and intention of the demographic questionnaire was to gain a better understanding of the study participants (Allen, 2017).

Operationalization of Variables

The independent variable in this study was counselor attitude related to TIC as measured by the Attitudes Related to Trauma Informed Care (ARTIC)-45 Scale seven subscales. The dependent variable was the severity of Secondary Traumatic Stress experienced and self-reported by counselors working in community mental health settings as measured by the Secondary Traumatic Stress Scale (STSS) total score (little to no STS = 27 or less; mild STS = 28-37; moderate STS = 28-43; high STS = 44-48; severe STS = 49+). In this section I detail the operational definition of the independent and dependent variables, how they are measured, and what the scores of each assessment signify.

Perspective regarding Trauma Informed Care: The attitudes and understanding of Trauma Informed Care from the perspective of counselors. This variable is continuous and measured at the interval level utilizing the Attitudes Related to Trauma Informed Care (ARTIC)-45 Scale. In this assessment, respondents are asked to consider two opposite statements, one in favor of TIC and one that is unfavorable of TIC (Baker et al., 2016). The assessment has two types (school or human services) and three lengths (10 question, 35 question, and 45 question), but for the purposes of this study respondents completed the 35 question, human services focused questionnaire. The variable includes subscales of underlying causes of problem behavior and symptoms, responses to problem behavior and symptoms, empathy and control, self-efficacy at work, and reactions to the work. Baker et al. (2016) conducted a study in which 760 human services or health care providers completed the questionnaire. Results supported factor structures for the ARTIC-35 and supported the reliability of the measure (Baker et al., 2021). An example of two of the opposite statements to consider from this scale are, "clients learning, and behavior problems are rooted in their behavioral or mental health condition," and "clients' learning and behavior problems are rooted in their history of difficult life events" (Baker et al., 2016, p. 67).

Severity of Secondary Traumatic Stress: The severity of trauma symptoms experienced by counselors who have been exposed to the traumatic experiences of their clients (Figley, 1995). This variable is considered continuous and is measured at the interval level utilizing the Secondary Traumatic Stress Scale. This variable includes subscales of Avoidance, Intrusion, and Arousal. Respondents to 17 statements to consider

in the last seven days using a five-point Likert-scale with responses ranging from 1 = never to 5 = very often (Bride et al., 2004). Subscales are added separately and then together for a grand total resulting in a range from "little to no Secondary Traumatic Stress" which is a score lower than 28 to "severe Secondary Traumatic Stress" which is a score of 49 or higher. An example statement to consider from this scale is, "I avoided people, places, or things that reminded me of my work with clients."

Type of licensure held: This variable is ordinal and was captured in the demographic questionnaire by the question, "which licensure do you currently hold?" There are four levels of responses: "Licensed Professional Counselor," "Licensed Professional Counselor-Associate," "Licensed Marriage and Family Therapist," "Licensed Marriage and Family Therapist-Associate."

Data Analysis Plan

In this section, I detail the software I used for data analysis as well as the strategy I used to clean and screen the data. I also reiterate the research question and associated hypotheses. Additionally, I discuss the statistical analyses I utilized to address the research question.

Software

I analyzed the data collected using a data analysis program, IBM SPSS Statistics Version 29. I chose this program as it has the capability to complete the data analyses needed for this study. This program is also user friendly for those that do not have a background in coding or experience with more sophisticated data analysis programs.

Data Cleaning and Screening

I cleaned the data manually as well as utilized SurveyMonkey and the SPSS software. I utilized SPSS functionalities to include graphing and plots to better understand the distribution of the data including any outliers that could have interfered with the statistical analyses results and usefulness. Outliers can contaminate data analysis by having an unfair influence on the analysis results due to their extreme difference from the mean (Osborne, 2008).

One outlier existed in the data. I invested additional time looking at the survey responses for that participant and decided to eliminate that data point. I utilized SurveyMonkey to detect any suspicious survey responses that may have also unduly impact the analysis results. This included incomplete or inconsistent survey responses. If demographic information is not completed the data was still included, but if there were missing responses for either of the two assessments, the Attitudes Related to Trauma Informed Care or the Secondary Traumatic Stress Scale, the data was eliminated.

Research Question

RQ1: Is there a statistically significant relationship between counselor attitude toward TIC, as measured by the seven subscales of the ARTIC-45 Scale, and the severity of STS, as measured by the STSS, among counselors working in community mental health settings?

$H_0$1: There is no statistically significant relationship between counselor attitude toward TIC, as measured by the seven subscales of the ARTIC-45 Scale, and the severity of STS as measured by STSS among counselors working in community

mental health settings.

H_a1: There is a statistically significant negative correlation between counselor attitude toward TIC, as measured by the seven subscales of the ARTIC-45 Scale, and the severity of STS as measured by the STSS among counselors working in community mental health settings.

Data Analysis

For this study I utilized SPSS Statistics Version 29 to analyze the data collected. My analyses included descriptive statistics to better understand the participant group. I used a chi-square test to compare the participant group to the counseling profession, noticing any similarities or differences (Warner, 2013). I utilized Cronbach's Alpha to test the internal consistency of each scale to better understand how closely related the items within each measure were (Warner, 2013). The independent variable was counselor attitude toward TIC as measured by the Attitudes Related to Trauma Informed Care (ARTIC) – 45 Scale. The dependent variable was severity of secondary traumatic stress as measured by the Secondary Traumatic Stress Scale.

I utilized a multiple regression statistical analysis to test the hypotheses. This statistical analysis is often used to compare multiple independent variables with a single dependent variable (Warner, 2013). These analyses were helpful in comparing the ARTIC-45 Scale's seven subscales, the predictor variables, with the results of the Secondary Traumatic Stress Scale, the dependent variable.

Threats to Validity

Threats to validity can be either internal or external and, when present, these

challenges could provide doubt regarding the results and if the results are accurately being depicted by the researcher (Creswell & Creswell, 2018). It is important for researchers to plan for any foreseeable threats to validity to ensure the integrity of the study as much as possible (Creswell & Creswell, 2018). One threat to external validity occurs when the population being studied does not accurately reflect the population as a whole and inaccurate generalizations are made about the results (Creswell & Creswell, 2018). In this study, participants responded to an email with a survey link making them non-probability or convenience sample (Creswell & Creswell, 2018). As the researcher, I did not know the makeup of the participants until the necessary total participant number was reached and I was able to analyze the data. To mitigate this potential threat to validity, I looked at the data and how the participants compare to the counseling profession as noted by the American Psychological Association (2023). I ensured that generalizations were accurate given the differences between the participants and the reported demographics of the counseling profession.

