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Counselor Perceptions of the Efficacy of Training and Implementation of Self-Care Strategies Related to Trauma Work

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Dedication

This dissertation is dedicated to my mother, Dr. Patricia Flannery Pearce. I will be forever grateful for her enthusiastic encouragement and unwavering support throughout my graduate studies. I am so appreciative for the invaluable input she provided during the dissertation process. Her passion for research and teaching is contagious – she is a gift to so many, and I am truly blessed to have her in my life. Thanks, Mom!

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Abstract

Various forms of trauma are regularly reported across the spectrum of counseling settings and the potential negative psychological effects on counselors who are repeatedly exposed to traumatic material are well documented. However, many researchers suggest that vicarious traumatization can be prevented and mitigated with personal and professional self-care strategies. The American Counseling Association (ACA) *Code of Ethics* indicates that counselors have a professional responsibility to engage in self-care activities, as efforts to ensure the psychological health of counselors will have a direct effect on their ability to help clients. The purpose of this mixed-method, descriptive, correlational research was to explore what types of educational preparation and training counselors have received regarding self-care and what types of self-care strategies counselors are using. The efficacy of those training methods and self-care strategies when implemented were also measured, from the perspective of the participants. The *Self-Care Training and Implementation Questionnaire* (STIQ), a 19-item, structured and semi-structured questionnaire developed for this research, was electronically sent to 3000 randomly selected members of ACA, resulting in 310 responses, 286 of which were deemed appropriate for inclusion. Analysis included descriptive analyses (quantitative data) and content and theme analyses (qualitative data). The results of this study indicated that counselors recognized the value of self-care and participated in activities that promoted a healthy lifestyle and mitigated stress, thus working toward a balance that fostered effective work performance. However, the findings demonstrated that most counselors do not receive formal self-care training and self-care has been an endeavor pursued independently, outside of education and work settings. Implications for counselor education, training, policy and research are discussed.

Keywords: trauma, vicarious traumatization, self-care, wellness

CHAPTER I

INTRODUCTION

The counseling process involves a special dialog in which success depends upon a very specific relationship between counselor and client. An intimate, empathic connection between the counselor and client is critical to helping clients achieve their individual goals (Rasmussen, 2005). This important connection required for client change is also the vehicle through which a counselor is exposed to the client's traumatic material (Rasmussen, 2005). Because the counselor is the primary tool in the counseling process, that individual must be in good psychological health in order to be effective in this dialog with clients (ACA, 2005; Cavanagh & Levitov, 2002).

Numerous studies have documented the profound negative psychological effects associated with helping clients cope with trauma, also known as vicarious traumatization (e.g., Adams & Riggs, 2008; Cunningham, 2003; Tehrani, 2007). As a result of vicarious traumatization, counselors may become less effective with clients and may leave the mental health field altogether, leading to a lack of qualified counselors to treat trauma victims (Fahy, 2007). Personal and professional self-care strategies often are suggested to prevent or mitigate the effects of vicarious traumatization (Harrison & Westwood, 2009; O'Halloran & Linton, 2000; Stebnicki, 2007; Trippany, White Kress, & Wilcoxon, 2004). However, there is little evidence regarding training provided to counselors with respect to self-care strategies. It is also unclear which self-care strategies are being used by counselors currently working with trauma victims, and which are perceived to be the most effective strategies when implemented.

Role of Counselor

The American Counseling Association (ACA) defines counseling as "a relatively short-term, interpersonal, theory-based process of helping persons who are basically psychologically healthy resolve developmental and situational problems" (ACA, 2010b, p.1). Counseling concerns include personal, social, vocational, empowerment and educational matters (ACA, 2010b). The application of counseling strategies occurs through a special dialog in which success depends upon "an emotional exchange in an interpersonal relationship which accelerates the growth of one or both participants" (Wolberg, 1977, p. 10). This interpersonal relationship between counselor and client is described in the ACA *Code of Ethics* as: "…counselors encourage client growth and development in ways that foster the interest and welfare of clients and promote formation of healthy relationships" (ACA, 2005, A, Introduction). The intimate, empathic connection that occurs within the counselor-client relationship is critical to helping clients achieve their goals.

Thus, counseling is a complex process that integrates academic knowledge, clinical skills and the personal characteristics of the counselor (Lauver & Harvey, 1997). Many counselor characteristics have been identified as necessary for effective counseling including self-knowledge, wholeheartedness, trustworthiness, honesty, strength, warmth, active responsiveness, patience, sensitivity, freeing, holistic awareness and psychological health (Cavanagh & Levitov, 2002). Good psychological health is important in that it gives the counselor support in understanding behavior and skills, and it allows the counselor to be a healthy model of behavior (Cavanagh & Levitov, 2002). Importantly, as Cavanagh and Levitov (2002) have discussed, a counselor's good psychological health also may prevent potential contamination of the counseling session. Because the counselor is the primary tool in counseling, it is essential that

counselors actively maintain their psychological health. "The better a counselor's psychological health, the more helpful the counseling relationship is likely to be" (Cavanagh & Levitov, 2002, p. 129).

Vicarious Traumatization

Trauma is often associated with exposure to a situation that involves threatened or actual death or serious injury, either to self or others (American Psychiatric Association, 2000). Trauma is a "powerful assault on the psychological well-being of a person and causes intense psychological pain" (Cavanagh & Levitov, 2002, p. 406). Common traumatic events include loss, physical or sexual assault, childhood sexual abuse, domestic violence, natural and human-made disasters, and school and work-related violence (James, 2008; Trippany, White Kress, & Wilcoxon, 2004). Mental health professionals in a variety of work settings regularly encounter clients who are victims of these types of traumatic events, which helps to explain the growing body of literature devoted to the topic (Munroe, 1999; Pearlman & Saakvitne, 1995; Trippany et al., 2004). According to Bride (2007), the incidence of individuals with a history of trauma seeking mental health treatment is between 60-90%. Therefore, it is not surprising that various forms of trauma are reported on a daily basis in sessions across the spectrum of counseling settings (Culver, McKinney, & Paradise, 2011).

Much attention has been devoted recently to the impact on mental health professionals themselves when attempting to help clients work through their traumatic material. Burnout, compassion fatigue (CF), vicarious traumatization (VT) and secondary traumatic stress (STS) are all used to describe aspects of this phenomenon (Salston & Figley, 2003; Trippany et al., 2004). The term *vicarious traumatization* was first offered by McCann and Pearlman (1990) to describe the process by which an individual experiences profound negative psychological effects as a

result of working with trauma victims. Through repeated exposure to clients' traumatic material, mental health professionals may experience significant adverse effects in core aspects of themselves, including their perception of themselves, others, and their world (Rasmussen, 2005; Trippany et al., 2004). "Vicarious traumatization emphasizes the way the therapist's experience of the self is altered in terms of identity, world view, spirituality, self capacities, ego resources, psychological needs, and the sensory system" (Rasmussen, 2005, p. 20). Mental health professionals may experience other disruptions to their sense of safety, trust, power, esteem, independence, intimacy and frame of reference (McCann & Pearlman, 1990).

The irony involved in vicarious traumatization goes to the core of counseling: an intimate, empathic connection between the mental health professional and client is crucial to helping clients achieve their goals, but it is also the vehicle through which a mental health professional is exposed to traumatic material.

> Over time, the therapist is changed as a consequence of empathic engagement in clients' stories of sadism, cruelty, betrayal, neglect, abandonment, and exploitation. Significantly, the trauma is often, although not exclusively, experienced as a consequence of intimate contact with other people who are expected to meet one's psychological needs. As such, the therapist's view of humanity is often painfully challenged. (Rasmussen, 2005, p. 21)

This secondary exposure to trauma often results in mental health professionals themselves experiencing the effects of trauma. Symptoms of vicarious traumatization include anxiety, suspiciousness, depression, somatic symptoms, intrusive thoughts and feelings, avoidance, emotional numbing and flooding, and increased feelings of personal vulnerability (Adams & Riggs, 2008).

An increased awareness of the stark reality and frequent occurrence of trauma combined with repeated exposure to vivid, detailed traumatic material leads to an impact on both the personal and professional functioning of a counselor (Trippany et al., 2004). The counselor's overall psychological health and functioning will affect his or her ability to be effective with clients within the counseling process (Cavanagh & Levitov, 2002). "The potential for clinical error and therapeutic impasse increases as the vulnerability that counselors experience increases" (Trippany et al., 2004, p. 82). Counselors affected by vicarious traumatization may doubt their knowledge and skills, compromise boundaries, experience disruptions in their empathic abilities, lose focus on clients' strengths, or even feel anger toward their clients (Herman, 1992; Trippany et al., 2004). Importantly, counselors may avoid discussion of traumatic material or be prematurely intrusive about the topic with their clients, leading to poor clinical outcomes (Munroe, 1999).

Although all mental health professionals working with trauma victims are at risk for vicarious traumatization, certain members of the mental health community are especially vulnerable. Emergency care practitioners including medical workers, rescue workers, and crisis intervention volunteers are at increased risk (Trippany et al., 2004; Warren, Lee, & Saunders, 2003). Mental health professionals who work primarily with trauma victims are at greater risk than those for whom trauma clients make up only a sporadic or a small percentage of their client base (Baird & Jenkins, 2003; Trippany et al., 2004). Novice therapists with minimal work experience are more vulnerable to vicarious traumatization than more experienced practitioners (Adams & Riggs, 2008; Baird & Jenkins, 2003). In addition, counselors with more education had lower vicarious traumatization scores (Baird & Jenkins, 2003).

Self-Care Strategies

Various professional associations related to the mental health field address the issue of self-care in their standards and ethical codes. The Council for Accreditation of Counseling and Related Educational Programs (CACREP) outlines program requirements for professional orientation and ethical practice including educational studies that provide an understanding of "self-care strategies appropriate to the counselor role" (CACREP, 2009, p. 10). The American Counseling Association (ACA) *Code of Ethics* addresses self-care in terms of professional responsibility by stating that counselors should "engage in self-care activities to maintain and promote their emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities" (ACA, 2005, p. 9). The American Psychological Association (APA) offers a self-care action plan that suggests adopting a proactive approach is "crucial for effectively managing occupational and personal stressors and for maintaining optimal wellness" (APA, 2009, p. 16).

Members of the ACA Ethics Committee have explored the idea of self-care in relationship to professional performance (Thomas & Levitt, 2010). The ACA *Code of Ethics* dictates that counselors should monitor their effectiveness and be sensitive to signs of impairment at work (C.2.d, C.2.g). Counselors should engage in activities that promote a healthy lifestyle and mitigate stress, thus achieving a balance that fosters effective work performance. Self-care is viewed as an ethical obligation and preventive tool in this context (Thomas & Levitt, 2010).

O'Halloran and Linton (2000) have maintained that implementing preventive self-care strategies is necessary for effective practice and have offered resources within six domains of wellness including social, emotional, cognitive, physical, spiritual and vocational. Counselors

should be aware of their own ideas about self, others and their world, as well as the possibility that these beliefs may be changed as a result of working with trauma victims. "An awareness of personal reactions to vicarious traumatization may allow counselors to implement self-care strategies to ameliorate such effects, thus minimizing potential ethical and interpersonal difficulties" (Trippany et al., 2004, p. 36). Trippany et al. (2004) recommended preventive measures that include balancing caseloads, peer supervision, agency responsibility, spirituality and personal coping mechanisms. Mental health professionals should help themselves as they would help their clients by harnessing their own strengths in order to work toward overall self-care (Trippany et al., 2004).

Purpose of the Study

The purpose of this research study was to explore: (a) the types of self-care training provided to counselors in their educational preparation and work settings, (b) the perceived effectiveness of that training, (c) the types of self-care strategies used by counselors to prevent and mitigate the effects of vicarious traumatization, and (d) the perceived effectiveness of those self-care strategies when implemented. The overarching goal was to understand counselor perceptions of their educational preparation regarding self-care, what self-care strategies are being used, and how effective those strategies are when implemented.

Importance of the Study

Various forms of trauma are reported on a daily basis in sessions across the spectrum of counseling settings (Culver, McKinney, & Paradise, 2011). The potential negative psychological effects on mental health professionals who are repeatedly exposed to traumatic material are well documented (Adams & Riggs, 2008; Cunningham, 2003; Tehrani, 2007). However, many researchers suggest that vicarious traumatization can be prevented and mitigated with various

self-care strategies (Trippany et al., 2004). Thus, there is a substantial need to educate counselors in preparation for counseling practice, to prevent contamination in the counseling process, to maximize self-care strategies for counselors, and ultimately to retain qualified, experienced counselors to treat trauma victims. Counselors should be adequately trained to treat trauma victims and should be equipped with tools to cope with the inevitable personal and professional consequences of this work (Trippany et al., 2004). All of these efforts to ensure the psychological health of counselors will have a direct effect on their ability to help clients. Mental health professionals who may be interested in this study include: (a) practitioners such as counselors, social workers, psychologists, psychiatric nurses and nurse practitioners; (b) educators including faculty and researchers; and (c) agency directors, school administrators, clinical and administrative supervisors, and policy makers.

Research Questions

The following general research questions served as the overarching guideline for this study:

1. What self-care training have counselors received in educational programs, practicum and internship experiences, work settings and continuing education formats?
2. How effective do counselors perceive these various forms of self-care training to be?
3. What personal and professional self-care strategies are being used by counselors to prevent and mitigate the effects of vicarious traumatization?
4. How effective do counselors perceive these self-care strategies to be when implemented?

The following derivative subquestions were addressed:

5. Is there a relationship between counselor demographics (e.g., educational level, present employment position, years worked in the mental health field, number of trauma victims counseled each week) and:
    a. training
    b. perceived effectiveness of training
    c. self-care strategies implemented
    d. perceived effectiveness of self-care strategies implemented
6. Is there a relationship between self-care educational preparation and implementation of self-care strategies?

Summary

Counseling offers substantial benefits for those clients and counselors who choose to engage in the process, but there are inherent risks for both parties (Cavanagh & Levitov, 2002). Many clients who seek mental health treatment have experienced some form of trauma and this traumatic material often is discussed in counseling sessions (Culver, McKinney, & Paradise, 2011). Through repeated exposure to clients' traumatic material, counselors may develop symptoms of vicarious traumatization (Rasmussen, 2005; Trippany et al., 2004). To prevent and mitigate the risk of vicarious traumatization, counselors should engage in personal and professional self-care strategies (Trippany et al., 2004). Although self-care is emphasized within the curriculum of CACREP-accredited educational programs and included in the ACA *Code of Ethics*, there is little empirical evidence regarding training provided to counselors about self-care strategies, or regarding which strategies are being used by counselors currently seeing clients with trauma or which strategies are perceived to be the most effective when implemented.

