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Residential Counselor Turnover: The Effects of Burnout, Vicarious Trauma, Environment, and Self- Care

Kristine Edmonds
Walden University

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Kristine Edmonds

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Walden University
2019

Abstract

Residential Counselor Turnover: The Effects of Burnout, Vicarious Trauma,
Environment, and Self-Care

by

Kristine Edmonds

MA, University of Denver 1991

BA, University of California, Santa Barbara 1987

Proposal Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Counselor Education and Supervision

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Abstract

Most youth receiving care in residential treatment centers (RTCs) have experienced significant childhood trauma and require intensive mental health treatment to recover from their traumatic childhood experiences. Staff turnover is one factor that can negatively affect outcomes for these children and adolescents. Understanding factors that predict the turnover of professional counselors providing counseling to youth in RTCs can help counselors, supervisors, and counselor educators address barriers to staff retention. The purpose of this quantitative cross-sectional study was to explore the relationship between the turnover of professional counselors providing counseling to youth in RTCs and their perception of the work environment, burnout, vicarious trauma, and self-care. The theoretical framework for this study was constructivist self-development theory, which described the impact of working with traumatized youth in RTCs. Professional counselors working in RTCs for youth across the United States received an online survey to measure the study variables and obtain data for the study. Results of the multiple regression data analysis indicated that the combination of perception of work environment, burnout, vicarious trauma, and self-care predicted counselor turnover. Independently, perception of work environment, burnout, and self-care also predicted turnover. This information may help to increase counselor retention in residential treatment centers and improve outcomes for the vulnerable youth receiving care in those settings. This research will contribute to positive social change by improving the quality of life for this marginalized population of youth and decreasing the long-term social and financial burden placed on the community at large.

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Dedication

I would like to dedicate this dissertation project to the youth and staff I have worked with for the past 27 years. So many of them have touched my life and inspired my decision to facilitate this research. I believe in the importance of the therapeutic work that happens in residential treatment centers throughout the United States. I am committed to improving the lives of the youth cared for in those facilities and the wellbeing of the staff who selflessly dedicate their time and love.

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Most importantly, I would like to thank my family and friends for their endless support and encouragement. Thank you first to the wonderful friends I made at Walden University and for all the phone conversations and text messages of support we shared throughout our dissertation process. They understood more than anyone the moments of exhaustion, frustration, and self-doubt and pushed me through.

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Chapter 1: Introduction to the Study

Residential treatment centers (RTCs) for youth are settings where children and adolescents with severe mental health and behavioral issues receive therapeutic care in a safe and secure environment (Brauers, Kroneman, Otten, Lindauer, & Popma, 2016; Hodgdon, Kinniburgh, Gabowitz, Blaustein, & Spinazzola, 2013). Most youth in RTCs have experienced multiple childhood traumas (Briggs et al., 2012; Harr, Horn-Johnson, Williams, Jones, & Riley, 2013). These youths require treatment interventions that will help them to heal from their traumatic experiences and reestablish healthy interpersonal relationships (Harr et al., 2013). One important predictor of positive outcomes for youth in RTCs is a consistent and positive relationship with their therapist (Byers & Lutz, 2015; Foltz, 2012; Roest, Van der Helm, & Stams, 2016). Counseling professionals including mental health counselors, marriage and family therapists, and clinical social workers provide individual, group, and family therapy to youths in RTCs. High staff turnover in RTCs is a serious problem that negatively impacts outcomes for these at-risk youth (Dozier et al., 2014; Seti, 2007; Zelechowski et al., 2013). In addition, staff turnover has a negative impact on service organizations and remaining mental health care providers (Seti, 2007). While high staff turnover is often cited as a serious issue in the provision of services in RTCs, Connor et al. (2003) is one of few researchers who explored the factors that predict or prevent this inherent problem.

Understanding the factors that contribute to high staff turnover in RTCs and interventions that will help to retain mental health providers is important for maintaining the wellbeing of counseling professionals in those settings and providing quality

therapeutic services to youth requiring this level of care. Children who do not recover from traumatic exposure experience impaired interpersonal relationships, poor physical health, morbidity, more frequent psychiatric hospitalization and involvement in the criminal justice system, and mortality in adulthood (Briggs et al., 2012; Cohen et al., 2016; McCormack & Adams, 2016). The American Counseling Association, Code of Ethics (ACA, 2014) stated that counselors avoid actions that “cause harm” to their clients (p. 3). Staff turnover in RTCs negatively impacts the therapeutic alliance between youth and their clinicians and can create stressors for organizations and counseling professionals that can negatively affect the quality of care provided to these vulnerable youths (Seti, 2007).

In this study, I explored factors that may contribute to the turnover of counseling professionals working with traumatized youth in RTCs and potential interventions to increase staff retention. This study provided information that will help counseling professionals, supervisors, and educators to address the work environment and counselor experiences in RTCs that lead to staff turnover and promote interventions that will increase retention. Retaining counseling professionals will improve the quality of care provided to the vulnerable youth in RTCs. Effective early intervention is essential to improve the quality of life for traumatized children throughout the life span and will potentially decrease the long-term social and financial burden placed on their communities.

In Chapter 1, I will provide the background that identifies the need for this study and the theoretical foundation that supports this research. I will describe the problem I

addressed, and the purpose and significance of this study. In addition, I will define key terms and explain the methodology of this study. I will also explain the research question and hypotheses, assumptions, and potential limitations to this research project.

Background of the Study

Staff Turnover in Mental Health Organizations

Staff turnover in mental health agencies can be disruptive to the clinical process and negatively impacts client outcomes, mental health organizations and their employees (Bliss, Gillsepie, & Gongaware, 2010). Bliss et al. (2010) facilitated a single case study to explore the impact of case manager turnover in a community based mental health agency. The staff members in this agency included clinical case managers with master's degrees in social work, psychology, and counseling. Bliss et al. (2010) examined the setting, the agency hiring and training procedures, and the staff and agency response to the staff turnover of clinical case managers in the community mental health center (CMHC).

Bliss et al. (2010), concluded that there was a link between agency knowledge (experience and knowledge required to perform job responsibilities) and turnover, and retaining staff will increase clinical knowledge in the agency. Hiring new staff members can decrease clinical knowledge in a CMCH. The greater the proportion of experienced case managers the more knowledge rich and synergistic the work environment. Bliss et al. also concluded that staff turnover and hiring delays could increase staff caseloads and lead to staff burnout. Knowledge-rich mental health centers will improve care to clients

and provide a more satisfying work environment for clinical case managers (Bliss et al., 2010).

Staff Turnover in Residential Treatment Centers

For the past 20 years scholars and practitioners have recognized that turnover in RTCs for youth is a problem that interferes with the agency's therapeutic mission and positive outcomes for youth living in those settings (Baker, Fulmore, & Collins, 2008; Braxton, 1995). Tremblay, Haines, and Joly (2016) studied staff turnover and the quality of services provided youth in RTCs. Tremblay et al. facilitated a correlational study to examine the relationship between staff turnover during a 3-year period and the youth's length of services required in the child welfare system, length of stay in the RTC, and number of subsequent stays in out of home care. The sample for the study included "rehabilitation staff working directly with clients" (Tremblay et al., 2016, p. 27).

High staff turnover resulted in youth requiring services in state custody for longer lengths of time and more repeat stays in out of home care (Tremblay et al., 2016). High staff turnover also resulted in shorter lengths of stay in the RTC suggesting that the youth were not successfully discharged resulting in longer lengths of services and increased number of subsequent stays (Tremblay et al., 2016). This study supported the findings of Connor et al. (2003) that staff turnover in RTCs negatively impacts the therapeutic alliance and the quality of clinical care in RTCs and decreases positive outcomes for youth.

Connor et al. (2003) identified the negative impact staff turnover had on youth in RTCs and recognized an absence of literature that addressed potential predictors and

intervention strategies. Researchers often cite Connor et al. (2003) as one of the only studies to have addressed the causes of staff turnover in RTCs for youth. Connor et al. studied the employee records and exit interviews of 402 staff members who worked at a nonprofit RTC for emotionally disturbed children and adolescents in Massachusetts between 1995 and 1999. The sample included teachers, residential staff, supervisors, administrators, and ancillary staff (office staff, maintenance, food service, janitors, and other non-clinical staff members). Connor et al. coded the data for demographic characteristics (age, gender, marital status, etc.), jobs characteristics (duration of employment, full/part-time status, department, etc.), and employer factors (salary increases, promotions, other job incentives).

Connor et al. (2003) found a staff turnover rate of 46.1% during the 3.5-year time frame of the study. Employee factors found to be significantly related to turnover were marital status and length of commute. Married employees and those with a commute of 30 minutes or less stayed in their positions longer. Staff members in positions with the most direct daily contact with the youth in the program had the highest turnover. Several job characteristics also had a statistically significant relationship with turnover. Work incentives including tuition reimbursement, salary increases, positive performance evaluations, and promotions increased job retention (Connor et al., 2003).

While Connor et al. (2003) provided valuable information about demographic and organizational factors associated with staff turnover in RTCs, there may be additional contributing factors not examined in this study. Residential care in RTCs provides “the highest level of care in the child welfare system’s continuum of care” (James, Zang, &

Landsverk, 2012, p. 48). Two factors that have also been associated with high staff turnover in the child welfare system are burnout and vicarious trauma. Research on staff turnover in the child welfare field and the potential causes, is also relevant to understanding the issue of staff turnover in RTCs and provided background for this study.

Staff Turnover in Child Welfare

Burnout and work environment. The estimated annual turnover rate of mental health professionals in the child welfare workforce ranged from 20% to 60% depending on the study (Boyas, Wind, & Kang, 2013; Salloum, Kondrat, Johnco, & Olson, 2015).

Boyas et al. (2013) studied the relationship between staff turnover in child welfare agencies and tenure, employment-based social-capital, job stress, and burnout.

Employment-based social capital for this study included environment factors such as perception of fairness, adequate compensation, shared norms and values, co-worker and supervisory support, influence in the organization, and organizational commitment.

Boyas et al. facilitated a cross-sectional quantitative study with a sample that consisted of 209 statewide employees in public child welfare agencies and found a difference in the relationship between burnout, job stress, and employment-based social capital and intent to leave the organization for employees who had been with the agency over 3 years and those with under 3 years of employment.

Boyas et al. (2013), found that for employees with tenure less than 3 years, organizational commitment and supervisory support had a statistically significant relationship with decreased intention to leave. Emotional exhaustion (one aspect of burnout), lack of influence within the organization, and job stress had a significant

relationship with increased intention to leave. For employees with tenure over 3 years, increased job stress, supervisory support, and depersonalization (one aspect of burnout) had a statistically significant relationship with increased intention to leave. These results suggested that employees with different lengths of tenure have different needs and may require different intervention efforts to decrease job turnover. Boyas et al. concluded that less experienced employees may need less autonomy and more supervisory support to maintain employment. More experienced employees may need less direct supervision and more opportunities for autonomy to continue to feel effective in their jobs and stay in their positions.

Boyas et al. (2013) also found that employment based social capital and burnout had independent relationships with staff turnover. The relationship between various aspects of the work environment and different components of burnout (emotional exhaustion and depersonalization) impacted turnover differently. While job stress related to the work environment did have an impact on burnout, the results of this study provided evidence that work environment factors and burnout each have an independent relationship with staff turnover in the child welfare field. This finding supported my decision to include both perception of work environment and burnout as independent variables in this dissertation project.

Work environment. Claiborne, Auerbach, Zeitlin, & Lawrence (2015) also studied the organizational factors that influenced the staff turnover of administrators and clinical professionals in nonprofit child welfare agencies, and estimated the rate of staff turnover in nonprofit child welfare agencies was 30% to 50%. The sample for this study

included administrators and clinical staff in 13 nonprofit child welfare agencies.

Administrators in this study included executive directors, program directors, managers, and department heads. Clinical staff included social workers, psychologists, and guidance counselors. These agencies provided prevention, foster care, residential, and community-based services within the child welfare system. The inclusion of staff working in RTCs in the sample of child welfare workers for this study provided background relevant to this current dissertation project.

Claiborne et al. (2015) found a significant relationship between job overload, role ambiguity, and organizational support and intent to leave for both administrators and clinical staff. Administrators but not clinicians also reported a significant correlation between job autonomy and decreased intention to leave. In addition to these findings, Claiborne et al. concluded that there is a need for more research to identify how to retain talented and committed professionals in the child welfare field.

Measuring turnover. Auerbach, Schudrich, Lawrence, Claiborne, & McGowan (2014) studied staff turnover in child welfare agencies and described the negative impact staff turnover had on children in care. This negative impact included longer lengths of time to achieve permanency and decreased physical and emotional well-being. Auerbach et al. advocated for more empirical research on staff turnover in the child welfare field, and developed the Intent to Leave Child Welfare Scale (ILCW) to measure an employee's intent to leave as a proxy for actual job turnover to more adequately facilitate this needed research.

Auerbach et al. (2014) studied 224 child welfare workers who indicated on the ILCW that they intended to leave the organization where they were employed. The agencies where the study participants were employed were private agencies contracting with city and county government to provide child welfare services in a northeastern state. Auerbach et al. reviewed the work status of those employees 12 months later to determine if they had left their positions. There was a significant correlation between participants who indicated they intended to leave on the ILCW and those who left the agency 12 months later. The ILCW had good content validity and found to be a strong predictor of actual turnover (Auerbach et al., 2014). The ILCW is an instrument that measures turnover in child welfare research that will help facilitate additional studies, including this dissertation, on staff turnover in the mental health field and child welfare.

Work Environment and Burnout in Mental Health Agencies

Researchers have also studied turnover in other mental health agencies (Acker, 2011). Acker (2011) studied the relationship between workplace conditions (counselor involvement with clients with severe mental illness, workload, and workplace support), role stress, burnout (emotional exhaustion) and intent to leave in other mental health agencies. The sample for this study included 460 mental health providers including social workers, case managers, and psychologists with college, associate, and high school levels of education. Acker used descriptive statistics, correlations, and linear regression data analysis methods to analyze the study participant's scores on validated instruments that measured workplace conditions, burnout, role stress, and intent to leave.

Acker (2011) found that 53% of the study participants reported experiencing emotional exhaustion, 73% reported moderate to high levels of role stress, and 50% reported an intent to leave. Role stress was a mediating variable between workplace variables and emotional exhaustion and emotional exhaustion mediated between role stress and intention to leave. Acker also concluded that mental health professionals who work with clients with severe mental illness are more stressed and experience more burnout than those who work with people with less serious emotional disorders. The correlational analysis of the study variables also provided evidence for future researchers that workplace conditions, role stress, and burnout were different constructs that can be studied independently (Acker, 2011).

Vicarious Trauma and Turnover

In addition to work environment and burnout, vicarious trauma is another factor associated with staff turnover in the child welfare workforce and other human services professions (Middleton & Potter, 2015). McCann and Pearlman (1990) described the impact of working with trauma survivors as vicarious traumatization. Helping professionals who work with trauma survivors can experience disruptions in their personal beliefs about trust, safety, esteem for self and others, intimacy, and efficacy. In addition, helping professionals exposed to another person's traumatic experiences can begin to exhibit signs and symptoms similar to the victim (intrusive thoughts and images and painful emotional reactions).

Middleton and Potter (2015) explored the relationship between vicarious traumatization and the turnover of mental health professionals working in the child

welfare field. The sample for this study included 1,192 administrators, supervisors, and caseworkers from five child welfare agencies in different regions of the United States. The study participants completed The Comprehensive Organizational Health Assessment (COHA). The COHA is an instrument created by the U.S. Children's Bureau to evaluate the health and functioning of child welfare agencies (Middleton & Potter, 2015). This assessment included a scale to measure vicarious trauma and intent to leave. Approximately 26 % to 35% of the study participants reported experiencing core aspects of vicarious trauma including a negative impact on their interpersonal relationships and emotional engagement. In addition, study participants who experienced higher levels of vicarious traumatization were more likely to report an intention to leave their work position (Middleton & Potter, 2015).

Self-Care in Child Welfare and RTCs

Self-care is a protective factor against burnout and vicarious trauma for staff working in RTCs and the child welfare system (Eastwood & Ecklund, 2008; Salloum et al., 2015; Steinlin, et al., 2017). Eastwood and Ecklund (2008) studied the relationship between vicarious trauma and burnout and self-care in residential childcare workers. The sample for this study included 57 residential child care workers (not including clinical staff) from two residential facilities for distressed, traumatized, and emotionally disturbed children and adolescents. Study participants voluntarily completed the Professional Quality of Life Survey Revision III (ProQOL-R III, Stamm, 2005) to measure burnout and vicarious trauma, a demographic questionnaire, and a self-care practices questionnaire. The ProQOL III is a measurement instrument frequently used in research

to measure the variables burnout and vicarious trauma (Stamm, 2005). Eastwood and Ecklund found that higher rates of burnout contributed to higher levels of compassion fatigue. Support at work and reading for pleasure resulted in decreased levels of compassion fatigue. Staff members who identified higher levels of stress and engagement in fewer self-care strategies reported increased levels of burnout. In addition, spending less time with family had a statistically significant negative relationship with burnout (Eastwood and Ecklund, 2008).

Salloum et al. (2015) also studied the relationship between self-care and burnout and secondary trauma among child welfare workers. The participants in this study included 108 case managers and supervisors in a private child welfare agency in Florida. The participants each completed the ProQOL Version 5 (ProQOL 5; Stamm, 2010) to measure levels of burnout and vicarious trauma and a trauma-informed self-care assessment validated for their study. The ProQOL 5 is an updated version of the ProQOL III, an instrument used to measure burnout and vicarious trauma.

Salloum et al. (2015) used Pearson correlations to analyze the data from these surveys and found a statically significant negative correlation between trauma-informed self-care and burnout but not secondary trauma. Salloum et al. concluded that symptoms of secondary trauma may be more severe than burnout and may require more intensive treatment interventions to assist with recovery. Professionals experiencing secondary trauma may need posttraumatic stress interventions in addition to self-care to decrease secondary traumatization. Salloum et al. also concluded that there is an absence of validated instruments to measure self-care and that more validated tools are necessary to

continue research on the relationship between self-care and burnout and vicarious trauma in the child welfare field.

Steinlin et al. (2017) studied the effects of self-efficacy, job satisfaction, and self-care on vicarious trauma and burnout among child and youth residential care workers in Switzerland. The participants in this study included 319 social education workers or social education workers in training with an average of 10 years experience working in residential child welfare institutions. The participants completed a Self-Care Questionnaire (Dolitzch, Fischer, Steinlin, Breymaier & Schmid, 2012), a self-efficacy questionnaire, a job satisfaction questionnaire, a posttraumatic stress (PTSD) assessment, a vicarious trauma assessment, and a burnout assessment.

Steinlin et al. (2017) used descriptive statistics and linear regression analysis to analyze the data and found that 20% of the employees reported prolonged vicarious trauma symptoms and burnout. Personal self-care strategies such as taking a break, taking time to eat, drink or use the bathroom, being able to delegate and say “no”, regular exercise, balanced nutrition, and spending time in nature decreased burnout and vicarious trauma symptoms. Organizational factors such as supervisor support, participation in the organization, and transparency within the organization were associated with fewer burnout symptoms. Communication, support within a team, and institutional structure promoting safety, and staff resources were associated with fewer vicarious trauma symptoms. Both burnout and vicarious trauma had a statistically significant negative relationship with enjoyment of work. Steinlin et al. did not directly address the potential relationship between self-care and turnover, but the relationship between self-care and

burnout and self-care and vicarious trauma in this and other studies (Eastwood and Eklund, 2008; Salloum et al., 2015) provided evidence that the association may be valuable to explore.

Summary

The research reviewed in this section provided a background for this study by illustrating the impact of staff turnover in the mental health field and identifying factors that potentially predict and promote staff retention. Burnout, vicarious trauma, and organizational factors have all been independently associated with staff turnover in child welfare and the mental health profession. Self-care is an important intervention for decreasing burnout and vicarious trauma but the relationship between self-care and turnover is less established. Few studies have specifically addressed the relationship between these variables and counselor turnover in RTCs. Without this study, there is limited information about the factors that predict and prevent the turnover of counseling professionals in RTCs.

Problem Statement

Mental health professionals who provide counseling services to youth in RTCs play an important role in those youth's successful outcomes (Schudrich et al., 2013). One significant factor associated with positive outcomes for youth in RTCs is the relationship between youth and their counselors (Byers & Lutz, 2015; Foltz, 2012; Roest et al., 2016). High staff turnover is disruptive to the relationship development between youth and their counselors (Seti, 2007) and negatively impacts emotional, behavioral, and physical outcomes (Dozier et al., 2014; Schudrich et al., 2013; Zelechowski et al., 2013).

In spite of the important roles consistent clinical care and the therapeutic relationship play in the treatment of traumatized youth in residential settings, there is an absence of studies that focus specifically on the job turnover of counseling professionals in RTCs.

Turnover in RTCs

Studies on staff turnover in RTCs are not current and focused almost exclusively on residential child care workers providing direct care to children and adolescents (Baker et al., 2008; Connor et al., 2003; Seti, 2007). Researchers in the child welfare field have focused more on the staff turnover of child protection workers in child welfare agencies (Auerbach et al., 2014; Boyas et al., 2013; McFadden, Campbell, & Taylor, 2015; Shim, 2014). The sample in some child welfare studies included staff working in RTCs (Claiborne et al., 2015; Middleton & Potter, 2015).

Turnover in Child Welfare

Several researchers in the child welfare field found a statistically significant relationship between the turnover in child welfare workers and job stress, burnout, and organizational factors (Boyas et al., 2014; Green, Miller, & Aarons, 2013; Salloum et al., 2015; Seti, 2007). Middleton and Potter (2015) also found a statistically significant relationship between vicarious trauma and job turnover. Researchers in child welfare also found a significant correlation between self-care practices and burnout and secondary traumatic stress and documented the need for more studies that will explore this relationship (Eastwood & Ecklund, 2008; Salloum et al., 2015; Steinlin et al., 2017).

Turnover in Other Mental Health Settings

Researchers have also focused on work environment, burnout, vicarious trauma and the turnover of mental health care professionals providing services in other settings (Acker, 2011; Cole, Craig, & Cowan, 2014). Acker (2011) found a statistically significant relationship between work environment and burnout and the mental health provider's intent to leave their work positions in mental health agencies. Cole et al. (2014) concluded from their literature review that the cognitive changes and symptoms that result from vicarious trauma can lead to high turnover and the early departure of human service professionals from the field.

Professional Counselors in RTCs

Very few studies specifically addressed the needs of professional counselors working in RTCs. Zelechowski et al. (2013) referred to high turnover in RTCs as an inherent problem in the provision of services, but did not address the potential variables that contributed to or prevented poor staff retention. The stressors associated with the work environment in RTCs (heavy case loads, role ambiguity, long work hours, and few financial incentives), burnout related to counseling clients with serious mental illness and few resources, and repeated exposure to clients' traumatic experiences may all play unique roles in the high turnover of counseling professionals counseling youth in RTCs. The work environment, burnout, and vicarious trauma each represent uniquely different challenges faced by professional counselors providing clinical care to youth in residential settings. Information about self-care and its potential relationship to counselor

turnover in RTCs is also important for addressing the specific needs of residential counselors.

After an exhaustive search of the literature, I found very few articles that addressed the turnover of counseling professionals who provide counseling services to youth in residential programs (Claiborne et al., 2015; Middleton & Potter, 2015). I did not find any articles that addressed the combination of challenges and stressors associated with providing clinical services to youth in RTCs. Without this study, there is limited information about factors that contribute to the high turnover of counseling professionals providing counseling to youth in RTCs and potential protective factors that will increase job retention. This study may provide information for counselors, supervisors, and educators that will improve the wellbeing of counselors working in RTCs and improve the quality of care provided to youth in those settings.

Purpose of the Study

The purpose of this quantitative cross-sectional multiple regression study was to explore the relationship between perception of work environment, burnout, vicarious trauma, and self-care and the job turnover of counseling professionals providing counseling to youth in RTCs.

Research Question and Hypotheses

The research question for this study is as follows:

RQ: What is the extent of the relationship between the turnover of counseling professionals providing counseling to youth in RTCs and perception of work environment, burnout, vicarious trauma, and self-care? The predictor variables are work

environment, burnout, vicarious trauma, and self-care. The outcome variable is staff turnover.

The null and alternative hypotheses are below:

H₀₁: Job turnover for counseling professionals providing counseling in RTCs cannot be predicted by perception of work environment.

H_{a1}: Job turnover for counseling professionals providing counseling in RTCs can be predicted by perception of work environment.

H₀₂: Job turnover for counseling professionals providing counseling in RTCs cannot be predicted by burnout.

H_{a2}: Job turnover for counseling professionals providing counseling in RTCs can be predicted by burnout.

H₀₃: Job turnover for counseling professionals providing counseling in RTCs cannot be predicted by vicarious trauma.

H_{a3}: Job turnover for counseling professionals providing counseling in RTCs can be predicted by vicarious trauma.

H₀₄: Job turnover for counseling professionals providing counseling in RTCs cannot be predicted by self-care practices.

H_{a4}: Job turnover for counseling professionals providing counseling in RTCs can be predicted by self-care practices.