Another possible threat to validity is response bias or random responding. If a respondent does not feel motivated to complete the survey or if they are not invested in the meaning of the research and potential benefits of the research study, they may answer randomly or with bias (Osborne & Blanchard, 2011). This type of behavior can cause the data to be skewed or inaccurate (Osborne & Blanchard, 2011). To mitigate this potential challenge, included information in the informed consent regarding the voluntary nature of the study, that the participant could stop the survey at any time, and explained the meaning behind the study with the intention of increasing motivation and investment in

the work. Once data was collected, it was analyzed using different methods to identify responses that may have been biased, random, or inaccurate.

Social desirability bias is another potential threat to validity. Studies have shown that respondents may answer questions inaccurately because it increases their perceived social desirability (Osborne & Blanchard, 2011). This challenge was also mitigated in the informed consent which included information about confidentiality and anonymity of the study. These aspects were intentional and a part of the reasoning for choosing an online survey research method. Participants were able to complete the survey completely on their own without anyone knowing their responses or if they engaged in the study at all if that is what they choose.

Lastly, environmental factors may pose a threat to validity. Choosing an online survey research methodology has several benefits, but challenges are inherent as well. One of which is not being able to provide a consistent, confidential space that is free from any distractions for respondents to complete the survey (Creswell & Creswell, 2018). Respondents could have chosen to complete the survey at work which may increase their level of bias when answering the questions due to social desirability, a toxic work environment, or lack of confidential space. Respondents could also have decided to complete the survey while others completed the survey in the vicinity. To mitigate this potential challenge, I provided guidelines or suggestions for completing the survey which included completing the survey alone in a quiet, confidential space.

Ethical Procedures

The American Counseling Association (ACA) code of ethics (2014) discusses

ethical requirements for conducting research in several sections of the document. The first ethical guideline that must be adhered to is that of avoiding harm to participants and having a plan in place to respond to harm that is not avoidable (ACA, 2014, Standard A.4.a). The informed consent for this study presented the risks of participation up front to allow the participants to better understand what they were volunteering for. It was possible that certain survey questions may have impacted participants negatively by bringing up past experiences, memories, negative feelings, etc. The informed consent included resources for participants in case they found the survey triggering in any way. These resources included 911 for any potentially dangerous situations to include mental health crises or suicidal ideation. There was also a list of counseling resources and hotlines for additional needs that were not as time sensitive and potentially dangerous.

The ACA code of ethics (2014) also tasks researchers with adhering to local and federal laws, institutional requirements, and scientific standards when conducting research. Walden University has an Institutional Review Board (IRB) that ensures guidelines, laws, and ethical practices are being upheld, ensuring increased participant safety and research integrity (Walden University Center for Research Support, n.d.). I received official IRB approval for this study before I began collecting data.

To recruit participants, I sent a SurveyMonkey link via email to program leadership from different community mental health agencies. Leadership staff then sent the link to their staff that fit the participant characteristics for the study (LPCs, LPC-Associates, LMFTs, and LMFT-Associates). I also posted the SurveyMonkey link in social media groups for mental health professionals. Using these methods increased

confidentiality and anonymity for participants because I never had access to names, email addresses, location, program, or any other identifiable information. Study participants were not required to provide approval as this study does not require collection of or access to any protected health information.

When participants clicked on the survey link sent via email, they were taken to the informed consent page for this study. The informed consent page included all of the information required by ethical guidelines which included information pertaining to: confidentiality and any potential limits to confidentiality, potential risks of participating in the study, how study results would be shared, how information and survey responses would be stored, participant rights, and a statement notifying participants that they would not be contacted once the survey was completed (ACA, 2014, standard G.2.a). Also, within the informed consent there was information discussing the purpose of the study and potential implications and benefits that may be expected from survey results (ACA, 2014, standard G.2.a). Lastly, the informed consent page included a statement informing participants that the study was completely voluntary, and they were free to discontinue providing their survey responses at any point, for any reason without threat of any potential negative consequence to include, changes in employment or disciplinary action. Participants were reminded that survey results would not be sent to program leadership and the only results that would be shared would be the aggregate data.

HIPAA has strict guidelines for collecting and storing data related to research studies that includes protected health information. This study did not include collection of this type of information, however, the HIPAA guidelines for data storage were still

adhered to. This included storing data in a HIPAA compliant platform, like SurveyMonkey, and once data was downloaded from that program it was stored on my personal computer that is password protected.

Summary

The purpose of this quantitative study was to evaluate for the potential relationship between counselor perspective regarding TIC and the severity of Secondary Traumatic Stress experienced by counselors working with clients in community mental health settings. The target population for this study included Licensed Professional Counselors, Licensed Professional Counselor-Associates, Licensed Marriage and Family Therapists, and Licensed Marriage and Family Therapists seeing clients in community mental health setting. I used validated instruments to collect data. These instruments include the Attitudes Related to Trauma Informed Care (ARTIC)-45 Scale that measures the participants perspective regarding TIC and the Secondary Traumatic Stress Scale (STSS) that measures the prevalence and severity of symptoms experienced by participants related to their exposure to the trauma of others by way of shared stories or therapy session content. I also utilized a demographic survey to gather data related to age, gender, race/ethnicity, geographic location, type of licensure held, number of years at their current site, and number of hours of therapeutic services provided to clients per week to better understand the participant population. I utilized SurveyMonkey, an online survey platform and I utilized SPSS software to analyze the data.

The intention of this study was to add to the mounting literature in support of TIC implementation and support, not only for clients being seen in differing settings, but also

for counselors seeing clients in differing settings. The focus on community mental health is intentional because of the population characteristics for those seeking services in a community mental health setting to include not having access to additional services should the services offered in the community mental health setting lack quality or usefulness. Community mental health settings are also sites for interns working in graduate programs to become counselors and for counselors that have recently graduated creating a need for increased support of these staff members as they are beginning their counseling careers.

Chapter 4: Results

The purpose of this quantitative study was to better understand the relationship between counselor attitudes related to TIC, and the severity of STS among counselors providing therapeutic services in a community mental health setting. The research question was "Is there a statistically significant relationship between counselor attitude toward TIC, as measured by the seven subscales of the ARTIC-45 Scale, and the severity of STS, as measured by the STSS, among counselors working in community mental health settings?" The independent variable in this study was counselor attitudes related to TIC as measured by the ARTIC-45 seven subscales, that include underlying causes of problem behavior and symptoms, the impact of trauma, responses to problem behavior and symptoms, on-the-job behavior, self-efficacy and work, personal support of trauma-informed care, and system-wide support for trauma-informed care. The dependent variable for this study was the severity of STS as measured by the STSS (Baker et al., 2016).

In Chapter 4, I outline the results of this study. In the first section I detail the data collection process, present the descriptive statistics, and assumptions testing. In the second section, I highlight the data analyses findings per the research question and stated hypotheses. In the findings section, I present the statistical tests and probability values used to examine the degree to which each of the seven subscales of the ARTIC-45 were related to the severity of the STSS.