Definition of Terms

American Counseling Association (ACA): A professional and educational organization that represents professional counselors in various work settings. The association's goal is to enhance the counseling profession through education, training, publications and advocacy (ACA, 2010a).

American Psychological Association (APA): A scientific and professional organization that represents psychologists in various work settings. The association's goal is to advance the creation, communication and application of psychological knowledge to benefit society and improve people's lives (APA, 2010).

Council for Accreditation of Counseling and Related Educational Programs (CACREP): A professional and accrediting organization dedicated to promoting standards and procedures for counseling and related programs in order to ensure that counseling professionals provide optimal services (CACREP, 2010).

Counseling: A relatively short-term, interpersonal, theory-based process of helping persons who are basically psychologically healthy resolve developmental and situational problems. Counseling concerns include personal, social, vocational, empowerment and educational matters (ACA, 2010b).

Self-Care: The process of maintaining and promoting a counselor's emotional, physical, mental, and spiritual well-being in pursuit of overall wellness (ACA, 2005).

Trauma: Direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing such an event; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (APA, 2000).

Vicarious Traumatization (VT): Process by which mental health providers experience profound negative psychological effects as a result of work with trauma victims (McCann & Pearlman, 1990).

CHAPTER II

REVIEW OF THE LITERATURE

This chapter includes a review of the published research and literature related to the educational preparation that counselors receive concerning work with trauma victims and self-care strategies as well as a brief exploration of trauma and related treatments. An overview of vicarious traumatization is offered, including the evolution of related terminology and concepts, the impact on counselors of exposure to traumatic material, as well as the variables that may be associated with the risk of vicarious traumatization. Literature regarding professional and personal self-care strategies for counselors working with trauma victims, including ethical considerations, is reviewed as well.

Trauma Work

Trauma is often associated with exposure to a situation that involves threatened or actual death or serious injury either to self or others (American Psychiatric Association, 2000). Not all traumatic events fit this criterion and other life events may fall into this category as they are similar to "living death" (Shallcross, 2010). Trauma is a "powerful assault on the psychological well-being of a person and causes intense psychological pain" (Cavanagh & Levitov, 2002, p. 406). Common traumatic events include loss, physical or sexual assault, childhood sexual abuse, domestic violence, natural and man-made disasters, as well as school and work-related violence (James, 2008; Trippany, White Kress, & Wilcoxon, 2004). Trauma affects all populations including children, adolescents, adults, and the elderly across all racial and ethnic groups (National Institute of Mental Health, 2010).

Approximately 7.7 million American adults are diagnosed with posttraumatic stress disorder (PTSD) in a given year (Kessler, Chiu, & Demler, 2005). PTSD is an anxiety disorder that is characterized by the development of a certain cluster of symptoms following exposure to an extremely traumatic event (*Diagnostic and Statistical Manual of Mental Disorders, IV-TR*, 2000). According to the *DSM-IV-TR*, the diagnostic criteria for PTSD include the following:

A. The person has been exposed to a traumatic event;
B. The traumatic event is persistently re-experienced psychologically;
C. Persistent avoidance of stimuli associated with the trauma;
D. Persistent symptoms of increased arousal;
E. Duration of the disturbance is more than one month;
F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (p. 467-468).

The Center for Financing, Access, and Cost Trends (1996) ranks trauma-related disorders among the top five mostly costly conditions; 34.9 million people with expenses are affected. Trauma-related disorders resulted in 46.2 billion dollars spent in 1996 and increased to 68.1 billion dollars spent in 2006 (Center for Financing, Access, & Cost Trends, 2006).

Mental health professionals in a variety of work settings regularly encounter clients who are victims of various types of traumatic events (Munroe, 1999; Pearlman & Saakvitne, 1995; Trippany et al., 2004). According to Bride (2007), the incidence of individuals with a history of trauma seeking mental health treatment is between 60-90%. Culver, McKinney and Paradise (2011) surveyed 30 counselors in the greater New Orleans area and found that 96% of participants reported working with between 1 and 20 trauma victims weekly (M = 5.17, SD = .75). The most common type of trauma reported was domestic violence (100%), followed by

childhood sexual abuse (93%), physical assault (86%), and natural disaster (86%) (Culver et al., 2011).

Posttraumatic stress disorder (PTSD) and other trauma-related disorders may be treated with psychotherapy, medications, or a combination of the two modalities (National Institute of Mental Health, 2010). Cognitive behavioral therapy (CBT) is a common psychotherapy and counseling approach used with trauma victims. Eye movement desensitization and reprocessing (EMDR), a process that involves altering the dysfunctionally stored memories of traumatic experiences, has also been an effective treatment method for PTSD (Solomon, Solomon, & Heide, 2009). Alternative methods for treating trauma victims include exposure therapy, art therapy, and body-based psychotherapy (Talwar, 2007).

Role of Counselor

The American Counseling Association (ACA) defines counseling as "a relatively short-term, interpersonal, theory-based process of helping persons who are basically psychologically healthy resolve developmental and situational problems" (ACA, 2010b, p.1). Counseling concerns include personal, social, vocational, empowerment and educational matters (ACA, 2010b). This application process occurs through a special dialog in which success depends upon "an emotional exchange in an interpersonal relationship which accelerates the growth of one or both participants" (Wolberg, 1977, p. 10). The ACA *Code of Ethics* describes the counselor-client relationship as: "…counselors encourage client growth and development in ways that foster the interest and welfare of clients and promote formation of healthy relationships" (ACA, 2005, p. 4). The intimate, empathic connection that occurs within the counselor-client relationship is critical to helping clients achieve their goals as it affords a safe space for the work to take place as well as helping to produce insight and growth.

Thus, counseling is a complex process that integrates academic knowledge, clinical skills and the personal characteristics of the counselor (Lauver & Harvey, 1997). Many counselor characteristics have been identified as necessary for effective counseling including self-knowledge, wholeheartedness, trustworthiness, honesty, strength, warmth, active responsiveness, patience, sensitivity, freeing, holistic awareness and psychological health (Cavanagh & Levitov, 2002). Good psychological health is important in that it gives the counselor support in understanding behavior and skills, and it allows the counselor to be a healthy model of behavior (Cavanagh & Levitov, 2002). Importantly, a counselor's good psychological health may also prevent potential contamination of the counseling session (Cavanagh & Levitov, 2002). Because the counselor is the primary tool in counseling, it is essential that counselors actively maintain their psychological health. "The better a counselor's psychological health, the more helpful the counseling relationship is likely to be" (Cavanagh & Levitov, 2002, p. 129).

Educational Preparation

The Council for Accreditation of Counseling and Related Educational Programs (CACREP) details requirements for educational programs in counseling that apply to the academic institution, roles of faculty and staff, curriculum content, and practicum and internship experiences (CACREP, 2009). CACREP outlines program requirements for professional orientation and ethical practice including educational studies that provide an understanding of "self-care strategies appropriate to the counselor role" (CACREP, 2009, p. 10). The American Counseling Association *Code of Ethics* (2005) dictates that counselors must receive relevant education, training and supervised experience prior to practicing (C.2.a, C.2.b). The code also addresses self-care in terms of professional responsibility by stating that counselors should

"engage in self-care activities to maintain and promote their emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities" (ACA, 2005, p. 9).

Several research reports, as well as anecdotal and editorial pieces, have been published regarding self-care education. Roach and Young (2007) examined the impact of counselor education programs on counselor wellness by surveying a sample of students at three points in their master's programs. They recruited 204 research participants from three CACREP-accredited universities located in the southeastern United States. Student wellness was measured with the 5F-Wel which is comprised of 91 items scored on a 5-point Likert scale. The instrument yields one score for Total Wellness, five factors of the Self and 17 factors including the Creative Self (Thinking, Emotions, Control, Work, Positive Humor), the Coping Self (Leisure, Stress Management, Self-Worth, Realistic Beliefs), the Social Self (Friendship, Love), and the Physical Self (Nutrition, Exercise). The researchers developed a demographic questionnaire designed to collect data regarding variables that might explain differences in student wellness levels. These variables included age, program track, number of graduate hours completed, and whether the program had a wellness course. Additionally, students were asked the following open-ended question: "What, if anything, have you learned in your counseling course work that has helped you develop knowledge and skills regarding your personal wellness?" (Roach & Young, 2007, p. 34).

Roach and Young (2007) empirically tested the influence of counselor education programs on counselor wellness by using a cross-sectional research design with students at three points in their training. Although the results indicated there was no significant trend among participants regarding student wellness, several other findings contributed to the overall understanding of student wellness training. Of the sample, 48% of students reported that their

program offered a wellness course, while 52% indicated there was no wellness course. However, many students pointed out that several of their courses emphasized wellness. Sixty-two percent of participants stated that their program required students to engage in personal counseling. It is worthwhile to note that the findings of this study are limited by the fact that only three programs were surveyed.

Despite the investigators providing an option for a narrative response from the students who participated in the research, only 41% of participants answered the open-ended question regarding what they had learned about personal wellness. However, these responses proved to be some of the most valuable. Students commented on social support by emphasizing the need to maintain healthy relationships in their personal lives. They referred to emotions by stressing the importance of being in touch with their own feelings and understanding themselves. One student commented on information gleaned from an ethics class, saying that, "We learned that self-care is a requirement, not a luxury" (Roach & Young, 2007, p. 40). Students participating in the survey reported the following activities as contributing to their knowledge and skills of wellness: (a) group projects, (b) in-class activities, (c) role playing, (d) self-care, (e) personal journals, and (f) supervision.

However, only one student specifically mentioned stress management as a skill emphasized for personal wellness. According to the findings, social, psychological and emotional aspects of counselor wellness were emphasized within the educational programs, while such components as nutrition, exercise or spirituality were not addressed (Roach & Young, 2007). The survey results indicated that students are aware of their own wellness because of exposure to the concept throughout coursework, but there is no evidence that students actually improve their wellness as they progress through the program. Roach and Young (2007)

suggested that a wellness model be developed to provide structure for instruction, and so that students may be more effectively evaluated in the area of wellness.

In research aimed at exploring counselor education preparation for trauma work, Kitzrow (2002) mailed questionnaires to 136 CACREP-accredited counselor education programs to inquire about what type of classes or training for sexual abuse work were being offered to students. Respondents were students who were asked to rate the importance of training counselors to work with this specific population. Of the 68 questionnaires that were returned, only 9% indicated that their program offered a required course specifically focused on sexual abuse and 22% reported that an elective course was offered. The majority of respondents (69%) reported that neither a required nor an elective course was offered, but 41% of the respondents indicated that other training, primarily the topic being addressed in other courses, was available. Despite the lack of required coursework, 60% of respondents indicated that this type of training was very important and 35% rated it as important. The respondents reported two major reasons for the importance of sexual abuse training: (a) high prevalence of sexual abuse so students will eventually work with these types of clients, and (b) specific training and supervision needed to understand the complexities of this type of treatment, especially for novice counselors (Kitzrow, 2002). This research helped illuminate an apparent disparity between the necessity of trauma-specific training and actual current practice.

In an anecdotal piece, O'Halloran and O'Halloran (2001) discussed the importance of addressing the difficulties of learning about trauma and violence in graduate level courses as well as working with clients who are dealing with these issues. Their goal in the classroom was to raise student self-awareness about the emotional responses to such powerful material as well as emphasize the importance of self-care. Their teaching approach included building safety,

remembrance and mourning, as well as reconnection. These are three psychotherapeutic stages outlined in a text by Herman (1992) entitled *Trauma and Recovery*.

To stress the importance of self-care to students, Sommer (2008) used the metaphor of a flight attendant explaining that in the case of an emergency, passengers are not able to assist others if they do not place their own oxygen masks on first. This concept supports the idea that self-care is critical in order to facilitate the caretaking of others. Sommer recommended several techniques that may be incorporated into counselor education programs to promote student awareness about self-care. The specific practices suggested included topical presentations, breath work, guided imagery and reflective reading (Sommer, 2008).

Skovholt, Grier and Hanson (2001) discussed how counselor training focused on helping others, with relatively sparse instruction related to helping oneself. The authors attempted to address this one-sided focus by offering a developmental framework for self-care throughout a counselor's professional career. Skovholt et al. (2001) emphasized the need for work/life balance, stating, "To be successful in the helping professions, we must continually maintain professional vitality and avoid depleted caring…thus, balancing self-care and other-care seems like a universal struggle for those in the helping professions" (p. 168).

Pearlman and Saakvitne (1995) suggested that a lack of formal, trauma-specific coursework may contribute to a counselor's susceptibility to trauma-related symptomology. Results of several other studies supported the idea that education and training could substantially contribute to mental health professionals more effectively coping with difficult client cases (Alpert & Paulson, 1990; Chrestman, 1995; Follette, Polusny, & Milbeck, 1994). "Students need substantial trauma-specific training in the context of a full semester of coursework or multiple intensive workshops in order to protect themselves against the potential negative impact of

trauma counseling" (Adams & Riggs, 2008, p. 32). The course could address various treatment methods for working with trauma victims, potential impacts on counselors, and self-care strategies. Counselor educators and supervisors should help students prepare for the inherent risks of trauma work through trauma-specific training including self-care strategies that may help prevent and ameliorate vicarious traumatization (Sommer, 2008).

Many mental health professionals will very likely encounter trauma clients during their practicum and internship experiences (Pearlman & Mac Ian, 1995). Therefore, students, counselors and supervisors should be educated about the warning signs of vicarious traumatization so that they may be equipped to cope with the symptoms (Sommer, 2008; Trippany, 2004). Otherwise, not only will counselors suffer from the effects of working with trauma victims, but they may potentially cause harm to their clients and negatively affect counseling outcomes. Counselors may encourage their clients to avoid traumatic material in session, or may be unable to be fully present with their clients because of the effects of vicarious traumatization (Munroe, 1999). Additionally, counselors may leave the mental health field altogether, resulting in a lack of qualified professionals to work with clients (Sommer, 2008).

Vicarious Traumatization

Terminology

Many conceptualizations have been put forth to describe the psychological strain associated with helping various populations. Countertransference, burnout, compassion fatigue (CF), secondary traumatic stress (STS), and vicarious traumatization (VT) are all terms used to describe aspects of this phenomenon (Fahy, 2007; Salston & Figley, 2003; Trippany, Kress, & Wilcoxon, 2004). It is worthwhile to explore the evolution of this terminology and related concepts as the constructs each describe unique aspects of the overall phenomenon.