Theoretical Foundation

The theoretical foundation for this study was constructivist self-development theory (CSDT). CSDT provided a theoretical framework for understanding the impact

working with traumatized clients has on mental health professionals (McCann & Pearlman, 1990). From a constructivist perspective, people develop schemas or categories for understanding themselves and their place in the world based on their life experiences. According to CSDT, trauma can affect five basic psychological schemas. These schemas are a person's beliefs about safety, trust, esteem, control, and intimacy (Saakvitne & Pearlman, 1996). The repeated exposure to the traumatic experiences of their clients can alter these cognitive schemas for counseling professionals (McCann & Pearlman, 1990). Within the context of CSDT, McCann and Pearlman (1990) defined the cognitive shift that occurs in helping professionals from exposure to trauma victims as vicarious traumatization. Figley (1995) added to this theory and described the symptomatic response to vicarious trauma, including posttraumatic stress symptoms, as secondary traumatic stress, or compassion fatigue.

Vicarious trauma is similar to but uniquely different from burnout (Evces, 2015; Harrison & Westwood, 2009). Maslach (2017) described burnout as an individual's response to prolonged job stressors associated with the human services profession and manifests as emotional exhaustion, detachment from clients, and feeling ineffective regarding one's work. Vicarious traumatization is specifically a helping professional's response to repeated exposure to traumatized clients (McCann & Pearlman, 1990). In the literature, researchers linked job burnout to high turnover in the mental health field and child welfare agencies (Acker, 2011; Boyas et al., 2012). Middleton and Potter (2015) also found a significant relationship between vicarious trauma and job turnover in the child welfare field.

CDST also predicts that mental health professionals who engage in self-care practices will experience decreased levels of burnout and vicarious trauma (McCann & Pearlman, 1990). Consistent with this prediction, researchers in the child welfare field discovered that increased levels of self-care correlated with decreased levels of burnout and other work environment stress (Salloum et al., 2015; Thompson et al., 2014). In addition, Eastwood and Ecklund (2008) found that decreased levels of burnout contributed to decreased levels of vicarious trauma. Empirical research on the influence of self-care on vicarious trauma is less conclusive (Eastwood & Ecklund, 2008; Salloum et al., 2015; Thompson et al., 2014).

According to CSDT, the effects of vicarious traumatization are long-lasting and can affect a person's sense of safety and vulnerability, self-worth, and efficacy. Counseling professionals providing counseling to youth in RTCs are exposed repeatedly to their client's traumatic childhood experiences and are vulnerable to vicarious traumatization (Eastwood & Ecklund, 2008). CSDT provided a framework for exploring the effects of working with traumatized youth and potential factors that predict and prevent counselor turnover. I will provide a more thorough explanation of the theoretical foundation for this study in Chapter 2.

Nature of the Study

The nature of this study was quantitative. Researchers use quantitative research methods to analyze numerical data (Punch, 1998). Quantitative researchers in the behavioral sciences use surveys and scales to measure and statistically analyze human experiences (Groves et al., 2009). Consistent with a quantitative approach, I used a

survey design to gather and analyze data for this study. I used correlation and multiple regression to explore the extent of the relationship between the predictor variables (perception of work environment, burnout, secondary trauma, and self-care) and the dependent variable job turnover of counseling professionals providing counseling to youth in RTCs. I used psychometrically sound instruments to measure the variables in this study. The variable work environment was measured by the Perceived Working Condition Scale (PWCS, Thompson, Amatea, & Thompson, 2014), burnout was measured by the ProQOL 5, vicarious trauma was measured by the ProQOL 5, self-care was measured by the Professional Self-Care Scale (PSCS, Dorociak, Rupert, Bryant, & Zahniser, 2017), and staff turnover was measured by the ICWS.

Definitions

Burnout: Maslach and Jackson (1981) defined burnout as the emotional and physical exhaustion experienced by human services workers. Three characteristics including exhaustion, cynicism, and a decreased sense of professional efficacy define this syndrome (Maslach, 2017).

Residential Treatment Centers (RTC): Inpatient settings that house and provide mental health and educational services to children and adolescents with significant emotional and behavioral issues (Brauers et al., 2016; Hodgdon et al., 2013).

Self-care: Actions or experiences that help to promote and maintain counselor well-being (Bradley, Whisenhunt, Adamson, & Kress, 2013).

Turnover: Turnover occurs when employees leave their position of employment (Bliss et al., 2010).

Vicarious Trauma: Disruptions in a person's beliefs about safety, trust, control/power, intimacy, and esteem due to empathic engagement with traumatized individuals (McCormack & Adams, 2016). Therapists can experience posttraumatic stress symptoms in addition to feeling distrustful of themselves and others; unsafe; powerless; inadequate; and disconnected from themselves and others (Dunkley & Whelan, 2006)

Work Environment: Work conditions related to compensation, workload, work hours, relationships with peers and supervisors, availability of resources, training, nature of job tasks, and organizational climate (Thompson et al., 2014).

Assumptions

This study relied on the self-report of the study participants. One significant assumption of this study was that participants would complete the assessments truthfully. A risk of self-report surveys is social desirability bias which occurs when participants answer questions in ways that will present them in a favorable light (Groves et al., 2009). Participants in this study may have had concerns that answering truthfully to burnout, vicarious traumatization, and intent to leave questions could negatively impact their employment. To address this concern, I kept the information provided by the study participants on the anonymous surveys confidential. The validity of the study was dependent on the respondent's willingness to answer the questions on the surveys truthfully.

Limitations and Delimitations

There were two potential limitations related to this study. The first was related to the generalizability of the results. The study only included master's level provisionally licensed or fully licensed counselors, marriage and family therapists, and clinical social workers providing counseling to youth in RTCs in the United States. The study did not include other personnel working with youth in those settings. The results, therefore, were not generalizable to residential counseling professionals working in other countries. The study results also were not generalizable to other professionals working in RTCs.

The second limitation was that the sample population was voluntary. Because participation in the study was voluntary, the sample may not have accurately reflected counseling professionals providing counseling in RTCs who chose not to participate. This limitation also reduced the generalizability of the study results.

Significance of the Study

The results of this study will provide information about the factors that contribute to and protect against the turnover of counseling professionals providing counseling services to youth in RTCs. Children receiving services in the child welfare system are a marginalized population who typically have experienced significant abuse and neglect (Toporek, Gerstein, Fouad, Roysircar, & Israel, 2006). Kagan and Spinazzola (2013) argued that these children and adolescents need consistent mental health services to recover from their traumatic experiences. Counseling professionals providing counseling services are in the unique position to intervene and facilitate positive outcomes for these youths.

Mental health staff working in RTCs for traumatized youth are at risk for burnout and vicarious trauma that can negatively affect their professional and personal lives as well as the quality of care they provide (Eastwood & Ecklund, 2008; Steinlin et al., 2017). High turnover of professionals working with children in the child welfare system has a negative impact on mental health professionals and the children in care (Auerbach et al., 2014; Bliss et al., 2010; Boyas et al., 2012; Salloum et al., 2015; Zelechowski et al., 2013). Addressing and preventing counselor impairment is an ethical responsibility in the counseling profession that requires attention in counselor education (Cole et al., 2014). The ACA, Code of Ethics (2014) stated that counselors should monitor their impairment and the impairment of colleagues and supervisees and refrain from providing services when impaired to prevent harm to clients. The National Association of Social Workers (NASW, 2018) required that social work professionals not allow their own impairment or the impairment of their colleagues to jeopardize the care they provide (NASW, 2018). Additionally, the American Association of Marriage and Family Therapy (AAMFT, 2015) stated that marriage and family therapists seek professional assistance with issues of impairment that may negatively impact their work performance or clinical judgement. This research project could help facilitate increased wellness in counseling professionals and improve the provision of mental health services and quality of life for the marginalized population of youth placed in RTCs.

Summary

Staff turnover in the child welfare and mental health fields has a negative effect on client care, organizations, and human service professionals. Staff turnover in residential settings for youth is an identified problem that negatively affects client outcomes but Connor et al. (2003) is one of few studies that addresses the potential predictors and interventions related to staff retention in RTCs. In lieu of research specifically about turnover in RTCs, I reviewed studies on this topic from the broader child welfare system. Those studies provided information regarding potential predictors and moderators of turnover in residential settings within the child welfare system of care.

Researchers have identified burnout, work environment factors (Acker, 2011; Boyas et al., 2013) and vicarious trauma (Middleton & Potter, 2015) as potential predictors of staff turnover in the mental health and child welfare fields. My review of background literature also summarized researchers' findings that self-care might decrease burnout and vicarious trauma, however, the relationship between self-care and turnover remains speculative. I reviewed CSDT to provide a theoretical framework for understanding the impact of working with traumatized youth in RTCs, the role self-care may play in protecting counseling professionals from burnout and vicarious trauma, and how those variables may impact staff turnover.

The absence of literature on staff turnover in RTCs and specifically the turnover of counseling professionals providing therapeutic services to youth in those settings creates a gap in the literature that justifies the need for this study. My research project explored the variables burnout, vicarious trauma, work environment, and self-care and

their potential relationship to counselor turnover in RTCs. My quantitative study provided information that may help improve counselor wellbeing and the quality of therapeutic care youth in RTCs receive. In this chapter, I also discussed the limitations and delimitations of this study. The results were generalizable only to master's level provisionally licensed or fully licensed counselors, marriage and family therapists, and clinical social workers providing counseling services to youth in RTCs in the United States. In addition, I explained that the sample was voluntary and may not have accurately captured the views of individuals who chose not to participate in the study.

In Chapter 2, I will elaborate further on the background literature for this study. I will provide the parameters of this study and my literature search strategies. In addition, I will explain the variables in this study more extensively. Lastly, I will provide a more comprehensive description and analysis of CSDT, the theoretical framework for my study.

Chapter 2: Literature Review

Introduction

The purpose of this study was to identify factors that predict and prevent counselor turnover in RTCs. Children and adolescents living in RTCs have experienced multiple traumatic events throughout their lifetime and require intensive therapeutic services to heal from those childhood traumas (Harr et al., 2013). Counseling professionals providing therapeutic services in RTCs play an important role in outcomes for those youths (Byers & Lutz, 2015; Kapp, Rand, & Damman, 2015). Unfortunately, high staff turnover is a serious problem that negatively affects the children in care, the remaining staff, and the organization (Benton, 2016; Middleton & Potter, 2015; Salloum et al., 2015; Shim, 2014). While high staff turnover is a problem in the provision of services to youth in the child welfare system, I found few studies about the causes or prevention of staff turnover in RTCs. I found even fewer studies specifically about the turnover of counseling professionals providing counseling services to youth in residential settings. There is a need for research that will help to determine the causes of turnover in RTCs and potential prevention interventions.

Factors associated with staff turnover in the child welfare field and counseling profession include the work environment, burnout, and vicarious trauma (Dombo & Blome, 2016; Salloum et al., 2015). Self-care is an important intervention to help mitigate the effects of the work environment and prevent burnout and vicarious trauma in the counseling field (Alani & Stroink, 2015; Bradley et al., 2013; Gutierrez & Mullen, 2016). In this chapter, I will describe the population of youth receiving treatment in

RTCs and the work environment of counselors and other professionals providing care to that client population. I will also provide a theoretical basis for this study and a summary of the relevant literature on burnout, vicarious trauma, self-care and staff turnover in the child welfare and counseling fields.

Literature Search Strategy

My search for literature related to this topic included access to the Walden University Library databases and Google Scholar. I used those resources to identify peer-reviewed articles relevant to my study. The databases I accessed through the Walden University Library included PsycINFO, PsycARTICLES, ERIC, Mental Measurements Yearbook, dissertation databases, and SocIndex with Full text. I chose those databases each time I conducted a search as an attempt to find all possible articles related to my topic. The keywords I used were *residential treatment, burnout, vicarious trauma, compassion fatigue, self-care, and turnover*. I also searched the following word combinations *residential treatment and burnout; residential treatment and vicarious trauma; residential treatment and compassion fatigue; residential treatment and youth; residential treatment and self-care; residential treatment and turnover*. Due to the absence of literature specifically on RTCs and the variables in my study, I also included *child welfare and counselors* as keywords. I expanded my word search combinations to include *burnout and child welfare; burnout and counselors; vicarious trauma and counselors; vicarious trauma and child welfare; compassion fatigue and counselors; compassion fatigue and child welfare; turnover and counselors; turnover and child welfare; self-care and counselors; self-care and child welfare; residential treatment and*

social workers. The research parameters I used were peer-reviewed articles and texts published in the last 10 years. I also included earlier research that provided a historical context for constructs in this study including burnout and vicarious trauma.

Theoretical Framework

CSDT

The theoretical framework for this study was CSDT. CSDT is a theoretical perspective developed by McCann and Pearlman (1990) that provided a foundation for understanding the internal transformation of therapists working with traumatized clients. Constructivist theorists believe that individuals construct meaning and a perspective for interpreting the world from their personal experiences (Evces, 2015). These internal constructs or perceptions are also called cognitive schemas (Trippany, Kress, & Wilcoxon, 2004). Cognitive schemas include beliefs, assumptions, and expectations about one's self, others, and the world that help individuals interpret life experiences (McCann & Pearlman, 1990). These constructs evolve as people grow developmentally and interact with the world. Individuals develop cognitive schemas to make sense of five basic psychological needs. These needs include safety, trust, control/power, esteem, and intimacy as they relate to self and others (McCann & Pearlman, 1990). Therapeutic work with traumatized clients can slowly disrupt those cognitive schemas (McCormack & Adams, 2016; Pearlman & Mac Ian, 1995). Therapists can become distrustful of themselves and others; believe that they and others are not safe; feel powerless; perceive inadequacy in themselves and others; and feel disconnected from themselves and others (Dunkley & Whelan, 2006; Saakvitne & Pearlman, 1996) This disruption in cognitive

schemas due to empathic engagement with traumatized individuals results in vicarious traumatization (McCormack & Adams, 2016).

CSDT also addressed the memory system and the ways therapists may internalize the traumatic imagery described by traumatized clients. As clients describe their traumatic experiences, counselors can incorporate those descriptions into their memories (Dunkley & Whelan, 2006). Those incorporated memories can lead to PTSD symptoms that mirror their clients' including flashbacks, dreams or intrusive thoughts, emotional arousal, and avoidance of similar stimuli (Aparicio, Michaloulos, & Unick, 2013; Dunkley & Whelan, 2006; McCormack & Adams, 2016). Disruption in the memory system can lead to uncomfortable emotional states that may lead to numbing and detachment from clients (McCann & Pearlman, 1990). The definition of vicarious traumatization includes a person's disruption in core beliefs and the PTSD symptoms experienced by counselors exposed to traumatized individuals (McCormack & Adams, 2016). These symptoms and disruptions in cognitive schemas resulting from vicarious traumatization can negatively impact the therapist both personally and professionally (Abassary & Goodrich, 2014; Newell, Nelson-Gardell, & MacNeil, 2016).

Previous Research Using the CSDT

Since 1990 researchers have used CSDT as the theoretical foundation for their study of the concepts of vicarious trauma and secondary traumatic stress. McCormick and Adams (2016) facilitated a qualitative study to explore the experience of mental health professionals providing clinical services to patients with complex trauma in a

hospital setting. The study participants reported “significant psychological distress” as a result of chronic exposure to clients with complex trauma histories (p. 198).

In another study, Middleton and Potter (2015) used CSDT as the theoretical framework to study the relationship between vicarious traumatization and staff turnover in the child welfare field. Middleton and Potter studied 1,192 child welfare professionals from five different child welfare organizations and found that study participants who experienced higher rates of vicarious traumatization were more likely to leave their organization. Williams et al. (2012) also studied vicarious traumatization based on CSDT in 131 mental health professionals working in community mental health centers and found that personal trauma history increased the risk of vicarious trauma and engagement in self-care and personal wellness decreased the vulnerability to vicarious traumatization. Engaging in self-care and personal wellness partially mediated the effect of previous personal trauma (Williams et al., 2012).

Rationale for Use of the CSDT as the Theoretical Framework

McCann and Pearlman (1990) developed CSDT to describe the common experience reported by therapists working with trauma survivors. This theory complimented and added to research about another stress response to working in the human services field known as burnout (Abassary & Goodrich, 2014; Newell et al., 2016). Both individual personality characteristics and organizational factors can impact whether an individual develops vicarious traumatization and burnout (Williams et al., 2012). Both vicarious traumatization and burnout can lead to depression, insomnia, difficulty in interpersonal relationships, detachment from clients, and absenteeism

(Steinlin et al., 2017). Burnout and vicarious trauma can both result in "physical symptoms, emotional symptoms, behavioral symptoms, work-related issues, and interpersonal problems" (Trippany et al., 2004, p. 32). The primary difference between these two concepts is that burnout is related to the demanding work of high needs clients and insufficient resources and vicarious traumatization is specifically a result of exposure to traumatized individuals (Galek, Flannelly, Greene, & Kudler, 2011). Eastwood and Ecklund (2008) also found that increased levels of burnout were related to increased levels of vicarious trauma.

I chose CSDT as the theoretical framework for this study to answer the question of whether the high turnover of counselors in RTCs is more closely related to work environment factors, the work demands associated with burnout, or if it is specifically related to disruptions in the therapist's core beliefs and PTSD symptoms associated with vicarious traumatization. An understanding of the impact clinical work in RTCs has on counseling professionals may help to identify intervention and prevention strategies that will be most effective to improve the wellbeing of counselors and the quality of care they provide to traumatized youth. Counselors working in RTCs for youth are particularly vulnerable to burnout and vicarious traumatization because of the high needs of their clients and the repeated exposure to their client's traumatic childhood experiences. CSDT provided a theoretical framework that explained the impact working with traumatized youth in RTCs may have on counseling professionals and why they leave their positions prematurely. This theoretical framework provided a lens for exploring and understanding the degree to which work environment factors, burnout, vicarious trauma,

and self-care predict the high turnover of counseling professionals providing counseling to traumatized youth in RTCs.

RTCs for Youth

RTCs for youth are inpatient settings that house and treat children and adolescents with significant mental health and behavioral issues (Brauers et al., 2016). Youth living in RTCs have experienced multiple traumatic childhood experiences. Briggs et al. (2012) estimated that 92% of a national sample of youth placed in RTC level of care reported having experienced multiple traumatic events. Harr et al. (2013) found that on average, youth entering residential care had experienced 2.3 traumas and almost half (47%) had experienced three or more traumatic events. Common childhood traumas experienced by youth in RTCs include physical, sexual, and verbal abuse; separation from family or loss of a parent; witnessing domestic violence; community violence; chronic and severe neglect; caregiver substance abuse and other impairment; and multiple moves or placement disruptions (Briggs et al., 2012; Harr et al., 2013; Kagan & Spinazzola, 2013).

Youth who have experienced childhood trauma require intensive therapeutic services to recover from those experiences (Habib, Labruna, & Newman, 2010; Zelechowski et al., 2013). Youth exposed to trauma are more likely to exhibit depression, anxiety, and other mental health disorders, as well as internalizing (suicidal ideation, self-harming) and externalizing (running away, delinquent behavior, and academic problems) behaviors (Harr et al., 2013). Youth placed in RTCs receive therapeutic services to address their significant mental health needs in an environment that provides more

“structure, security, and predictability” than other less restrictive settings (Hodgdon et al., 2013, p. 679).

In 2013, approximately 58,000 youth were living in residential treatment settings in the United States (Dozier et al., 2014). The highest percentage of youth in RTCs, approximately 70%, are youth in the child welfare system (Sternberg et al., 2013). A smaller percentage of youth receiving care in RTCs are placed there through the juvenile justice system, community mental health agencies, insurance providers, and private placements (Sternberg et al., 2013). RTCs provide the highest and most expensive level of care in the child welfare continuum of services (James et al., 2012). Approximately 134,000 youth experience removal from their homes annually due to neglect and abuse and are placed in out of home care (James et al., 2012). According to a US Department of Health and Human Services (2014) report, 14% of child welfare youth in out-of-home placements are living in RTCs.

Residential Treatment Outcomes

There is significant controversy among child welfare professionals over the benefits of providing mental health services to youth in residential centers versus outpatient community-based settings (James et al., 2015; Kapp et al., 2015). This controversy, in addition to a growing interest in implementing evidence-based practices and the high cost of residential treatment have led to an increase in research on outcomes for youth in residential treatment (Briggs et al., 2012; DeSwart et al., 2012, James et al., 2012). Trauma is one of the strongest predictors of outcomes for youth in residential care (Boyer, Hallion, Hammell, & Button, 2009; Briggs et al., 2012; Habib et al., 2013; Harr

et al., 2013; Zelechowski et al., 2013). Evidence-based practices identified in the literature associated with positive outcomes include family engagement (Brown et al., 2010; James, Alemi, & Zepeda, 2013; Ninan et al., 2014) and trauma informed care (Boel-Studt, 2017; Bryson et al., 2017; Cohen et al., 2016; Greenwald et al., 2012; Habib et al., 2013; Hodgdon et al., 2013; Kagan & Spinazzola, 2013; Knoverek, Briggs, Underwood, & Hartman, 2013). A strong therapeutic alliance also improved outcomes for youth in RTCs (Byers & Lutz, 2015; Foltz, 2012; Kagan & Spinazzola, 2013; Lamers & Vermeiren, 2015; Ormhaug, Jensen, Wentzel-Larsen, & Shirk, 2015; Ormhaug, Shirk, & Wentzel-Larsen, 2013). Despite the expense and restrictive nature of residential treatment, it remains one of the most promising and utilized forms of treatment for youth who have not made clinical gains in lesser levels of care (Briggs et al., 2012; Dozier et al., 2014; Kapp et al., 2015; Whittaker et al., 2016). Youth who have experienced childhood trauma require more intensive and extensive treatment services (Briggs et al., 2012; Harr et al., 2013).

Therapeutic Alliance

The therapeutic alliance is a significant predictor of treatment outcomes for children and adolescents (Brauers et al., 2016; Shirk, Karver, & Brown, 2011). A strong therapeutic alliance is the result of shared goals, an agreement on tasks to achieve those goals, and an emotional bond characterized by mutual respect, trust, appreciation and concern for each other (Bordin, 1979). According to Byers and Lutz (2015), youth receiving treatment in RTCs who have a positive relationship with their therapist are less likely to "act out or run away" (p. 5). Youth in RTCs reported therapy was most helpful

when they felt connected to their therapist (Foltz, 2012). Youth who reported having a voice in their treatment and feeling satisfied with the mental health staff reported more improvement in their problem severity and overall functioning (Kapp et al., 2015). Additionally, Roest et al. (2016) found that a strong therapeutic alliance can positively influence treatment motivation in youth in residential treatment settings.

Forming a therapeutic alliance with youth in RTCs can be difficult (Byers & Lutz, 2015; Hurley, Lambert, Van Ryzin, Sullivan, & Stevens, 2013; Ormhaug et al., 2013). This problem is concerning because the therapeutic alliance can be especially important for traumatized youth (Ormhaug et al., 2015). Youth who have experienced trauma often view the world as unsafe and people as untrustworthy (Ormhaug et al., 2013). A strong therapeutic alliance can play an important role in the healing process for traumatized youth (Harr et al., 2013; Kagan & Spinazzola, 2013; Ormhaug et al., 2015). Practitioners who are reassuring and supportive and help traumatized youth to feel safe and empowered can overcome their resistance and form a trusting relationship (Ayotte, Lanctot, & Tourigny, 2015). Staff turnover in RTCs is an inherent problem that negatively affects the youths' ability to form a trusting relationship with the mental health staff in those settings (Dozier et al., 2014; Zelechowski et al., 2013). While researchers have identified the therapeutic alliance as an important factor related to client outcomes, there are limited studies (Claiborne et al., 2015) in the literature that focus specifically on the counseling professionals who provide clinical care in RTCs. Little is known about the experience of counseling professionals in RTCs and the factors that contribute to the high turnover and retention of those care providers.

Staff Turnover

Turnover in the work environment occurs when employees leave their position of employment (Bliss et al., 2010). Staff turnover in social service and mental health organizations ranges from 30% to 60% (Bliss et al., 2010). This turnover rate is in comparison to other related professions such as teaching with a turnover rate of 13.2% and nursing with a rate of 12.0% (Young, 2015). According to Auerbach et al. (2014), public and private child welfare agencies have annual turnover rates ranging from 20% to 40% and the average employee length of stay is two years. Staff turnover rates in private not-for-profit agencies including RTCs can range from 30% to 50% (Claiborne et al., 2015).

Staff turnover can have both positive and negative effects on an organization (Bliss et al., 2010). Staff turnover can increase productivity by eliminating employees that are a poor fit with the organizational culture and by bringing in employees with new and fresh ideas (Bliss et al., 2010; Young, 2015). In many cases, however, high employee turnover is a serious concern that can have a negative impact on human service organization and child welfare agencies (Auerbach et al., 2014; Middleton & Potter, 2015). High turnover in social service and mental health organizations is a significant problem that researchers have associated with high financial costs, poor client outcomes, and poor staff morale (Benton, 2016; Seti, 2007; Shim, 2014; Young, 2015). In public child welfare agencies high staff turnover is associated with an increased workload for the remaining employees and lower permanency rates for children in the child welfare system (Salloum et al., 2015). In addition, turnover has a negative impact on the

meaningful therapeutic alliance between clinicians and patients (Bliss et al., 2010; Young, 2015).