Data Collection

I received approval to conduct this study from the Walden University IRB on September 5th, 2023 (approval #09-05-23-1011155). The data for this study was collected via an anonymous online survey through the SurveyMonkey platform. No identifying information was collected from the research respondents. Snowball sampling was used as I emailed the survey link to several individuals that held leadership positions in community mental health settings that had agreed to share my survey link. I sent the survey link to these individuals once a week for 3 weeks. Respondents were also able to share the survey link with other counselors they knew that fit the inclusion criteria.

The final number of respondents included 184 individuals. However, nine respondents were eliminated from the data set because they did not meet the study criteria of being a counselor (LPC, LPC-Associate, LMFT, or LMFT-Associate). An additional 51 respondents were eliminated from the data set as these respondents did not complete the survey in its entirety, and one respondent was eliminated due to meeting the requirements of an outlier as this data point had residuals greater than three standard deviations (Laerd Statistics, 2023). The G*Power Statistic was analyzed during the proposal and when the 20% increase for response rate planning was added the final required sample size was 124. The steps highlighted above resulted in a final study sample of 124 respondents satisfying the minimum sample size.

The first page respondents encountered when they utilized the SurveyMonkey link included the informed consent. The informed consent informed the participants of the voluntary nature of this study along with a statement regarding the online survey

being anonymous and confidential. Respondents were also notified that this study was voluntary, and they could discontinue the survey at any time, for any reason, without penalty. The informed consent also included a section informing the respondents that their organization leadership would have access to the overall study results, but not individual survey responses or identifiers.

The final sample of 124 counselors reported being 89% female (n = 110). Data USA (n.d.), that analyzes U.S. Census Bureau data, reported similar statistics in that there are far more women, 72%, in the counseling field than men, 28%. Table 1 highlights descriptive data regarding the race and ethnicity of research participants.

Table 1

Frequency Distribution of Respondents Gender

		n	%
Valid	Cisgender Female	110	88.7
	Cisgender Male	9	7.3
	Non-Binary	4	3.2
	Transgender	1	.8
	Total	124	100.0

The race and ethnicity of survey respondents were mostly White or European American (77% or n = 96). Table 2 highlights descriptive data regarding the race and ethnicity of research participants. Respondents reported diverse geographical locations. Table 3 highlights descriptive data regarding the geographical location of research participants. The sample size included 60% LPCs (n = 75), 32%. Table 4 highlights descriptive data regarding the type of licensure for research participants.

Table 2

Frequency Distribution of Respondents by Race and Ethnicity

		N	%
Valid	Black or African American	2	1.6
	Asian or Pacific Islander	4	3.2
	Multiethnic or Multiracial	8	6.5
	Hispanic	14	11.3
	White or European American	96	77.4
	Total	124	100.0

Table 3

Frequency Distribution of Respondents by Geographical Location

		N	%
Valid	Suburb Near a Large City	39	31.5
	Small City or Town	35	28.2
	Large City	30	24.2
	Rural Area	20	16.1
	Total	124	100.0

Table 4

Frequency Distribution of Respondents by Type of Licensure

		n	%
Valid	Licensed Professional Counselor	75	60.5
	Licensed Professional Counselor Associate	40	32.3
	Licensed Marriage and Family Therapist	7	5.6
	Dually Licensed	2	1.6
	Total	124	100.0

Finally, respondents reported varying years of experience in the counseling field

with 6% of respondents reporting less than 1 year in the counseling field (n = 7), and 31% of respondents reported 10 years of experience or more in the counseling field (n = 39). Table 5 highlights descriptive data regarding the number of years of experience of research participants.

Table 5

Frequency Distribution of Respondents by Years of Experience

		n	%
Valid	Less than 1 year experience	7	5.6
	1 to less than 3 years experience	25	20.2
	3 to less than 5 years experience	27	21.8
	5 to less than 10 years experience	26	21.0
	10 years of experience or more	39	31.5
	Total	124	100.0

Data Analysis

First, I conducted several statistical analyses to ensure the multiple regression model was a good fit for this dataset. For the overall model, R^2 was 49.1% with an adjusted R^2 of 46.1% meaning that the independent variables included in the regression model explain 46.1% of the variance in the dependent variable. These results suggest a large effect size (Cohen, 2013). Next, I assessed the overall statistical significance of the model reviewing the ANOVA table. This table showed the subscales of the ARTIC-45 statistically significantly predicted the overall score of the STSS, $F(7,116) = 16.004$, $p < .001$, $R^2 = .46$.

Results

Table 6 includes descriptive statistics of this data set that include the range, mean, and variance for the seven subscales of the ARTIC-45 and the STS.

Table 6

Descriptive Statistics for Study Variables

	N	Range	Minimum	Maximum	Mean	SE	SD	Variance
Underlying Causes of Problem Behavior and Symptoms	124	2.86	4.14	7.00	5.6265	.05501	.61256	.375
Responses to Problem Behavior and Symptoms	124	3.14	3.86	7.00	5.8884	.06099	.67918	.461
On-The-Job Behavior	124	2.43	4.57	7.00	6.1924	.05245	.58411	.341
Self-Efficacy at Work	124	4.00	3.00	7.00	5.7327	.07856	.87484	.765
Reactions to the Work	124	4.14	2.86	7.00	5.8052	.07142	.79532	.633
Personal Support for Trauma-Informed Care	124	3.40	3.60	7.00	6.0758	.07083	.78878	.622
System-Wide Support for TIC	124	5.80	1.20	7.00	5.6097	.10575	1.17753	1.387
STS Total Score	124	50	0	50	19.26	1.017	11.321	128.161
ARTICTOTAL	124	2.73	4.27	7.00	5.8477	.04979	.55441	.307
Valid N (listwise)	124							

According to Laerd Statistics (2023) there are eight assumptions that must be met to allow a researcher to provide information regarding accuracy of predictions, assess if the regression model fits the dataset, identify variation of the dependent variable explained by the independent variable, and test the hypothesis. To meet the first two assumptions, the dependent variable must be continuous, and there must be two or more independent variables that are either categorical or continuous. The data measurements for the dependent and independent variables of this study meet the requirements for these

assumptions.

The third assumption that must be met for a multiple regression is the assumption of independence of observations (Laerd Statistics, 2023). This assumption is measured by the Durbin-Watson statistic, that tests if adjacent observations are correlated. If a correlation is found, a multiple regression statistic would not be an appropriate statistical analysis as observations need to be independent of each other for this type of analysis. Results of the Durbin-Watson statistic range from 0 to 4, but a value of approximately 2 indicates that a correlation does not exist between the residuals (Laerd Statistics, 2023). For this dataset there was independence of residuals, as assessed by a Durbin-Watson statistic of 1.847 (see Table 7).