Countertransference is an important concept first attributed to Freud, which involved the perspective that strong emotional reactions to the client were a result of the analyst's failure to maintain "psychological neutrality, distance, and objectivity" (Fall, Holden, & Marquis, 2004, p. 73). The concept has evolved and currently refers to the counselor's emotional reaction to clients and their material as a result of the counselor's personal life experiences (Figley, 1995). Countertransference offers both advantages and disadvantages within the counseling process. For instance, countertransference is helpful "when it teaches counselors something about themselves…but countertransference can also be a hindrance to counseling because strong, inappropriate feelings – positive or negative – dangerously interfere with the counselor's clinical judgment" (Cavanagh & Levitov, 2002, p. 25). In the trauma literature, countertransference is differentiated from vicarious traumatization in that countertransference occurs around counseling sessions, while the effects of vicarious traumatization affects other aspects of the counselor's life (Trippany et al., 2004).

Burnout is a common term first identified by Pines and Maslach (1978) to describe exhaustion experienced by clinicians on a variety of levels, which impacts their mental and physical resources (Fahy, 2007). The symptoms of burnout may include depression, cynicism, boredom, loss of compassion and discouragement (Freudenberger & Robbins, 1979). Burnout is a term which certainly resonates with practitioners, but acts as a catch all and is not sufficiently precise to assist clinical directors, policy makers or researchers in prevention methods (Fahy, 2007). Fahy points to an additional problem with the connotation of the term, stating that "the unspoken message is if you are burned out it's already too late" (p. 201). While there is little evidence to support this idea, burnout is an easily understood concept that aptly describes the unfortunate experience of some mental health workers. Burnout may be distinguished from

vicarious traumatization in that it is not specifically linked to trauma history or exposure, but rather to workplace variables such as job structure, workload and lack of support (Baird & Jenkins, 2003).

Cunningham (2003) points out the deficiency in both countertransference and burnout by stating that neither term "adequately accounts for the impact on the clinician of the graphic material presented by the traumatized client" (p. 451). *Compassion fatigue* (CF) is a term first used to describe a unique form of burnout which involves the emotional stress experienced as a result of working with individuals who are suffering or have been traumatized (Dominguez-Gomez & Rutledge, 2009). Fahy (2007) asserted that compassion fatigue is a more useful term than burnout in that it is solution focused and "encourages workers and supervisors to dialogue about solutions to the hazards of empathic work" (p. 201).

Secondary traumatic stress (STS) is defined as the presence of posttraumatic stress disorder (PTSD) symptoms in the caregiver which have developed as a result of daily exposure to traumatic material in combination with the caregivers' empathetic response and their own previous traumatic experiences (Dominguez-Gomez & Rutledge, 2009). Symptoms of PTSD include recurrent and intrusive recollections of the event, persistent avoidance of stimuli associated with the trauma, as well as persistent symptoms of increased arousal (DSM-IV-TR, 2000). Secondary traumatic stress involves sudden onset of this PTSD symptomology whereas vicarious traumatization is "a theory-driven construct which emphasizes more gradual, covert, and permanent changes in cognitive schema" (Baird & Jenkins, 2003, p. 75).

McCann and Pearlman (1990) first offered the term *vicarious traumatization* to describe the relationship between the graphic, painful material that trauma clients often present to clinicians and the clinician's cognitive schemas about self and others. The authors asserted that

individuals who work with trauma victims may experience profound psychological effects that may include painful thoughts, feelings and intrusive images associated with their clients' memories (McCann & Pearlman, 1990). These effects may be short-term reactions similar to those associated with countertransference, or the effects could be long-term alterations in the clinician's assumptions and beliefs about self, others and the world (McCann & Pearlman, 1990).

These various constructs are helpful in that they raise awareness of the potential negative effects of empathic work. However, the argument has made that more specificity related to these concepts could help guide practitioners to more effectively prevent and mitigate these conditions (Kanter, 2007). Although the distinctions between terms are noteworthy, there are common effects of empathic work with trauma victims that each of these concepts share. These include, but are not limited to, intrusive thoughts, hyper arousal, hyper vigilance, emotional numbing and avoidance behaviors (Fahy, 2007).

Impact of Exposure to Traumatic Material on Counselors

Much attention has recently been devoted to the impact on mental health professionals themselves as a result of attempting to help clients work through their traumatic material. Through repeated exposure to clients' traumatic material, mental health professionals may experience significant adverse effects in core aspects of themselves, including their perception of themselves, others and their world (Rasmussen, 2005; Trippany et al., 2004). "Vicarious traumatization emphasizes the way the therapist's experience of the self is altered in terms of identity, world view, spirituality, self capacities, ego resources, psychological needs, and the sensory system" (Rasmussen, 2005, p. 20). Symptoms of vicarious traumatization include anxiety, suspiciousness, depression, somatic symptoms, intrusive thoughts and feelings,

avoidance, emotional numbing and flooding, and increased feelings of personal vulnerability (Adams & Riggs, 2008).

Mental health professionals may experience other disruptions to their sense of safety, trust, power, esteem, independence, intimacy and frame of reference (McCann & Pearlman, 1990). Similarly, Trippany et al. concluded that a counselor's need for safety, trust, esteem, intimacy and control are all affected by vicarious traumatization. An increased awareness of the stark reality and frequent occurrence of trauma combined with repeated exposure to vivid, detailed traumatic material leads to an impact on both the personal and professional functioning of a counselor (Trippany et al., 2004). The counselors' overall psychological health and functioning will affect their ability to be effective with clients within the counseling process.

Skovholt, Grier and Hanson (2001) offered a developmental framework for understanding the hazards of mental health practice. The authors asserted that the cycle of caring, which involves empathic attachment, active involvement and felt separation, strains counselors' natural abilities including their hope to make a difference, the ability to tolerate ambiguity, and the belief in self-actualization. The following counseling hazards were identified:

1. Clients have an unsolvable problem that must be solved
2. All clients are not "honor students"
3. There is often a readiness gap between the client and counselor
4. Counselor's inability to say no
5. Constant empathy, interpersonal sensitivity, and one-way caring
6. Elusive measures of success
7. Normative failure (p. 169-170).

Skovholt et al. (2001) conceded that the seven hazards were not an exhaustive list of the difficulties inherent in mental health work, but they did illustrate the intrinsic challenges that counselors regularly face. It is important to note that these hazards are often out of the control of the counselor.

Variables Affecting Risk of Vicarious Traumatization

While all mental health professionals working with trauma victims are at risk for vicarious traumatization, certain members of the mental health community are especially vulnerable. Emergency care practitioners including medical workers, rescue workers, and crisis intervention volunteers are at increased risk (Trippany et al., 2004; Warren, Lee, & Saunders, 2003). Mental health professionals who work primarily with trauma victims are at greater risk than those for whom trauma clients make up only a sporadic or a small percentage of their client base (Baird & Jenkins, 2003; Trippany et al., 2004). Novice therapists with minimal work experience are more vulnerable to vicarious traumatization than more experienced practitioners (Adams & Riggs, 2008; Baird & Jenkins, 2003). "This finding is in line with models of trainee development and supporting research suggesting that students beginning applied training are more preoccupied with self-concerns than more advanced students, and consequently more likely to be vulnerable to countertransference issues that require close and careful supervision" (Adams & Riggs, 2008, p. 32). Baird and Jenkins (2003) similarly found that novice counselors reported more emotional exhaustion when compared to experienced counselors. In addition, counselors with more education had lower vicarious traumatization scores (Baird & Jenkins, 2003).

The role of a clinician's own traumatic history as a predictor of vicarious traumatization is commonly explored in the literature. A history of sexual abuse has been found to be positively correlated with working with sexual abuse clients (Cunningham, 2003; Way, VanDeusen, &

Cottrell, 2007). The results of several studies have demonstrated a relationship between a clinician's own personal trauma history and vicarious traumatization (Cunningham, 2003; Follette, Polunsy, & Milbeck, 1994; Pearlman & Mac Ian, 1995). It seems reasonable to expect that counselors who have experienced their own personal traumas may have strong responses to the disclosures of traumatized clients (Baird & Jenkins, 2003).

Cunningham (2003) examined how various types of trauma presented by clients might impact social workers differently. Cunningham was particularly interested in the distinction between human-induced trauma such as sexual abuse compared to naturally caused trauma such as cancer. The results indicated that clinicians working with clients who were sexual abused reported more symptoms of vicarious traumatization than those who worked with cancer victims. It may be that these differences can be explained by the nature of the trauma – whether it was the result of another human or just naturally caused. However, the difference may also be attributed to the fact that sexual abuse victims could relay detailed accounts of their trauma while cancer patients might talk about their experience by less vivid means.

Another factor that may influence counselors' susceptibility to vicarious traumatization is their resilience. Masten and Coatsworth (1998) defined resilience as a pattern of positive adaptations to challenges throughout an individual's life. Vicarious resilience is a term used to describe the process by which counselors become empowered through their work with trauma victims (Hernandez, Gangsei, & Engstrom, 2007). Hernandez et al. (2007) qualitatively explored the experiences of 12 psychotherapists who worked with victims of political violence and kidnapping. The participants described the effects of working with clients who coped constructively with significant adversity and reflected upon the client's capacity to heal. The

reinstillment of hope through recovery and change was a powerful result for both clinicians and clients doing psychotherapeutic work (Hernandez , 2007).

For the purposes of this study, a figure depicting the vicarious traumatization process was developed by the researcher (see Figure 1). A counselor is exposed to a variety of traumatic material through clinical practice which potentially leads to symptoms of vicarious traumatization. The variables influencing susceptibility to vicarious traumatization act as both protective and risk factors for the counselor including (a) type of trauma presented, (b) type of intervention used, (c) counselor's own trauma history, (d) counselor's experience level, and (e) counselor's workload. It is suggested that self-care strategies can play an important role in preventing and mitigating the acquisition of vicarious traumatization.

Figure 1. Vicarious Traumatization Process

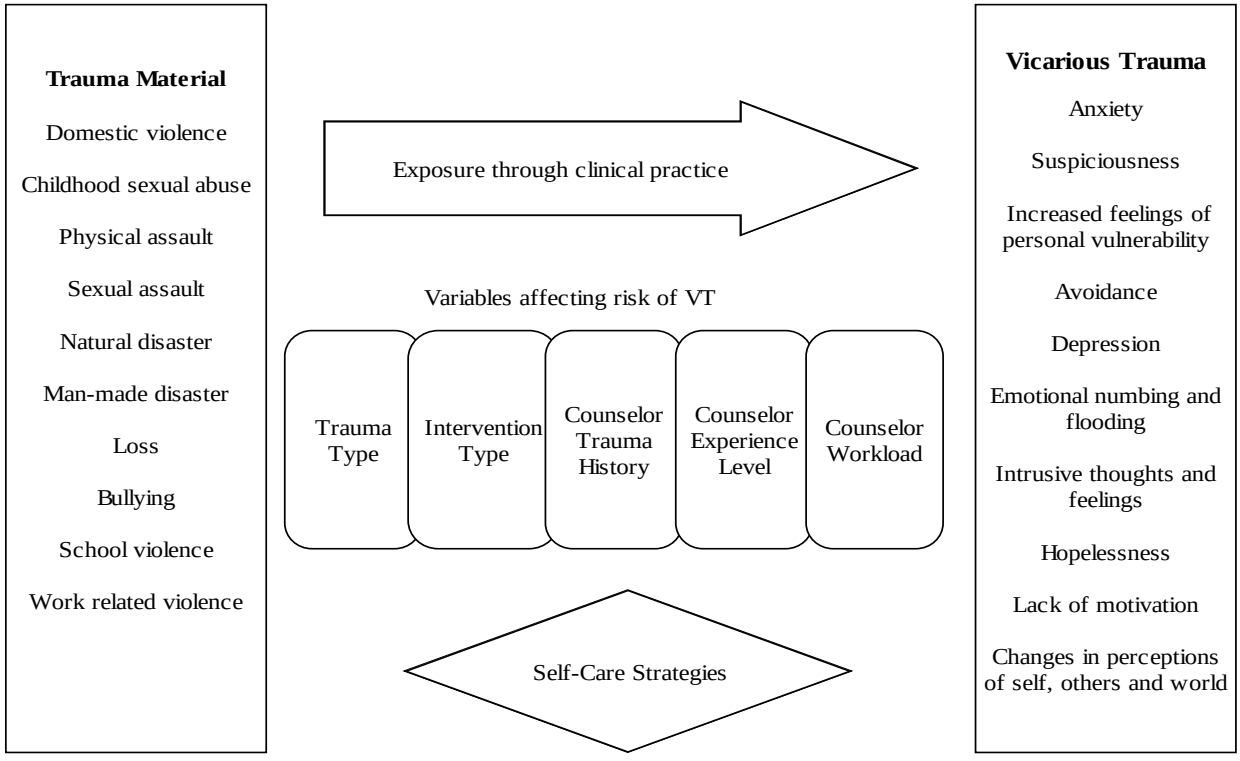


Figure 1. Vicarious traumatization model. Rectangle on left denotes traumatic material commonly reported in counseling sessions, rectangle on right denotes symptoms of vicarious traumatization. Factors influencing susceptibility to vicarious traumatization are grouped in center.

Self-Care

Self-Care within the Context of Wellness and Impairment

Self-care in the context of the counseling profession is important for the overall wellness of counselors as well as their clients (Stebnicki, 2007). Wellness is related to living a meaningful life that is whole and balanced in a variety of domains (ACA, 2003). The American Counseling Association's Taskforce on Counselor Wellness and Impairment identified five wellness domains including physical, cognitive, emotional, spiritual and social (ACA, 2003). Implementing self-care strategies in these various areas is critical for effective counseling practice as they promote resiliency and prevent empathy fatigue in counselors (O'Halloran & Linton, 2000; Stebnicki, 2007).

All counselors are necessarily on the spectrum from "well" to "impaired" at any given point in time (ACA, 2003). Impairment indicates that there is a "significant negative impact on a counselor's professional functioning which compromises client care or poses the potential for harm to the client" (ACA, 2003). It is important to note that impairment does not always result in unethical behavior, but this may occur as a symptom of impairment, and that counselors who are not impaired may still act unethically (ACA, 2003). In contrast, wellness may be understood in terms of an individual's overall physical, psychological, spiritual and professional functioning (Lawson & Venart, 2003). Self-care activities are often suggested as tools for preventing and mitigating impairment as well as pursuing wellness (ACA, 2003).