Employee Turnover in Child Welfare

There is a significant amount of research in the literature that focuses on the high turnover of child welfare workers in public child welfare agencies and mental health care providers in community mental health centers (CMHC, Benton, 2016; Bliss et al., 2010; Boyas et al., 2012; Kim et al., 2012; Middleton & Potter, 2015; Shim, 2014). Bliss et al. (2010) facilitated a single case study to develop a theory and simulation model for understanding the relationship between caseworker turnover and clinical knowledge in community mental health centers. Bliss et al. collected data from key informants in the agency about the hiring process, agency orientation, staff training, state and local rules and regulations regarding service provision, and dates of hire and termination for agency employees during a 3-year period and concluded that high turnover of caseworkers in community mental health centers decreased organizational knowledge (knowledge and understanding required to perform job responsibilities) and had an adverse effect on client care and employee satisfaction. Mental health professionals require a complex set of skills and the ability to develop a strong therapeutic alliance to provide quality mental health treatment (Bliss et al., 2010). This study demonstrated how employee turnover can negatively affect staff and clients in CMHC's and supports the need for more studies that address factors that predict and prevent turnover in the mental health field. Bliss et al. (2010) suggested that future researchers include topics such as burnout, job

satisfaction, job stress, and financial issues to increase the benefits of this theory and model for understanding turnover in CMHC.

Turnover and work environment factors. Benton (2016) used a mixed methods design to explore the differences between employees who chose to stay and those who chose to leave a child welfare agency. The sample consisted of 1,102 public child welfare workers from public child welfare agencies. The study participants completed a survey that collected both quantitative and qualitative data. Higher salaries, more hours worked, and supervisor support all increased job retention. Higher levels of client-related stress decreased job retention. In this study, client related stress included the intrinsic responses to client issues such as the death of a client, child abuse, and removing children from parents. The findings from this study both supported and contradicted findings from previous research. Connor et al. (2003) found that higher salaries increased job retention. Boyas et al. (2012) found that supervisor support increased job retention. McFadden et al. (2015) found that supervisor support decreased turnover and that more hours worked increased turnover. Benton (2016) suggested that there was a need for more studies to replicate the relationship found between client related stress and job retention.

Benton (2016) suggested that more research exploring the variables from this study will help to strengthen the generalizability of the findings. The participants in this study were from one state in the United States and therefore the results may not be generalizable to all public child welfare agencies. Despite the limitations associated with the sample, the findings provided information about factors that predict and deter staff

turnover in child welfare agencies. These factors may also be relevant to work environment issues in RTCs and provide background for the choice of variables in my study. The work conditions studied as variables in this study including exposure to childhood abuse and neglect are also present for counseling professionals working with youth in RTCs.

Shim (2014) also studied work environment factors and their relationship to turnover in child welfare agencies. Shim hypothesized that agencies with more positive organizational climate and culture would have less employee turnover. Organizational culture included three subscales including achievement/innovation/competence (AIC), emphasis on rewards (ER), and co-operation/supportiveness/responsiveness (CSR). Organization climate included four subscales including role conflict (RC), personal accomplishment (PA), emotional exhaustion (EE), and workload (WL).

In this quantitative study, Shim (2014) selected 13 public child welfare agencies with the highest turnover rate and 12 with the lowest turnover rate in New York state over a 5-year period. The researcher invited staff members from the 25 agencies to complete a survey of 134 questions that included items related to organizational culture and climate. Shim found from a two-sample t-test that agencies with low staff turnover were more likely to have a positive organizational culture and climate.

In contrast, only emphasis on rewards and lower caseloads had a statically significant relationship with lower staff turnover. The researcher found no significant difference in high and low turnover agencies and the other organizational culture and climate subscales (Shim, 2014). These contradictory results suggested the need for

additional research on organization culture and climate and their relationship to employee turnover in child welfare. Limitations of this study also included a relatively low sample size and the inclusion of child welfare agencies only in the state of New York.

Additional research in other states and a larger sample may help to provide a clearer understanding of how organizational culture and climate affect employee turnover in child welfare agencies.

Turnover and burnout. Several researchers also identified the negative impact of turnover on client care and employee well-being and found a significant relationship between burnout and staff turnover in public child welfare agencies (Boyas et al., 2012; Kim et al., 2012). Boyas et al. (2012) facilitated a cross-sectional quantitative study to explore the impact of employment-based social capital (coworker support, fairness, supervisor support, and influence), job stress, and burnout on intent to leave among child protection workers in child welfare agencies. The sample for the study consisted of all public child welfare employees from 12 agencies in a New England state. The study participants answered demographic questions in addition to questions related to job stress, coworker support, fairness, supervisor support, influence, and burnout on a provided survey. Boyas et al. statically analyzed the collected data and found that in younger workers, job stress and emotional exhaustion were significantly correlated with their intent to leave. In older workers, depersonalization and organizational commitment were significantly correlated with intent to leave (Boyas et al., 2012). The consistent finding among both older and younger employees that emotional exhaustion (one component of burnout) had a significant correlation with intention to leave supports the

need for more research about the impact of burnout on employee turnover in the mental health field. This dissertation project added to current research on the role burnout plays in the high turnover of mental health professionals in the child welfare field. Also, my study addressed the limited generalizability of the results from this study by expanding the research to additional geographic locations.

Kim et al. (2012) also studied the relationship between burnout and employee turnover. Kim et al. hypothesized that higher levels of burnout in social workers in social work agencies would increase intention to leave and that organizational justice would moderate the impact of burnout on intention to leave. The researchers defined organizational justice in the study as the staff member's perception of fairness related to allocation of resources and work performance incentives and consequences within the agency (Kim et al. 2012). The sample for this quantitative study was social workers in social welfare service agencies in Korea. Study participants completed surveys that measured intent to leave, burnout, and organizational justice. Kim et al. found that job tenure, depression, burnout, and organizational justice had a significant correlation with the study participants intention to leave their social work positions. The results also supported the hypothesis that organizational justice would moderate the relationship between burnout and intention to leave (Kim et al., 2012). This study suggested that burnout and work environment factors related to fairness and having a voice are relevant factors to study as they relate to job turnover. I expanded this research with my study by exploring these variables in other child welfare settings and other mental health professionals.

Turnover and vicarious trauma. Researchers, though they are fewer, have also studied the relationship between vicarious traumatization and turnover in the child welfare field (Middleton & Potter, 2015). Middleton and Potter (2015) studied the relationship between vicarious traumatization and turnover among child welfare professionals and found a statistically significant relationship. Middleton and Potter collected data through a web-based and/or paper survey for this quantitative study. Supervisors, administrators, and caseworkers within five diverse child welfare agencies in a southern state participated in the study. The survey included scales that measured vicarious traumatization and intent to leave. The results of the study supported the researcher's hypothesis that higher rates of vicarious trauma would have a positive significant relationship with intention to leave. Middleton and Potter identified RTCs as a location where child welfare professionals are employed and identified more research on the relationship between vicarious traumatization and turnover as a need in the field. This study supported my inclusion of vicarious trauma as a variable in my research project and addressed the need for additional research on this relationship. I expanded on this research by exploring the potential role self-care will play in mediating the relationship between vicarious trauma and employee turnover.

Turnover in Residential Treatment

In the literature, staff retention is referred to as an inherent problem in the delivery of services in RTCs (Dozier et al., 2104; James et al., 2015; Zelechowski et al., 2013). In a survey of RTCs in New York state, Baker et al. (2008) found that 81% of agencies indicated that staff turnover negatively impacted the provision of mental health

services and concluded that staff turnover created a barrier to the provision of individual therapy, establishing a therapeutic alliance, and creating a safe therapeutic milieu (Baker et al., 2008). Other researchers have also concluded that staff turnover is a barrier to implementing evidence-based practices including trauma-informed care in RTCs (Boel-Studt, 2017; Cohen et al., 2016; Garner, Hunter, Godley, & Godley, 2012; Hodgdon et al., 2013; James et al., 2015). High staff turnover rates in RTCs remains a concern that potentially can impede positive outcomes for youth in residential care (James et al., 2015; Ninan et al., 2014). Tremblay et al. (2016) found that high staff turnover resulted in youth requiring services for longer periods of time and more subsequent residential placements. Staff stability in RTCs is necessary to create a stable and safe environment, and staff turnover can negatively affect the youth in those programs (Connor et al., 2003; Seti, 2007).

In recent years, several researchers have focused on the staff turnover of social workers in the child welfare field providing child protection with much less emphasis on other professionals working with the same population of traumatized youth. Claiborne et al. (2015) and Schudrich et al. (2013) identified the lack of research on other professionals as a significant concern related to the treatment of traumatized children. Claiborne et al. (2015) studied factors related to intention to leave in not-for-profit child welfare agencies including RTCs. The sample for this quantitative study consisted of administrators and clinical professionals from child welfare agencies providing prevention, foster care, residential, and community-based services.

Claiborne et al. (2015) concluded that there was a significant correlation between job overload, role ambiguity, and organizational support and intent to leave for both administrators and clinicians in the agencies they studied. Claiborne et al. also found a significant correlation between job autonomy and intent to leave in administrators but not clinicians. One limitation to making causal inferences from this study is that the researchers collected the data at one point in time and the results might not be the same at a future or previous time. In addition, the participant's perception of the organization is based on self-report and may be vulnerable to social desirability bias. My cross-sectional study with data based on self-report has the same limitations. This study does, however, support the variable, perception of work environment in my study and the need for additional research on professionals other than social workers and child protection workers providing services in child welfare agencies.

In another study, Schudrich et al. (2013) identified the need for studies about staff turnover that focused on employees who have direct contact with traumatized children in the child welfare system other than social workers in the role of child protection workers and case workers. Schudrich et al. facilitated a quantitative study with a sample that included prevention workers in child welfare agencies and educators providing special education, career and vocational instruction, tutoring, and mentoring in residential and day treatment programs in the child welfare system. Study participants completed surveys that measured job satisfaction and intended turnover. There were significant similarities between child prevention workers and educators and the factors that predicted intended turnover. Satisfaction with contingent rewards was most predictive of intended

turnover in both groups and satisfaction with promotion opportunities was least predictive for both groups. Nature of the work was more predictive of intention to leave for prevention workers than educators. One potential limitation of the study is that the study participants came from one state and the results may not generalize to other geographic locations. In addition, the authors disclosed that fewer prevention workers than educators participated in the study. Nonetheless, this study expanded on prior research about the staff turnover in child welfare system by studying additional professionals who work with traumatized children. My study further expanded this knowledge by studying counseling professionals who provide clinical services in RTCs.

Few researchers have explored factors that cause and potentially mitigate staff turnover in RTCs (Connor et al., 2003). Fewer researchers have specifically studied the turnover of clinical staff in RTCs (Claiborne et al., 2015). Conner et al. (2003), often cited as one of the few studies about staff turnover in RTCs, found a turnover rate of 46.1% in a three-year period at a single RTC. Connor et al. reviewed the personnel files of employees at a single RTC over a period of three years and concluded that employees with positions that require the closest contact with the youth in the program had the highest rates of turnover. In addition, employees who were married, had shorter commutes, took advantage of tuition reimbursement incentives, and had pay increases were most likely to maintain their employment with the agency. The authors of this study only collected data from one agency, and therefore the results are not generalizable to other human service organizations. In addition, the researchers did not conduct any formal inter-rater reliability checks to statically strengthen the generalizability of the

findings. The variables in this study were limited to demographic data collected from personnel files and did not include other potential variables closely related to working with traumatized youth. My study expanded on the findings of Connor et al. (2003) by studying other variables that may be more closely related to the work environment and counselor responses to working with youth in RTCs.

In other research, Seti (2007) studied other variables potentially associated with turnover in RTCs by conducting a literature review of articles on burnout in RTCs with the intent to identify potential causes and treatments. Seti found in this review of the literature that researchers frequently recognized burnout as a significant factor related to the high turnover of RTC staff. Seti (2007) did not provide any empirical evidence of this connection. This absence of empirical data is a gap in the literature that my study addressed by collecting and analyzing data on the relationship between burnout and the turnover of counseling professional working in RTCs

While I could find no studies specifically on the relationship between vicarious trauma and staff turnover in RTCs, Middleton and Potter (2015) studied the turnover of child welfare professionals from five diverse child welfare organizations. In the introduction to their study, these authors identified RTCs as one of the settings where child welfare professionals work. Middleton and Potter found a significant correlation between secondary trauma and turnover. This study supported my decision to include vicarious trauma as a predictor variable to explore the turnover of counseling professionals in RTCs in this dissertation study.

My review of studies on the factors that contribute to staff turnover in RTCs provided evidence that scholars and practitioners need additional research to understand turnover and find potential effective interventions. Few researchers have addressed the issue of staff turnover in RTCs despite the negative effect it can have on outcomes for youth in residential treatment settings. My dissertation project will fill this gap by providing research that will address factors that predict counselor turnover in RTCs as well as potential interventions to increase staff retention.

Burnout

Professionals working in the human services field are impacted both personally and professionally by their work (Rollins et al., 2016; Sprang, Craig, & Clark, 2011). One risk experienced by human services professionals is burnout. Burnout is a syndrome introduced by Maslach and Jackson (1981) to describe the emotional and physical exhaustion experienced by human service workers. Maslach (2017) defined this syndrome as consisting of three characteristics including exhaustion, cynicism, and decreased professional efficacy. Leiter and Maslach (2016) described exhaustion as feeling depleted, fatigued, and lacking energy; cynicism as a detachment from one's job and clients, negativity, irritability, loss of ideals, and withdrawal; and decreased efficacy as feeling ineffective and a lack of accomplishment resulting in lower productivity and morale. Burnout in the mental health field has negative consequences for mental health professionals, organizations, and clients in care (Green et al., 2013).

Burnout in human services professionals can result in decreased productivity and job performance, insensitivity to client needs, poor physical and mental health, problems

in family and social relationships, absenteeism, and increased turnover (Rollins et al., 2016; Salyer et al., 2015). Researchers in the human services field frequently refer to the close association between burnout and voluntary job turnover (Ducharme, Knudsen, & Roan, 2008; Green et al., 2013; Salyer et al., 2015). While researchers frequently associated burnout with employee turnover in the mental health field, Paris and Hoge (2010) suggested after their review of the literature, that more empirical evidence is needed to make this causal inference.

Counselor Burnout

Burnout in counseling professionals is a serious problem that can negatively affect the counselor's well-being and the quality of care they provide to their clients (Cieslak et al., 2014; Green et al., 2013; Lee, Cho, Kissinger, & Ogle, 2010). Counselors have frequent and intense involvement with clients who present complex and emotionally draining problems. This empathic engagement in addition to managing heavy caseloads, completing paperwork, billing, and crisis intervention without adequate resources can contribute to the risk of counselor burnout (Gutierrez & Mullen, 2016; Lin, 2012; Thompson et al., 2014). Burnout can lead to counselor impairment that diminishes a counselor's ability to be effective in their role as a mental health clinician (Gutierrez & Mullen, 2016; Salyer et al., 2015; Wardle & Mayorga, 2016).

Salyer et al. (2015) facilitated a quantitative study to explore the impact counselor burnout had on the quality of care in a community mental health center (CMHC). The sample consisted of 113 staff members from a CMHC. The study participants completed a survey that included scales to assess burnout, job satisfaction, intention to turnover,

expectations of consumer recovery, and self-reported quality of care. Consistent with their hypothesis, Salyer et al. (2015) found a significant negative correlation between burnout and self-reported quality of care. Counselors with higher levels of burnout reported that they provided poorer quality of care. One limitation of this study is that the measure of client quality of care was self-reported. Additional research that correlated burnout with client reports of quality of care may help to strengthen these findings. None the less, there is substantial evidence based on the definition of burnout and the ways it affects counselors both personally and professionally that it can negatively impact client care.

Burnout tends to gradually build up over time and often counselors are unaware it is happening (Galeck 2011; Lin, 2012; Wardle & Mayorga, 2016). Counselors experiencing burnout cannot provide the highest quality of counseling services and experience a decrease in their quality of life and personal wellbeing (Green et al., 2013; Gutierrez & Mullen, 2016; Wardle & Mayorga, 2016). When counselors become cynical about their work, they can diminish the therapeutic alliance by depersonalizing their clients (Gutierrez & Mullen, 2016). Counselor burnout also negatively impacts clients and the counseling field because feelings of exhaustion, cynicism, and diminished self-efficacy will eventually prompt the counselor to leave the field (Green et al., 2013; Wardle & Mayorga, 2016).

Green et al. (2013) explored the relationship between burnout and employee turnover and potential interventions in the mental health field. Green et al. facilitated a quantitative study that explored the relationship between burnout and staff turnover and

the potential mediating role of transformational leadership. The sample for this study came from public mental health programs providing mental health services to children, adolescents, and families. A total of 388 community mental health providers voluntarily participated in the study. Study participants completed surveys that measured levels of emotional exhaustion, the extent to which they perceived various leadership activities from their supervisors, their intent to leave, and demographic control variables. Green et al. found a significant positive correlation between emotional exhaustion and turnover intention. In addition, transformational leadership reduced the association between emotional exhaustion and turnover intention. Inherent to the design of this study, the results may not be generalizable to the larger population of service providers in CMCH's. The sample was voluntary and may not represent people who chose not to participate. Counselors who chose not to participate may be experiencing more burnout. In addition, the study was limited to CMCH's in one geographic location (Green et al., 2013).

While the results of this study are encouraging, additional research is needed to understand and prevent burnout in the counseling field. Most research on counselor burnout has focused on organizational changes that may prevent burnout, however, Hardiman and Simmons (2013) also suggested that exploring personal resources and other protective factors may be constructive for prevention. My dissertation project addressed this need by including burnout and self-care as two of the variables I studied in relation to counselor turnover in RTCs.

Burnout in Residential Treatment Centers

Counseling professionals in RTCs are also vulnerable to burnout. These professionals provide empathic care to youth with complex mental health issues, provide crisis intervention, have heavy workloads, work long hours, experience role confusion, and have inadequate resources to perform their jobs (Lipschitz-Elhawi, 2009; Seti, 2007). Counselors working in community mental health agencies and inpatient settings report more burnout than those working in private practice (Galek et al., 2011; Hardiman & Simmonds, 2013; Seti, 2007; Thompson et al., 2014). Currently, I could find only one study specifically about mental health professionals providing counseling services in RTCs (Lipschitz-Elhawi, 2009).

Lipschitz-Elhawi (2009) studied social workers providing therapeutic services in RTCs. In this qualitative study, Lipschitz-Elhawi provided a case study on her therapeutic work with an adolescent girl in an RTC and concluded that professionals providing therapeutic services in RTCs often experience feelings of hopelessness and helplessness that negatively impacts the care they provide to the youth in those programs. Lipschitz-Elhawi attributed this hopelessness to the anger and lack of trust youth in RTCs feel towards adults as well as the limited resources available to provide the intense care needed to treat these traumatized children. Supervision, taking proactive treatment steps, focusing on reality, adopting a positive approach, and finding meaning in her work helped to increase feelings of hopefulness in her therapeutic work. This qualitative study represents one person's experience with aspects of burnout working in RTCs. This qualitative study leads the way for additional empirical research that will explore the

existence of burnout and potential interventions to prevent burnout in professionals providing clinical services to youth in RTCs. My dissertation project expanded on Lipschit-Elhawi (2009) by potentially providing empirical evidence of burnout in counseling professionals providing counseling services to youth in RTCs and identifying potential interventions.

Researchers have also studied residential child care workers (excluding clinical staff) who provide direct care to children in residential treatment settings and burnout (Lakin, Leon, & Miller, 2008; Seti, 2007). Seti (2009) reviewed the literature on burnout and concluded that burnout in human service workers can be attributed to personal characteristics, job/role characteristics, and organizational characteristics. Seti identified several organizational factors that potentially contributed to the burnout of child care workers in RTCs including low pay, role confusion, daily exposure to the internalizing and externalizing behavior of children in care, inadequate co-worker and supervisor support, lack of decision making power, and lack of advancement opportunities. Seti concluded that providing supervisor and co-worker support, ensuring employee understanding of their job responsibilities, and allowing involvement in decision making were strategies to help prevent burnout in child care workers in RTCs. Factors that contributed to and prevented burnout in child care workers might also apply to other employees in these settings such as administrators and clinical staff (Seti 2007). This literature review (Seti, 2007) provided valuable information about potential work environment factors that contributed to and prevented burnout in RTCs, however, there remains a need for empirical research that will expand upon these findings.

Lakin et al. (2008) facilitated a quantitative study with a cross-sectional survey design that included direct care staff from 21 RTCs in the state of Illinois. Participants completed a demographic questionnaire and surveys that measured the three components of burnout (emotional exhaustion, depersonalization, and decreased self-efficacy), empathic concern, emotional contagion, communicative responsiveness, and the BFI that measured five dimensions of personality. Larkin et al. found that employees with inadequate training experienced more burnout, while higher levels of empathic concern for clients resulted in less burnout. Staff members who identified as extroverts and who had realistic expectations of themselves and others also experienced less burnout. Lastly, supervisory support had a significant negative correlation with burnout. One limitation to this research is the lack of generalizability beyond the Illinois region. In addition, the sample was voluntary and may not represent study participants who chose not to participate. Additional, research to support these findings in other geographic regions will help to add weight to the findings of this study.

The studies reviewed in this section were not current within the past five years. I was unable to find any more current studies that addressed burnout specifically in RTC staff. Burnout negatively impacts employees, organizations, children in care, and is presumed to be a significant factor leading to high staff turnover in RTCs (Seti, 2007). Researchers have emphasized the need for continued focus on understanding burnout and the prevention of employee burnout for staff working in RTCs (Lakin et al., 2008; Lipschitz-Elhawi, 2009; Seti, 2007). My study contributed to this need for additional

studies by providing additional empirical research relevant to understanding and preventing burnout in counselors and potentially other professionals working in RTCs.

Burnout in Other Child Welfare Settings

Researchers have also studied burnout in child protection workers and social workers in child welfare agencies providing services to the same client population as those receiving services in RTCs (Boyas et al., 2013; Kim et al., 2012). Boyas et al. (2012) found that elements of burnout influenced by job stress, organizational factors, and quality of work relationships influenced intention to leave. Job stress included the daily exposure to and responsibility for high need children and families. Kim et al. (2012) found that a perception of organizational justice moderated the relationship between burnout and intent to leave in social workers working in child welfare agencies.

Salloum et al. (2015) also studied burnout in child welfare providers and found that burnout was a significant problem in child welfare and trauma informed self-care had a significant negative correlation with burnout. Salloum et al. concluded that burnout was a significant barrier to the provision of services to traumatized children and suggested the need for further studies to explore burnout, its connection to turnover, and the prevention of burnout. Salloum et al. (2015) identified the use of an unvalidated scale to measure self-care as a limitation to the study and the study findings. These authors' findings and the limitations of this study provided background evidence that there was a need for this dissertation study.

Vicarious Trauma

Another occupational hazard associated with working with traumatized individuals is vicarious trauma (Dombo & Blome, 2016; Middleton & Potter, 2015). While there are similarities between burnout and vicarious trauma (VT), they are distinctly different (Evces, 2015; Harrison & Westwood, 2009). Both constructs describe a mental health professional's response to the stress of working in a helping profession (Thompson et al., 2014). Burnout, however, is associated with prolonged exposure to emotionally demanding work (Cieslak et al., 2014; Figley, 1995). In contrast, vicarious trauma is specifically related to the helping professional's exposure to the traumatic experiences of others (Knight, 2013; Perkins & Sprang, 2013; Thompson et al., 2014). Individuals exposed to the traumatic stories and memories of others can be affected personally by the traumatic event (Dombo & Blome, 2016). Over time a counselor's empathic engagement with trauma survivors can result in fundamental changes to beliefs about themselves, others, and the world (McCann & Pearlman, 1990). This transformation in how counselors view the world can have a detrimental effect on their personal and professional lives (Trippany et al., 2004).

Another construct used to describe a helping professional's response to working with trauma survivors is secondary traumatic stress (STS) or compassion fatigue (Ivicic & Motta, 2017). Secondary traumatic stress, also called compassion fatigue (CF), refers to the posttraumatic stress symptoms manifested in helping professionals exposed to the traumatic experiences of other individuals (Hensel, Ruiz, Finney & Dewa, 2015). Research on whether burnout and VT may have an additive effect on each other or

whether one is a precursor to the other is inconclusive (Cieslak, 2014; Galeck, 2011; Newell et al., 2016). There is evidence that increased levels of burnout may increase the risk of vicarious trauma (Eastwood & Ecklund, 2008)

VT, STS, and CF History and Definitions

VT is a concept that emerged in the 1990's and is largely attributed to the work of Lori Ann Pearlman (Newell et al., 2016). VT refers to transformation in a helping professional's cognitive schemas based on secondary exposure to another person's traumatic experiences (Pearlman & Mac Ian, 1995). VT is based on CSDT and McCann and Pearlman (1990) suggested that a mental health provider's beliefs, expectations, and assumptions about the world are influenced by empathic engagement with trauma survivors. VT impacts the therapist's worldviews regarding safety, trust, intimacy, self-esteem, and control as they relate to self and others (Robinson-Keilig, 2014; Saakvitne & Pearlman, 1996).