Table 7

Durbin-Watson to Assess Assumption 3: Independence of Observation

Model	R	R^2	Adjusted R^2	SE of the Estimate	Durbin-Watson
1	.701[a]	.491	.461	8.314	1.847

a. Predictors: (Constant), System-Wide Support for Trauma Informed Care, Responses to Problem Behavior and Symptoms, Reactions to the Work, Personal Support for Trauma-Informed Care, Underlying Causes of Problem Behavior and Symptoms, On-The-Job Behavior, Self-Efficacy at Work

b. Dependent Variable: STS Total Score

The fourth assumption requires linearity between the dependent variable and each independent variable, as well as the dependent variable and the independent variables collectively (Laerd Statistics, 2023). Partial regression plots for each independent

variable (i.e., underlying causes of problem behavior and symptoms, the impact of trauma, responses to problem behavior and symptoms, on-the-job behavior, self-efficacy at work, personal support of trauma-informed care, and system-wide support for trauma-informed care) and the dependent variable (i.e., STS total score). Each of these scatterplots indicates possible linearity between the independent variables and dependent variable.

Figure 1

Scatterplot STS Total Score by Underlying Causes of Problem Behavior and Symptoms

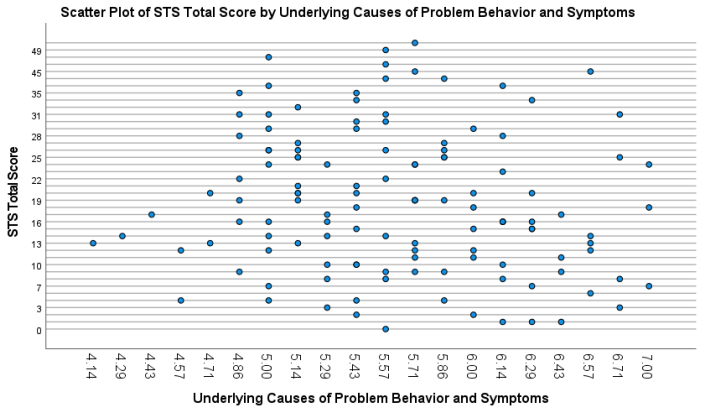


Figure 2

Scatterplot STS Total Score by Responses to Problem Behavior and Symptoms

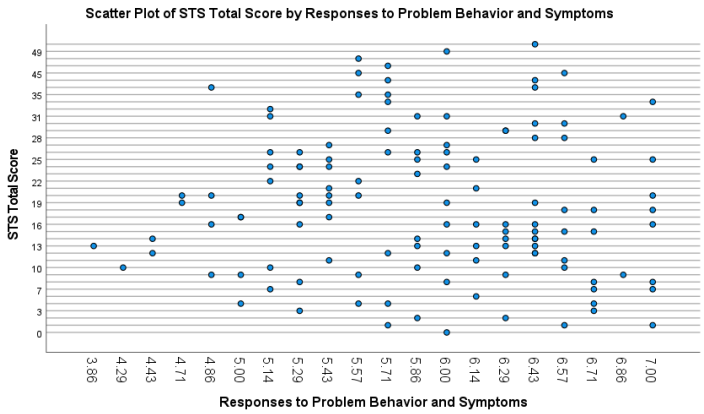


Figure 3

Scatterplot STS Total Score by On-the-Job Behavior

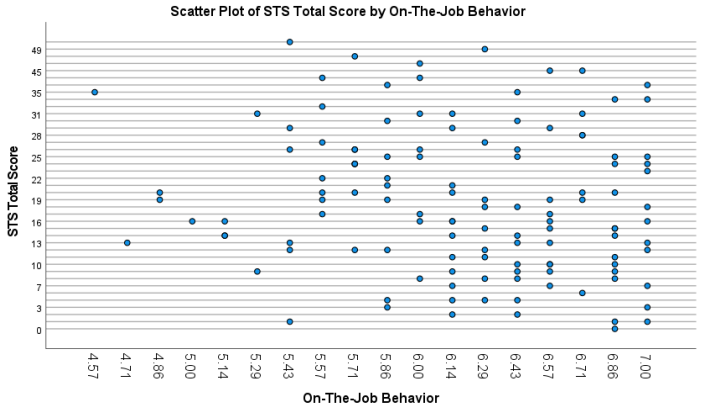


Figure 4

Scatterplot STS Total Score by Self-Efficacy at Work

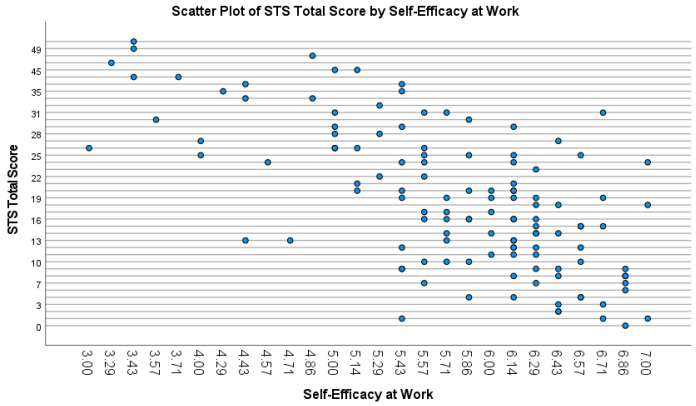


Figure 5

Scatterplot STS Total Score by Reactions to the Work

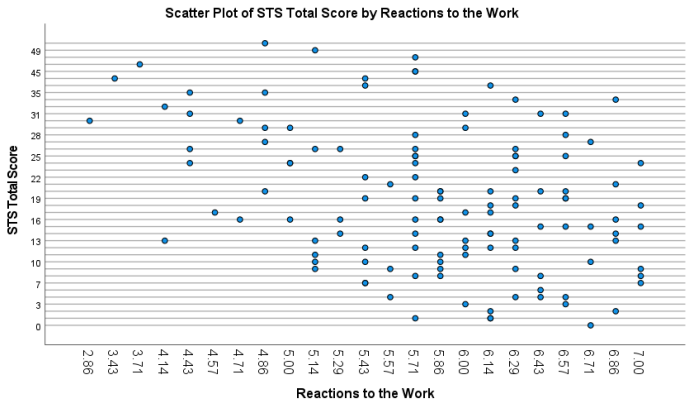


Figure 6

Scatterplot STS Total Score by Personal Support for Trauma-Informed Care

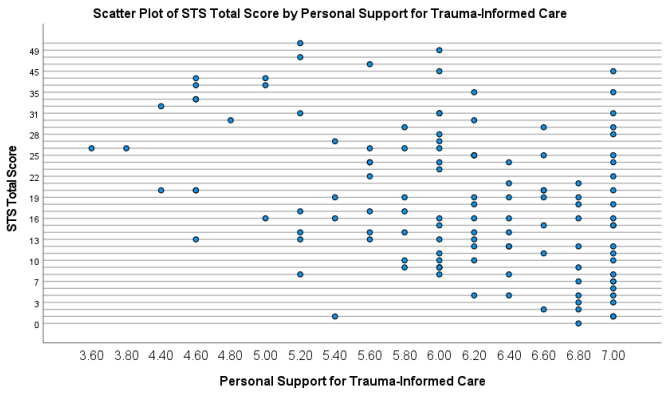
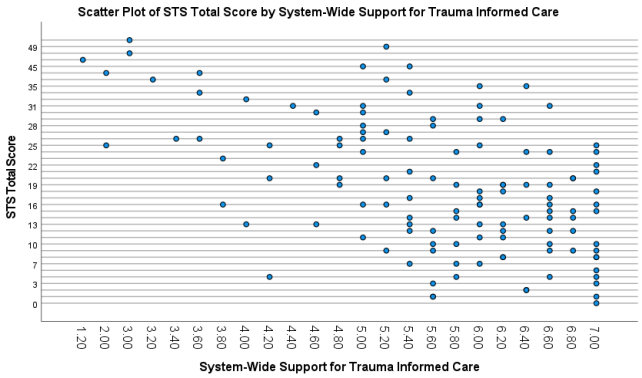