Wherever counselors are located on the spectrum of wellness and impairment, they must attend to self-care activities in pursuit of healthy functioning (Lawson & Venart, 2003). Although impairment is recognized as a common consequence of empathic work, the argument has been made that counselors can effectively prevent and mitigate these conditions with

professional and personal self-care strategies (Trippany et al., 2004). Counselors who are equipped with tools to cope with the inevitable consequences of their work will be in better psychological health which will have a direct effect on their ability to help clients (Trippany et al., 2004).

Ethical Considerations

Various professional associations related to the mental health field address the issue of self-care in their guidelines and ethics codes. The Council for Accreditation of Counseling and Related Educational Programs (CACREP) outlines program requirements for professional orientation and ethical practice including educational studies that provide an understanding of "self-care strategies appropriate to the counselor role" (CACREP, 2009, p. 10). The American Counseling Association (ACA) *Code of Ethics* addresses self-care in terms of professional responsibility by stating that counselors should "engage in self-care activities to maintain and promote their emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities" (ACA, 2005, p. 9). Counselors should engage in activities that promote a healthy lifestyle and mitigate stress, thus achieving a balance that fosters effective work performance. Self-care is viewed as an ethical obligation and preventive tool in this context (Thomas & Levitt, 2010). The organization offers the following materials for counselors interested in managing their own self-care: (a) self-care assessment worksheet, (b) self-care strategies worksheet, (c) self-care life pie worksheet, and (d) self-care social support worksheet.

ACA's Task Force on Counselor Wellness and Impairment (2003) recognized the impact of counselors' fatigue reactions to clients, labeling this as "counselor impairment." The ACA *Code of Ethics* dictates that counselors should monitor their effectiveness and be sensitive to signs of impairment at work (C.2.d, C.2.g). The code states that counselors should be "alert to

the signs of impairment from their own physical, mental, or emotional problems and refrain from offering or accepting professional services when such impairment is likely to harm a client or others" (C.2.g). Counselors are also instructed to assist by recognizing professional impairment in their colleagues and supervisees (C.2.g).

The American Psychological Association (APA) *Ethical Principles* outlines similar guidelines for psychologists with personal problems that may interfere with work performance. Psychologists are encouraged to "take appropriate measures such as obtaining professional consultation or assistance" (APA, 2009, Section 2.06) in order to determine how to proceed with work-related duties. The APA offers a self-care action plan that suggests adopting a proactive approach is "crucial for effectively managing occupational and personal stressors and for maintaining optimal wellness" (APA, 2009, p. 16).

The *Feminist Therapy Code of Ethics*, first developed by the Feminist Therapy Institute in 1987, stresses the importance of professional competency in a section titled Therapist Accountability (Worell & Remer, 1996). The code stipulates that a feminist therapist must attend to her own personal and professional needs using "ongoing self-evaluation, peer support, consultation, supervision, continuing education, and/or personal therapy to evaluate, maintain, and improve work with clients, her competencies, and her emotional well-being" (Worell & Remer, 1996, p. 295). Feminist therapists are encouraged to continually engage in self-care activities (IV. D). "She acknowledges her own vulnerabilities and seeks to care for herself outside of the therapy setting. She models for the ability and willingness to self-nurture in appropriate and self-empowering ways" (Worell & Remer, 1996, p. 296).

A review of the ethics codes and guidelines related to self-care within the mental health profession demonstrates the emphasis on maintaining good overall health. A healthy balance

achieved through a combination of professional and personal self-care activities promotes wellness and will ultimately help clinicians better serve their clients. The fact that the ethical codes discuss self-care in terms of both the personal and professional realms underlines the holistic approach that counselors implement when working with their clients.

Self-Care Strategies

Because counselors will be both inevitably and repeatedly exposed to their clients' painful material, it is essential that they work to mitigate their reactions so they can continue to be effective clinicians. The American Counseling Association's Taskforce on Counselor Wellness and Impairment identified five wellness domains to which counselors should attend, including physical, cognitive, emotional, spiritual and social (ACA, 2003). The ACA *Code of Ethics* states that counselors should work to maintain their "emotional, physical, mental, and spiritual well-being" (ACA, 2005, p. 9). Much of the vicarious traumatization and self-care literature organizes self-care strategies into categories that are consistent with the wellness domains and ethical guidelines constructed by ACA (e.g., O'Halloran & Linton, 2000; O'Halloran & O'Halloran, 2001; Stebnicki, 2007; Trippany, White Kress, & Wilcoxon, 2004).

O'Halloran and O'Halloran (2001) offered four categories of self-care strategies: (a) biobehavioral strategies, (b) affective and cognitive strategies, (c) relational strategies, and (d) spiritual strategies. Biobehavioral strategies include nutrition, exercise, sleep, medication, relaxation and play. Affective and cognitive strategies may involve self-care plans, resource lists, positive self-statements, inspirational readings, humor, journaling, and crying. Relational strategies are interpersonal in nature and may include developing personal and professional support systems, personal counseling and companionship through pets. Spiritual strategies that emphasize a connection to a greater source may involve regular religious practice, rituals,

creating meaning in life, or a connection with the environment through activities such as hiking, camping, gardening and traveling.

Counselors have unique challenges related to overall wellness as they are "regularly and intimately involved in the painful experiences of other peoples' lives" (Lawson & Venart, 2003, p. 6). Harrison and Westwood (2009) conducted a qualitative study aimed at identifying protective practices that might mitigate vicarious traumatization. The sample was comprised of six peer-nominated master therapists whose clientele included survivors of torture and natural disasters, survivors of sexual and physical abuse, refugees from countries at war, firefighters, and pediatric and adult palliative care patients and their families. Each therapist was asked, "How do you manage to sustain your personal and professional well-being, given the challenges of your work with seriously traumatized clients?" (Harrison & Westwood, 2009, p. 203). Through narrative analysis, nine major themes emerged from the data collected: (a) countering isolation in professional, personal, and spiritual realms, (b) developing mindful self-awareness, (c) consciously expanding perspective to embrace complexity, (d) active optimism, (e) holistic self-care, (f) maintaining clear boundaries and honoring limits, (g) exquisite empathy, (h) professional satisfaction, and (i) creating meaning. These findings confirm the recommendations extended from previous studies regarding protective practices for counselors, with the exception of exquisite empathy. Empathic engagement is typically considered a risk factor for clinicians, but the experience of the master therapists was that a "discerning, highly present, sensitively attuned, well-boundaried, heartfelt" form of empathy could actually help bolster the clinician's practice (Harrison & Westwood, 2009, p. 213).

It is critical for mental health professionals to be aware of their own ideas about self, others and their world as well as the possibility that these beliefs may be changed as a result of

working with trauma victims. "An awareness of personal reactions to VT may allow counselors to implement self-care strategies to ameliorate such effects, thus minimizing potential ethical and interpersonal difficulties" (Trippany, Kress, & Wilcoxon, 2004, p. 36). Trippany et al. (2004) recommended preventive measures that include balancing caseloads, peer supervision, agency responsibility, spirituality, and personal coping mechanisms. Stebnicki (2007) offered three major self-care strategies to prevent empathy fatigue: (a) awareness, (b) balance, and (c) connections (personal and professional associations). Mental health professionals should help themselves as they would help their clients by harnessing their own strengths in order to work toward overall self-care (Trippany et al., 2004).

For the purposes of this study, the researcher developed a figure depicting the role of self-care strategies within the counselor formation process (see Figure 2). Self-care strategies should be incorporated in counselors' educational preparation and training so that they are adequately prepared for client work (Adams & Riggs, 2008; Roach & Young, 2007; Sommer, 2008) The ACA *Code of Ethics* (2005) maintains that self-care is a professional, ethical responsibility. Self-care strategies may be divided into organizational categories, such as professional, physical, emotional, mental, spiritual, and relational, the combination of which helps ensure a counselor's overall health.

Figure 2. Self-Care Strategies

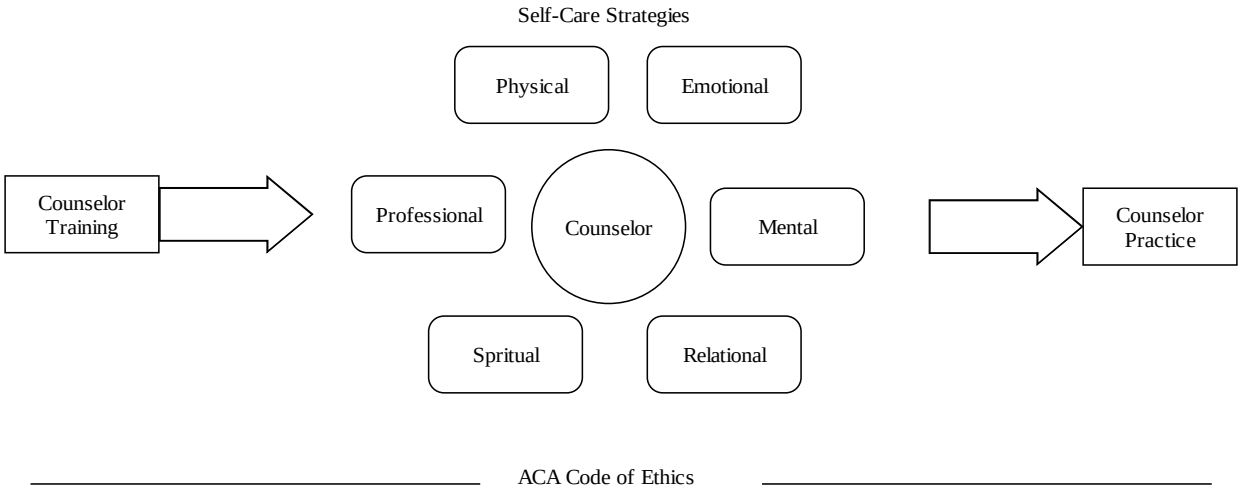


Figure 2. Self-care strategy model. Strategies are depicted in categories and the central placement denotes importance of training counselors for clinical practice.

Healthy Counselor Characteristics

Counseling is a complex process that integrates academic knowledge, clinical skills and the personal characteristics of the counselor (Lauver & Harvey, 1997). Many counselor characteristics have been identified as necessary for effective counseling including self-knowledge, wholeheartedness, trustworthiness, honesty, strength, warmth, active responsiveness, patience, sensitivity, freeing, holistic awareness and psychological health (Cavanagh & Levitov, 2002). Good psychological health is important in that it gives the counselor support in understanding behavior and skills, and it allows the counselor to be a healthy model of behavior (Cavanagh & Levitov, 2002). Importantly, a counselor's good psychological health may also prevent potential contamination of the counseling session (Cavanagh & Levitov, 2002). Because the counselor is the primary tool in counseling, it is essential that counselors actively maintain their psychological health. "The better a counselor's psychological health, the more helpful the counseling relationship is likely to be" (Cavanagh & Levitov, 2002, p. 129).

A qualitative study of counselors working with battered women explored the use of counselor strengths in preventing symptoms of secondary trauma (Bell, 2003). The strengths which were identified as useful included (a) having a sense of competence about coping, (b) maintaining an objective motivation, (c) resolving personal traumas, (d) drawing on positive role models of coping, and (e) having buffering personal beliefs (Bell, 2003). Other self-care strategies that have been identified include recognizing the hazards of mental health practice, being self-aware and diversifying professional activities (Norcross, 2000).

Counselors who practice effective self-care will continually work toward balance in their lives. A self-care program should encompass activities across a variety of domains including physical, cognitive, emotional, social and spiritual activities (ACA, 2003). Healthy counselors will exploit their strengths, identify areas of vulnerability and actively pursue wellness (Lawson & Venart, 2003).

Self-Care Related to Trauma Work

Those individuals who are drawn to the helping field often have an "acute sense of empathy to the experiences of others" (Lawson & Venart, 2003). This empathic capacity coupled with intimate, regular exposure to traumatic material can result in serious problems for the mental health professional (Figley, 1995). Countertransference, burnout, compassion fatigue (CF), secondary traumatic stress (STS), vicarious traumatization (VT) and posttraumatic stress disorder (PTSD) are all terms used to describe aspects of the psychological strain associated with helping various populations (Fahy, 2007; Salston & Figley, 2003; Trippany et al., 2004). These various constructs are helpful in that they raise awareness of the potential negative effects of empathic work. While the distinctions between terms are noteworthy, there are common effects

that each of these concepts share including intrusive thoughts, hyper arousal, hyper vigilance, emotional numbing and avoidance behaviors (Fahy, 2007).

Through repeated exposure to clients' traumatic material, mental health professionals may experience significant adverse effects in core aspects of themselves, including their perception of themselves, others and their world (Rasmussen, 2005; Trippany et al., 2004). McCann and Pearlman (1990) first offered the term *vicarious traumatization* to describe the relationship between the graphic, painful material that trauma clients often present to clinicians and the clinician's cognitive schemas about self and others. The authors asserted that individuals who work with trauma victims may experience profound psychological effects that may include painful thoughts, feelings and intrusive images associated with their clients' memories (McCann & Pearlman, 1990). These effects may be short-term reactions similar to those associated with countertransference, or the effects could be long-term alterations in the clinician's assumptions and beliefs about them self, others and the world (McCann & Pearlman, 1990). "Vicarious traumatization emphasizes the way the therapist's experience of the self is altered in terms of identity, world view, spirituality, self capacities, ego resources, psychological needs, and the sensory system" (Rasmussen, 2005, p. 20). Symptoms of vicarious traumatization include anxiety, suspiciousness, depression, somatic symptoms, intrusive thoughts and feelings, avoidance, emotional numbing and flooding, and increased feelings of personal vulnerability (Adams & Riggs, 2008).

It is extremely likely that counselors in a variety of work settings will encounter trauma victims (Munroe, 1999; Pearlman & Saakvitne, 1995; Trippany et al., 2004). The potential negative psychological effects on mental health professionals who are repeatedly exposed to traumatic material are well documented (Adams & Riggs, 2008; Cunningham, 2003; Tehrani,

2007). It is critical for counselors to be aware of their own ideas about self, others and their world as well as the possibility that these beliefs may be changed as a result of working with trauma victims. "An awareness of personal reactions to vicarious traumatization may allow counselors to implement self-care strategies to ameliorate such effects, thus minimizing potential ethical and interpersonal difficulties" (Trippany, Kress, & Wilcoxon, 2004, p. 36).