Also, during the 1990's, Charles Figley introduced the concepts of STS and CF (Newell et al., 2016). STS and CF are concepts used interchangeably (Figley, 1995). Figley (1995) suggested that mental health professionals providing care to traumatized individuals can develop trauma symptoms that mirror their clients. These care providers may begin to exhibit symptoms consistent with Post Traumatic Stress Disorder (Figley, 1995; Hensel et al., 2015; Ivicic & Motta, 2017). Three clusters of symptoms include intrusive reexperiencing, avoidance of trauma-related stimuli, and increased physical arousal (Cieslak et al., 2014). For mental health professionals, these symptoms can include intrusive thoughts, flashbacks, nightmare associated with client traumas,

emotional arousal, and avoidance of clients and client situations (Figley, 1995; Galek et al., 2011; Gil & Wainberg, 2015; Newell et al., 2016).

While there are differences in how VT and STS describe the impact of working with traumatized clients, there is no evidence they are distinct constructs (Bercier & Maynard, 2015). CSDT describes and provides an explanation for both VT and STS (Dunkley & Whelan, 2006; McCann & Pearlman, 1990). Both VT and STS are psychological responses associated with providing counseling to clients who have experienced trauma (Craig & Sprang, 2010). There is agreement that working with trauma survivors can result in psychological distress, cognitive shifts, and a disturbance in relationships (Aparicio et al., 2013; Bercier & Maynard, 2015). There is also agreement that VT and STS can be debilitating to mental health professionals and have a negative effect on the clients in their care (Abassay & Goodrich, 2014; Bercier & Maynard, 2015; Hensel et al., 2015; Ray, Wong, White, & Heaslip, 2013). McCormack and Adams (2016) stated that they included CF and STS within their discussion of VT as all three refer to "traumatic distress experienced from vicarious exposure" (p. 192). In this study, I followed the lead of McCormack and Adams (2016) and used the terminology VT to refer to all three constructs unless I was citing a specific study and used the language of the author.

Counselors and Vicarious Trauma

Counseling professionals are at risk for VT because of the work they do with traumatized clients (Abassay & Goodrich, 2014; Robinson-Keilig, 2014). Ivicic and Motta (2017) facilitated a quantitative study to explore the presence of STS and variables

associated with STS among mental health professionals. The sample for this study consisted of 88 mental health professionals from social service agencies in New York state and a listserv of trauma therapists. Participants completed a demographic questionnaire, a secondary trauma scale, a life events checklist, job satisfaction questionnaire, and a supervision scale. The participants also participated in a modified stoop procedure, an instrument that measured participants response times to trauma-related stimuli, to measure STS. Ivicic and Motto found that between 22.7% and 27.3% of licensed mental health clinicians in the study experienced some degree of STS. Female participants and those with personal trauma histories experienced more secondary trauma. There was no relationship between the level of trauma exposure, quality of supervision, and job satisfaction and secondary traumatization. One limitation of this study was that the researchers used the modified stoop to measure STS. Ivicic and Motto (2017) acknowledged limited empirical evidence that the modified stoop is a reliable and valid method to measure STS. The results of this study contradicted other researchers' findings that the most significant predictor of STS was exposure to traumatized clients (Hensel et al., 2015; McKim & Smith-Adcock, 2014; Robinson-Keilig, 2014).

While counseling professionals have largely accepted that VT is a potential risk associated with providing clinical care to traumatized clients (Bercier and Maynard, 2015; Robinson-Keilig, 2014), researchers have historically found conflicting results about the factors that predict and protect against this occupational hazard. The factor most frequently associated with the risk of VT is the amount of exposure to traumatized clients (McKim & Smith-Adcock, 2014). McKim and Smith-Adcock (2014) facilitated a

quantitative study to explore the relationship between work place variables and CF and compassion satisfaction (CS). The sample consisted of 98 mental health providers recruited from the International Society for Traumatic Stress Studies (ISTSS) and the Association for Traumatic Stress Specialists (ATSS). These voluntary participants completed the Professional Quality of Life Scale (ProQOL, Stamm, 2005), the Psychologist's Burnout Inventory (PBI) and the Stressful Life Experiences – Short Form (Stam, 1997). The PBI is a scale that measures four workplace factors correlated with burnout but not VT and the Stressful Life Experiences – Short Form measured personal trauma history (McKim & Smith-Adcock, 2014). McKim and Smith-Adcock analyzed the data with correlation and multiple regression data analysis methods and found that the perception of less control over their workplace, more over-involvement with clients, and a higher amount of secondary exposure to their client's traumatic experiences resulted in increased CF.

In another quantitative study, Robinson-Keilig (2014) studied mental health professionals providing therapy to trauma clients. A total of 316 participants completed surveys to measure STS, relationship and intimacy variables, communication patterns, and a sexual dysfunction assessment. Robinson-Keilig analyzed the correlations between variables and found that being female, fewer years of experience, and a higher caseload of trauma clients resulted in higher levels of STS. Lower levels of relationship satisfaction, social intimacy, constructive communication patterns, and interest in sexual activity were related to higher levels of STS (Robinson-Keilig, 2014).

Additionally, Hensel et al. (2015) facilitated a meta-analysis of previous research and concluded that there was a significant relationship between STS and the proportion of traumatized clients and personal trauma history. Gil and Weinberg (2015) also facilitated a quantitative study to explore factors that predicted and prevented STS in mental health providers. The sample for this study included 160 social work therapists in Israel who were treating clients who were victims of trauma. Gil and Weinberg (2015) concluded from their hierarchical regression analysis that coping strategies including seeking emotional support and disengaging, personal trauma history, and high exposure to traumatized clients increased levels of STS, and optimism, feelings of mastery, and weekly supervision decreased STS symptoms. The findings from these studies (Ivicic & Motta, 2017; Gil & Weinberg, 2015; Hensel et al., 2015; McKim & Smith-Adcock, 2014; Robinson-Keilig, 2014) are significant because counselors experience frequent exposure to the traumatic content of their client's experiences (Abassay & Goodrich, 2014). This is particularly true of counselors working in RTCs. As mentioned previously, 92 % of youth in RTCs have experience multiple traumatic events (Briggs et al., 2012; Harr et al., 2013; Zelechowski et al., 2013)

While the association between perception of work environment and burnout and turnover is fairly established, fewer researchers have addressed the relationship between vicarious trauma and staff turnover. Cole et al. (2014) wrote a position paper on human service providers and CF and addressed risk factors and protective factors associated with CF. Cole et al. concluded that CF is a significant problem in the mental health field that contributes to the high turnover rate of human services practitioners and has a negative

effect on client outcomes. The Middleton and Potter (2015) study remains one of the only empirical studies I could find that made a connection between VT and staff turnover in the mental health field. There remains a need for additional studies that will address the predictive role VT may play in the turnover of mental health professionals. In this dissertation project, I addressed this need by studying the potential role VT plays in the turnover of counseling professional providing counseling services to youth in RTCs.

Vicarious Trauma in Residential Counselors

There is limited research in the counseling and child welfare literature specific to VT and residential counselors. McCormick and Adams (2016) studied trauma therapists providing clinical services to adults in an inpatient setting. Childhood maltreatment including sexual and physical abuse are common among adult patients in these settings. The participants in this qualitative study included four mental health professionals working in an Australian inpatient psychiatric facility. McCormick and Adams coded data from participant interviews and concluded from the themes that emerged that participants in the study experienced "significant psychological distress" as a result of chronic exposure to clients with complex trauma histories (p. 198). The qualitative nature of this study limited the generalizability of the results. These researchers, however, provided valuable information about the impact working with traumatized clients from inpatient settings may have on counselors. This study provided background information about the potential for counselors in RTCs to experience VT and supported my inclusion of this construct as a variable in this dissertation project.

Practitioners working in therapeutic milieus with traumatized children are at risk for VT (Steinlin et al., 2017; Wolf, Green, Nochajski, Mendel, & Kusmaul, 2014; Zerach, 2013). Steinlin et al. (2017) facilitated a quantitative study of staff working in RTCs for youth in Switzerland and potential STS and burnout interventions. One conclusion from this study was that staff members working with children and adolescents in RTCs are vulnerable to STS due to reading and hearing about the traumatic experiences of those youths. Approximately 69% of the study participants reported STS symptoms directly after hearing about or reading a traumatizing event, and approximately 20% continued to experience STS symptoms after four weeks. While his study was not specific to counselor providing clinical services, the sample included clinical staff. Other findings from this study were that personal factors such as self-care and organizational factors including perceived support from co-workers and environmental safety were negatively correlated with STS symptoms (Steinlin et al., 2017). One limitation to this study was that the sample was voluntary and the researchers collected the data self-report surveys. This data, however, does support other researchers who found that the work environment in RTCs for youth is one that can contribute to VT in mental health professionals.

Zerach (2013) facilitated a quantitative study of 212 direct care providers for youth in RTCs and concluded that residential child care workers are at risk for VT. Zerach compared the experiences of residential child care workers (RCW) to a control group of educational boarding school workers (BSW). The study participants completed several surveys to measure VT, personality characteristics, and spirituality practices. Both RCS's and BSW's were vulnerable to STS due to providing care to youth with

behavioral and emotional problems. Personality resources including spirituality decreased the effect of STS and reduced high staff turnover.

In another study, Whitfield and Kanter (2014) concluded from their review of the literature that helping children heal from traumatic experiences can make the people supporting them vulnerable to VT. This study also did not specifically address counselors working in RTCs. I found no current studies that specifically addressed the relationship between VT and turnover of professional counselors providing counseling services to youth in RTCs.

Vicarious Trauma in Child Welfare

There is significantly more research on vicarious trauma in social workers and child welfare workers than counselors providing therapeutic services to traumatized children. Some of these studies refer only to social workers providing child protection services in public child welfare agencies (Dombo, 2016; Geoffrion, Morseli, & Guay, 2016; Salloum et al., 2015; Sprang et al., 2011; Tavormina & Clossey, 2017), while others cast a broader net and include mental health professionals working in other agencies and capacities with children in the child welfare system (Middleton & Potter, 2015). Child welfare workers who work daily with children who have experienced trauma are particularly vulnerable to experiencing VT (Dombo & Blome, 2016; Geoffrion et al., 2016; Middleton & Potter, 2015; Sprang et al., 2011; Tavormina & Clossey, 2017).

Dombo and Blome (2016) facilitated an exploratory qualitative study and found several factors in child welfare agencies that contribute to VT. Dombo and Blome

invited directors from child welfare organizations from ten regions in the U. S. to participate in a phone interview to help the researchers learn more about organizational responses to VT. The researchers used thematic analysis to analyze the data. Seven themes emerged including strengths in the organizations, barriers to addressing needs, organizational culture, organizational responsibility, need for training of workers, supervision of workers, and resources. Dombo and Blome concluded that factors within these child welfare agencies including many needs, too few resources and numerous agendas to fulfill contributed to VT. Administrators interviewed by the researchers suspected that VT contributed to staff turnover (Dombo & Blome, 2016). The exploratory nature of this study and the small sample size limited the generalizability of these results. The researchers expressed concern that their sample may not have achieved saturation because directors from only five out of the ten agencies contacted participated. This study provided exploratory research that supported my current study. This dissertation will potentially add to the empirical evidence of the relationship between VT and employee turnover in the child welfare field.

In another study, Tavormina and Clossey (2017) used a grounded study design to explore the impact of working with maltreated children and perception of crisis from the perspective of child protection workers. Four themes emerged in the data including child protection worker's perception of crisis as the breakdown of biopsychosocial resources; workers must triage when crisis occurs; workers experience secondary trauma; and the personal lives of child protection workers are affected by their work (Tavormina & Clossey, 2017). This study was also exploratory and provided background that supports

the need for empirical research that will explore the existence of VT in child welfare professionals and its relationship to turnover.

Salloum et al. (2015) facilitated a quantitative study and reported that 31.7% of the study participants reported some level of CF. There was a significant negative correlation between trauma-informed self-care and burnout but surprisingly not CF. This study included only child welfare workers in child welfare agencies and did not include other counseling professionals working with the same group of traumatized children.

Middleton and Potter (2015) also facilitated a quantitative study to explore turnover in child welfare and found a significant positive correlation between VT and intent to leave in child welfare professionals. This study included mental health professionals working in RTCs. Middleton and Potter concluded that there is a need for research that will study other professionals working with traumatized children, including clinical staff in RTCs, and the link between VT and staff turnover (Middleton & Potter, 2015). My research provided information to fill this gap.

Self-Care

Self-care is “any actions or experiences that enhance or maintain counselors’ well-being” (Bradley et al., 2013, p. 456). Richards (2010) facilitated a quantitative study to explore the effects of self-care, self-awareness, and mindfulness on counselor well-being and found that counselors who believed self-care was important had a greater sense of well-being. A total of 148 mental health professionals with a bachelor's degree or higher in the northeastern United States participated in the study by completing surveys to measure the variables. Richards concluded from their data analysis that self-

care had both indirect and direct effects on well-being. One limitation of this study and other research on self-care is that the self-care measure is based on self-report.

Counselors may understand the importance of self-care and wellbeing and overstate the existence of both (Richards, 2010).

The ACA, Code of Ethics (2014) identified self-care as a required practice to maintain emotional, physical, mental, and spiritual health to provide quality care to their clients. Counselors who do not engage in self-care are more vulnerable to counselor impairment including burnout and VT (Bradley et al., 2013; Bressi & Vaden, 2017; Brennan, 2013; Gutierrez & Mullen, 2016; Mailloux, 2014; Pearlman & MacIan, 1999). Organizations and individuals both have a responsibility to promote self-care and counselor wellness (Alani & Stroink, 2015; Iqbal, 2015; Knight, 2013; Lin, 2012; Pearlman & Saakvitne, 1995).

Self-care strategies include practices that promote resilience that will help counselors to withstand the emotional demands of their work (Simms, 2017). These practices help to maintain physical and psychological wellbeing. These include healthy life choices such as exercise, a healthy diet, and adequate sleep; leisure activities outside of work; and social support within and outside the work environment (Alani & Stroink, 2015). Another approach to self-care includes practices that transform the effects of counseling work into personal and professional growth (Simms, 2017). This type of self-care includes mindfulness and self-reflective activities. These activities help counselors to make meaning out of the experiences of their clients and their role in their healing process. Some researchers have speculated that while self-care practices that promote

resilience may be enough to mediate the effects of burnout, approaches that provide a transformative experience may also be necessary to prevent and heal from VT (Maillkoux, 2014; Saakvitne & Pearlman, 1996; Salloum et al., 2015; Simms, 2017).

Scholars in the mental health field have long promoted the value of self-care practices for preventing counselor impairment (Bradley et al., 2013; Brennan 2013; Hendricks, Bradley, Borgan III, & Brogan, 2009; Iqbal, 2015; Ivicic & Motta, 2017; Knight, 2013; Mailloux, 2014; Mayorga, Devries, & Wardle, 2015; Pearlman & Saakvitne, 1995; Williams et al., 2010). There is, however, limited empirical research on the relationship between self-care and counselor impairment including burnout and VT (Bradley et al., 2013; Jordan, 2010; Miller and Sprang, 2017; Paris & Hoge, 2010; Williams et al., 2010). Researchers have predominantly used qualitative designs to explore counselor's experiences with burnout, VT, and self-care (Alani & Stroink, 2015; Barlow & Phelan, 2007; Breiddal, 2012; Christopher & Maris, 2010; Christopher et al., 2011; Harrison & Westwood, 2009; Lin, 2012; Patsiopoulos & Buchanan, 2011)

Evidence that self-care is an important intervention to prevent burnout and VT is largely speculative and anecdotal. Bercier and Maynard (2015) stated the need for more research, both qualitative and quantitative, to identify protective factors for burnout and vicarious trauma. While self-care is a variable that appears to mediate burnout and VT, and scholars and practitioners believe there is an association between burnout and VT and turnover in helping professions, very few researchers have studied the potential relationship between self-care and turnover in the mental health field (Paris & Hoge, 2010). Paris and Hoge (2010) concluded from their review of relevant mental health

literature that self-care strategies could decrease burnout and prevent turnover in the behavioral health workforce.

Counselors and Self-Care

Limited empirical research exists in the counseling and child welfare literature on the relationship between self-care and burnout and VT. Beaumont, Durkin, Martin, and Carson (2016) facilitated a quantitative study to explore the relationship between self-compassion and STS and burnout. A sample of 54 student counselor and cognitive behavioral psychotherapists participated in the study by completing self-report surveys that measured the variables in the study. Beaumont et al. found that student counselors and cognitive behavioral psychotherapists who engaged in self-care practices that promoted self-compassion had a greater sense of wellbeing that decreased the risks of burnout and VT. The sample size for this study, however, was small and only represented students in the mental health field. The results, therefore, may not be generalizable to counselors already working in the profession. Nonetheless, these researchers were able to demonstrate a relationship between self-care and STS and burnout.

In earlier research, Harrison and West (2009) facilitated a qualitative study to explore the relationship between self-care and VT and burnout. Participants in this study included trauma counselors working in the field longer than ten years. Harrison and West interviewed study participants who scored below average on the burnout and CF scales of the Pro-QOL and concluded by analyzing the thematic content of the data that mindfulness practices, holistic self-care, professional satisfaction, active optimism, clear

boundaries, and honoring limits all contributed to less than average levels of VT and burnout. The small sample size consistent with qualitative research limits the generalizability of these results. These results do, however, replicate the findings from other researchers and suggested the need for additional research with larger sample sizes to add to the current understanding of the relationship between self-care, burnout, and VT.

In another qualitative study, Lin (2012) interviewed nine female counselors in a University Counseling Center in Taiwan. Lin utilized a phenomenological design to understand the experience of burnout, self-care, and recovery from the perspective of the mental health practitioners and concluded from their thematic analysis of the interviews that work environment factors contributed to counselor burnout and that engaging in self-care activities helped counselors to recover from the impacts of burnout. The sample for this study was small and only included women which limited the generalizability of the study results. Nonetheless, these findings were consistent with previous findings of the relationship between self-care and burnout. These studies on the relationship between self-care and burnout and VT provided background to support the inclusion of self-care in my study. It is possible that the relationship between self-care and burnout and VT will facilitate a mediating role between self-care and burnout and VT and staff turnover.

Self-Care Themes in the Literature

Several themes emerged in my review of the literature on counselor wellness and self-care. The first theme is that self-care is an ethical requirement for counselors to avoid impairment and provide quality care to their clients (Brennan, 2013; Hendricks et

al., 2009; Iqbal, 2015; Mailloux, 2014). Brennan (2013) wrote an article that provided guidelines for ethical practice for mental health counselors in private practice. Brennan included attending to well-being and engaging in self-care as a requirement for providing ethical treatment to clients. In another study, Iqbal (2015) provided a theoretical paper on counseling ethics and VT and concluded that therapists must be honest with themselves about the impact of VT and have a responsibility to their colleagues and clients to "take responsibility for their wellbeing through the use of self-care" (p. 50). Mailloux (2014) also reviewed ethical standards in the counseling field and endorsed the requirement that trauma counselors engage in self-care to protect their clients.

The second theme that emerged in the literature is that while counseling professionals understand the importance of self-care, they often do not engage in self-care practices (Alani & Stoinik, 2015; Barlow & Phelan, 2007; Bradley et al., 2013; Mailloux, 2014). Alani and Stoinik (2015) facilitated a qualitative study to explore self-care practices and barriers among mental health professionals working with female survivors of domestic violence. Alani and Stoinik interviewed seven women working in different organizations in a city in Ontario and found from the emergent themes that female counselors often did not engage in self-care activities due to responsibilities in their homes that took precedence over self-care activities. This lack of self-care was despite understanding the importance of this practice.

Barlow and Phelan (2007) also identified a barrier to self-care in their qualitative study. Barlow and Phelan facilitated a single case study of a trio of grief counselors who met weekly for six weeks for support and peer supervision. The barrier to self-care that

emerged from the data analysis of this case study was a work environment that does not support time for self-care or acknowledge the personal impact staff members experience from emotional work.

The third theme that emerged is the recognition that self-care activities that promote resilience may not be enough in themselves to prevent and heal from the effects of VT. Mental health professionals may also need self-care strategies that transform the experience and promote concepts such as post-traumatic growth and compassion satisfaction (Christopher & Maris, 2010; Christopher et al., 2011; Miller & Sprang, 2017; Patsiopoulos & Buchanan, 2011; Simms, 2017). Posttraumatic growth refers to the personal growth that can result from traumatic experiences (Newswald-Potter & Simmons, 2016). Compassion satisfaction refers to the positive feelings and benefits associated with helping people who are suffering or traumatized (Salloum et al., 2015).

Christopher and Maris (2010) facilitated a qualitative study to explore the effects of mindfulness practices on personal wellbeing by introducing mindfulness exercises to their students in counseling courses and concluded from their interviews with students that mindfulness training was transformative. Students reported a noticeable change in their personal and professional wellbeing (Christopher & Maris, 2010). In another qualitative study, Patsiopoulos and Buchanan (2011) found that self-compassion was a self-care strategy in addition to other self-care strategies that promoted a good work/life balance and contributed to a greater sense of wellbeing that potentially helped counselors avoid burnout.

Researchers including Miller and Sprang (2017) proposed that self-care practices that focus on self-nurturing and escape are not enough to address and prevent burnout and VT. Miller and Sprang (2017) proposed that a model for counselor training that incorporated aspects of mindfulness, affect regulation, and compassionate supervision would be more effective than self-nurturing self-care strategies alone. Miller and Sprang identified the need for further empirical testing to determine the effectiveness of this model for reducing VT. Thompson et al. (2014) also facilitated a quantitative study on the predictors of VT and burnout in mental health counselors. The sample for this study included 213 voluntary mental health counselors from the American Mental Health Counselors Association (AMHCA). Study participants completed an online survey with questions that represented the variables in the study. Thompson et al. statistically analyzed the data and found a significant negative correlation between mindfulness attitudes and positive coping strategies including social support and religious beliefs and levels of burnout and CF. The research I reviewed in this section provided rationale for my decision to use self-care measurement instrument that include self-nurturing and transformational self-care items to gather data for this dissertation study.

Self-Care and Residential Counselors

There is limited literature on the benefits of self-care for staff providing mental health services to youth in RTCs (Eastwood & Ecklund, 2008; Lakin et al., 2008; Steinlin et al., 2017). Steinlin et al. (2017) facilitated a quantitative study and concluded that reading and hearing about the traumatic experiences of youth in RTCs could lead to VT and burnout. Steinlin et al. further concluded there was an association between self-care

and fewer symptoms of STS and burnout. Lakin et al. (2008) studied frontline staff in RTCs for youth and concluded that programs should focus on self-care to reduce the stress level of their staff and to decrease burnout.

In another study that addressed VT and self-care in RTCs, Eastwood and Ecklund (2008) collected data from 57 residential child care workers from two RTCs in a city in California. Participation in the study was voluntary. Study participants completed the ProQOL III (Stamm, 2005) to measure burnout and CF and a self-care practices questionnaire at an inservice training. Eastwood and Ecklund concluded from analyzing the data that leisure activities outside of work and family support decreased levels of burnout and CF. Study participation was limited to front-line child care workers and the results may not apply to other professionals working in RTCs. After an exhaustive search of the literature, I found no studies that addressed the potential relationship between self-care and staff turnover.

Self-Care and Child Welfare Workers

Researchers in both social work and counseling professions have concluded that in addition to self-care practices that focus on resilience, self-care strategies must also focus on meaning-making and self-discovery (Bressi & Vaden, 2017; McGarrigle & Walsh, 2011; Salloum et al., 2015). Bressi and Vaden (2017) provided a position paper that suggested the need for rethinking self-care strategies for social workers. Bressi and Vaden suggested that self-care must include “mechanisms for meaning-making and self-discovery” (p. 37).

In addition, McGarrigle and Walsh (2011) facilitated a mixed methods study to explore mindfulness, self-care, and wellness in social workers. Study participants participated in an 8-week meditative group that incorporated mindfulness practices for maintaining wellness. The study participants completed two brief surveys at the beginning and end of the class to assess their stress level and mindfulness awareness and wrote in an anonymous self-reflective journal at the beginning of each class. McGarrigle and Walsh concluded that mindfulness practices decreased the stress associated with their professional work and increased their quality of care. The limited sample and qualitative design of this study limit the generalizability of these results. The results, however, in combination with other similar research supports the value of mindfulness and other transformational self-care strategies. Salloum et al. (2015) also addressed the need for more transformational self-care methods and suggested that their finding that trauma-informed self-care did not predict VT indicated that child welfare workers potentially needed a more transformative process not measured in their self-care instrumented to prevent and recover from VT.