Figure 7

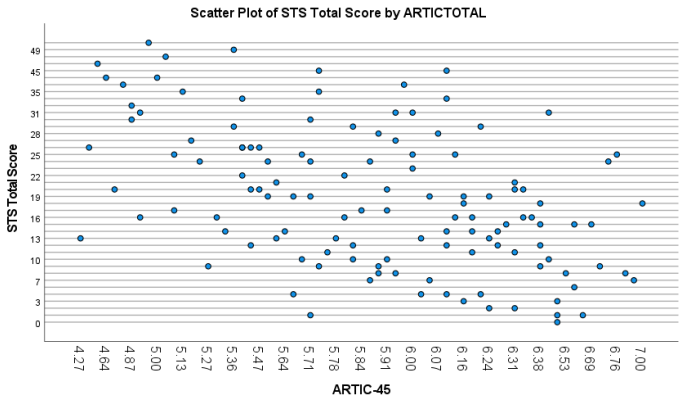
Scatterplot STS Total Score by Systemwide Support for Trauma-Informed Care



To assess for the second part of this assumption, linearity between the dependent variable and independent variables collectively, I generated an additional scatterplot that visually indicated linearity between these variables. This scatterplot was used to assess for the fifth assumption as well (see Figure 8).

Figure 8

Regression Assumption to Assess Homoscedasticity Between the ARTIC Total and the STS Total Score



The fifth assumption requires homoscedasticity meaning the residuals are equal for all values of the dependent variable (Laerd Statistics, 2023). This assumption is met, as indicated in the scatter plot, due to the lack of an increase or decrease in the residuals across predicted values (see Figure 8).

Assumption six states that the independent variables cannot show multicollinearity (Laerd Statistics, 2023). A correlation statistic can be used to test multicollinearity. This assumption is met for this study because none of the independent variables are highly correlated, meaning that none of the correlations are greater than 0.7. Table 8 also indicates there is not an issue with multicollinearity as all the Tolerance values are greater than 0.1. Table 8 shows the coefficients table to assess if each independent variable was a predictor of STSS on its own and the results show that participants' STSS was predicted by self-efficacy at work ($\beta = -.634$, $t = -5.933$, $p < .001$). Therefore, the regression suggests that with each additional increase in self-efficacy at work score, the STSS score decreases by approximately .63. When assessing the overall relationship between the ARTIC-45 and the STSS the null hypothesis should be rejected because there is a statistically significant relationship between the overall ARTIC-45 and the STSS as well as a statistically significant relationship between one of the ARTIC-45 subscales (Self-Efficacy at Work).

Table 8

Coefficients to Assess for Multicollinearity Among Variables

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	95.0% Confidence Interval for B		Correlations			Collinearity Statistics	
		B	Std. Error	Beta			Lower Bound	Upper Bound	Zero-order	Partial	Part	Tolerance	VIF
1	(Constant)	55.252	8.845		6.247	<.001	37.734	72.771					
	Underlying Causes of Problem Behavior and Symptoms	.830	1.812	.045	.458	.648	-2.758	4.419	-.112	.043	.030	.456	2.192
	Responses to Problem Behavior and Symptoms	.785	1.418	.047	.553	.581	-2.024	3.593	-.027	.051	.037	.606	1.650
	On-The-Job Behavior	1.963	1.938	.101	1.013	.313	-1.874	5.801	-.152	.094	.067	.439	2.279
	Self-Efficacy at Work	-8.210	1.384	-.634	-5.933	<.001	-10.951	-5.469	-.673	-.482	-.393	.383	2.608
	Reactions to the Work	.340	1.375	.024	.247	.805	-2.383	3.062	-.378	.023	.016	.470	2.126
	Personal Support for Trauma-Informed Care	-.830	1.273	-.058	-.652	.516	-3.352	1.692	-.375	-.060	-.043	.557	1.795
	System-Wide Support for Trauma Informed Care	-1.303	.946	-.136	-1.377	.171	-3.177	.572	-.542	-.127	-.091	.453	2.210

a. Dependent variable: STS Total Score

Assumption seven requires that the dataset does not include any outliers, leverage, or influential points (Laerd Statistics, 2023). Initially when the casewise diagnostic was produced, there existed one outlier with a residual of higher than three standard deviations. This data point was removed and when the statistics were produced again, the casewise diagnostic no longer included standardized residuals less than ± 3 standard deviations. In addition to this diagnostic, the leverage values for each case were examined and all cases had leverage values of less than 0.2 meaning they can be classified as safe from having high leverage in the data set. Lastly, Cook's Distance was examined for each case and all cases had a Cook's Distance of less than 1 meaning they are not classified as influential points in the data set.

Lastly, assumption eight requires that the residuals are approximately normally distributed (Laerd Statistics, 2023). Figure 9 displays a normal distribution of residuals, and Figure 10 displays a P-P plot, also showing a normal distribution of residuals thus satisfying this assumption.

Figure 9

Regression Assumption to Assess Normality: Histogram

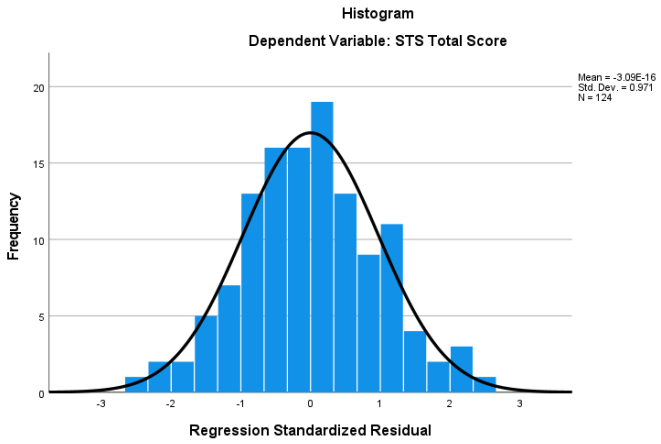
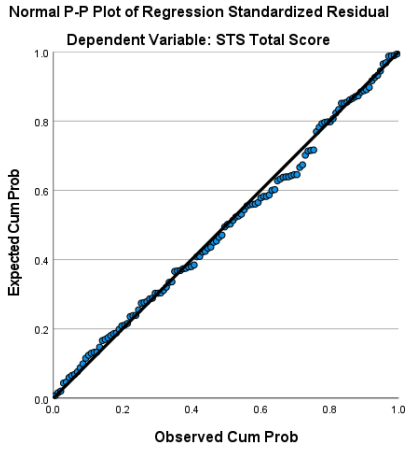