Educational and personal preparation for working with trauma victims is critical for successful client and counselor outcomes. There is a substantial need to educate counselors in preparation for counseling practice, to prevent contamination in the counseling process, to maximize self-care strategies for counselors, and ultimately to retain qualified, experienced counselors to treat trauma victims. Counselor educators and supervisors should help students prepare for the inherent risks of trauma work through trauma-specific training including self-care strategies that may help prevent and ameliorate vicarious traumatization (Sommer, 2008). Roach and Young (2007) suggested that a wellness model be developed to provide structure for instruction, and so that students may be more effectively evaluated in the area of wellness. All of these efforts to ensure the psychological health of counselors will have a direct effect on their ability to help clients.

Summary

This chapter included a review of published literature related to the educational preparation that counselors receive concerning work with trauma victims and self-care strategies as well as a brief exploration of trauma and related treatments. An overview of vicarious traumatization was offered, including the evolution of related terminology and concepts, the impact of exposure to traumatic material on counselors, and the variables that may influence the risk of vicarious traumatization. The chapter concluded with a review of literature regarding

professional and personal self-care strategies for counselors working with trauma victims including ethical considerations.

CHAPTER III

METHODOLOGY

This chapter contains a description of the methodology that was used in this study, including subsections that detail the purpose of the study, research questions and participant selection criteria. Instrument development involving content validation with an expert panel is described. Also addressed in this chapter are procedures related to data collection, management and analysis. Ethical considerations are discussed as well.

Purpose

The purpose of this research study was to examine what types of educational preparation concerning self-care strategies related to trauma work are being offered to counselors, and how effective this training is perceived to be by counselors. The purpose was also to investigate which self-care strategies are being used to prevent and mitigate the effects of vicarious traumatization, as well as which strategies are perceived to be the most effective when implemented. The goal was to understand counselor perceptions of their educational preparation in self-care related to trauma work, what strategies are being used, as well as how effective those strategies are when implemented.

Research Questions

The following general research questions served as the overarching foundation for this study:

1. What self-care training have counselors received in educational programs, practicum and internship experiences, work settings and continuing education formats?
2. How effective do counselors perceive these various forms of self-care training to be?

3. What personal and professional self-care strategies are being used by counselors to prevent and mitigate the effects of vicarious traumatization?

4. How effective do counselors perceive these self-care strategies to be when implemented?

The following derivative subquestions were addressed:

5. Is there a relationship between counselor demographics (e.g., educational level, present employment position, years worked in the mental health field, number of trauma victims counseled each week) and:
    a. training
    b. perceived effectiveness of training
    c. self-care strategies implemented
    d. perceived effectiveness of self-care strategies implemented
6. Is there a relationship between self-care educational preparation and implementation of self-care strategies?

Sample

The population of interest was counselors who work directly with individuals with trauma history. Participants in the study were members of the American Counseling Association (ACA) who identified themselves as currently providing direct clinical services to any number of trauma victims. ACA is a professional and educational organization that represents professional counselors in various work settings. The association's goal is to enhance the counseling profession through education, training, publications and advocacy (ACA, 2010a). Currently, the total membership of ACA is approximately 45,000, representing a national population. It is important to note that ACA members represent diverse ethnic backgrounds, various educational

and experience levels, as well as a range of employment positions and specialties. Because the members of ACA represent a national population and subscribe to the ACA *Code of Ethics*, this was an appropriate population from which to draw the sample for the current study.

A random membership list of 3000 members was purchased from ACA at a cost of $500 for use in a web-based survey. Members who identified themselves as students, no longer working in the counseling field, or retired were excluded before an ACA software program randomly selected the records, as these individuals did not necessarily work with trauma victims on a weekly basis and therefore did not meet the criteria for participating in the survey. The list included member names and email addresses. Because emails can be potentially identifying, all information was held within high levels of confidentiality, including a password protected laptop, by this researcher. It was estimated that approximately 300 participants were needed for the study, and there were 310 total responses, 286 of which were deemed appropriate for inclusion in the study. The sample was comprised of 286 participants out of 3000, resulting in a response rate of 9.5%.

Prior to participant recruitment, institutional review board approval was obtained from the University of New Orleans. Research materials including the intended instrument as well as an approved IRB form was submitted to ACA for review prior to purchasing the mailing list, as required by ACA policy.

Instrument Development

There have been no published reports of studies conducted to examine the types of self-care training related to trauma work offered to counselors or to measure the perceptions of efficacy of that training. Therefore, no appropriate survey was available for use in this study. Similarly, there have been no published reports of studies conducted to collect information about

what types of self-care strategies are being used by counselors who do trauma work, nor are there studies designed to measure counselor perceptions of the efficacy of those strategies when implemented. Due to lack of published reports, and no identifiable survey used to investigate the topic, a survey instrument was developed.

The *Self-Care Training and Implementation Questionnaire* (STIQ) was developed by me for the purpose of this research and was designed to determine the following: (a) what self-care preparation have counselors received in educational programs, practicum and internship experiences, work settings and continuing education formats, (b) how effective do counselors perceive these various forms of self-care training to be, (c) what personal and professional self-care strategies are being used by counselors to prevent and mitigate the effects of vicarious traumatization, (d) how effective do counselors perceive these self-care strategies to be when implemented, and (e) counselor demographics.

The STIQ is a 19-item survey divided into three sections. Section I, Demographic Information, was comprised of items related to personal information about participants including sex, age, ethnicity, education level, professional licensure and certification, present employment, years working in the mental health field, and estimated total number of clients and number of trauma victims counseled each week. Section II, Self-Care Training, was designed to capture information regarding what self-care training counselors have received in educational programs, practicum and internship experiences, work settings and continuing education formats, as well as how they effective they perceive this training to be. Section III, Self-Care Implementation, measured what personal and professional self-care strategies are being used by counselors to prevent and mitigate the effects of vicarious traumatization as well as how effective counselors perceive these self-care strategies to be when implemented. In order to acquire data regarding

self-care training received and self-care strategies implemented, 8-point Likert scales with anchored responses at each point were used. The counselors' perceptions of the efficacy of self-care training and strategies used were measured with the same 8-point Likert scales. The possible responses included exceptionally effective (1), very effective (2), somewhat effective (3), neutral (4), somewhat ineffective (5), very ineffective (6), not effective at all (7), and not applicable (8). Free form fields were included to solicit additional information and explanation from survey participants about these topics. In addition, participants were asked to identify which types of self-care training methods were used in various educational and work formats, and they were asked to rate the effectiveness of those training methods.

As shown in Table 1, each item included in the STIQ had a corresponding answer set. Each answer set was assigned an answer mechanism such as toggle buttons, a drop down menu or a free form field. The answer set determined what level of data would be collected for each item.

Table 1

Format: Self-Care Training and Implementation Questionnaire (STIQ)

Number	Category and Item	Answer Set	Answer Mechanism	Level of Data
I. DEMOGRAPHIC INFORMATION				
1	Sex	Male, Female	Toggle buttons	Categorical
2	Age	1-99	Drop down menu	Continuous
3	Ethnicity	▪ White/Caucasian ▪ Black/African American ▪ American Indian ▪ Alaska Native ▪ Asian Indian ▪ Chinese ▪ Filipino ▪ Japanese ▪ Korean	Drop down menu Free form field to accommodate "other" response	Categorical

Table 1, continued

Number	Category and Item	Answer Set	Answer Mechanism	Level of Data
		▪ Vietnamese ▪ Native Hawaiian ▪ Guamanian ▪ Samoan ▪ Other Asian ▪ Other Pacific Islander ▪ Other		
4	Highest education level. Check highest degree and program level attained.	▪ Bachelors Degree ▪ Masters in Social Work ▪ Masters in Counseling ▪ Masters in Psychology ▪ Ph.D. in Social Work ▪ Ph.D. in Counseling ▪ Ph.D. in Psychology ▪ Other	Drop down menu Free form field to accommodate "other" response	Categorical
5	Professional license and certification. Check all that apply.	▪ LPC ▪ LMFT ▪ LSW ▪ LMHPC ▪ Licensed Psychologist ▪ NCC ▪ NCSC ▪ None ▪ Other	Toggle buttons Free form field to accommodate "other" response	Categorical
6	Present employment position. Check the one most prominent position.	▪ Agency counselor ▪ School counselor ▪ In patient facility counselor ▪ Educator ▪ Administrator ▪ Researcher ▪ Private practice ▪ Other	Toggle buttons Free form field to accommodate "other" response	Categorical

Table 1, continued

Number	Category and Item	Answer Set	Answer Mechanism	Level of Data
7	How many years have you worked in the mental health field?	1-60	Drop down menu	Continuous
8	Do you work with trauma victims? According to the American Psychiatric Association (2000), trauma is often associated with exposure to a situation that involves threatened or actual death, or serious injury to self or others. For the purposes of this study, trauma can include loss, physical or sexual assault, childhood sexual abuse, domestic violence, natural and man-made disasters, as well as school and work-related violence.	▪ Yes ▪ No	Toggle buttons	Categorical
9	Please estimate the total number of clients you counsel, on average each week, including intakes and ongoing clients.	1-60	Drop down menu	Continuous
10	Please estimate the number of clients with trauma histories you counsel, on average each week, including intakes and ongoing clients.	1-60	Drop down menu	Continuous
II. SELF-CARE TRAINING				
11	In your counselor educational program, was there at least one course offered specifically regarding self-care or wellness?	▪ Yes ▪ No	Toggle buttons	Categorical

Table 1, continued

Number	Category and Item	Answer Set	Answer Mechanism	Level of Data
12	Please rate the effectiveness of the self-care or wellness training you received in each of the following educational and work settings. Please select "not applicable" if you did not receive any training in that particular format.	8-point Likert Scale: (1) Exceptionally effective (2) Very effective (3) Somewhat effective (4) Neutral (5) Somewhat ineffective (6) Very ineffective (7) Not effective at all (8) Not applicable	Toggle buttons	Interval
13	Please comment and/or provide examples of your positive and/or negative self-care training experiences.	Narrative	Free form field	Narrative
14	Please rate the effectiveness of each self-care or wellness training method which you experienced. Please select "not applicable" if you did not receive any training in that particular format.	8-point Likert Scale: (1) Exceptionally effective (2) Very effective (3) Somewhat effective (4) Neutral (5) Somewhat ineffective (6) Very ineffective (7) Not effective at all (8) Not applicable	Toggle buttons	Interval
15	Please comment and/or provide examples of your training experiences.	Narrative	Free form field	Narrative

Table 1, continued

Number	Category and Item	Answer Set	Answer Mechanism	Level of Data
III. SELF-CARE IMPLEMENTATION				
16	Please rate the effectiveness of each of the following self-care strategies that you use or have used to prevent and/or mitigate the effects of working with trauma victims. Rate only those that apply to your own experience. Please select "not applicable" if you have not used the strategy.	8-point Likert Scale: (1) Exceptionally effective (2) Very effective (3) Somewhat effective (4) Neutral (5) Somewhat ineffective (6) Very ineffective (7) Not effective at all (8) Not applicable	Toggle buttons	Interval
17	Please comment and/or provide examples of your self-care strategies.	Narrative	Free form field	Narrative
18	Please rate the following statement. Counselors working with trauma victims should make self-care a high priority.	7-point Likert Scale: (1) Strongly agree (2) Moderately agree (3) Mildly agree (4) Neutral (5) Mildly disagree (6) Moderately disagree (7) Strongly disagree	Toggle buttons	Interval
19	Any additional comments regarding self-care and wellness are welcome.	Narrative	Free form field	Narrative

The items included in the STIQ were developed based on guidelines from ACA and CACREP, as well as current published research regarding self-care training and strategies related to mental health work with trauma victims. A detailed account of the literature that supports inclusion of each item is included in Table 2.

Table 2

Instrument Development: Self-Care Training and Implementation Questionnaire (STIQ)

Item Number	Guidelines and Published Literature Reference
1-10	Participant demographic information
11	ACA (2005); CACREP (2009); Kitzrow (2002); Roach and Young (2007)
12	ACA (2005); CACREP (2009); Roach and Young (2007)
13	Free form field for comments, examples and explanations
14	O'Halloran and O'Halloran (2001); Roach and Young (2007); Stebnicki (2007)
15	Free form field for comments, examples and explanations
16	ACA (2005); Harrison and Westwood (2009); O'Halloran and O'Halloran (2001); Stebnicki (2007); Trippany, Kress, and Wilcoxon (2004)
17	Free form field for comments, examples and explanations
18	ACA (2005); Harrison and Westwood (2009); O'Halloran and O'Halloran (2001); Stebnicki (2007); Trippany, Kress, and Wilcoxon (2004)
19	Free form field for comments, examples and explanations

Content Validation

Content validity is defined as "the extent to which the questions on the instrument and the scores from these questions are representative of all the possible questions that could be asked about the content or skills" (Creswell, 2005, p. 590). It is important that the items on the survey measure the content they were intended to measure, otherwise the results may be meaningless. Items included on the survey were developed based on the current published research literature regarding the content domain of interest: self-care training and implementation in the context of trauma work.

Content validity is difficult to evaluate when measuring variables such as attitudes, beliefs and dispositions (DeVellis, 2009). Expert panels can provide services such as (a) rating how relevant each item is to what the researcher intends to measure, (b) evaluating the items for clarity and conciseness, and (c) suggesting alternate methods to measure the intended phenomenon (DeVellis, 2009). A panel of five counselors screened survey items for content validity as well as for ease of understanding and administration. This expert panel consisted of licensed professional counselors currently providing direct clinical services to at least one trauma victim on a weekly basis. The counselors were drawn from non-profit community mental health agencies and private practices in the Greater New Orleans area. All the counselors were current members of ACA, but were excluded as potential respondents to the research. A pool of the best items as determined by panel recommendations were identified for final inclusion in the instrument. Minor modifications to the existing items were made based on recommendations from the expert panel.

Recruitment

In an effort to ensure an adequate representation from the population, study participants were recruited from a random list of ACA members. The STIQ was electronically sent to all 3000 counselors included on the purchased mailing list from ACA via email using *Qualtrics*™ survey software (Qualtrics Lab Inc., 2010). The mass email included a message in the body briefly describing the study, a request for participation, and information regarding informed consent. Informed consent considerations included confidentiality issues, risks and benefits of participating, and the voluntary nature of participation (Creswell, 2005). The email included a secure electronic link to the survey and by clicking on the link, participants were acknowledging their voluntary participation in the study.