Researchers in child welfare have focused on the relationship between self-care, burnout, VT, and job turnover (Csiernik, Smith, Dewar, Dromgone, & O'Neill, 2010; Griffiths & Royse, 2017; Shannon, Simmelink-McCleary, Im, Becher, & Crook-Lyon, 2014). In a mixed methods study, Griffiths and Royse (2017) studied the reasons child welfare workers leave their positions. The sample for this study consisted of former child welfare workers known to the researchers. Qualitative data included interviews with the study participants. Griffiths and Royse collected quantitative data through a literature

review and coded items that contributed to employee turnover in child welfare organizations. Self-care emerged in the data analysis as an intervention that could have prevented turnover in staff members who left their positions.

In another study, Csiernik et al. (2010) facilitated quantitative research to study workplace stress and social support in child welfare workers. The sample included 13 newly hired social workers at a child welfare agency. Study participants participated in an 8-session social support group and completed a before and after questionnaire. Csiernik et al. discovered that child welfare workers do experience STS symptoms and that a support group helped social workers to manage those reactions to traumatic exposure. Though the authors provided no conclusive evidence, they speculated that this type of self-care could decrease turnover in the child welfare field.

Lastly, Shannon et al. (2014) facilitated a qualitative study to examine the value of including self-care practices in a trauma treatment course. Study participants included advanced social work students who volunteered to participate in a weekly class that addressed diagnostic assessment of complex trauma and VT. The researchers encouraged the students to participate in self-care practices taught in the class and analyzed the student's weekly journal entries. Shannon et al. concluded from analyzing the data in the journals that teaching self-care practices may increase longevity in the social work profession. The limited sample size and scope of the study participants limited the generalizability of the study results to the larger population of counseling professionals. However, these researchers added to a growing body of research by finding that self-care may decrease staff turnover in the child welfare field. These researchers, as well as the

other researchers introduced in previous paragraphs, provided data that supported my hypothesis that engagement in self-care practices will have a significant relationship with counselor turnover in RTCs. Counseling professionals in RTCs provide counseling services to traumatized youth similar to those encountered by other mental health professionals in the child welfare field.

Summary

Staff turnover in the child welfare field is a significant problem that negatively affects organizations, mental health professionals, and the quality of care they provide their clients (Benton, 2016; Middleton & Potter, 2015; Salloum et al., 2015; Shim, 2014). Staff turnover in RTCs for youth can negatively impact the alliance between traumatized youths and their therapists (Dozier et al., 2014; Zelechowski et al., 2013). This disruption in the alliance can decrease positive outcomes for youth receiving mental health services in residential programs (Byers & Lutz, 2015; Kapp et al., 2015; Roest et al., 2016). Researchers have associated staff turnover with the work environment, burnout, vicarious trauma (Dombo & Blome, 2016; Salloum et al., 2015) and self-care (Paris & Hoge, 2010). Counselor burnout and VT can cause counselor impairment that is detrimental to the personal and professional lives of counseling professionals and can negatively affect the care they provide clients (Steinlin et al., 2017). This study explored the relationship between work environment, burnout, vicarious trauma, self-care, and the turnover of counseling professionals providing counseling services to youth in RTCs. In Chapter 3, I will present the research design, sample population, methods for statistical analysis and the potential limitations of this study.

Chapter 3: Research Method

Introduction

The purpose of this quantitative study was to examine the relationship between perception of work environment, burnout, vicarious trauma, and self-care and the turnover of counseling professionals providing counseling to youth in RTCs. In Chapter 2, I provided a literature review of relevant research on this topic and the theoretical framework guiding this study. In Chapter 3, I will provide more detailed information about the methodology of this study. I will describe the design of the study and the methodology of this research project. In the methods section, I will describe the population I studied and how I chose the study participants. In this chapter, I will also explain the instruments I used to gather data, my procedures for analyzing the data, any potential threats to the validity of this study, and any potential ethical issues I addressed.

Research Design and Rationale

This quantitative study was a cross-sectional multiple regression design that utilized online surveys to gather the data. Researchers use multiple regression data analysis to determine the degree to which two or more independent variables will predict the outcome of a single dependent variable (Field, 2013; Uyanik & Guler, 2013). Researchers use cross-sectional survey designs to gather data from the study participants at one point in time (Zheng, 2015). Cross-sectional designs can also be less expensive to facilitate and take less time to complete than other study designs that require data collection over longer periods of time (Creswell, 2009; Dutwin & Buskirk, 2017). This was an appropriate design for my study because the intent was to determine the degree to

which four predictor variables (work environment, burnout, vicarious trauma, and self-care) would predict the outcome variable job turnover. This cross-sectional method was also appropriate because I collected the data from study participants at one point in time and the design accommodated the limited budget and academic deadlines of this dissertation project.

Surveys were an effective data collection method for this study because they allowed me to obtain a larger sample size than other methods of data collection such as interviewing or focus groups. This method was supported by previous researchers who have also used surveys as measurement instruments to gather data to examine the relationship between work environment, burnout, and vicarious trauma and job turnover in the mental health and child welfare fields (Boyas et al., 2013; Claiborne et al., 2015; Middleton & Potter, 2015).

To conduct this quantitative cross-sectional multiple regression study, I used SurveyMonkey, an online data collection format to measure the predictor and outcome variables. I measured the variables with reliable, valid, and frequently utilized instruments as well as a demographic questionnaire. I chose an online format because it was a convenient format for participants, is less expensive for the researcher to conduct, could easily reach potential participants in remote areas of the United States, was user friendly for participants, and is a common data collection format familiar to study participants (Dutwin & Buskirk, 2017; Groves et al., 2009). I used an online format to obtain data on the following variables with the corresponding instrument: perception of work environment with the PWCS (Thompson et al., 2014), burnout and vicarious

trauma with the ProQOL-5 (Stamm, 2010), self-care with the PSCS (Dorociak et al., 2017), and turnover with the ILCW (Auerbach et al., 2014). Lastly, I used a demographic questionnaire to collect general information to describe the participants.

I analyzed the data gathered from the measurement instruments using methods recommended by Field (2013) to assess the relationships between the predictor and outcome variables. These data analysis methods included: descriptive statistics, bivariate correlations of each pairing of independent and dependent variables, assessing model assumptions, and multiple regression assessing for statistical and practical significance to thoroughly answer the research question. The research question for this study was: what is the extent of the relationship between the turnover of counseling professionals providing counseling services to youth in RTCs and perception of work environment, burnout, vicarious trauma, and self-care practices?

Methodology

The methodology for this study was quantitative cross-sectional multiple regression. I provided voluntary participants with a survey to gather their demographic data and measure the predictor variables (perception of work environment, burnout, vicarious trauma, and self-care), and the outcome variable (turnover). I used multiple regression data analysis to make conclusions about the potential relationship between the variables in this study in order to answer the research question.

Participants

The inclusion criteria for participation in this study was master's level provisionally licensed or fully licensed counselors, marriage and family therapists, and

clinical social workers within the United States who provide counseling services to children and adolescents in RTCs. The sample included both provisionally licensed (working towards licensure) and fully licensed counselors, marriage and family therapists, and clinical social workers because RTCs are a work setting where newly graduated counseling professionals often find employment while they are accumulating their required hours towards licensure. The sample included professionals with master's degrees in mental health counseling, marriage and family counseling, social work, and other related counseling degrees. There were participants from no other region than the United States within this sample. No other delimitations existed.

I conducted two a priori power analyses methods to identify an appropriate estimated sample size. Researchers use power analysis to calculate the appropriate sample size for a quantitative study to mitigate the risk of type I and type II errors (Fugard & Potts, 2014). Type I errors occur when researchers find a relationship between study variables that does not exist, and type II errors occur when a relationship between the variables does exist and the researcher does not find it. First, I used the G*Power software to estimate the sample size. This software accounts for the probability of finding a statistically significant result (power), along with the desired magnitude of the relationship (effect size), and an acceptable margin of error to determine the sample size for a study. Within the G*Power analysis, I estimated an 80% chance that a statistically significant relationship would be found if one existed, a 95% margin of error, a medium effect size of .15, and entered that there would be four independent variables. The G*Power sample size calculated for my study was 85.

An alternative method to calculating an a priori power analysis to estimate sample size is a paper-pencil, hand calculation model. Green (1991) recommended calculating sample size by starting with a minimum of participants greater than or equal to 104 and then adding one additional participant for every independent variable included in the statistical analysis. Consistent with this study, I entered four independent variables. Thus, a sample size of 108 contains sufficient power for this proposed study. This sample size was higher than what G*Power calculated. To mitigate the difference in calculations, I planned to focus on obtaining a sample between 85 and 108.

I conducted this a priori power analysis because after an exhaustive search I could not find a directory of counseling professionals providing counseling services to youth in RTCs in the United States. I also was not able to determine the total population of counseling professionals providing counseling services to youth in the United States after I solicited help from RTC directors to provide information about their clinical staff. I identified 245 RTCs in the United States from which I solicited study participants. Each agency had a minimum of one counselor. If the total population was reported to be less than 200, I planned to calculate a sample size that was 30 to 50% of the total population to assure sufficient power to mitigate the risk of a type I or type II error. This would have been in place of the a priori calculated sample size of 85 to 108.

Sampling Procedures

The sampling methods I chose for this study were nonprobability and purposive sampling with inclusion criteria for the participants to meet. A nonprobability sample is not chosen randomly from the larger population and therefore cannot assure that the

sample represents every unit in the larger population (Etikan, Musa, & Alkissim, 2016). I did not choose a probability sample for the study because it is not feasible to obtain a complete list of all counseling professionals providing counseling services to youth in RTCs and then randomly choose a sample from that list. According to Etikan et al. (2016) nonprobability samples are used in place of probability samples when a list of the entire population is not available and when convenience and funding constraints outweigh the advantages of a probability sample. The disadvantage of a nonprobability sample; however, is that the results may be less accurate and cannot generalize to the larger population (Dutwin & Buskirk, 2017).

The purposive sample method of this study consisted of limiting participation to master's level provisionally licensed or fully licensed counselors, marriage and family therapists, and clinical social workers within the United States who provide counseling services to youth in RTCs. Counseling professionals in the United States was a purposive sample because as the researcher I used my subjective judgment to assume that counseling professionals who chose to participate in the study would represent the larger population (Etikan et al., 2016).

Procedures for Recruitment, Participation, and Data Collection

Recruitment. I recruited master's level provisionally licensed or fully licensed counselors, marriage and family therapists, and clinical social workers from 245 RTCs within the United States who provided counseling services to youth to participate in the study. I recruited these participants by soliciting the support of executive directors or clinical directors at RTCs I identified from the Substance Abuse and Mental Health

Services Association (SAMSA) Directory of Mental Health Facilities, an internet search, the Association of Children's Residential Centers' 2018 membership, and assistance from the 2018 Director of the Colorado Association of Family and Children Agencies (CAFCA). Each executive director or clinical director at RTCs for youth that I identified in the United States received an email. This email explained the study and asked the directors for assistance with obtaining study participants. I provided two options for the executive directors or clinical directors to assist me with sharing information about the study with their clinicians. These two options included the following: (a) the executive director or clinical director could send me the email list of their clinicians who meet the participation criteria or (b) the executive directors or clinical directors could choose to send out the announcement about the opportunity to participate in the survey as well as the link to their clinicians directly without sharing the email addresses. The email instructed the executive director or clinical director to return the letter of cooperation if they chose to send me the email addresses of their employees. The directors did not have to return the letter of cooperation if they choose to forward the survey to their clinician themselves.

Based on the executive director or clinical director preference of how to pass along the invitation to participants, I followed up with the matching communication. If the executive director or clinical director provided the names and email addresses of master's level clinicians at their sites, then I sent an email including a brief description of the research project, informed consent information, and a link to the survey directly to the clinicians. If the executive director or clinical director preferred not to share the names

and email of their clinicians but were willing to personally send out the invitation to participate in the survey and the link, I emailed a pre-written message including a description of the research project, informed consent and a link to the survey to the executive director or clinical director. The email included the information that the executive director or clinical director could forward to their clinicians. I sent a reminder email to the clinicians I contacted directly in two and four weeks from the initial email thanking them or reminding them to take the survey. I also sent a reminder email to the executive directors and clinical directors at two and four weeks from the original email thanking them for their participation or encouraging them to send the survey link to their clinicians.

Participation. Once study participants received the invitation to participate in their email inbox, they had the opportunity to review the overview of the study, the informed consent information, and click on the survey link if they chose to participate in the study. As recommended by Remley and Herlihy (2014), the informed consent stated the nature of the study highlighting that deception was not utilized, potential risks for participants, and information about potential compensation for participating in the study. The consent also outlined that participation in the study was voluntary, anonymous, confidential, and study participants could choose to withdraw from the study at any time without consequence (ACA, 2014). The consent disclosed how the data would be stored, when and how the data will be destroyed, as well as how data would be utilized or disseminated by the researcher (ACA, 2014; Remley & Herlihy, 2014). The email

indicated that clicking in the survey link would take study participants to a customized page via SurveyMonkey.

SurveyMonkey is a confidential, secure, internet-based administrator for online surveys (SurveyMonkey, 2018). The online survey included the informed consent, a demographic questionnaire and the instruments needed for measuring the independent and dependent variables. Participants began the study by reviewing consent to participate in the study. Participants selected yes or no to indicate their desire to participate in the SurveyMonkey online survey. If participants selected yes, they were taken to the data collection instrument. If they selected no, they were excised from SurveyMonkey. Study participants had the option to exit the survey and rescind their consent to participate in the study at any time. If participants left the survey and came back, they would have to restart the survey. Participants were also informed that the survey would take approximately 12 to 15 minutes to complete. The instruments included in the survey included a demographic questionnaire, the PWCS (Thompson et al., 2014), the ProQOL V (Stamm, 2010), the PSCS (Dorociak et al., 2017), and the ILCW (Auerbach et al., 2014).

Once study participants fully completed the online survey, they reached the final informational page displayed in SurveyMonkey. Here, I provided participants with educational information about burnout, vicarious trauma, and self-care. I also provided a link to the Headington Institute, which is an online resource with information about how to recognize, treat, and prevent vicarious trauma and burnout (Headington Institute,

2018). I also included a link for participants to access the comprehensive results of the study at completion.

Data Collection. I collected the data for this study completely online through a customized survey webpage via Survey Monkey. SurveyMonkey is a confidential and secure internet-based site that allows researchers to create and customize online surveys and collect data (Survey Monkey, Inc, 2018). To protect the data, SurveyMonkey employs a range of security measures to protect survey data (Survey Monkey, Inc., 2018). SurveyMonkey uses accredited data centers and provides around the clock monitoring and mandatory entry requirements for anyone using/accessing their hardware. SurveyMonkey encrypts all data transmitted from participants and ensures their staff adhere to existing privacy practices (Survey Monkey, Inc., 2018).

The data collected via the SurveyMonkey survey belongs only to me. My faculty committee and I were the only ones to view the data. I only used the collected data for research purposes. To protect the SurveyMonkey account, I created a password different from existing passwords on personal accounts and did not share the password or allow additional third parties to access to the account. Once I downloaded the data from SurveyMonkey, I securely store it on a password protected flash drive. I will keep the data for a period of five years, as required by the university, and then destroy it.

I estimated the length of time for data collection to be four weeks from the time I sent the survey directly to study participants or the directors who were to forward the study information and survey link to their clinicians. I did not include the initial email seeking community partnership with executive directors or clinical directors in the data

collection timeframe. I had clarification from the Institutional Review Board (IRB) that it was acceptable to send this initial email prior to IRB approval. I closed the data collection when I have received a minimum of 85 fully participating surveys to ensure sufficient power for the study and planned data analysis. When I did not receive the required number of surveys within the four-week timeframe, I extended the time frame in two week increments until I obtained the required number of surveys. I also sent a follow up email two weeks and four weeks after the initial request to study participants, or their executive and clinical director contacts, thanking them or reminding them to participate in the study. The data collection time frame did not exceed the approved one-year time limit. If I had not received the required number of surveys when 10 months approached, I would have filed an extension for data collection with the IRB if needed. I would also have considered expanding the search criteria to a broader geographic location and recruiting study participants from relevant professional conferences.

Instruments and Operationalization of Constructs

I used several pre-existing measurement scales and a demographic questionnaire to gather data for this study. The pre-existing instruments include the PWCS (Thompson et al., 2014), the ProQOL5 (Stamm, 2010), the PSCS (Dorociak et al., 2017) and the ILCW (Auerbach et al., 2014). I chose those measurement tools because they have been used in similar research in the human services field and because all four have shown validity and reliability in past studies.

Demographic questionnaire. The purpose of the demographic questionnaire was to obtain information from the study participants that would allow me to describe the

sample, identify who was participating, and ensure that the participants included in the study met the designated criteria. The demographic questionnaire included questions related to age, gender, number of years worked in RTCs, education level, type of degree, type of licensure currently held, frequency of contact with traumatized youth, age range of client population, and type of residential agency. I used the education level, type of highest degree, type of licensure held, and age range of clients to screen participants to ensure eligibility for inclusion in the study. To address the reliability and validity of the demographic questionnaire, I had an expert in the field review the questions, follow diversity and ethical best practices for formulating question language, and had a literacy specialist review the questions for readability (Bradburn, Sudman, & Wansink, 2004).

PWCS. Thompson et al. (2014) developed the PWCS to measure one of the variables in their study of mental health counselors' experience with compassion fatigue and burnout. The purpose of the study was to explore the impact of gender, length of time in the field, appraisal of working conditions, and personal resources on the level of burnout and compassion fatigue in counselors. The PWCS was developed to measure the study participants' appraisal of their working environment. Thompson et al. established the content validity of the PWCS scale by consulting a panel of three mental health counselors and counselor educators who had expertise in occupational stress and burnout. The authors also conducted confirmatory factor analysis on study participant responses to determine the reliability of the scale (Thompson et al., 2014). Forty-six items loaded on one underlying factor with correlations of .40 or greater. A sum of the 46 items provided an overall perception of work environment score with a Cronbach's alpha of .94.

The PWCS measures how often counselors experience eight different working conditions. These include fairness in administrative decision-making, adequate financial compensation, flexibility of hours worked, quality of supervision, quality of coworker relationships, clinical preparedness to serve the types of clients on their caseload, nature of the job tasks, and overall organizational climate. Participants report the frequency they experience these eight different working conditions on a five-point Likert scale. The items include both positive and negative working conditions. The negative working conditions are reversed scored. Examples of positive working condition items from the PWCS include "The atmosphere at my work setting is collegial" and "My boss is reasonable with his or her demands". Examples of negative working condition items include "The amount of paperwork I have to complete is overwhelming" and "I feel it is next to impossible to help the clients on my caseload". The sum score is totaled and the higher the total score, the more positively the participants perceive their working environment (Thompson et al., 2014).

The purpose of this study was to explore the factors that predict the turnover of counselors working in RTCs for youth. This PWCS was appropriate to measure the variable perception of work environment because the norming population for the scale was mental health counselors. In addition, counselors and counselor educators helped to establish the content validity of the items on the instrument. This scale was also used by the researcher in other studies that explored burnout and vicarious trauma in mental health counselors (Thompson et al., 2014). Permission to use the scale as well as a copy of the instrument was provided by the developers.

ProQOL 5. The Professional Quality of Life Scale (ProQOL 5, Stamm, 2010a) was developed to measure the impact of working with individuals who have experienced stressful life experiences. The ProQOL 5 is the most recent version of the instrument and has separate subscales to assess levels of secondary traumatic stress, burnout, and compassion satisfaction. I used scores from the secondary traumatic stress scale and the burnout scale in the data analysis for this project. The secondary traumatic stress subscale consists of 10 items that participants rate on a five-point Likert scale from "very often" to "never". Higher scores indicate higher levels of secondary traumatic stress. A reported Cronbach's alpha of .81 established the reliability (Stamm, 2010b). Thompson et al. (2014) also used the subscale for their study of burnout and compassion fatigue in mental health counselors and reported a Cronbach's alpha of .83 on the secondary traumatic stress subscale in their results.

The burnout subscale consists of 10 items respondents rate on a 5 point Likert scale based on how often they have experienced each statement in the past 30 days. The scale ranges from "very often" to "never". A combined score represents the participants level of burnout. The higher the combined score, the higher the level of burnout. Stamm (2010b) found a Cronbach's alpha of .75 and Thompson et al., (2014) found a Cronbach's alpha of .74 for the burnout subscale in their study. These alpha scores represent good reliability.

The ProQOL 5 is an instrument that has been used by researchers exploring burnout and vicarious trauma in the same study (Eastwood & Ecklund, 2008; Perkins & Sprang, 2013; Salloum et al., 2015; Thompson et al., 2014). According to Stamm

(2010b), approximately half of the studies that explore vicarious trauma, compassion fatigue, or secondary traumatic stress use the ProQOL-5 to measure the construct. While initial norming group consisted of mental health counselors, the group norms can apply to any helping profession. This instrument is the most commonly used instrument to measure the effects of working with people who have experienced extremely stressful events (Stamm, 2010b).

A potential limitation to using the ProQOL 5 to measure both burnout and vicarious trauma was that there could be greater shared variance between the constructs than if they were measured with distinct instruments (Cieslak et al., 2014). Stamm (2010b) maintained; however, that burnout and secondary traumatic stress are different constructs and that the shared variance in the measure is due to the emotional distress associated with both conditions. I obtained permission to use the ProQOL 5 from the www.proqol.org website. The researchers provided a copy of the instrument as well as granted permission to use the ProQOL 5 freely as long as the author is credited, no changes are made, and it is not sold.

ILCW. Auerbach et al. (2014) validated the ILCW as a proxy for actual job turnover in the child welfare workforce. These authors recognized a need for more validated instruments to study the serious problem of turnover in the child welfare field. The norming population for this study included child welfare workers from public childwelfare agencies. Auerbach et al. (2014) validated the scale with a confirmatory factor analysis method. Auerbach et al. found that two out of three participants who indicated they planned to leave the agency in the past year actually left. The best fitting

model was the three-factor model with the combined effect of thinking, looking, and acting ($\chi^2 = 28.6$, $p = .04$). Reliability was established with a Cronbach's alpha for thinking (alpha = .92), looking (alpha = .89), and acting (alpha = .83) all indicated good to excellent reliability (Auerbach et al., 2014). Auerbach et al. conducted binary logistic regression to determine the odds ratios to predict who left the agency. All three latent factors were significantly predictive (thinking: OR = 1.24, $p = 0.00$, looking: OR = 1.25, $p = 0.00$; acting: OR = 1.28, $p = 0.01$).

The ILCW consists of three subscales including thinking, looking, and acting. The instrument has a total of 8 questions. Participants rate each of the eight items on a five-point Likert scale depending on the frequency they engage in the activity. These items together provide a score that indicates how intent a person is to leave their current job (Auerbach et al., 2014). This score is a proxy for actual job turnover. Researchers frequently study turnover in longitudinal studies by tracking actual turnover (Auerbach et al., 2014). The time constraints associated with this dissertation project did not allow for a longitudinal study or other methods for obtaining staff turnover data. Auerbach et al. developed the ILCW as a turnover proxy and is appropriate for this study. I obtained a copy of the instrument as well as written permission from the author to use the ILCW for this study.

PSCS. The PCSC (Dorociak et al., 2017) was developed to measure the self-care practices of psychologists and other mental health professionals. Dorociak et al. (2017) recognized that while there was a great deal of focus on the importance of self-care in professional codes of ethics and literature in the mental health field, there was limited

empirical research on the topic. The lack of validated psychometric instruments to measure self-care was one of the barriers to this research. Dorociak et al. (2017) conducted two studies to establish the reliability and validity of the PSCS. Dorociak et al. generated items for the survey from the literature on self-care and established content validity by consulting with three doctoral-level psychologists who had published or presented on the topic of self-care and professional wellbeing. An original list of 90 items was first reduced to 50 items and eventually to 21 items. Study participants included psychologists working in both inpatient and outpatient mental health settings.

Dorociak et al.(2017) established concurrent validity of the instrument by comparing items on the PSCS with items on scales that measure similar constructs. The PSCS was found to have good internal consistency with the Perceived Stress Scale (PSS; Cohen, Kamarck, & Mermelstein, 1983) with a Cronbach's alpha .86; the Satisfaction With Life Scale (SWLS; Diener, Emmons, Larsen, & Griffin, 1985) with a Cronbach's alpha .87; and the Maslach Burnout Inventory-Human Service Survey (MBI-HSS; Maslach & Jackson, 1996) with an adequate Cronbach's alpha of .73. The remaining 21 items were divided into five subscales with good reliability. These included a five-item Professional Support Subscale (alpha = .83), a five-item Professional Development Subscale (alpha = .80), a four-item Life Balance Subscale (alpha = .81), a four-item Cognitive Awareness Subscale (alpha = .72), and a three-item Daily Balance Subscale (alpha = .70). Dorociak et al. (2017) used a confirmatory factor analysis method to determine the reliability of the instrument. A five factor model was the best fit with good factor reliabilities. These reliabilities included .85 for Professional Support, .79 for

Professional Development, .80 for Life Balance, .71 for Cognitive Awareness and .69 for Daily Balance.