Figure 10

Regression Assumption to Assess Normality: Normal P-P Plot



Summary

In Chapter 4, I highlighted the statistical analyses utilized to answer the research question and I provided an interpretation of the results. I provided evidence to show that the dataset met all the assumptions for appropriate use of a regression statistic. The results indicated a statistically significant negative correlation between the ARTIC-45

subscale, self-efficacy at work, and the STSS. As the ARTIC-45 subscale measure increased one unit, the STSS output decreased by approximately .63. Statistically significant correlations were not found for six of the seven subscales (i.e., underlying causes of problem behavior and symptoms, the impact of trauma, responses to problem behavior and symptoms, on-the-job behavior, and personal support of trauma-informed care, system-wide support of TIC).

In Chapter 5, I link the literature reported in Chapter 2 to the results highlighted in this chapter to identify ways in which this research adds to the current literature in this topic area including support for utilizing the results of this study to promote positive social change. I also provide an interpretation of the research findings as well as the limitations of this study. I also discuss my recommendations for future research and, lastly, I discuss the implications of the research findings for promoting positive social change.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this quantitative study was to examine the relationship between counselor attitudes toward TIC and the severity of STS for counselors working with clients in community mental health settings. I collected data through an anonymous online survey that included demographic questions, the ARTIC-45, and the STSS. The findings provide further support for TIC implementation in community mental health settings, as a statistically significant correlation was identified between the STSS and one subscale of the ARTIC-45, self-efficacy at work. Findings indicated that as the respondents' ARTIC-45 score increased in self-efficacy at work, their STSS score decreased, meaning they were reporting fewer symptoms and a lower severity of STS symptoms. This chapter includes an interpretation of these research findings, a discussion regarding the limitations of the study, recommendations, and implications for promoting positive social change.

A total of 124 counselors working with clients in community mental health settings were recruited across the United States for participation in this quantitative web-based survey study. Multiple regression analysis was conducted to examine for a predictive relationship between the seven subscales of the ARTIC-45 and the STSS. The results of this study indicate that there is a statistically significant relationship between one of the seven subscales of the ARTIC-45, self-efficacy at work, and the STSS. Therefore, I conclude that the null hypothesis should be rejected. Further the STSS for participants was predicted by self-efficacy at work. The regression suggested that with each additional increase in self-efficacy at work score on the ARTIC-45, the STSS score

decreases by approximately .63. These findings indicate that as the respondent's ARTIC-45 score increases in self-efficacy at work, their STSS score decreases, meaning they are reporting fewer symptoms and a lower severity of STS symptoms. The other six subscales of the ARTIC-45 (i.e., reactions to the work, personal support for TIC, on-the-job behavior, underlying causes of problem behavior and symptoms, responses to problem behavior and symptoms, and system-wide support for TIC) were not shown to have statistically significant relationships with the STSS. This chapter will focus more on the study findings in connection with the field literature and theoretical frameworks as well as future research possibilities.

Interpretation of Findings

This study focused on the self-reported experience of counselors regarding their attitude toward TIC and experience of STS. This study focused on counselors' self-reported experience, addressing a gap in the literature regarding research with a focus on TIC related to counselors instead of the main focus being on clients. I focused this study on counselor attitudes related to trauma informed care because TIC implementation has been a trend in recent years in community mental health settings without a thorough understanding of the efficacy of such efforts (DeCandia et al., 2020). An agency can implement many initiatives to improve the quality of services and promote trauma informed practices, but it seems more meaningful to measure how staff perceive these efforts and whether these efforts truly have an impact on the work of counselors and on the wellbeing of counselors working in this type of setting (DeCandia et al., 2020). Another reason I focused on counselors was because most TIC implementation efforts

seem to be more focused outward with client care and client outcomes, that impact counselors' job satisfaction and wellness but do not counselor perspective as a determinant of outcomes for counselors (Damian et al., 2017; Goddard et al., 2020; Passmore et al., 2020; Schmid et al., 2020). The experience of staff and staff well-being will have an impact on the care that clients receive (Kim et al., 2018). I wanted to provide more research that focuses on the counselor and adds to the research in support of the efficacy and positive impacts of TIC.

A central result of this study is that counselor attitude toward TIC is negatively correlated to the severity of STS amongst counselors working with clients in community mental health settings. The construct of "counselor attitude" consists of several subscales or areas that impact this construct, and one of these subscales had more of an impact than others when it comes to STS. The ARTIC-45 subscale, self-efficacy at work, had the only statistically significant correlation among the seven subscales of the ARTIC-45. There could be several potential explanations for this finding. For example, many counselors enter the counseling profession to make a positive impact on their future clients and their community (Rønnestad & Skovholt, 2003). If a counselor perceives they are not effective, they may be more vulnerable to the negative impact of listening to the traumatic experiences of others in a therapeutic setting. If a counselor is consistently exposed to this trauma but perceives that they are unable to assist or be effective with clients, it could significantly impact the counselor's mental and emotional well-being, especially if this exposure to trauma and perception of ineffectiveness is prolonged.

Research has also shown that low job satisfaction can also lead to burnout

resulting in more negative outcomes for clients being served, less longevity in the counseling field, and somatic symptoms of stress (Kim et al., 2018). All these constructs and associated symptoms overlap and are interrelated. While job satisfaction and self-efficacy at work influence vulnerability to experiencing increased levels of STS, experiencing STS, in turn, can also lead to even lower job satisfaction (Alavi et al., 2022). Consequently, reduced job satisfaction can lead to burnout and one of the symptoms of burnout is a sense of ineffectiveness in one's work with clients (Kim et al., 2018). The self-efficacy at work subscale of the ARTIC-45 asks the respondent about their perceived level of skill, how difficult they feel their job is, and if they have support in growing in the profession. These are the key factors that could help a counselor increase self-efficacy and ultimately decrease their likelihood of developing STS or STS symptoms.

The results of this study uphold previous research focusing on STS and the importance of TIC. For instance, results from a study conducted by Small and Huser (2019) supported counselor attitude and buy-in for TIC practices contributing to the perceived efficacy of the counselors' therapeutic skills. The current study supports this notion as well, as counselors reporting lower levels of self-efficacy at work as it is related to working with clients that have experienced trauma, predicted the severity of STS symptoms they were reporting.