All 3000 potential participants were sent a second email two weeks after the original participation request. This reminder email thanked those who had participated and request participation again from those who had not yet completed the survey. The end of the study was announced via a third email which indicated that data collection had concluded. This final email message thanked participants and offered a means of requesting a copy of the final results of the study.

The emails soliciting participation in the research included a brief description of the purpose of the study. Recipients of the email were encouraged to complete the survey so as to contribute to the knowledge base regarding self-care training in counselor education. No other participant incentives were offered.

Data Collection

Data were confidentially collected through a survey using *Qualtrics*™ software (Qualtrics Lab Inc., 2010). Although the potential participants were identifiable by means of their electronic mail addresses prior to data collection, the data collection tool itself did not provide a means for identifying participants. Also, the STIQ was designed to protect the identity of survey participants and did not contain any items that might breach their confidentiality.

Data Management

All data collected with the electronic questionnaire were kept securely online through a password-protected account with *Qualtrics*™ software (Qualtrics Lab Inc., 2010). Data were uploaded electronically from *Qualtrics*™ software into SPSS v.16 (IBM, Chicago, IL). Data will be kept confidentially for at least 3 years, in accordance with APA regulations.

Data Analysis

All survey data were analyzed by descriptive, correlation and inferential statistics. Relevant demographic comparisons (independent variables) were made for educational level, years of experience in the mental health field, number of trauma clients, employment position with self-care training and implementation on key questionnaire items (dependent variables). For any statistical analyses other than descriptive statistics, a conservative alpha level of $p \leq .01$ was used. It should be noted that a confirmatory reliability estimate was made at the end of the data collection on the items using Cronbach's alpha in a post hoc analysis. The result was a 0.91 indicating a high level of internal consistency reliability. All statistical analyses used SPSS.

Descriptive statistics were used to describe the basic features of all data collected from the STIQ. Frequency distributions (f, percentages) were reported for categorical level data and measures of central tendency (mean, median, mode) and measures of variability (standard deviation, range) were reported for continuous or interval level data. Pearson product-moment correlation coefficients were calculated to measure the relationships between counselor demographics [e.g., educational level (bachelors, masters, doctoral), present employment position (yes or no in current position), years worked in the mental health field (number), number of trauma victims counseled each week (number)] and: (a) training (Likert scale 1-8), (b) perceived effectiveness of training (Likert scale 1-8), (c) self-care strategies implemented (Likert scale 1-8), and (d) perceived effectiveness of self-care strategies implemented (Likert scale 1-8). Pearson product-moment correlation coefficients were also calculated to measure the linear relationship between self-care educational preparation and implementation of self-care strategies. Effects sizes (r^2) for each statistically significant correlation were calculated as well.

Qualitative data collected from the free form fields included on the survey (items 13, 15, 17, and 19) were analyzed using content and thematic analyses in accordance with procedures suggested by Creswell (2009). Responses for each of the four survey items were grouped into four separate sets uniquely, as related to the questionnaire items from which the responses were derived. Within each set, statements were divided into themes and perspectives, and then coded utilizing *in vivo* and open codes. Codes were merged into thematic categories, and then linked to the survey items to provide more in depth information and augment the quantitative data. ATLAS.ti software version 6 (GmbH, Berlin, 2009) was used throughout the coding process to manage the data, streamline coding, and group the responses.

The *Self-Care Training and Implementation Questionnaire* (STIQ) was designed to capture data related to the research questions. Each item included in the survey was linked to a research question. The data collected were used in a specific analysis plan. See Table 3 for a detailed account of the research question analysis plan.

Table 3

Research Question Analysis: Self-Care Training and Implementation Questionnaire (STIQ)

Research Question	Relevant Questionnaire Item	Data Analysis
1. What self-care training have counselors received in educational programs, practicum and internship experiences, work settings and continuing education formats?	11 12 (a-d) 13 14 (a-j) 15	*Descriptive statistics (frequency distribution - items 11, 12, 14)* *Qualitative content analysis (items 13, 15)*
2. How effective do counselors perceive these various forms of self-care training to be?	12 (a-d) 13 14 (a-j) 15	*Descriptive statistics (frequency distribution – items 12,14)* *Qualitative content analysis (items 13-15)*

Table 3, continued

Research Question	Relevant Questionnaire Item	Data Analysis
3. What personal and professional self-care strategies are being used by counselors to prevent and mitigate the effects of vicarious traumatization?	16 (a-e) 17	*Descriptive statistics (frequency distribution – item 16)* *Qualitative content analysis (item 17)*
4. How effective do counselors perceive these self-care strategies to be when implemented?	16 (a-e) 17	*Descriptive statistics (frequency distribution – item 16)* *Qualitative content analysis (item 17)*
Sub-questions:		
5. Is there a relationship between counselor demographics (see details below) and: a. training b. perceived effectiveness of training c. self-care strategies implemented d. perceived effectiveness of self-care strategies implemented	1-10 Demographics 4 and 11 4 and 12 (a-d) 4 and 14 (a-j)	*Descriptive statistics (frequency distribution – items 1, 3, 4, 5, 6, 8)* *Measures of central tendency (mean, median, mode – items 2, 7, 9, 10)* *Measures of variability (standard deviation, range – items 2, 7, 9, 10)* *Pearson correlations, effect sizes*
Counselor demographics:	4 and 16 (a-e)	
<u>Education level</u> Bachelors Master Doctoral	6 and 11 6 and 12 (a-d) 6 and 14 (a-j) 6 and 16 (a-e)	*Pearson correlations, effect sizes*
<u>Present employment position</u> Agency counselor School counselor In patient facility counselor	7 and 11 7 and 12 (a-d) 7 and 14 (a-j) 7 and 16 (a-e)	*Pearson correlations, effect sizes*
Educator Administrator Researcher	10 and 11 10 and 12 (a-d) 10 and 14 (a-j)	*Pearson correlations, effect sizes*

Table 3, continued

Research Question	Relevant Questionnaire Item	Data Analysis
Private practice Other Years worked in mental health field 1-60 Number of trauma victims counseled each week 1-60	10 and 16 (a-e)	
6. Is there a relationship between self-care educational preparation and implementation of self-care strategies?	11 and 16 (a-e) 12 (a-d) and 16 (a-e) 14 (a-j) and 16 (a-e)	*Pearson correlations, effect sizes* *Pearson correlations, effect sizes* *Pearson correlation, effect sizes*

Assumptions of the Study

A basic assumption of this study was that the instrument designed to survey counselors about their educational preparation, practice and perceptions of self-care strategies related to work with trauma victims was valid and accurately measured these items. In all survey and questionnaire research a basic assumption is that the instrument will validly and accurately measure the content it was designed to measure (Creswell, 2009).

Limitations and Delimitations

A general limitation in all survey research is the possibility of response bias which occurs when "the responses do not accurately reflect the views of the sample and the population" (Creswell, 2005). A significant limitation in survey research is that participants are self-selected, and therefore may not represent an accurate sampling of the population (Creswell, 2005). The sample may be skewed in that participants who chose to complete the survey may have strong ideas about trauma work or self-care and those counselors who do not have strong ideas opted

not to participate in the survey. It is possible that many counselors who are or were victims of vicarious traumatization did not acknowledge this. Many of those who have experienced vicarious traumatization may not be practicing and may have been unavailable to take the survey. It is also possible that the topic is too personal for those counselors suffering from vicarious traumatization, and therefore the sample was comprised of self-selected, healthy counselors. Perhaps, counselors did not respond to the survey because of the time demands of their work. These sampling biases may have resulted in a misrepresentation of the general counselor population. In an effort to ensure an adequate representation from the population, study participants were recruited from a randomly selected list of members of the American Counseling Association (ACA). Once data were collected, it was determined how closely the sample resembled the known demographics of this counselor population by comparing sample demographics to membership demographics by visual inspection.

Another important limitation of this type of research is the assumption that participants who choose to complete the survey will answer questions and admit problems honestly. However, participants may want to provide socially desirable responses to survey items regarding self-care training and implementation. Also, participants may have difficulty answering items that could be embarrassing or have a stigma attached to them. These are typical problems associated with all survey research and many of these limitations were minimized in the randomized selection process and survey design. The anonymity of an electronic, web-based survey should have helped minimize these limitations.

A delimitating factor is that the survey was distributed only to members of ACA; therefore, the findings are generalizable only to this membership population. In order to generalize the results of the study to the population being studied, a high response rate was

needed (Creswell, 2005). A response rate is simply the percentage of questionnaires completed and returned to the researcher (Creswell, 2005). Response rates to electronic questionnaires fluctuate based on many variables, including the research topic being studied and timing. After the initial email was sent to solicit survey participation, a second follow-up email reminder was sent as well as a final email requesting participation which may have helped increase response rates. The final sample was comprised of 286 participants of 3000, resulting in a response rate of 9.5%.

Summary

This chapter contained a description of the methodology that was used in this study including subsections that detailed the purpose of the study, research questions and participant selection criteria. Instrument development involving content validation with an expert panel was described. Also addressed in this chapter were procedures related to data collection, management and analysis. Ethical considerations were discussed as well.

CHAPTER IV

RESULTS

This descriptive study incorporated an exploration of self-care training and implementation from the perspectives of counselors who work with trauma clients. The first purpose was to examine what types of educational preparation concerning self-care strategies related to trauma work are being offered to counselors, and how effective this training is perceived to be by counselors. The second purpose was to investigate which self-care strategies are being used to prevent and mitigate the effects of vicarious traumatization, as well as which strategies are perceived to be the most effective when implemented. The *Self-Care Training and Implementation Questionnaire* (STIQ), a 19-item questionnaire comprised of structured (quantitative) and semi-structured (qualitative) items developed for this research, was designed by me to answer these general research questions as well as specific questions related to potential relationships between counselor demographics, self-care training and implementation. Both quantitative and qualitative items were included on the STIQ to measure responses related to this topic.

This chapter contains two primary sections. In the first section, the sample is described and compared to the known demographics of the population from which it is drawn. The second section includes a summary of the data analysis, procedures and results. The data are organized by research question. The overarching goal was to understand counselor perceptions of their educational preparation in self-care related to trauma work, how effective that training was perceived to be, what self-care strategies are being used by counselors who work with trauma victims, as well as how effective those strategies are when implemented.

Prior to determining sample demographics and running statistical procedures, the researcher systematically cleaned the data set obtained for the study. There were no systematic missing data, and for any given variable the maximum missing was seven participant responses, all seemingly random. For participants with missing data, pairwise deletion analysis was used. Participants were excluded from the study if there were more than three responses missing. Also, those individuals who indicated they did not work with trauma victims were excluded as they did not meet participant criteria.

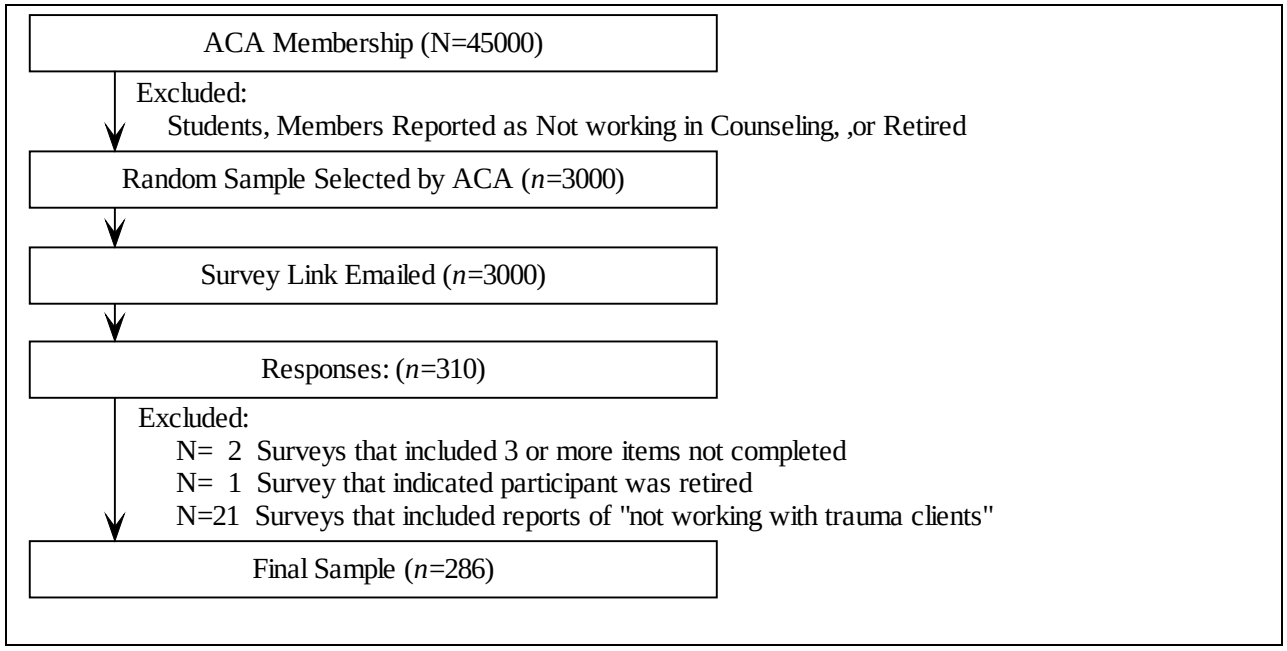
Sample

The population of interest was counselors who work directly with individuals with trauma history. Participants included in the study were drawn from a randomly selected list of members of the American Counseling Association (ACA) who subsequently identified themselves as currently providing direct clinical services to any number of trauma victims. ACA is a professional and educational organization that represents professional counselors in various work settings. The association's goal is to enhance the counseling profession through education, training, publications and advocacy (ACA, 2010a). Currently, the total membership of ACA is approximately 45,000, representing a national population. It is important to note that ACA members represent diverse ethnic backgrounds, various educational and experience levels, as well as a range of employment positions and specialties. Because the members of ACA represent a national population and subscribe to the ACA *Code of Ethics*, this was an appropriate population from which to draw the sample for the current study.