The PSCS consists of five subscales and a total of 21 items. Participants rate the items on a 5 point Likert Scale depending on how frequently they engage in the self-care activity. This scale is a validated instrument that will allow me to measure the predictor variable self-care in my study. One limitation of previous research on mental health professionals and self-care has been the absence of psychometric measurement tools (Dorociak et al., 2017; Salloum et al., 2015). I used this newly developed instrument to provide empirical research on self-care in the mental health field. One potential limitation of using this scale was that it is newly developed. Dorociak et al. (2017) acknowledged that further research is needed that will continue to support the reliability and validity of this measure.

Another potential limitation is that the instrument does not have items related to physical self-care (Dorociak et al., 2017). Physical self-care is frequently cited in the literature as an important activity for personal and professional wellbeing (Bradley et al. 2013; Saakvitne & Pearlman, 1996). While items related to diet, physical exercise, sleep, and physical health were in the original list of items, they did not load into a meaningful physical self-care subscale (Dorociak et al., 2017). The authors suggested that physical self-care falls under the personal life domain and the range of behaviors may be too diverse to comprise a subscale with three to five items. Items that reflected more reactive than proactive self-care behaviors were also not included in this measure. If physical self-care activities or reactive self-care behaviors play a significant role in predicting

turnover, their effect was not be measured. I obtained a copy of the instrument as well as permission from the author to use this instrument in my study.

Data Analysis Plan

I used the instructions provided by Green and Salkind (2014) to enter data into IBM SPSS statistical software, version 25, to complete the data analysis. My first step in the data analysis process was to screen and clean the collected data downloaded from SurveyMonkey. I screened for missing data and outliers in the data set. Surveys with missing data were removed from the data analysis. Outliers are scores that are significantly different from the majority of the scores in the data and can be removed from the data (Aguinis, Gottfredson, & Joo, 2013). Researchers use graphs to identify outliers in the data (Aguinis et al., 2013). Researchers also use z-scores to identify outliers in the data that may be less obvious (Green & Salkind, 2014) According to Green and Salkind (2014) there are no set score for determining outliers. For this study any z-score greater than 3 or less than -3 was considered an outlier. When I identified outliers, I removed the entire data point from the data.

My second step was to check the data for compliance with the required model assumptions for the upcoming data analysis. The statistical analyses I conducted for this study included the Pearson correlation and multiple linear regression. The assumptions that must be met for the use of a correlational analysis and regression analysis include (a) normality of residuals, (b) homogeneity of variance, (c) linearity of regression, and (d) independence of error terms (Green & Salkind, 2014; Hoekstra, Kiers, & Johnson, 2013). I verified that these assumptions had been met prior to my data analysis. I verified

normality per Hoekstra et al. (2013) by examining the distribution of the dependent variables and standardized residuals for skewness and kurtosis. SPSS software uses zero as the value for normal distribution and the further the data is from zero the more likely the data is not normally distributed (Field, 2013). I also interpreted the Shapiro-Wilk analysis and reviewed the box plots to determine normality (Ernst & Albers, 2017). I checked for homogeneity of variance by conducting a Levene's test and verified homoscedasticity and linearity assumptions by analyzing the scatterplots (Ernst & Albers, 2017; Field, 2013). Lastly, I checked for independence of errors with the Durbin-Watson test. I used robust methods including bootstrapping to address violations I found to the assumption of homoscedasticity (Williams, Grajales, & Kurkiewicz, 2013). Robust tests are sophisticated methods that are relatively unaffected by these assumption violations (Field, 2013).

My third step was to review the descriptive statistics including the demographic information provided by the study participants as well as the other variables in my study. I described my participants by presenting data on age, gender, years worked in RTCs, frequency of contact with traumatized youth, education level, type of master's degree, and type of license. This information helped me to fully understand the participants that represent the sample for my study. I also reviewed measures of central tendency suggested by Hussain (2012) such as the mean, median, mode, range of scores, standard deviation, and high and low scores for the independent and dependent variables. These descriptive statistics provided information about trends in the data and quantitative information that I used for the statistical analysis.

In the descriptive data analysis stage, I also reviewed the individual correlations between each pairing of the independent and dependent variables using the Pearson product-moment correlation (Field, 2013). A Pearson product-moment correlation coefficient is used to determine the strength of a relationship between two variables (Field, 2013). The confidence interval for the Pearson product-moment correlation coefficient is +1 to -1. A +1 score indicates a perfect positive relationship between the variables and a -1 score indicates a perfect negative relationship between variables. Both scores indicate a linear relationship. A 0 coefficient score indicates no relationship between the variables and is a non-linear relationship (Field, 2013). I used these scores to determine the relationship between the independent variables and dependent variables as they relate to the research question for this study. I also used the Pearson product-moment correlation coefficient to check data for multicollinearity. Multicollinearity exists when there is a strong correlation between two or more of the independent variables (Vatcheva, Lee, McCormick, & Rahbar, 2016; Williams et al., 2013). This correlation between variables can lead to inferences from the data analysis that are not reliable (Vatcheva et al., 2016).

Lastly, I used a multiple linear regression data analysis method to answer the research question of the study. Multiple linear regression is a statistical method used to determine the relationship between one outcome variable and two or more predictor variables (Field, 2013; Uyanik & Guler, 2013). I used multiple linear regression in this proposed study to determine the degree to which each of the predictor variables (perception of work environment, burnout, vicarious trauma, and self-care) predicts the outcome variable (job turnover of MHC's providing counseling in RTCs). I analyzed the

data to determine if one variable or a combination of the predictor variables can predict the dependent variable (Green & Salkind, 2014; Uyanik & Guler, 2013). I also used multiple linear regression to determine the strength of the relationship between job turnover and each of the predictor variables (perception of work environment, burnout, vicarious trauma, and self-care) or a combination of the predictor variables (Uyanik & Guler, 2013). Within the multiple regression analysis I assessed the beta weights of the predictor variables, structure coefficients, and R^2 to assess the significance of the linear relationship between predictor and outcome variables (Green & Salkind, 2014).

I analyzed the predictor variables (perception of work environment, burnout, vicarious trauma, and self-care) as an “unordered set of predictors” (Green & Salkind, 2014, p. 258). This method allowed me to assess the significance of each predictor variable to the outcome variable and all potential combinations (Green & Salkind, 2014). I used SPSS, a data software program, to compute the multiple linear regression with an unordered set of predictors. The data analysis provided p values to determine if there is a significant relationship between the predictor variables and the outcome variable (Green & Salkind, 2014). I used a level of significance of $p = .05$. If the level of significance is .05 or below, the relationship between the variables was significant and the null hypothesis was rejected. If the level of significance is .05 or above, the relationship between the variables was not significant and the null hypothesis was accepted.

I also calculated a multiple correlation squared (R^2) for each predictor variable and the outcome variable and each combination of predictor variables and the outcome variable. R^2 represents the amount of variance that is shared between two variables

(Field, 2013; Nimon & Oswald, 2013). The R^2 value can be reported as a proportion or a percentage of how much one variable predicts another variable. I used the p value and R^2 to determine if I can accept or reject the null hypothesis that there is no statistically significant relationship between the turnover of counselors providing counseling in RTCs and perception of work environment, burnout, vicarious trauma, and self-care.

Threats to Validity

External Validity

Threats to the external validity of a study occur when a researcher makes incorrect assumptions about other populations, settings, and time periods based on the study results (Steckler & McLeroy, 2008). The population studied is counseling professionals in the United States, and the setting was RTCs for youth. The study took place at the present time. This limited sample decreased the generalizability of my study results. I cannot assume that the results of this study will apply to populations other than counseling professionals in the United States or that they apply to counseling professionals working in settings other than RTCs. In addition, I cannot assume that these results describe other populations or settings in the future or the past. Additional research with other populations, other settings, and replication of the study at other times will help to increase the generalizability of the study results.

Internal Validity

Internal validity refers to the researcher's ability to make correct inferences from the data as it relates to the population in the study (Torre & Picho, 2016). The greatest threat to the internal validity of my study was I did not select a random and participation

was voluntary. Because I did not randomly select the sample from the entire population of counseling professionals working in RTC in the United States, I cannot assume that the sample represented everyone in the population. Counseling professionals who chose to participate in the study may be different than those who did not. The correlations I found between the predictor variables (perception of work environment, burnout, vicarious trauma, and self-care) and the outcome variable (turnover) may be a result of a specific characteristic of the participants who chose to participate in the study rather than a true relationship between the variables. Threats to internal validity are inherent in correlational studies. I used statistical data analysis methods to increase the reliability and validity of the study results. Other threats to internal validity including history, maturation, regression, mortality, and diffusion of treatment (Torre & Picho, 2016) were not be relevant in the design of this quasi-experimental study.

Ethical Procedures

I obtained ethical approval for this study from the University Institutional Review Board (IRB). I also provided every potential study participant with an informed consent letter explaining the purpose of the study, that participation in the study is voluntary, and that their responses will be confidential. One important ethical consideration for this study was how completing questionnaires related to burnout and vicarious trauma and other variables in the study could impact study participants. Participation in the study could raise awareness for the study participants about symptoms of burnout or vicarious trauma they may be experiencing, or dissatisfied feelings related to their work. To

address those concerns, I provided study participants with educational information about burnout and vicarious trauma and ways to address and prevent those conditions.

Study participants could also be concerned about confidentiality. The participants may have concerns that their responses to the survey could jeopardize their employment. I assured study participants that their responses would be anonymous and that participation in the study was voluntary. I stored data on a password-protected flash drive without names of the study participants. In addition, I will destroy the data no later than five years after the study per the recommendations of Creswell (2009).

Summary

In Chapter 3, I provided detailed information about the design and methodology of this study. I used a quasi-experimental correlation design to study the relationship between four predictor variables (perception of work environment, burnout, vicarious trauma, and self-care) and one outcome variable (turnover). I recruited study participants from RTCs for youth in the United States. The sample included master's level licensed and provisionally licensed counseling professionals providing counseling to youth in RTCs. This purposive sample limited the generalizability of the results beyond the population, setting, and time frame of this study. I measured the variables in this study with preexisting surveys that have good reliability and validity per previous research. I used a multiple regression data analysis method to determine if perception of work environment, burnout, vicarious trauma, and self-care independently or in combinations predict the turnover of counseling professionals providing counseling services to youth in RTCs. In this chapter, I also addressed potential threats to the internal and external

validity of this study and ethical issues that I addressed. In Chapter 4, I will share the analysis of the data and the results of this study.

Chapter 4: Results

Introduction

The purpose of this quantitative cross-sectional multiple regression study was to explore the relationship between the predictor variables perception of work environment, burnout, vicarious trauma, and self-care and the outcome variable job turnover of counseling professionals providing counseling to youth in RTCs. The sample for this study included master's level licensed and provisionally licensed professional counselors within the United States who provide counseling to youth in RTCs. My review of the literature supported the potential relationship between the turnover of professional counselors and their perception of the work environment, burnout, vicarious trauma, and engagement in self-care practices. The research question I intended to answer with this study is as follows:

RQ: What is the extent of the relationship between the turnover of counseling professionals providing counseling to youth in RTCs and perception of work environment, burnout, vicarious trauma, and self-care?

The null and alternative hypotheses are below:

H₀₁: Job turnover for counseling professionals providing counseling in RTCs cannot be predicted by perception of work environment.

H_{a1}: Job turnover for counseling professionals providing counseling in RTCs can be predicted by perception of work environment.

H₀₂: Job turnover for counseling professionals providing counseling in RTCs cannot be predicted by burnout.

Ha2: Job turnover for counseling professionals providing counseling in RTCs can be predicted by burnout.

H₀3: Job turnover for counseling professionals providing counseling in RTCs cannot be predicted by vicarious trauma.

Ha3: Job turnover for counseling professionals providing counseling in RTCs can be predicted by vicarious trauma.

H₀4: Job turnover for counseling professionals providing counseling in RTCs cannot be predicted by self-care practices.

Ha4: Job turnover for counseling professionals providing counseling in RTCs can be predicted by self-care practices.

I interpreted the statistical findings from the data analysis for this study to determine whether to accept or reject these null and alternative hypotheses.

In Chapter 3, I described the design and methodology of the study and provided information about the study participants, data collection process, and the data analysis method. In Chapter 4, I will provide a detailed description of the results of the study. This chapter will include a review of the data collection process, demographic features of the sample population, and a summary of the data analysis and statistical findings. I will review the research question and hypotheses for the study and provide an explanation of how my statistical findings relate to the research question and hypotheses.

Data Collection

The intended population for this study was professional counselors in the United States who provide counseling to youth in RTCs. To obtain a sample for this study, I

contacted the directors of 245 RTCs across the United States through email, and requested their help with identifying potential study participants. I identified these RTCs and their directors from the 2016 SAMSA Directory of Mental Health Facilities, the 2018 membership list for the Association of Child Residential Centers (ACRC), an Internet web search, and assistance from the director of the Colorado Association of Child and Family Agencies (CAFCA). The RTC directors were given the option to forward an email with the survey link to their master's level counselors or provide me with the email addresses of their counselors so that I could send them the survey link myself. All directors who responded to my request chose to forward the survey link themselves.

Professional counselors who received the survey link from their directors and agreed to participate, completed a survey through Survey Monkey. The survey included a demographic questionnaire and questions to measure the four predictor variables and outcome variable. The survey included questions from the PWCS to measure perception of work environment, the ProQOL-5 to measure burnout and vicarious trauma, the PSCS to measure self-care, and the ILCW to measure turnover. Participants returned surveys from 24 states within the United States.

I collected data between August 27, 2018 and November 21, 2018 to achieve an adequate sample size. I began the data collection within the seven Rocky Mountain states. With IRB approval, I expanded the search parameters on October 5, 2018 to include all states within the United States in order to obtain the required sample size. A total of 170 participants responded. I eliminated surveys that were not complete and

study participants who did not meet criteria for the study. The criteria for study participation were that they were master's level licensed and provisionally licensed professional counselors providing counseling services to youth in RTCs in the United States. After eliminating surveys that were not complete and those participants who did not meet inclusion criteria, the remaining sample size was $N = 131$ participants. This sample size is adequate based on two a priori power analyses that determined a sample size between 85 and 108 would have sufficient power. I was unable to obtain the actual number of residential counselors in the United States even after contacting the RTC directors because I did not have a complete list of all existing RTCs in the U.S. In addition, not all directors I contacted responded to my email request, and the directors who did respond forwarded the surveys to their counselors themselves.

The sample for this study included 131 professional counselors throughout the United States who provide counseling to youth in RTCs (see Table 1). The sample for this study consisted of 112 females (85.5%), 18 males (13.7%), and one participant identified as other (.8%). The participants' ages ranged from 23 to 67 with a mean age of (M) = 36. Length of employment ranged from less than a year to 38 years with a mean number of years (M) = 6. Participant reports indicated that 113 (86%) of the counselors worked with youth who had experienced trauma 5 days per week, eight (6.1%) worked 4 days a week, six (4.5%) worked 7 days a week, two (1.5%) worked 6 days a week, one (.76%) worked 3 days a week, and one (.76%) worked 2 days a week.

The sample was racially and ethnically nearly homogeneous. Based on the participant's completed surveys, the sample consisted of 118 Caucasian or non Hispanic

White participants (90%), five African American participants (3.8%), four Hispanic participants (3.1%), two Asian American participants (1.5%), one Arab American participant (<1%), and one Pacific Islander participant (<1%). All study participants were professional counselors and held a master's degree. Fifty-eight (44.3%) reported that they held a master's degree in social work, 44 (33.6%) held a master's degree in mental health counseling, 17 (13%) held another master's level counseling degree, and 12 (9.2%) participants held a master's degree in marriage and family therapy. Based on self report data, 101 (78.9%) of the study participants worked for private nonprofit agencies, 22 (17.2%) worked for private for-profit agencies, and five (3.8%) of the participants worked for a state-run facility.

The study sample appears consistent with reported national statistics for mental health providers in the United States. According to the U.S. Department of Labor (2018) there were 476,560 social workers (excluding healthcare social workers), 540,430 counselors (excluding rehabilitation counselors), and 42,880 marriage and family therapists employed in the U.S. in May of 2017. The majority of mental health professionals in the child welfare field are women (Claiborne et al., 2013). In addition persons of color represent only "17.5 percent of social workers, 10.3 percent of counselors, and 7.8 percent of marriage and family therapists" (SAMSA, 2013, p. 8).

Table 1

Table of Demographic Data for Nominal Variables

	Frequency	Percent
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(table continues)

	Frequency	Percent
Gender		
Female	112	85.5%
Male	18	13.7%
Other	1	.8%
Race/Ethnicity		
Caucasian/Non-Hispanic White	118	90%
Black/African American	5	3.8%
Hispanic	4	3.1%
Asian	2	1.5%
Arab-American	1	<1%
Pacific Islander	1	<1%
Type of master's degree		
Social Work	58	44.3%
Mental Health Counseling	44	33.6%
Other Counseling Degree	17	13%
Marriage and Family Therapy	12	9.2%
Type of RTC		
Private Nonprofit	101	78.9%
Private for Profit	22	17.7%
State Run Facility	5	3.9%
Time Spent Working with Traumatized Youth		
5 days per week	113	86%
4 days per week	8	6.1%
7 days per week	6	4.5%
6 days per week	2	1.5%
3 days per week	1	<1%
2 days per week	1	<1%

Also, according to SAMSA (2012), significantly more children receive care in private RTCs than public RTCs. I was unable to find any statistics that described the population of master's level mental health professionals providing counseling services specifically in RTCs. Based on these national statistics for mental health providers the

study sample appears to adequately represent the larger population of professional counselors in the U.S.

Results

In this results section, I will describe my data analysis process. I began by screening and cleaning the data and then testing the assumptions for the data analysis methods used. I then conducted correlation and multiple regression analysis of the study data. I will also share the results of the Pearson correlations and multiple regression analysis I conducted and the findings of the study.

Data Screening and Cleaning

My first step in the data analysis process was to download the data collected through Survey Monkey into SPSS-25. I then screened the data for missing data as described in the previous section, and eliminated surveys that were not complete. My next step in the data analysis process was to check the data for outliers. Outliers are scores that are significantly different from the majority of the scores in the data set (Aguinis et al., 2013). I used graphs including histograms and boxplots to identify potential outliers. Based on the graphs I found outliers in the self-care variable data set and the turnover variable data set. The boxplots for the self-care variable and the turnover variable with the outliers are presented in Figures 1 and 2.

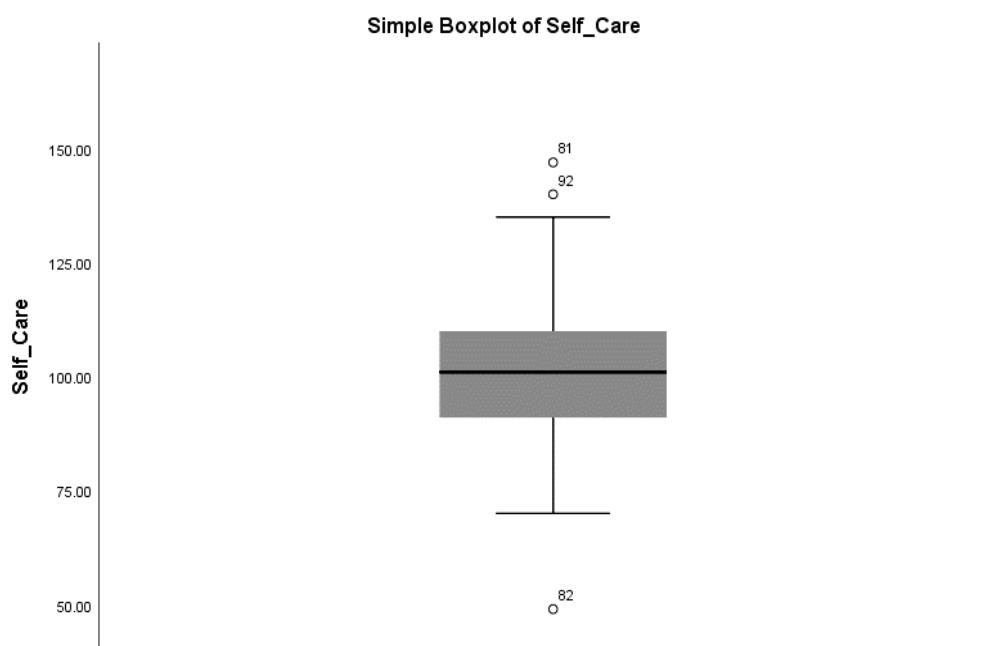


Figure 1. *Boxplot of Self-Care.*

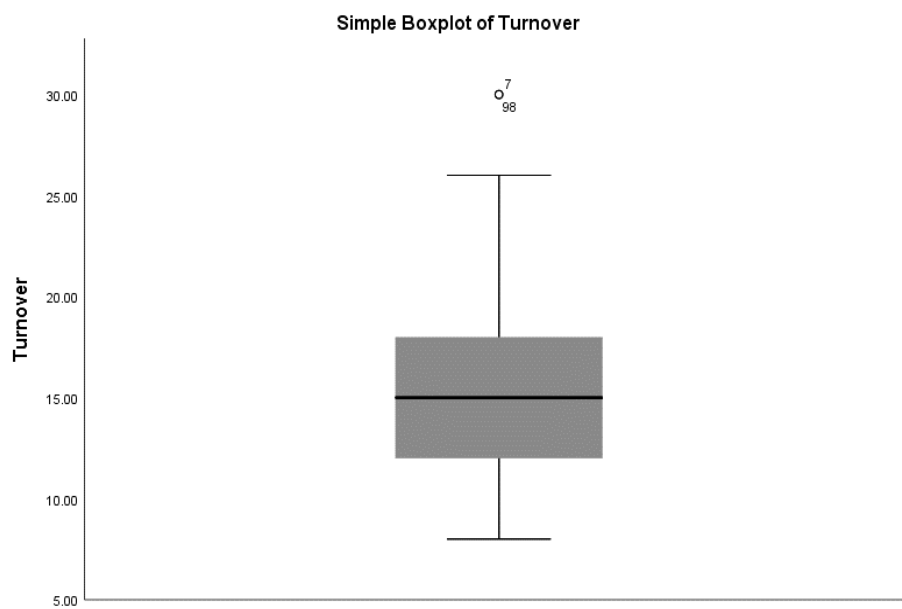


Figure 2. *Boxplot of Turnover.*

Having identified these outliers in the boxplot graphs, I converted the data scores to z scores to determine if any of the outliers fell outside the parameters I set for this study. The parameter I set for the study was to eliminate outliers with z scores above 3 or less than -3. One outlier with a z score of 3.35 was eliminated from the self-care variable data set and two outliers with a z score of 3.09 were eliminated from the turnover variable data set. The mean scores and standard deviations for self-care with the outlier was (M) = 100, (SD) = 15.4 and without the outlier (M) = 101, (SD) = 14.74. The mean score and standard deviation for turnover with the outliers was (M) = 15.3, (SD) = 4.73 and without the outliers (M) = 15.13, (SD) = 4.39. While the data did not appear to be significantly different with or without the outliers, I chose to eliminate the outliers from the data.

Statistical Assumptions

The statistical tests I used to complete the data analysis for this study included Pearson correlation and multiple linear regression. The required model assumptions for these statistical tests include (a) normality of residuals, (b) homogeneity of variance, (c) linearity of regression, and (d) independence of error terms. The next step in my data analysis process was to test these assumptions.

Normality of residuals. To test the assumption of normality, I began by examining the frequency distribution in a histogram and a P-Plot for each of the study variables. Frequency graphs provide valuable information about the shape of the data distribution (Hoekstra et al., 2013). I estimated from the graphic representation of each of my variables that they were normally distributed. In each P-P Plot the data points fell

close to the diagonal line representing a normal distribution (See figures 3, 4, 5, 6, and 7). There did, however, appear to be some deviation from the normal line particularly in the distributions of the turnover variable. The graphic distribution of the turnover variable was slightly skewed towards the higher end of the scale. This skew in the positive direction suggested that some study participants had higher turnover scores than the mean (see Figure 7).