These results have critical implications for client care, especially in settings, like community mental health, where clients typically do not have a choice in where or with whom they receive their services (Thornicroft, 2021). If clients do not have access to

services outside of community mental health, and the services they are receiving are low quality, there is a mental health service inequity that requires attention (Alegría et al., 2022). Additionally, counselor self-efficacy at work seems to be a cyclical construct in self-efficacy impacting the severity of STS, STS being the leading cause of burnout, and burnout being the biggest contributing factor of decreased counselor self-efficacy (Kim et al., 2018). If counselors feel more efficacious in their therapeutic skills in working with populations that historically report more trauma than others, they are more likely to have decreased symptoms of STS in working with this population, that could result in mitigating the negative consequences of STS that result in decreased positive outcomes for clients and counselors.

One study that somewhat conflicts with the results of this study in this specific context was conducted by Hales et al. (2017). The results of this study indicated that no single factor was more important than other factors in determining which increased positive outcomes for clients over others; all the factors of TIC implementation were of equal importance (Hales et al., 2017). The current study results, in the context of STS severity as predicted by attitudes related toward trauma informed care, indicate counselor perceived self-efficacy at work was the only statistically significant predictor of STS severity. This finding suggests that this specific construct may be more important than others in this context.

Significance to Theory

The theoretical framework for this study was Lazarus and Folkman's Theory of Transactional Stress (1984). Lazarus and Folkman (1984) posited that an individual's

transaction with their environment is important when determining their stress response and level of stress. Also, individuals are constantly assessing the environment in terms of stress and the resources they have available to cope with what is happening in their environment (Lazarus & Folkman, 1984). The results of the current study confirm this theory in that counselors' reported feelings of self-efficacy at work, in relation to working with clients that have experienced trauma, predict the severity of STS they report. As Lazarus and Folkman (1984) indicated, it is not the environment or the characteristics of the environment that are notable; it is the individual's experience and perception of that environment that cause the significant impact on the individual. In this context, it is not the community mental health setting that includes a population of clients that report higher levels of experienced trauma, it is the perception of the counselor's self-efficacy in working with these clients that impacts the counselor the most as the other subscales did not show a statistically significant relationship. Also, as indicated in the literature review, community mental health settings are often a space in which newly trained counselors first begin to gain experience and this experience has a significant impact on their overall career and professional development (Kimbel & Levitt, 2017). When these counselors experience their clients' trauma and assess the environment along with the resources they have available to cope with this environment, they may find a larger deficit than an experienced counselor as they are newer to the field and have not necessarily learned the strategies they may need to feel efficacious with clients reporting high levels of trauma.

The conceptual framework for this study was Harris and Fallot's Creating Cultures of Trauma Informed Care or CCTIC (2001). This theory outlines core values of

safety, trustworthiness, choice, collaboration, and empowerment (Harris & Fallot, 2001). This theory provides an outline for TIC implementation that is structured and holistic. Of the five core values, the value of choice and collaboration is important and confirmed through the results of the current study. This definition of this value includes a focus on staff experience, as staff need a sense of choice, ownership, and control over their work experience and the services provided. This is important when conceptualizing the current study results because a staff member who does not feel effective in their therapeutic skills with clients that have experienced trauma would have a decrease in feelings of choice, ownership of their work, and a sense of control over their overall work experience that impact the other parts of TIC implementation and decrease the effectiveness of overall impact of TIC implementation (Harris & Fallot, 2001).

Limitations of the Study

One limitation of the current study was a lack of diversity in respondent licensure type. Of the 124 respondents that qualified for and completed the survey entirely, there were 117 Licensed Professional Counselors or Licensed Professional Counselor Associates and only 5 Licensed Marriage and Family Therapists. There were also two respondents who were dually licensed. I would have liked a more balanced group of respondents regarding licensure but understood before the study commenced that many community mental health settings, including the organizations that agreed to share my survey link, had many more Licensed Professional Counselors and Associates than Licensed Marriage and Family Therapists and Associates. Due to this imbalance in licensure, I refrained from making any inferences based on differences between types of

licensures as there were not enough data points from LMFTs and LMFT-Associates to make the dataset generalizable to that specific population or to compare this type of licensure with LPCs and LPC-Associates.

Another limitation of the current study was the possibility of social desirability bias or a survey respondent answering survey questions with answers they perceive to be more socially desirable or acceptable even if these answers are not truthful (Bernardi & Nash, 2023). This could be a threat to the validity of this study if respondents answered the survey questions based on social desirability rather than their truthful thoughts and experiences. Respondents were informed and reminded that their survey responses were anonymous and that their program leadership would not have access to their individual responses or any identifiable information. This strategy was used to decrease the possibility of this type of bias from occurring during data collection. In addition, data was collected for this study using a self-administered, online survey that has been shown to be effective in mitigating this type of bias (Bernardi & Nash, 2023).

Data from the current study was also lacking in race, ethnicity, and gender diversity. Most of the participants indicated they were female (88.7%) and white (77.4%). There was not enough representation of counselors of color and male counselors. The diversity of this sample is generalizable to the counseling profession as Data USA (n.d.), reported similar statistics for gender, race, and ethnicity, but a more diverse sample would have been meaningful. This lack of diversity in the sample is attributed to the convenience sampling procedure and increased diversity would require a more targeted sampling approach.

Recommendations

This study addressed a gap in the literature as there were not any other studies that specifically looked at the relationship between TIC and STS severity for counselors working in community mental health settings. As this specific focus was new, there are several ways in which research on this topic area, STS and TIC, to include impact of self-efficacy at work, could be expanded.

For example, it could be beneficial for this topic area to be studied using a qualitative method to explore the lived experiences of similar respondents, including follow-up questions to learn more about what has been beneficial for those reporting highly favorable attitudes toward TIC. Additionally, it would be valuable to learn what would help those who responded unfavorably to, or not in support of, TIC, better understand TIC. This could include gaining a better understanding of resources and support that would help with TIC implementation, and if there are additional challenges that the ARTIC-45 does not seem to assess for.

In looking at the questions asked in the subscale, self-efficacy at work, results of this study seem to indicate that counselors need more support from colleagues and to better understand the positive impacts of their work to include their current skills and efficacy in their work. The questions in this subscale ask about peer support and perception of efficacy in the counselor's work. Further quantitative studies could be conducted to measure the impact of these types of initiatives to address counselor self-efficacy at work. This could include closing feedback loops, taking a strengths-based, trauma-informed approach to supervision, creating case consultation groups for staff to

give and receive support to one another, educational and professional opportunities, as well as collecting additional data from clients to measure the efficacy of services, and sharing data analyses results with staff.

Organizations need to close feedback loops and share data to ensure counselors are aware of the efficacy of their work as reflected by the data typically communicated to funders to ensure programs continue receiving support, but this data may not always be shared with staff and the community. Research could be conducted to measure the efficacy of these types of practices to advocate for more formal structures that are consistent across organizations to increase perceived counselor self-efficacy at work.