A random membership list of 3000 members was purchased from ACA at a cost of $500 for use in this web-based survey. Members who identified themselves to ACA as students, no longer working in the counseling field, or retired were excluded from possible selection as these

individuals did not necessarily work with trauma victims on a weekly basis and therefore did not meet the criteria for participating in the survey. Because emails can be potentially identifying, all information was held within high levels of confidentiality, including a password protected laptop. It was estimated that approximately 300 participants were needed to run the statistical procedures planned for the study, and there were 310 total responses, of which 286 were deemed appropriate for inclusion in the study. Twenty-one participants reported not working with trauma victims; therefore they were excluded from the study as they did not meet participant criteria of currently counseling trauma victims. Seventeen participants reported not working with trauma clients, but indicated on a separate item that they worked with one or more trauma clients each week; therefore these participants were included in the study. Two participants were excluded because there were three or more item responses missing from their completed survey. One participant was excluded because he was retired. The sample was comprised of 286 participants out of 3000, resulting in a response rate of 9.5%.

Figure 3. Flow Diagram of Participant Inclusion and Exclusion Number and Rationale



Note. Diagram adapted from Shulz, K. F., Altman, D. G., and Moher, D. (2010).

Of the 286 study participants, there were 52 males and 232 females, whose ages ranged from 24 to 78 years, with a mean of 46. Participants identified themselves by ethnicity in the following categories: 259 White/Caucasian, 19 Black/African American, 3 American Indian, 1 Asian Indian, 1 Korean, 1 Pacific Islander, and 17 Others. Because of the preponderance of White/Caucasian ethnicity reports, the ethnicity category was subsequently collapsed into two categories, majority (White/Caucasian) and minority, for data analysis purposes.

Participants were asked to identify their highest education level (baccalaureate, masters, doctoral, other), with the option of providing narrative description for category of "other." Participants who named "other" degree programs (e.g., Masters in Art Therapy, Ed.D. in Educational Psychology, Ed.S. in Professional Counseling, Ph.D. in Pastoral Counseling) were assigned one of the following educational levels: pursuing degree, bachelors or less than masters, masters, between masters and doctoral, doctoral. Prior to data analysis, all participants were assigned one of these five educational levels. Participants reported having a wide variety of licenses and certifications (e.g., ASC, CRC, LADC, LCPC, PCC, RN). It was determined that tallying the number of licenses and certifications would be most helpful for data analysis; therefore each participant was assigned a number from 0 to 10 based on their response to this survey item. Participants reported being presently employed in a number of different positions including private practice, agency counselor, educator, school counselor, administrator, inpatient facility counselor and researcher. However, 54 participants reported other employment positions, indicating their work as college counselor and consultant.

In response to the questionnaire item asking the participant to indicate years worked in the mental health field, answers ranged from 1 to 42 years (n=286, M=12, SD=9.62). In response to the item asking for number of clients, including intakes, that counselors saw on average each

week, the participants reported between 1 and 60 (n=283; *M*=17). Participants reported seeing between 1 and 50 (n=280, *M*=8) clients with trauma histories each week.

Specific demographics of study participants are detailed in Table 4. The sample is similar to the population from which it is drawn. Both ACA members and sample participants were predominantly Caucasian women with master's degrees. Both groups reported a myriad of specialties and employment in a variety of work settings including agencies, private practices, schools and colleges. However, the most current membership report available for ACA (2010) includes demographic information for only 16,885 members, which is representative of only 38% of total membership.

Table 4

Participant Demographics by Frequency or Means, Standard Deviations, and Ranges (n=286)

	Frequency	*M, SD*. Range		
Variable	n (%)	*M*	*SD*	Range
Age (in years)		46.47	12.63	24-78
Sex*				
Male	52 (18.2)			
Female	232 (81.1)			
Ethnicity**				
Majority (White)	241 (84.3)			
Minorities	38 (13.3)			
Highest Education Level				
Pursuing Degree	1 (0.4)			
Bachelors or less than Masters	1 (0.4)			
Masters	221 (77.8)			
Between Masters and Doctoral	5 (1.8)			
Doctoral	56 (19.7)			
Number of Licenses and Certifications		1.43	0.91	0-10
0	24 (8.5)			
1	142 (50.2)			
2	97 (34.3)			
3	17 (6.0)			
4	2 (0.7)			
10	1 (0.4)			

Table 4, continued

Variable	Frequency n (%)	*M*, *SD*, Range *M*	*SD*	Range
Present Employment Position				
Agency Counselor	80 (28.2)			
Private Practice	97 (34.3)			
School Counselor	22 (7.7)			
Educator	21 (7.4)			
Other	64 (22.3)			
Years Worked in Mental Health Field		12.28	9.62	1-42
Number of Weekly Clients		17.04	10.54	1-60
Number of Weekly Trauma Clients		8.38	7.11	1-50

Note. *2 participants missing, **7 participants missing

Results

What self-care training have counselors received in educational programs, practicum and internship experiences, work settings and continuing education formats?

The current study was designed to answer several research questions regarding self-care training and implementation within the context of trauma work. The initial question explored was what self-care training have counselors received in educational programs, practicum and internship experiences, work settings and continuing education formats. Of the 286 participants, only 62 (21.9%) indicated that there was at least one course offered concerning self-care or wellness in their counselor education program, while 221 (78.1%) indicated there was no such course offered. When asked about their self-care or wellness training experiences, 44.6% of participants reported training was not included in their counselor education programs, 35.9% of participants reported training was not included in their practicum and internship experiences, 31.5% of participants reported training was not included in their current work settings, and 26.2% of participants reported training was not included in continuing education formats. See Table 2 for details regarding participant responses related to self-care training.

Participants were offered the opportunity to comment or provide examples of their self-care or wellness training experiences in a free form field. Many participants reported that there was no formal self-care training provided in their educational or work settings:

> *Self-care was not addressed in any of my counseling coursework, in my internship, or at my work setting for the first three years.* [Participant 013]
>
> *Little was talked about in terms of seeking assistance, impairment, ethics, or other related issues in terms of self care.* [Participant 122]
>
> *In 15 years of clinical work and almost 22 years of academic work, there has not been much emphasis.* [Participant 150]

According to comments offered by participants, self-care is a topic often only briefly touched upon during counseling coursework and in work settings:

> *None were specifically offered.....just general phrases "remember self-care."* [Participant 100]
>
> *Most of the training consists of a few minutes of discussion in a class.* [Participant 124]
>
> *Need mentioned in intro course, no real instruction in how.* [Participant 244]
>
> *Most was too simple or trivial.* [Participant 304]
>
> *Sometimes literature is made available at work. There is no intentional or mandatory education on this topic.* [Participant 114]

Many participants indicated that learning about self-care has been an endeavor taken on independent from education and work settings:

> *Have not been offered any self-care training opportunities in any setting, it is something I've had to learn to do on my own.* [Participant 033]

Any self-care training has been through independent reading of journal articles. [Participant 049]

Other participants reported examples of minimal self-care training in their educational and work settings:

As part of the required coursework in my Masters Program, we were required to attend weekly "growth groups" which provided a therapeutic outlet for students to discuss their personal problems. [Participant 004]

My internship supervisor conducted group consultations with a focus on self-care that was helpful because as a group we explored the importance of self-care and options for self care. [Participant 053]

It has been my experience that while agencies or trainings preach self care is important, time/availability/opportunity to practice this is not provided. [Participant 198]

I have attended one or two full day workshops on care for the caregiver/preventing professional burnout. [Participant 096]

How effective do counselors perceive these various forms of self-care training to be?

Participants rated the effectiveness of the four training formats (educational programs, practicum and internship experiences, work settings and continuing education formats) on a 7-point Likert-type scale. The possible responses included exceptionally effective (1), very effective (2), somewhat effective (3), neutral (4), somewhat ineffective (5), very ineffective (6), not effective at all (7). A "not applicable" option was available in the questionnaire format for participants who did not receive self-care training in any of the four settings. Results indicated that those participants who received self-care training in any of these four educational or work formats considered that training to be "somewhat effective."

Participants also rated the effectiveness of various, specific training methods. Similarly, the results indicated that participants perceived the methods to be "somewhat effective." Supervision (*M*=2.33, *SD*=1.33), readings (*M*=2.93, *SD*=1.14), journaling (*M*=2.47, *SD*=1.19) and in-class activities (*M*=2.99, *SD*=1.44) were considered slightly more effective than the other training methods. The majority of the mean scores for each training item were around 3, indicating that the participants perceived these training methods to be "somewhat effective." A detailed account of these ratings is presented in Table 5.

Table 5

Means and Standard Deviations for Counselors Report on Effectiveness of Self-Care Training (n=286)

Item	*M*	*SD*	Not Applicable (%)
Counselor coursework	3.22	1.47	44.6%
Practicum/Internship	3.23	1.55	35.9%
Current work setting	3.11	1.47	31.5%
Continuing education	2.91	1.24	26.2%
Lecture	3.09	1.14	28.9%
Readings	2.93	1.14	12.4%
Worksheets	3.40	1.36	50.5%
Video	3.06	1.24	59.6%
Role play	3.15	1.49	57.3%
Self reflection	2.14	0.99	14.1%
Journaling	2.47	1.19	33.3%
Group projects	3.26	1.51	50.0%
In-class activities	2.99	1.44	48.8%
Supervision	2.33	1.33	19.1%

Note. Likert scale included 1=Exceptionally effective, 4=Neutral, 7=Not effective at all

For the item regarding the effectiveness of various training methods, participants were again offered the opportunity to discuss their training experiences in a free form field within the

questionnaire. Following are several comments shared by participants that reflected upon their positive self-care training experiences:

> *A particularly helpful project was the completion of wellness assessments and self reflection journals regarding the results.* [Participant 144]
>
> *Mindfulness training; Gestalt practice; experiential exercises; meditation; required individual counseling outside of the educational program.* [Participant 058]
>
> *Lecturing and creating a burn out prevention program. In supervision, my supervisor has always highlighted the need for self care and time management. In group supervision, we have engaged in stress relief exercises.* [Participant 216]
>
> *Discussions in supervision and staff meetings.* [Participant 157]
>
> *Continuing education classes, professional journals.* [Participant 127]

A small number of participants shared comments that reflected upon their negative self-care training experiences:

> *The course material provided information on activities that a clinician should try and advised consultation with fellow practitioners. However, the material did not include any hands on experience or really provide an adequate or realistic view of the realities of working with trauma survivors.* [Participant 109]
>
> *Self-care strategies alarmingly absent in any training I have received.* [Participant 065]
>
> *The supervision through employment is very ineffective- it is administrative, not clinical.* [Participant 036]

What personal and professional self-care strategies are being used by counselors to prevent and mitigate the effects of vicarious traumatization?

Participants were asked to indicate which types of personal and professional self-care strategies they have used to prevent and mitigate the effects of vicarious traumatization. The survey offered 29 different strategy examples across five different wellness domains including professional, physical, emotional and mental, relational and spiritual. The most popular self-care activities included spending time with friends and family (n=282, 99.3%), sleep (n=276; 98.2%), empathy (n=277; 98.2%), humor (n=278; 98.2%), and maintaining boundaries (n=280; 98.2%). A "not applicable" option was available for participants who had never used a particular self-care strategy. The self-care strategies that counselors most frequently reported as "not applicable" included medication (56.9%), gardening (42.9%), journaling (29.2%), and personal counseling (27.9%). See Table 3 for a detailed listing of participant responses regarding the implementation of self-care strategies.

How effective do counselors perceive these self-care strategies to be when implemented?

Participants were asked to rate the effectiveness of each of the self-care strategies they had personally implemented to prevent and mitigate the effects of vicarious traumatization using a 7-point Likert-type scale. The possible responses included exceptionally effective (1), very effective (2), somewhat effective (3), neutral (4), somewhat ineffective (5), very ineffective (6), not effective at all (7). Again, a "not applicable" option was available for those participants who had not implemented a particular strategy. The results indicated that those self-care strategies implemented by counselors are perceived to be "very effective" overall. Spending time with family and friends (M=1.81, SD=0.82), sleep (M=1.96, SD=1.01), humor (M=1.83, SD=0.86) and maintaining boundaries (M=1.92, SD=0.89) were considered "exceptionally effective." Participants' responses regarding the efficacy of each of the self-care strategies are illustrated in Table 6.

Table 6

Counselors Report on Self-Care Strategy Implementation and Effectiveness (n=286)

Item	*M*	*SD*	Not Applicable (%)
Supervision	2.23	1.02	13.5%
Case consultation	2.18	0.81	8.1%
Balancing caseload	2.53	1.16	17.5%
Continuing education	2.69	1.07	17.3%
Maintaining boundaries	1.92	0.89	1.8%
Nutrition	2.36	1.06	9.5%
Exercise	2.08	1.03	6.3%
Sleep	1.96	1.01	1.8%
Medication	3.26	1.26	56.9%
Relaxation	2.08	0.92	2.5%
Play	2.03	0.87	6.8%
Gardening	2.63	1.34	42.9%
Positive self statements	2.53	1.04	8.2%
Inspirational readings	2.39	1.04	14.0%
Journaling	2.48	1.18	29.2%
Humor	1.83	0.86	1.8%
Crying	2.90	1.25	11.7%
Mindfulness	2.00	0.93	6.0%
Optimism	2.01	0.90	2.8%
Empathy	2.15	1.05	1.8%
Self-talk	2.23	1.03	5.0%
Spending time with friends and family	1.81	0.82	0.7%
Companionship through pets	2.11	1.11	16.5%
Personal counseling	2.10	0.98	27.9%
Travel	2.27	1.08	10.9%
Religious activities	2.49	1.29	24.4%
Meditation	2.25	1.04	20.1%
Creating meaning	2.15	1.00	11.1%

Note. Likert scale included 1=Exceptionally effective, 4=Neutral, 7=Not effective at all

Participants were offered the opportunity to comment or provide examples of their self-care or wellness strategies in a free-form field. Following are examples of self-care strategies provided by participants:

> *Drawing, breathing, acupuncture, massage, working puzzles, origami, walking, reading, dancing.* [Participant 125]
>
> *Exercise, limit setting, meditation, therapy and supervision, time with friends and family, being out in nature, having a positive attitude.* [Participant 232]
>
> *Hiking, biking, meditation, traveling, camping, reading, loving, movies, workshops, theater, talking.* [Participant 300]

Many participants commented on the importance of physical activity for self-care:

> *I exercise 4-6 times each week and read for enjoyment.* [Participant 231]
>
> *I exercise 5 days/week and meditate daily before work.* [Participant 030]
>
> *I exercise and try to eat correctly.* [Participant 162]
>
> *Exercise is by far my most effective self-care strategy.* [Participant 184]
>
> *Exercise most days of the week.* [Participant 222]
>
> *Exercise, eating right and getting 8 hours sleep makes a huge difference for me.* [Participant 257]