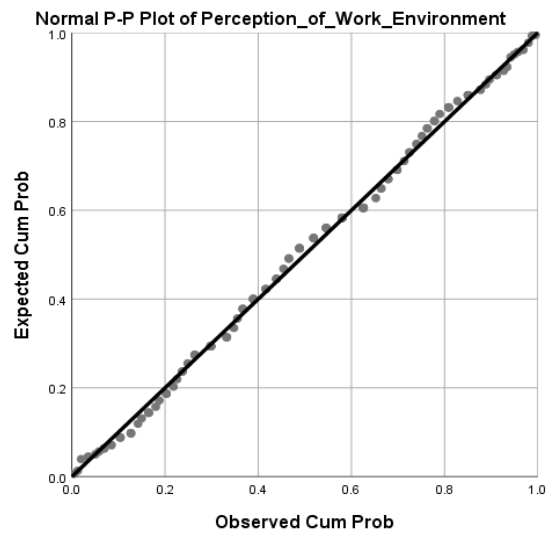


Figure 3. *P-P Plot of Perception of Work Environment.*

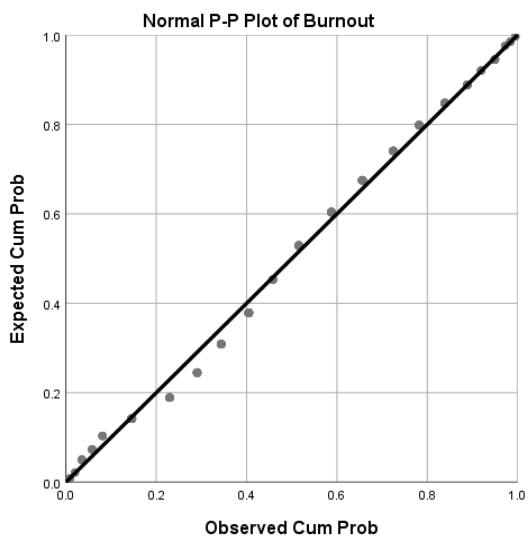


Figure 4. *P-P Plot of Burnout.*

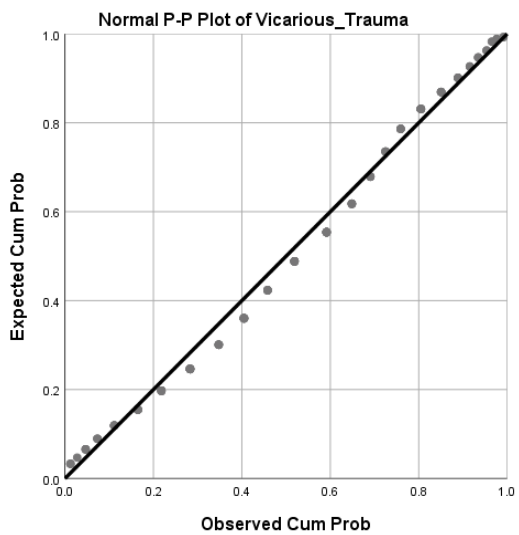


Figure 5. *P-P Plot of Vicarious Trauma.*

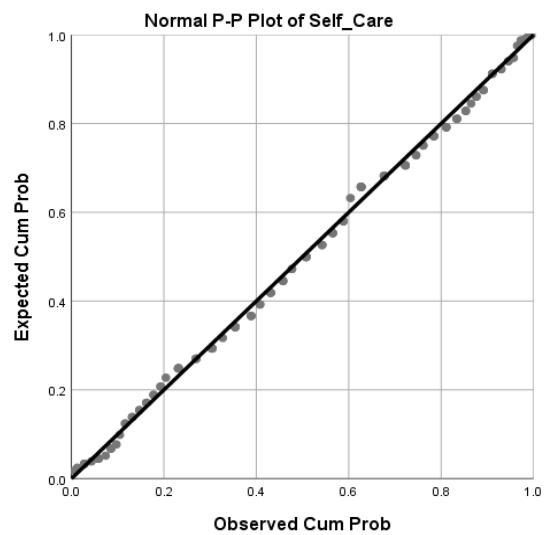


Figure 6. *P-P Plot of Self-Care.*

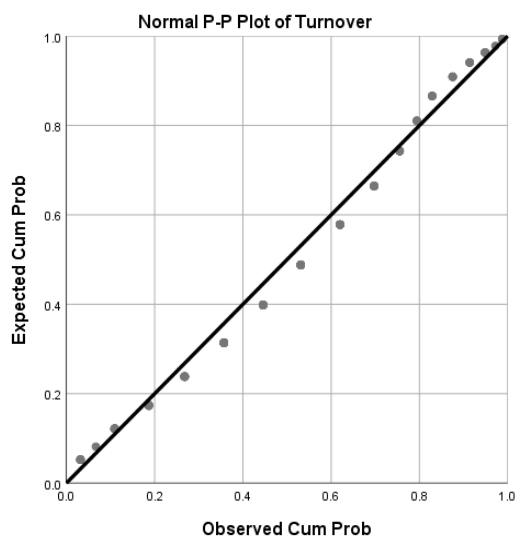


Figure 7. *P-P Plot of Turnover.*

The second method I used to test the assumption of normality was to examine the skewness and kurtosis values. Based on Fisher's measure of skewness the value of 0 represents a normal distribution (Blanca, Arnau, Lopez-Montiel, Bono, & Bendayan, 2013). The skewness and kurtosis scores for all the variables fell between -1 and 1. This indicated the data for each variable did not show any significant skewness or kurtosis and were normally distributed. In addition, the absolute value of the skewness and kurtosis scores for each variable did not fall above three times the standard error for each score indicating that they were normally distributed.

The third method I used to test the normality of the data was a Shapiro-Wilk test. I used this test to compare the distribution of the variable sample to a normally distributed sample with the same mean and standard deviation (Field, 2013). If the relationship between the two distributions is significant then the variable sample differs from the normally distributed sample and is potentially not normal. If the relationship between the two distribution is not significant, the data sets are similar, and the distribution of the variable sample is likely normal (Field, 2013). This test produced results that differed from the previous methods I used to test the assumption of normality for the variables vicarious trauma and turnover. The variable burnout, $W(131) = .988, p = .311$; perception of work environment, $W(131) = .994, p = .846$; and self-care, $W(130) = .988, p = .312$ did not significantly deviate from normal; however, vicarious trauma, $W(131) = .977, p = .023$ and turnover, $W(129) = .965, p = .002$ were both significantly non-normal.

While the difference in outcome based on these methods is potentially concerning, it is not surprising. In large samples (> 30 or 40), normality tests find significant results even when the deviation from normal is very small (Ghasemi & Zahediasl, 2012). Ghasemi and Zahediasl (2012) suggested that normality tests such as the Shapiro-Wilk test play a supplemental role to graphical assessments of the data. Based on my graphical assessment of the data and the skewness and kurtosis values the deviation from normal appeared to be very small for all the variables in the study. I determined that the data met the assumption of normality.

Homogeneity of variance. Homogeneity of variance is the assumption that the variance in the independent variables and the dependent variable are the same across the sample. The first method I used was examining the graphic representation of the standardized residuals against the standardized predicted values. The scatter plot was dispersed in a relatively normal pattern, however, one data point exceeded 3 on the y-axis indicating some potential heterogeneity of variance.

The second method I used to test the assumption of homogeneity of variance was the Levene's test. When I compared the means of the dependent variables and the independent variables, I found a non-significant relationship indicating homogeneity of variance between burnout and turnover, $F(19, 106) = 1.098, p = .346$ and vicarious trauma and turnover, $F(23, 103) = 1.48, p = .094$. However, I found a significant relationship that violated the assumption of homogeneity for perception of work environment and turnover, $F(31, 66) = 1.78, p = .026$, and self-care and turnover, $F(34, 76) = 1.63, p = .029$. All the variables had non-significant relationship when I compared

the medians. Comparing the medians is another method for testing homogeneity of variance (Field, 2013). Based on the finding that the assumption of homogeneity was violated according to the Levene's test, I chose to use a robust method known as bootstrapping when I performed the correlation and multiple regression data analyses. Bootstrapping is the process of calculating parameters of the mean in place of confidence intervals when there is question that the data may not be normally distributed (Field, 2013; Williams et al., 2013).

Linearity of regression. The assumption of linearity requires that there is a linear relationship between the outcome variable and each of the predictor variables (Ernst & Albers, 2017) (Williams et al., 2013). I examined the assumption of linearity of regression by again examining the scatterplot of the relationship between the outcome variable turnover and each of the predictor variables (perception of work environment, burnout, vicarious trauma, and self-care). Based on the scatter plot representations all the combinations appeared to have a relatively linear relationship (see Figure 8).

Independence of error. Independence of error assumes that the errors in the data are independent of each other (Ernst & Albers, 2017; Field, 2013). In other words, the participants in the study were not influenced by each other. I tested this assumption with the Durbin-Watson test. The Durbin-Watson value calculated in SPSS was 2.24 (see Table 2). This value is close to 2 and therefore indicates that the data met the assumption of independence of error (Field, 2013).

Scatterplot Matrix Perception_of_Work_Environment,Burnout,Vicarious_Trauma...

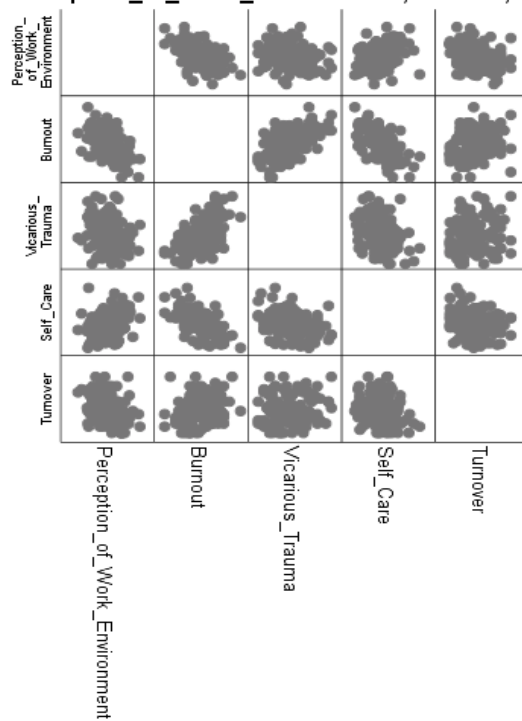


Figure 8. Scatterplot Matrix of Study Variables.

Table 2

Testing for Independence of Error, Durbin Watson Table

Model	R	R Square	Adjusted R Squared	Std. Error	Durbin-Watson
1	.410 ^a	.168	.141	4.08	2.24

- a. Predictors: (Constant), Self-care, Vicarious Trauma, Perception of Work Environment, Burnout
 b. Dependent Variable: Turnover

Statistical Analysis

Demographic information. I used a demographic questionnaire to gather information about the study participants. Based on the information gathered in the demographic questionnaire the sample population appeared to adequately represent the general population of counseling professionals in the United States. The sample for this study was 85.5 % female and 13.7% male. Based on the participant's reports the sample included 90% Caucasian or non Hispanic White participants, 3.8% African American participants, 3.1% Hispanic participants, 1.5% Asian American participants, <1% Arab American participant, and <1% Pacific Islander participants. The age of the participants ranged from 23 to 67 with a mean age (M) = 37. Approximately 92% of the participants reported that they worked with traumatized youth five or more days a week. Years of experience ranged from less than a year to 38 years with a mean of (M) = 6. All the study participants had a master's degree in a counseling related profession and were licensed or working towards licensure in their state. Clinical social workers made up 44.3% of the sample, 33.6% were mental health counselors, 13% were marriage and family therapists, and 9.2% held another type of counseling degree. Lastly, 78.9% of the participants reported that they worked for a private nonprofit agency, 17.7% reported that they worked for a private for-profit agency, and 3.9% reported that they worked for a state-run program.

Descriptive statistics. I reviewed trends in the data by calculating the mean, median, mode, range of scores, the standard deviation, and the lowest and highest score for each of the predictor variable (perception of work environment, burnout, vicarious

trauma, self-care) and the outcome variable turnover of professional counselors working in RTCs for children. The first variable I reviewed was perception of work environment. I used the PWCS to measure the variable perception of work environment. Participants rated how frequently they experienced 46 different working conditions on a 5-point Likert scale ranging from never to almost always. The working conditions are categorized in five domains (a) Characteristics of the Clientele, (b) Clinical Efficacy, (c) Nature of Coworker Relationships, (d) Nature of Job Tasks, and (e) Nature of Administrative and Overall Atmosphere. The higher the total score on the PWCS the more positive the perception of the work environment. The maximum possible score is 230. The mean score for this sample was, (M) = 161 with a standard deviation of (SD) = 17.28. The median score was (Mdn) = 162 and the mode was (Mo) = 152. The range was 88 points with the lowest score 118 and the maximum score 206. These results seem to indicate that most study participants were moderately happy to happy with their work environment.

I used the ProQOL-5 to measure the variable burnout. The participants reported how often they experienced ten questions on the ProQOL-5 on a 5-point Likert scale ranging from never to very often. Scores less than 22 are considered a low level of burnout, scores between 23 and 41 are considered an average level of burnout, and scores of 42 or more are considered a high level of burnout. The mean score of the participants was (M) = 24.61 with a standard deviation of (SD) = 5.24. The median score was (Mdn) = 25 and the mode was (Mo) = 19. The range was 27 with the lowest score 12 and the

highest score 39. This data seems to indicate that most of the sample appears to experience an average level of burnout.

I also measured the variable vicarious trauma with the ProQOL-5. The participants again answered how frequently they experienced 10 items on the survey on a 5-point Likert scale ranging from never to very often. The mean score was (M) = 23.18 with a standard deviation of (SD) = 6.08. The median score was (Mdn) = 23 and the mode was (Mo) = 19. The range was 26 with the lowest score 12 and the highest score 38. Scores of 22 or less indicate a low level of secondary traumatic stress, scores between 23 and 41 indicate an average amount of secondary traumatic stress, and a score 42 or higher indicates a high level of secondary traumatic stress. Based on these results, it appears as though the participants in this sample were experiencing average to low average levels of secondary traumatic stress associated with vicarious trauma.

I measured the predictor variable self-care with the PSCS. Study participants rated how often they engaged in 21 self-care activities on a 7-point Likert scale that ranged from never to always. The activities on the PSCS are divided into five subscales that include professional support, professional development, life balance, cognitive awareness, and daily balance. The highest possible score on the scale is 147. The mean score for self-care was (M) = 101.02 with a standard deviation of (SD) = 14.75. The median score was (Mdn) = 101 and the mode was (Mo) = 108. The range was 77 points with the lowest score 70 and the maximum score 147. This data seems to indicate that most of the study participants engage in several self-care activities.

Lastly, I measured the dependent variable turnover with the ILCW scale.

Participants rated three subscales including thinking, looking, and acting on a 5-point Likert scale. The thinking scale ranged from almost never to almost every day, the looking scale ranged from never to daily, and the acting scale ranged from none to >6 times. The maximum total score on the ILCW scale is 40. The mean score for the variable turnover was (M) = 15.13 with a standard deviation of (SD) = 4.40. The median score was (Mdn) = 15 and the mode was (Mo) = 13. The range was 18 with the lowest score 8 and the highest score 26.

The subscales on the ILCW are also important to consider as each subscale can predict turnover independently (Auerbach et al., 2014). The thinking scale identifies people who are thinking about leaving but have not yet acted. The total possible score for the thinking subscale is 10. The mean score (M) = 6, with a standard deviation of (SD) = 2.00. The median score was (Mdn) = 6 and the mode was (Mo) = 7. The range was 8 with the lowest score 2 and the highest score 10. Of the 131 study participants 46 indicated that they thought about leaving “some of the time” (35%), 67 indicated that they thought about leaving “often” to “almost every day” (51%) and 94 indicated that they talked about leaving with a friend/spouse/partner “often” to “almost every day” (72%).

The looking subscale identifies people who are looking but have not taken further action. The total possible score on the looking subscale is 15. The mean score was (M) = 4 with a standard deviation of (SD) = 1.57. The median score was (Mdn) = 5 and the mode was (Mo) = 4. The range was 7 with the lowest score 3 and the highest score 10.

Fifty-five percent of the study participants indicated they looked on the internet every few months. Most indicated that they had never looked in the paper (73%) or in professional journals (83.2%).

The acting subscale identifies people who have acted towards leaving by applying or interviewing for other positions. The highest possible score on the acting subscale is 15. The mean score was (M) = 4.12 with a standard deviation of (SD) = 1.65. The median score was (Mdn) = 3 and the mode was (Mo) = 3. The range was 8 with the lowest score a 2 and the highest score 10. Seventy-one percent of the study participants indicated that they had not made any phone inquiries, 61.8% indicated that they had not sent out any resumes, and 71.8% indicated they had not been to any interviews.

Based on these results, it appears as though a high number of participants were thinking about leaving their current position, but fewer had started looking or acting. According to Auerbach et al. (2014), 60% of people who indicated that were thinking about leaving on the ILCW left their positions within the next year. The ILCW is a valid and reliable instrument used as a proxy for actual turnover. The scores on this instrument suggested that there was high turnover of the clinical staff working with youth in RTCs.

Correlations. The next step in my data analysis process was to perform a Pearson product-moment correlation between each of the predictor variables and the outcome variable. These are the results of the Pearson correlations. Bias corrected, and accelerated bootstrap 95% CIs are reported in square brackets. There was a significant negative relationship between the variable perception of work environment and turnover, $r = -.378 [-.526, -.222], p = .000$. This correlation coefficient (r) indicated that there was

a medium effect size (strength of the relationship between variables). Researchers typically interpret effect size based on r as .01 small, .03 medium, and .05 large (Cohen, 1992). Nine items on the PWCS were significant at the $p < .005$ level.

- The atmosphere at my work setting is collegial.
- I receive the administrative support that I need to care for clients.
- My boss is reasonable in her/his demands.
- My coworkers seem discouraged and overwhelmed.
- I believe that the organization I work for doesn't care about my well-being.
- The size of my caseload is reasonable given the other commitments that I have at my work setting.
- I have the training I need to work effectively with each of the clients on my caseload.
- Effective client treatment is a top priority in this work organization.
- Staff in my work setting are open to trying new innovative counseling approaches

There was a significant positive relationship between burnout and turnover, $r = .321$ [.142, .491], $p = .000$. This correlation coefficient (r) indicated that there was a medium effect size. There was also a significant negative relationship between self-care and turnover, $r = -.244$ [-.378-.116], $p = .005$. This correlation coefficient (r) indicated that there was a small to medium effect size. Three subscales on the PSCS had a significant relationship with turnover. Professional support, $r = -.219$, $p = .013$,

professional development, $r = -.214$, $p = .013$, and daily balance $r = -.244$, $p = .005$ had a significant correlation with turnover with a low to medium effect size.

There was not a significant relationship between vicarious trauma and turnover, $r = .125$ [-.063, .301], $p = .159$. When I analyzed the correlations between vicarious trauma and the turnover subscales, however, there were significant results. There was a significant positive relationship between vicarious trauma and thinking, $r = .210$ [.053, .356], $p = .019$ with a low to medium effect size. There was a significant relationship between vicarious trauma and looking, $r = .195$ [-.017, .394], $p = .03$. The confidence interval, however, with the bootstrap 95 % correction indicates this may not be a significant relationship. There was not a significant relationship between vicarious trauma and acting, $r = .07$ [-.124, .275], $p = .435$.

The Pearson correlations between the other variables in the study also identified other significant results (see Table 3). There was a significant relationship between self-care and burnout, $r = -.618$ [-.709, -.502], $p = .000$, self-care and vicarious trauma, $r = -.355$ [-.477, -.216], $p = .000$, and self-care and perception of work environment, $r = .364$ [.173, .545], $p = .000$. There was also a significant relationship between burnout and vicarious trauma $r = .619$ [.502, .715], $p = .000$, burnout and perception of work environment, $r = -.561$ [-.670, -.427], $p = .000$ and vicarious trauma and perception of work environment $r = -.279$ [-.424, -.135], $p = .001$.

I also tested for multicollinearity during this step of the data analysis process. While there was a significant relationship between several of the predictor variables, the correlates were not high enough to cause concern that multicollinearity would negatively

affect the data analysis. According to Field (2013), a correlation value under .80 or .90 is acceptable. None of the correlates between the predictor variable exceeded .80 or .90.

Table 3

Correlations Between Study Variables

	Perception of Work Environment	Burnout	Vicarious Trauma	Self-Care	Turnover
Perception of Work Environment	1	-.561**	-.279**	.364**	-.378**
Burnout	-.561**	1	.619**	-.618**	.321**
Vicarious Trauma	-.279**	.619**	1	-.355**	.120
Self-Care	.364**	-.618**	-.355**	1	-.244**
Turnover	-.378**	.321**	.120	-.244**	1

** Correlation is significant at the 0.01 level (2-tailed)

Multiple regression analysis. The final step in my data analysis was to conduct a multiple regression data analysis to answer the research question and to test the hypotheses for this study. The research question for this study was: What is the relationship between the turnover of professional counselors working with youth in RTCs and their perception of the work environment, burnout, vicarious trauma, and self-care. I began the process by conducting a regression analysis for each of the predictor variables (perception of work environment, burnout, vicarious trauma, and self-care) and the outcome variable (turnover) to address each individual hypothesis. I then conducted an

unordered multiple regression analysis to determine if and how the combination of predictor variables predict turnover.

H₀₁: Job turnover in counseling professionals providing counseling in RTCs cannot be predicted by perception of work environment.

H_{a1}: Job turnover in counseling professionals providing counseling in RTCs can be predicted by perception of work environment.

The first hypothesis predicted that the job turnover of counseling professionals could be predicted by perception of work environment. The results of the regression analysis indicated that perception of work environment did significantly predict turnover $F(1, 127) = 21.17, p = .000, R^2 = .143, R^2_{\text{Adjusted}} = .136, b = -.096 [-.137, -.058], t(128) = -4.60, p = .000, f^2 = .167$ (see Table 4). The *Cohen's f²* value indicated a small effect size. Guidelines for the effect size based on *Cohen's f²* are as follows: .1 is a small effect size, .3 is a medium effect size, and .5 is a large effect size (Cohen, 1992). The significant negative relationship between the variables indicated that as perception of work environment increased, turnover decreased. Based on these results I rejected the null hypothesis. However, this analysis also showed that while there is a significant negative relationship between perception of work environment and turnover, perception of work environment only explained 14% of the variance in turnover.

H₀₂: Job turnover in counseling professionals providing counseling in RTCs cannot be predicted by burnout.

H_{a2}: Job turnover in counseling professionals providing counseling in RTCs can be predicted by burnout.

The second hypothesis predicted that the turnover of professional counselors working in RTCs could be predicted by burnout. The results of the regression analysis indicated that burnout did significantly predict turnover $F(1, 127) = 15.09, p = .000, R^2 = .106, R^2_{\text{Adjusted}} = .099, b = .273 [.108, .426], t(128) = 3.89, p = .000, f^2 = .119$ (see Table 5). The *Cohen's* f^2 value indicated a small effect size. The significant positive relationship between the variables indicated that as the level of burnout increased, turnover increased. Based on these results I rejected the null hypothesis. However, this analysis also showed that while there is a significant relationship between burnout and turnover, burnout only explained 10% of the variance in turnover.

H₀₃: Job turnover in counseling professionals providing counseling in RTCs cannot be predicted by vicarious trauma.

H_{a3}: Job turnover in counseling professionals providing counseling in RTCs can be predicted by vicarious trauma.

The third hypothesis predicted that the turnover of professional counselors working in residential treatment centers could be predicted by vicarious trauma. The results of the regression analysis indicated that vicarious trauma did not significantly predict turnover $F(1, 127) = 2.00, p = .159, R^2 = .016, R^2_{\text{Adjusted}} = .008, b = .090 [-.049, .226], t(128) = 1.42, p = .159, f^2 = .016$ (see Table 6). The *Cohen's* f^2 value indicated an insignificant effect size. Based on these results I did not reject the null hypothesis.

Table 4

Results of Linear Regression Analysis for H₀₁

Model	<i>b</i>	SE B	Standardized Beta	<i>p</i>
Constant	30.66	3.40		.000
Perception of Work Environment	-.10 (-.14, -.06)	.02	-.38	.000

$$R^2 = .14, R^2_{\text{Adjusted}} = .14, p < .001$$

Note: Perception of work environment as predictor variable, with 95% bias corrected and accelerated confidence intervals reported in parentheses. Confidence intervals and standard errors based on 1000 bootstrap samples

Table 5

Results of Linear Regression Analysis for H₀₂

Model	<i>b</i>	SE B	Standardized Beta	<i>p</i>
Constant	8.40	1.90		.000
Burnout	.27 (.11, .43)	.07	.33	.000

$$R^2 = .11, R^2_{\text{Adjusted}} = .10, p < .001$$

Note: Burnout as predictor variable, with 95% bias corrected and accelerated confidence intervals reported in parentheses. Confidence intervals and standard errors based on 1000 bootstrap samples

Table 6

Results of Linear Regression Analysis for H₀₃

Model	<i>b</i>	SE B	Standardized Beta	<i>p</i>
Constant	13.05	1.52		.000
Vicarious Trauma	.09 (-.05, .23)	.63	.13	.16

$R^2 = .02$, $R^2_{\text{Adjusted}} = .01$, $p < .001$

Note: Vicarious trauma as predictor variable, with 95% bias corrected and accelerated confidence intervals reported in parentheses. Confidence intervals and standard errors based on 1000 bootstrap samples

H₀₄: Job turnover in counseling professionals providing counseling in RTCs cannot be predicted by self-care practices.

H_{a4}: Job turnover in counseling professionals providing counseling in RTCs can be predicted by self-care practices.

The fourth hypothesis predicted that the job turnover of counseling professionals could be predicted by self-care. The results of the regression analysis indicated that self-care did significantly predict turnover $F(1, 127) = 8.01$, $p = .005$, $R^2 = .060$, $R^2_{\text{Adjusted}} = .052$, $b = -.073$ [-.115, -.027], $t(128) = -2.83$, $p = .005$, $f^2 = .056$ (see Table 7). The *Cohen's f²* value indicated a trivial effect size. The significant negative relationship between the variables indicated that as self-care increased, turnover decreased. Based on these results I rejected the null hypothesis. However, this analysis also shows that while

there is a significant negative relationship self-care and turnover, self-care only explained 6 % of the variance in turnover.