Data for this study was collected using a convenience sampling method which resulted in a sample that was lacking diversity in gender, race, and ethnicity. Future studies either replicating this study or focusing on the topics listed above would benefit from a more targeted approach to sampling to ensure a diverse sample. The current study sample was generalizable to the lack of diversity in these areas in the counseling profession, but a more diverse sample would be meaningful for the profession and to highlight the experiences of male counselors and counselors of color.

Implications

I focused my study on counselors working in a community mental health setting for several reasons. The first reason is that many counselors who are new to the counseling profession often work in community mental health settings to earn their hours toward full licensure and this period has the potential to promote the most professional growth for the counselor than any other period throughout their career (Kimbel & Levitt,

2017). Also, clients who seek services in community mental health settings often report elevated levels of trauma and these clients often do not have access to services outside of community mental health (Alegria et al., 2022).

Recommendations for organizations to be more trauma-informed for their staff would include training programs that give counselors what they need to feel and be effective in their work. Training to increase knowledge of content and practice in a specific area has been shown to be effective in increasing self-efficacy (Brown & Han, 2023). Research also indicates that increased self-efficacy predicts increased commitment to TIC implementation (Sundborg, 2019). Promoting and investing in strategies that increase self-efficacy in counselors, which this study shows to be important, as well as their commitment to TIC implementation, would decrease their vulnerability to experiencing STS. Counselors who feel more equipped in their role could promote more positive outcomes for clients and for counselors themselves as they experience better health and wellness and longer careers in the counseling field.

Organizations could also utilize mentorship programs for counselors that are new to the field to receive support from more seasoned counselors. Lastly, it is important for counselors to understand their impact on clients as much as possible. For organizations that do not have a formal structure in place for sharing outcome data with staff, I would recommend implementing a formal structure to ensure data is shared with counselors regarding health outcomes, progress toward goals, and deliverables. This may help counselors to feel more effective. Being a counselor is a position in that the provider often does not get to see the progress or breakthroughs that happen for clients later after

services are completed. This can especially be true for counselors working in community mental health settings as many of these types of services are shorter-term in duration. Agencies need a formal process to ensure data from assessments like posttests or follow up surveys are shared with counselors providing services to these individuals.

Significance to Practice

In addition to recommendations for organizational TIC implementation strategies, additional roles responsible for supporting counselors during their educational journey and beyond could also use these study results to inform their practices in working with counselors. This could include a focus on TIC implementation, strategies, STS awareness, and action planning during counselor education programs. Also, ensure that the institutions themselves are following TIC approaches with the counselors in training at their institution, but also the staff tasked with supporting future counselors. While future counselors are completing their degree, they are required to complete internship hours where site supervisors are responsible for supporting these students as they gain experience in the field. Site supervisors could also benefit from utilizing a trauma informed approach with their supervisees while ensuring self-efficacy is a topic of supervision. This could mean that site supervisors are addressing self-efficacy, utilizing the self-efficacy scale, and action planning to promote growth and improvement, or it could also mean taking a strengths-based approach to supervision to ensure these counselors in training are able to understand and embrace their effectiveness with their clients, their locus of control, and the boundaries of their working alliance with their clients.

The results of this study confirm the need for increased TIC implementation to include training for counselors. Counselors reporting decreased efficacy in working with clients who have experienced trauma could be the result of numerous factors, one of which being lack of adequate training and supervision. Counselors have completed formal education, as a master's degree is required for licensure, but this type of training may be lacking in terms of helping clients with trauma and translating book knowledge to practical skills used in the counseling field in direct service roles. This also tracks, in the context of community mental health, with research conducted by Li et al. (2022), which indicated that counselors involved in their study did not feel like they were adequately trained to serve clients in the community mental health setting where they were providing services. Organizations could provide additional opportunities for professional development for all their staff that could include lecture-based training, workshops with more hands-on, experiential learning, and increased supervision to support counselors as they are gaining experience. An additional strategy that could be implemented is the use of consistent case consultation among teams within an organization. This practice could include a rotation of counselors sharing their challenges with the group to problem solve, provide, and receive support from colleagues. This would help to address support needs from colleagues as assessed for in the self-efficacy at work subscale of the ARTIC-45.

Another strategy that could be utilized in community mental health settings is a mentorship program between counselors. This could include counselors that report feeling more efficacious in their job with counselors that report lower levels of efficacy in their work. This would include a need for additional assessment that was not confidential

to identify mentors and mentees. Additionally, partner colleagues that have less experience in the counseling field or in community mental health specifically could be partnered with others that have more experience. An organization could ask for potential mentors to volunteer their time if they feel called to do so, to support staff that would also voluntarily sign up to get a mentor. The last strategy aligns with Harris and Fallot's (2001) core value of choice and collaboration as well.

Lastly, organizations could implement a formal structure that is consistent across the organization for offering and implementing effective supervision. The results of this study indicated that self-efficacy was more important in terms of the impact on STS symptoms experienced. Significant research has been done to indicate supervision practices that are useful in increasing counselor self-efficacy. One such strategy is ensuring that supervisors directly observe counselors providing services, either live or via video or audio recording, and providing feedback to identify counselor strengths and provide guidance to support counselors as they improve their therapeutic skills (Gray et al., 2009).

Significance to Social Change

Racial disparities exist in community mental health settings with populations of color being more likely to seek services from a community mental health setting (Alegria et al., 2022). Community mental health settings also tend to serve populations that have been historically oppressed and marginalized (Alegria et al., 2022). If services offered in community mental health settings are low quality and subpar that is an injustice to individuals who do not have a choice in where or how they receive the mental health care

they need. Decreasing the severity of STS for counselors providing services in this setting is imperative as Alavi et al. (2022) discussed in their research, the quality of client care decreases as STS increases. All these pieces put together paint a picture of vulnerability on the client side as well as the counselor side. Increasing TIC implementation and potentially decreasing the severity of STS in counselors working in community mental health has benefits for counselors who are just starting out in the counseling profession. These counselors may be less likely to experience burnout and prematurely leave the profession while also being more likely to gain the valuable experience needed to be effective in their work. As the efficacy and longevity of counselors in this setting increases, the clients served in community mental health may experience higher quality services with more positive and meaningful therapeutic outcomes. The findings of this study could be used to show the positive impacts of TIC for clients and counselors while advocating for funding or support to increase TIC implementation initiatives in community mental health settings and beyond.

Conclusion

This study examined the relationship between counselor attitudes related to TIC and the severity of STS among counselors working with clients in a community mental health setting. This quantitative study was conducted using an anonymous, online survey that included the ARTIC-45 and the STSS. The data collected came from respondents with varying years of experience, licensure status, and diverse geographical locations.

The current findings provide support for the importance of TIC implementation in community mental health settings as there was a statistically significant negative

correlation between severity of STS among the counselors that completed the survey and attitude toward trauma informed care, specifically Self-Efficacy at Work. Implications include increased training and support, mentorship, and formalized supervision structures for counselors working in community mental health.

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