Table 7

Results of Linear Regression Analysis for H₀₄

Model	<i>b</i>	SE B	Standardized Beta	<i>p</i>
Constant	22.45	2.62		.000
Self-Care	-.07 (-.12, -.03)	.03	-.24	.005

$$R^2 = .06, R^2_{\text{Adjusted}} = .05, p < .01$$

Note: Self-care as predictor variable, with 95% bias corrected and accelerated confidence intervals reported in parentheses. Confidence intervals and standard errors based on 1000 bootstrap samples

Multiple regression. I conducted a multiple regression analysis to determine how well the four predictor variables perception of work environment, burnout, vicarious trauma, and self-care, predicted the turnover of professional counselors working with youth in RTCs. I entered these variables as an unordered set of predictors. The combination of these predictor variables can predict the job turnover of professional counselors working with youth in RTCs, $F(4, 123) = 6.22, p = .000, R^2 = .168, R^2_{\text{Adjusted}} = .141, f^2 = .201$ (see Table 8). The *Cohen's f²* value indicated a small to medium effect size. Approximately 16% of the variance in turnover can be accounted for by the combination of perception of work environment, burnout, vicarious trauma, and self-care. In this model perception of work environment played a significant role in predicting turnover, $t(123) = -2.77, p = .006$. Burnout, vicarious trauma, and self-care added little

additional predictive power. The multiple regression results suggested that professional counselors dissatisfied with their work environment, who are experiencing burnout and vicarious trauma, and engage in few self-care activities are more likely to leave their positions of employment.

Table 8

Results of Multiple Regression Analysis for Predictors of Turnover

	<i>b</i>	SE B	Standardized Beta	<i>P</i>
Constant	26.02 (13.0, 41.0)	7.05		.000
Perception of Work Environment	-.07 (-.12, -.03)	.03	-.28	.006
Burnout	.16 (-.10, .39)	.12	.19	.182
Vicarious Trauma	-.07 (-.22, .09)	.08	-.10	.368
Self-care	.02 (-.09, .06)	.03	-.06	.554

$R^2 = .17$, $R^2_{\text{Adjusted}} = .14$, $p < .01$

Note: Perception of work environment, burnout, vicarious trauma, and self-care reported with 95% bias corrected and accelerated confidence intervals reported in parentheses. Confidence intervals and standard errors based on 1000 bootstrap samples

Follow Up Analysis

I conducted follow up analysis to determine if the turnover sub scores, thinking, looking, and acting could be predicted by vicarious trauma. The results of the regression analysis indicated that vicarious trauma did predict thinking about leaving, $F(1, 129) = 4.22$, $p = .04$, $R^2 = .032$, $R^2_{\text{Adjusted}} = .024$, $b = .058$ [.009, .103], $t(129) = 2.05$, $p = .042$, $f^2 = .033$. Vicarious trauma did predict looking, $F(1, 126) = 4.0$, $p = .048$, $R^2 = .031$,

$R^2_{\text{Adjusted}} = .023$, $b = .045$ [-.007, .098], $t(126) = 2.0$, $p = .048$, $f^2 = .032$. The confidence interval, however, with the bootstrap 95 % correction indicates that vicarious trauma does not predict looking. Vicarious trauma did not predict acting on leaving, $F(1, 126) = .663$, $p = .417$, $R^2 = .005$, $R^2_{\text{Adjusted}} = -.003$, $b = .20$ [-.031, .071], $t(126) = .82$, $p = .417$, $f^2 = .005$. The results of this regression analysis indicated that vicarious trauma did predict professional counselors thinking about leaving their positions of employment, however, it did not predict looking or acting on leaving. This variable, however, still did not add any predictive power to the perception of work environment as the most significant predictor of turnover in the model. Vicarious trauma only accounted for 3% of the variance in the turnover thinking subscale.

I also conducted follow up analysis to explore the relationship between burnout and vicarious trauma and the five self-care subscales on the PSCS. There was a significant negative relationship between burnout and all five of the subscales: burnout and professional support, $r = -.492$ [-.611, -.342], $p = .000$; burnout and professional development, $r = -.487$ [-.615, -.333], $p = .000$; burnout and life balance, $r = -.461$ [-.393, -.287], $p = .000$; burnout and cognitive awareness, $r = -.445$ [-.590, -.296], $p = .000$; burnout and daily balance, $r = -.389$ [-.523, -.231], $p = .000$. There was also a significant negative correlation between vicarious trauma and all five self-care subscales: vicarious trauma and professional support, $r = -.263$ [-.417, -.103], $p = .002$; vicarious trauma and professional development, $r = -.202$ [-.371, -.001], $p = .021$; vicarious trauma and life balance, $r = -.287$ [-.393, -.027], $p = .016$; vicarious trauma and cognitive awareness, $r =$

-.360 [-.492, -.200], $p = .000$; vicarious trauma and daily balance, $r = -.325$ [-.451, -.187], $p = .000$.

Summary

The purpose of this cross-sectional multiple regression quantitative study was to determine the relationship between the turnover of professional counselors working in RTCs and their perception of the work environment, burnout, vicarious trauma, and self-care. I conducted a regression analysis for each predictor variable and the outcome variable to test the four study hypotheses. The regression analysis indicated that the turnover of professional counselors working with youth in RTCs was predicted by their perception of the work environment, burnout, and self-care practices. I accepted alternative hypotheses 1, 2, and 4. The regression analysis also indicated that the turnover of professional counselors working in RTCs was not predicted by vicarious trauma. I did not reject the null hypothesis for hypothesis 3. I also conducted a regression analysis for vicarious trauma and the three turnover subscales. This analysis indicated that vicarious trauma did significantly predict thinking about leaving, but not looking or acting.

The last step in my data analysis was to conduct a multiple regression analysis to determine how well the combination of the predictor variables predicted turnover. The regression analysis indicated that the combination of the predictor variables perception of work environment, burnout, vicarious trauma, and self-care significantly predicted turnover. In this model, perception of work environment played the most significant role in predicting turnover and the remaining three predictor variables did not play an additive

role in the strength of the relationship. While the data analysis indicated that the turnover of professional counselors working in RTCs was predicted by perception of work environment, burnout, vicarious trauma, and self-care, these variables only predicted 16% of the variance in turnover. These four variables only explained 16% of what influences professional counselors working with youth in residential treatment centers to leave their positions of employment. This data analysis suggests there are additional factors not explored in this study that contributed to the turnover of these professionals. I will provide a more thorough discussion of these findings, their limitations, and implications for the counseling field in Chapter 5.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose for facilitating this quantitative multiple regression study was to examine the relationship between the turnover of professional counselors providing counseling services to youth in RTCs and their perception of the work environment, burnout, vicarious trauma, and self-care. Staff turnover in RTCs for youth can have a negative effect on the therapeutic alliance which in turn can lead to poor outcomes for youth in residential settings. Exploring factors that may predict staff turnover in RTCs may help to identify interventions and practices that will increase staff retention. Findings from this study may help to promote positive social change by addressing the needs of traumatized youth in the child welfare system and facilitate more positive outcomes. Understanding factors that affect staff turnover and potential interventions to increase retention may also address the needs of counselors working in those settings and facilitate a healthier workforce of professional counselors working with youth.

I recruited master's level professional counselors working in RTCs throughout the United States to complete a survey that measured the variables in this study. Based on my data analysis, I determined that counselor turnover in RTCs had a significant relationship with and was predicted by perception of work environment, burnout, and self-care. Turnover did not have a significant relationship with vicarious trauma, however, the subscale thinking about leaving did have a significant relationship and was predicted by vicarious trauma. My data analysis further indicated that a combination of the predictor variables in this study did predict turnover in counselors working in RTCs

for youth. While the findings indicated that the predictor variables for the study did predict turnover, they accounted for only 16% of the variance in terms of the reasons why these professional counselors intended to leave their positions as counselors for youth in RTCs.

Interpretation of Findings

The results of this study both confirm and contradict previous research about the job turnover of mental health professionals working with youth in RTCs. One finding that was confirmed by this study is that staff turnover is high in residential settings. Auerbach et al. (2014) found that 60% of individuals who indicated on the ILCW that they had thought about leaving their positions had left within the next year. The results of the ILCW indicated that 51% of study participants thought about leaving often to almost every day and 72% indicated that they talked about leaving with a friend/spouse/partner often to almost every day.

Perception of Work Environment

The results of the study also confirmed the findings of other researchers (Benton, 2016; Boyas et al., 2012; McFadden et al., 2015; Shim, 2014) that child welfare professionals' positive perception of their work environment decreases turnover. My findings indicated that professional counselor's perception of aspects of the work environment including the atmosphere and administration, daily job tasks, characteristics of the clients, coworker relationships, and feelings of efficacy contributed to their turnover. This confirmed findings from other researchers that organizational support, supervisory support, role ambiguity, job overload, organizational justice, client related

stress, and coworker support had a significant influence on staff turnover in child welfare settings (Benton, 2016; Claiborne et al., 2015; Kim et al., 2012; Seti, 2007). Themes in the data from this study suggested that the working conditions most associated with turnover were perception of administrative support, coworker relationships, and workload. The regression analysis indicated that perception of work environment predicted 16% of the variance in turnover.

Burnout

My data analysis also supported the findings of previous researchers (Acker, 2011; Boyas et al., 2013; Green et al., 2013; Kim et al., 2012) that burnout increases staff turnover in the child welfare system and mental health profession. The results of this study indicated that the relationship between burnout and turnover is also true for professional counselors providing counseling services in residential settings. The regression analysis from this study provided additional information about the extent of the relationship between these two variables. My finding that burnout only predicted 10% of turnover contradicted the assumption burnout played a large role in why mental health professionals left their employment. Acker (2011) also concluded that burnout accounted for 10% of the variance in turnover.

One other finding that may be significant to highlight is that researchers (Acker, 2011; Boyas et al., 2013; Green et al., 2013; Lakin et al., 2008) who reported a strong correlation between burnout and turnover used measures such as the Maslach Burnout Inventory (MBI) that reported subscores on the three characteristics that define burnout (emotional exhaustion, depersonalization, and decreased self-efficacy). The relationship

reported between burnout and turnover in other studies (Acker, 2011; Green et al., 2013) was often specific to the significant relationship found between turnover and emotional exhaustion. Perhaps using the ProQOL 5, a scale that provided a burnout score that combined of all three subscales, decreased the significance of the relationship between burnout and turnover. It is possible that emotional exhaustion, one characteristic of burnout, may play a larger role in predicting turnover in the mental field than the other aspects of burnout. If that assumption is true, I may have found a more significant relationship between burnout and turnover if I had used a measurement instrument with subscales that measured the three characteristics of burnout independently.

Vicarious Trauma

There is little research about the relationship between vicarious trauma and turnover in child welfare or RTCs. However, some researchers, have found a significant relationship between vicarious trauma and turnover in child welfare settings including RTCs (Middleton & Potter, 2015). My finding that there was not a significant relationship between vicarious trauma and turnover contradicted this research. My finding that vicarious trauma did not significantly predict turnover in RTCs was also surprising based on the theoretical framework of this study. CSDT suggests that individuals who are exposed to the traumatic experiences of others are vulnerable to vicarious traumatization (McCann & Pearlman, 1990). Professional counselors working with youth in RTCs are repeatedly exposed to the traumatic stories of their clients. Symptoms of vicarious traumatization including feeling disconnected from self and others, low esteem for self and others, avoidance of clients and the work environment,

and feeling distrustful of themselves and others intuitively could be related to work turnover.

Based on the study findings, vicarious trauma did have a significant correlation with and predicted the turnover subscale thinking about leaving. Vicarious trauma did not have a significant correlation or predict looking or actively seeking other employment. Perhaps vicarious trauma influenced professional counselors' desire to leave their employment but did not predict looking or acting due to symptoms specifically associated with secondary traumatic stress. Professional counselors experiencing low esteem, decreased safety, lack of connection, and depression may lack the motivation, energy, and confidence necessary to look and actively seek another work position. An alternate explanation is that counselors who experience symptoms associated with vicarious trauma have the resources to transform those experiences. While vicarious traumatization prompts counselors to think about leaving, this syndrome does not prompt looking for or acting on finding other employment. Further research would provide additional information to better understand the relationship between vicarious trauma and the job turnover of professional counselors.

Self-Care

My finding that self-care had a significant inverse relationship with turnover, supported other researchers' findings that self-care may protect against job turnover in the mental health field (Paige & Hoge, 2009). However, this relationship between self-care and turnover in other research, has been mostly speculative. While I did find a significant negative relationship between these variables, self-care added very little to the

regression model with all the predictor variables. This study did not provide any conclusive evidence that promoting self-care practices will decrease job turnover. The correlational analysis of this data did demonstrate a significant negative correlation between self-care and burnout and self-care and vicarious trauma consistent with other research (Steinlin et al., 2017). Promoting self-care activities may provide more benefit when associated with decreasing burnout and vicarious trauma in professional counselors working with youth in RTCs. The data showed a significant negative correlation with a medium to high effect size for burnout and all five of the self-care subscales. The data also showed a significant negative correlations with a medium effect for vicarious trauma and all five of the self-care subscales. This finding provided evidence that self-care may be an effective intervention for decreasing burnout and vicarious trauma in professional counselors.

Theoretical Framework Revisited

Constructivist self development theory provided a lens for this study by describing the potential impact of counseling individuals who have experienced trauma. This theory suggests that individuals who are exposed to the traumatic experiences of others will begin to incorporate those experiences into their perception of themselves and the world in terms of safety, trust, self-worth, self-efficacy, and intimacy. This process is referred to as vicarious traumatization. The experience of vicarious traumatization is also closely related to burnout, another potential result of working with clients with significant mental health needs (Abassary & Goodrich, 2014; Eastwood & Ecklund, 2008; Thompson et al., 2014). The exact nature of the relationship between these two

occupational hazards is still unclear. However, this study supported evidence that the two conditions are highly correlated. Several researchers have concluded that based on the emotional and physical impact of vicarious trauma and burnout, they may have a significant relationship with turnover in the mental health field (Dombo & Blome, 2016; Middleton & Potter, 2015; Salloum et al., 2015). Constructivist self development theory also suggests that self-care may be a protective factor against burnout and vicarious traumatization (Saakvitne & Pearlman, 1996). Researchers have speculated that by decreasing burnout and vicarious trauma, self-care practices may reduce job turnover (Paris & Hoge, 2010).

The results of this study indicated that most of the professional counselors working with traumatized youth in RTCs experienced below average to average amounts of vicarious trauma and average amounts of burnout. Based on the amount of contact these professional counselors have with clients who have experienced multiple traumatic events, the CDST would suggest higher levels of vicarious trauma and burnout in this population. This discrepancy may indicate that vicarious trauma and burnout do not impact this population of professional counselors as much as speculated. It is also possible that the sample did not accurately represent the population. In addition, vicarious trauma did not significantly predict turnover. This finding did not support other researcher's assumptions based on CSST that vicarious trauma would be significantly correlated with turnover. In contrast, burnout did significantly predict turnover but independently only accounted for 10% of the variance in the turnover of this sample population.

The assumption that self-care may decrease staff turnover in this population based on CSDT was also not supported. However, the study results did indicate that there was a significant negative correlation between self-care and burnout and self-care and vicarious trauma. This finding supported CSDT that self-care can address and prevent burnout and vicarious trauma. The results of the study also indicated that this sample of professional counselors engaged in several self-care practices. The below average to average levels of vicarious trauma and burnout in this sample may have been related to their competency with engaging in self-care.

The study results also indicated that the factor that predicted most of the variance in turnover was the participants' perception of their work environment. This suggests that while focusing on the internal process of counseling professionals in RTCs is beneficial and may increase the wellness of these staff members, focusing on improving organizational factors may have more of an impact on increasing staff retention. Encouraging and supporting self-care practices may promote a healthier workforce that will positively affect outcomes for youth. However, encouraging self-care practices may not be the most effective intervention for decreasing turnover. Administrators and supervisors may be more effective in decreasing staff turnover by exploring organizational factors within their agencies that are impacting staff retention. The results of this study suggest that vicarious traumatization as described by CSDT may play less of a role in the lives of professional counselors than the theory predicts. Work environment factors may have more of an impact of professional counselor's work experience than client related factors.

Limitations of the Study

I discussed the limitations to the study in Chapter 1. The first limitation was that I did not select a random sample of professional counselors working in RTCs in the United States. The total population was not available and therefore I recruited a voluntary sample. This method limited the generalizability of the results because there may have been a difference between the counselors who chose to participate in the study and those who did not. It is possible that potential study participants who chose not to participate were experiencing more burnout or vicarious trauma and that impacted their decision whether or not to take the survey. The results of this study should be cautiously generalized to the larger population of professional counselors working in RTCs for youth. The study was also limited to professional counselors providing counseling services to youth in RTCs and should be cautiously generalized to professional counselors in other settings or other mental health professionals working in RTCs for youth.

Another potential limitation to the study was that the survey was disseminated to potential study participants by the directors of their agencies. Study participants may have felt reluctant to express true feelings related to their level of burnout and vicarious trauma, their perception of the work environment, and their intent to leave due to concerns their supervisors may have access to their survey answers. Study participants may have wanted to present themselves in a more positive light or preferred not to disclose true feelings about their work environment or intent to leave resulting from concerns their job status may be negatively impacted. Relying on agency directors to

distribute the survey may also have been a limitation because some directors agreed to assist with the study and some did not. There may have been a difference in the agencies with directors who chose to participate versus those who did not that impacted the study participants. Potential study participants in agency that were not included may have answered the survey differently.

The measures I chose to use for the study may also have been a limitation. More recently validated scales for vicarious trauma may have provided items that more accurately captured the study participants level of secondary traumatic stress. People often do not recognize the symptoms of vicarious trauma or burnout as problematic because these symptoms can build gradually (Newswald-Potter & Simmons, 2016). The measure also did not include items that identified the traumatic content study participants may have experienced to gauge the potential for developing secondary traumatic stress. The researchers in a previous study estimated that one fifth of their study participants experienced prolonged symptoms of burnout and vicarious trauma by including questions specific to their responses directly after a traumatic work experience and one month after the experience (Steinlin et al., 2017). A measurement instrument for burnout that identified subscales for the components of burnout may also have provided more detailed information about the study participants experience with this work related stress. The PSCS and PWCS are also a recently validated scales and have not been used extensively in other studies to further confirm the validity and reliability of those scales. In addition, the measurement instruments I chose to measure the study variables created a long survey that may have deterred some study participants from completing the survey.

Recommendations

Findings from this study indicated that the predictor variables, perception of work environment, burnout, vicarious trauma, and self-care only predicted 16% of the variance for job turnover of professional counselors working with youth in RTCs. This finding indicated that there are other factors not examined in this study that play a larger role in predicting the job turnover of these study participants. Other factors potentially associated with job turnover such as the job market and economic climate may play a more significant role (Auerbach et al., 2014; Claiborne et al., 2015).

Other researchers have also suggested that personal factors such as marital status and length of commute and organizational factors such as incentives and positive performance evaluations played a significant role in turnover (Connor et al., 2003). One other possibility is that the reason for accepting employment in an RTCs may play a role in retention. Young professionals who accept counseling positions in RTCs may intend to stay a short period of time in order to gain experience and/or licensure. Those who plan to stay for a short time will leave, while those who find a fit or niche in providing counseling to traumatized youth stay.

Lastly, compassion satisfaction is another variable not examined in this study that may contribute to the retention of counseling professionals. Compassion satisfaction is the positive feelings associated with being in a helping profession and has been associated with decreased burnout and secondary traumatic stress (Ray et al., 2013; Salloum et al., 2015). Without further research I can only speculate on the other variables that may predict the turnover of these counseling professionals. Additional

research that explores other variables will expand on the findings in this research project and provide a more comprehensive understanding of the factors that predict and may prevent staff turnover. Qualitative studies may also provide more information about other variables not studied in this research project that impact the turnover of professional counselors in residential settings.

I also recommend that future quantitative researchers seek a more random sample to avoid the bias that may be associated with the voluntary sample selected for this study. A more random sample may provide a more accurate representation of the relationship between these study variables and potentially a more comprehensive understanding of the degree to which these study variables predict the turnover of professional counselors working with youth in RTCs. A more random sample would also increase the generalizability of the study results.

Another recommendation I have is that researchers who decide to study staff turnover in RTCs, contact potential study participants directly rather than seeking assistance from agency directors. The method I chose for data collection relied on the cooperation of agency directors and may have created concerns on the part of the study participants that their directors may have access to their answers. This method for distributing the study surveys may have inadvertently created bias in participant responses. Relying on agency directors to distribute the study survey also made it difficult to follow up with reminders to the study participants and may have decreased the potential sample size. In addition, many agency directors either did not respond to my email requests or responded and indicated they did not want to participate. This may also

have created bias as there may have been differences in the agencies where directors chose to forward the survey and in those that did not. This is particularly relevant as work environment factors had a significant negative relationship with turnover.

Lastly, I also suggest that future researchers explore the benefits of other instruments also being used to measure the study variables. While the ProQOL is the most frequently used measurement instrument for vicarious trauma and burnout, there are also more recently validated instruments that may provide a more accurate representation of the participants level of burnout and vicarious trauma. Measurement instruments that measure the subscales of burnout may also provide an more accurate information about the different aspects of burnout affect turnover. In addition, the combination of measurement tools for this study created a lengthy survey that some study participants did not complete. Approximately 40 study participants out of 170 submitted incomplete surveys and exited SurveyMonkey before answering all the questions. There may have been a difference between those who completed the survey and those who did not that may also have created bias in the study and decreased the generalizability of the findings. One recently validated instrument to measure vicarious trauma for example consists of only four items (Middleton & Potter, 2015).

Implications

Staff turnover in RTCs has a negative impact on the youth receiving counseling services in those programs, the mental health providers, and the organizations. Addressing factors that impact this turnover will potentially improve client outcomes and create healthier work environments for the staff working in those centers. Youth within

the child welfare system are a marginalized population who need effective interventions and a strong and consistent workforce to help them recover from their traumatic childhood experiences.

While the relationship I found between the turnover of professional counselors working with youth in RTCs and perception of work environment, burnout, vicarious trauma, and self-care did not predict all of the reasons those professional counselors left their positions, this study did validate that those factors play a role. Addressing organizational factors related to administrative support, coworker relationships, and workload could improve staff retention and improve outcomes for traumatized youth. In addition, promoting interventions including self-care that decrease burnout and vicarious traumatization could improve counselor wellness and client care, and promote increased staff retention.

Professional counselors are called by their profession to promote positive social change. Counselor wellness is an important variable that impacts their ability to fulfill this societal need. Improving counselor wellness will create a healthier workforce that in turn will be more effective at creating positive social change. Healthy counselors will be more capable of creating positive change and promoting social justice by effectively meeting the needs of their clients and improving their bio/psycho/social circumstances. Addressing barriers to professional counselor wellness and retention in RTCs may play a significant role in improving outcomes for youth who have experienced childhood trauma. Improving outcomes for youth in the childwelfare system is a positive social change that

will improve the quality of life for this population and decrease the social and financial burden associated with the high needs of this marginalized group.

In addition to providing mental health services to the community, professional counselors are also members of the community. Impaired functioning related to the professional work environment can affect counselors both in their personal and professional lives. Counselors who feel emotionally exhausted or disconnected from intimate relationships may disengage from family and friends and cause harm to themselves and the individuals in their lives. Counselor turnover can also lead to economic insecurity and increase the vulnerability of professional counselors and their families. Improving counselor wellness and decreasing turnover is a positive social change that will improve the quality of life for helping professionals and their families, as well as the quality of care they provide their clients.

Addressing the organizational and personal factors that contribute to the high turnover of counseling professionals working with traumatized youth in residential settings is an important responsibility of administrator, counselor supervisors, counselors, and counselor educators preparing counseling students to work in those settings. The responsibility of providing counseling services to individuals who have experienced trauma is significantly important. Professional counselors touch the lives of many individuals both inside and outside their work environment. Understanding the factors that predict counselor turnover will provide counseling professionals, supervisors and counselor educators with the information necessary to increase staff retention and potentially improve counselor wellness. The increased understanding of how work

environment factors, burnout, vicarious trauma, and self-care affect counselor turnover and counselor wellness that this study provided will offer an opportunity for developing proactive approaches that will help counseling professionals to be effective agents of positive social change.

Conclusion

My purpose for facilitating this study was to determine the role work environment factors, burnout, vicarious trauma, and self-care played in professional counselor turnover in RTCs for youth. The results of this study verified that those factors play a significant role in why professional counselors leave counseling positions in RTCs. These findings suggest that administrators and counselor supervisors can increase retention by addressing issues in the work environment related to counselor perception of administrative support, co worker relationships, and work load. In addition, supervision and training that addresses burnout, vicarious trauma, and importance of engaging in self-care practices will increase counselor wellness and potentially decrease staff turnover. Maintaining a consistent and effective workforce is essential for providing quality care to traumatized youth receiving care in RTCs. Preventing turnover by addressing the factors explored in this study will potentially decrease the organizational cost of staff turnover and improve outcomes for clients by creating organizations with a healthy and knowledgeable workforce that has the adequate resources to provide quality care to the vulnerable population of youth receiving care in RTCs.

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