Religion and spirituality were considered by many participants to be an integral part of their self-care:

> *I attend church regularly, work out every day, read my Bible and spend time with friends and family. All of these things are incredibly important.* [Participant 052]
>
> *I am a deeply spiritual person but not at all religious. That set of readings, practices, and understanding of mankind is my only salvation in my work with literally thousands*

of traumatized clients. That combined with the love of my wife of forty four years and my children sustain me. [Participant 171]

My spirituality grounds me and keeps me focused. It is the single most important self-care discipline that is exceptionally effective for me. [Participant 297]

Religious retreats, prayer, and fellowship with church friends, my husband, and children have been the primary source of personal mental wellness for me. [Participant 008]

Relationship with God. [Participant 107]

Prayer, religious activities, individual therapy. [Participant 061]

Prayer, reading Bible. [Participant 302]

Professional self-care strategies were commented on by several participants:

I cut my case load when I feel stressed. [Participant 261]

Supervision and case consultation have been helpful for me in previous settings to provide support and self-care. Within the community agency setting these events are generally geared towards optimal billing than therapeutic effectiveness. [Participant 027]

Debriefing after crisis shifts. [Participant 251]

Consulting with peers. [Participant 065]

In a related theme, participants reported that maintaining boundaries was important for self-care:

I leave work at work. [Participant 025]

I try to leave work at work when I can. Sometimes its hard when we're on call 24/7, but I try to not think about my clients' problems when I'm home. [Participant 040]

Leaving work at work - allowing my 25 minute commute to and from work be first and last place I think about work as much as possible. [Participant 032]

Several participants commented on the importance of being aware of their personal experiences and responses when conducting trauma work:

> *Constant self-evaluation, being aware of personal trauma.* [Participant 100]
>
> *I learned the most about self-care when I was undergoing the transition from trauma victim to trauma survivor.* [Participant 125]
>
> *Self-care is something that I struggle with as I am still relatively young in the field. I wish there was more training on establishing emotional boundaries and self-care tips while working within this field. Working with trauma victims can be very overwhelming and sometimes invokes an anxiety response in me.* [Participant 273]

The results indicated that counselors are implementing a wide variety of self-care strategies to prevent and mitigate the effects of working with trauma clients. And counselors perceived the strategies they implement to be very effective. Participants reported that physical health maintained through exercise, nutrition and sleep, was an important part of self-care. And while 24% of participants selected "not applicable" when asked to rate the effectiveness of religious activities, there were many participant comments which described the importance of their spiritual health in terms of self-care. Professional self-care strategies, especially case consultation and maintaining boundaries, appeared to be useful for counselor wellness.

Is there a relationship between counselor demographics (e.g., educational level, present employment position, years worked in the mental health field, number of trauma victims counseled each week) and:

a. training

b. perceived effectiveness of training

c. self-care strategies implemented

d. perceived effectiveness of self-care strategies implemented

Pearson product-moment correlation coefficients were calculated to measure the relationships between counselor demographics (i.e., sex, age, educational level, years worked in the mental health field, number of trauma victims counseled each week) and: (a) training (Likert scale 1-7), (b) perceived effectiveness of training (Likert scale 1-7), (c) self-care strategies implemented (Likert scale 1-7), and (d) perceived effectiveness of self-care strategies implemented (Likert scale 1-7). Because of the multiple correlations a conservative p level of $p < .01$ was used as the alpha level.

There were no significant relationships identified between the demographic variables (sex, age, ethnicity, education, licenses/certifications, number of years in the field and number of trauma clients) and the self-care training received in participants' current work setting and continuing education. The results indicate a statistically significant, positive relationship between a participant's education level and self-care training received in counselor coursework (r=0.21, p<.01). The higher the participant's educational level, the more effective they perceived the self-care training they received in their counselor coursework to be. However, the effect size was small, indicating a weak relationship between variables, which likely translates into low practical significance. The number of years participants worked in the field was positively correlated to the self-care training they received in their practicum and internship experiences (r=0.19, p<.01). Again, although statistically significant, this was small effect size, which indicated a weak relationship. For instance, only 3.6% of of that self-care training can be explained by the participant's years of experience in the field.

There were no significant relationships identified between the demographic variables (sex, age, ethnicity, education, licenses/certifications, number of years in the field and number of

trauma clients) and self-reported training methods such as lecture, role play and supervision as well as self-reported self-care strategies implemented including supervision, continuing education, maintaining boundaries, exercise, sleep, positive self statements, inspirational readings, humor, self talk, religious activities and creating meaning. There were 14 statistically significant correlations between variables which were statistically significant at the $p < .01$ level. The correlation coefficients ranged from -0.26 ($p<.01$) through +0.28 ($p<.01$); therefore, the effect sizes were low, indicating only weak relationships between variables. These correlations represent 6.8% to 7.8% explanation of the relationships between variables.

Reading as a self-care training method was negatively correlated with sex ($r=-0.17$, $p<.01$) and age ($r=-0.16$, $p<.01$). Sex was also negatively correlated with the self-care training method worksheets ($r=-0.23$, $p<.01$), as well as self-care strategies including case consultation nutrition ($r=-0.23$, $p<.01$), medication ($r=-0.26$, $p<.01$), journaling ($r=-0.23$, $p<.01$), and mindfulness ($r=-0.19$, $p<.01$). It appears that sex is negatively related to these various training methods and self-care strategies. Given the preponderance of women in the sample, it seems that they rated these activities as less effective. However, the effect size was small, so the weak relationships between these variables may have low practical significance.

There were two other statistically significant correlations between participant demographic variables and self-care training methods. Age was negatively correlated with the self-care training method of reading ($r=-0.16$, $p<.01$), while the number of years in the field reported by participants was positively correlated to in-class activities ($r=0.26$, $p<.01$) as a self-care training method. While these relationships were weak, as indicated by the low effect size, the results demonstrated that the older the participant, the more effective they perceive reading to

be as a self care method. Conversely, the more experience a participant has in the field, the less effective they perceive in-class activities to be as a self-care training method.

Several participant demographic variables were found to be related to implementation of self-care strategies. The highest correlation existed between participants' level of education and implementation of medication as a self care strategy (r=0.28, p<.01), or 7.8%. These results convey that participants with more education are less likely to perceive medication as an effective self-care strategy. The number of trauma clients that participants reported seeing each week was negatively correlated to play (r=-0.18, p<.01) and companionship through pets (r=-0.17, p<.01) as self-care strategies. These results demonstrate that the more trauma clients that a participant worked with, the more likely they were to engage in these self-care strategies. And finally, ethnicity was negatively correlated with companionship through pets (r=-0.20, p<.01). Again, these correlation coefficients indicated low effect sizes, which show weak relationships between variables. See Table 7 for a complete list of correlations between self-care training and implementation and participant demographics.

Of all the relationships explored, the strongest correlations occurred between the demographic variables sex and education with the self-care strategy medication. Given the preponderance of females in the sample, it seems they feel strongly that medication is either not something they considered using or thought to be effective as a self-care strategy as there was a negative correlation between these variables (r=-0.26, p<.01). Or perhaps they do not perceive medication to be a self-care strategy at all. Given positive correlation with education, (r=0.28, p<.01) it can be presumed that the higher the education, the less likely a counselor is to use medication as a form of self-care. While these correlation coefficients are statistically

significant, they are small effect sizes demonstrating weak relationships, which likely means low practical significance.

Table 7

Correlations between Self-Care Training and Implementation and Participant Demographics

Variable	Sex	Age	Ethnicity	Education	Licenses / Certifications	Years in Field	# Trauma Clients/week
Counselor coursework	-.15	.12	.08	**.21 ***	-.10	.13	.01
Practicum/Internship	-.04	.15	.08	.11	-.08	**.19 ***	-.09
Current work setting	-.13	-.12	.07	.05	.04	.05	.05
Continuing education	-.05	.04	.12	-.01	-.08	.02	-.02
Lecture	-.12	.03	.05	-.03	.03	.03	-.20
Readings	**-.17 ***	**-.16 ***	.09	-.10	-.06	-.15	-.01
Worksheets	**-.23 ***	.07	.08	-.02	-.02	.13	-.12
Video	-.09	-.09	.24	-.12	-.05	-.03	.04
Role play	-.10	-.05	.10	-.02	-.17	.00	-.17
Self reflection	-.10	.01	.00	-.09	-.07	-.09	-.16
Journaling	-.15	.12	.08	-.05	.01	.06	-.11
Group projects	-.14	.09	.12	-.03	.03	.17	-.10
In-class activities	-.18	.14	.09	.09	.01	**.26 ***	-.07
Supervision	-.07	.08	-.06	.06	-.02	.11	.03
Supervision	-.01	.03	.01	-.01	-.01	.04	.03
Case consultation	-.16	-.02	.01	.05	-.13	.03	-.04
Balancing caseload	-.09	.04	-.14	.00	-.04	-.05	.01
Continuing education	-.06	-.11	.03	-.00	-.06	-.06	-.03
Maintaining boundaries	-.01	-.06	-.05	-.05	-.04	-.11	-.11
Nutrition	**-.23 ***	-.00	.02	.00	-.08	.01	-.16
Exercise	-.12	.01	.06	-.01	.02	.01	-.08
Sleep	-.08	.03	-.02	-.04	-.01	-.00	-.06

Table 7, continued

Variable	Sex	Age	Ethnicity	Education	Licenses / Certifications	Years in Field	# Trauma Clients/week
Medication	**-.26 ***	.06	-.01	**.28 ***	.12	.16	-.06
Relaxation	-.08	-.12	-.04	-.06	-.03	-.10	-.05
Play	-.11	.11	-.06	-.11	.00	-.05	**-.18 ***
Gardening	.02	-.16	.10	-.04	.04	-.12	-.09
Positive self statements	-.07	-.07	.06	-.06	-.10	.03	-.09
Inspirational readings	-.07	-.07	.08	.02	-.06	-.04	-.01
Journaling	**-.23 ***	.12	-.10	.08	-.06	.07	-.07
Humor	-.05	-.01	-.07	-.07	-.06	-.10	-.12
Crying	-.15	.02	-.11	.14	-.03	-.03	-.12
Mindfulness	**-.19 ***	-.09	.05	.01	-.11	-.09	-.12
Optimism	-.08	-.15	-.02	-.05	-.03	-.11	-.02
Empathy	.00	-.15	-.07	-.12	-.10	-.15	-.04
Self-talk	-.11	-.12	.04	-.09	-.12	-.09	-.03
Spending time with friends and family	-.10	.15	-.04	-.00	.00	.06	-.05
Companionship through pets	-.14	.03	**-.20 ***	.02	-.01	-.02	**-.17 ***
Personal counseling	-.07	-.03	-.14	.12	.01	.01	-.07
Travel	-.13	.08	.01	.12	.02	-.06	.04
Religious activities	-.09	.05	.06	.10	-.04	-.03	.09
Meditation	-.14	-.17	.11	-.03	-.06	-.12	.02
Creating meaning	-.06	-.10	-.08	-.08	-.04	-.10	-.08

* $p < .01$

All four training formats (counselor coursework, practicum and internship, current work setting and continuing education) were positively correlated to the seven training methods examined (readings, worksheets, video, role play, self-reflection, journaling, group projects, in-class activities and supervision). These correlations ranged from 0.21 to 0.52 ($p<.01$) indicating small to medium effect sizes or low to moderate strength relationships. However, the following variables were not correlated: counselor coursework with video and worksheets, practicum and internship with video and role play, as well as current work setting with lecture, video, role play and journaling.

The correlations between counselor coursework and training methods ranged from 0.28 to 0.51 ($p<.01$): role play was the least strong relationship and in-class activities and readings were the strongest relationships. The correlations between practicum and internship with training methods ranged from 0.23 to 0.35 ($p<.01$) with journaling the weakest and supervision the strongest relationship. Current work setting had the weakest correlations overall to training methods with a range of 0.23 ($p<.01$) to 0.37 ($p<.01$) with self reflection the weakest and in-class activities the strongest. Of all four training formats, continuing education had the highest number of strong, positive correlations with a range of 0.21 to 0.52 ($p<.01$). Video (0.52, $p<.01$), worksheets (0.50, $p<.01$) and readings (0.50, $p<.01$) were all moderately correlated to self-care training in continuing education. These were medium effect sizes while demonstrates moderate relationships between variables. See Table 8 for a complete list of correlations between counselor self-care training formats and methods.

The results indicate that the correlations were generally stronger in counselor coursework and continuing education formats, while practicum and internship and current work setting had the weaker relationships. This illustrates that counselors perceive these self-care training

methods to be most often and effectively implemented in counselor coursework and continuing education formats. There is a moderate relationship in the perception of these participants to their coursework and continuing education experiences to the various forms of learning about self-care strategies. It is possible that continuing education rated highest for self-care training methods due to participant demographics such as the high number of years in the field (M=12.28, SD=9.62), therefore they are long beyond coursework. However, the standard deviation points to quite a bit of variability among respondents, which demonstrated that participant responses were spread out on this topic. Perhaps the implication is that practicum and internship experiences are lacking in self-care training and current work settings are also not integrating self-care training.

Table 8

Correlations between Counselor Self-Care Training Formats and Methods

Item	Correlation			
	Counselor coursework	Practicum / Internship	Current work setting	Continuing education
Lecture	.36 *	.34 *	.19	.46 *
Readings	.41 *	.30 *	.28 *	.50 *
Worksheets	.21	.28 *	.32 *	.50 *
Video	.28	.23	.24	.52 *
Role play	.28 *	.23	.25	.43 *
Self reflection	.38 *	.29 *	.23 *	.33 *
Journaling	.32 *	.23 *	.14	.23 *
Group projects	.34 *	.33 *	.32 *	.41 *
In-class activities	.51 *	.29 *	.37 *	.43 *
Supervision	.34 *	.35 *	.31 *	.21 *

* $p < .01$

Is there a relationship between self-care educational preparation and implementation of self-care strategies?

Pearson product-moment correlation coefficients were also calculated to measure the linear relationship between self-care educational preparation and implementation of self-care strategies. The results indicated that counselor coursework and continuing education have the most significant relationships with implementation of self-care strategies. For example, counselor coursework was significantly correlated with supervision (r=0.26, p<.01), case consultation (r=0.28, p< .01), balancing caseload (r=0.24, p<.01), nutrition (r=0.28, p<.01), exercise (r=0.23, p<.01), sleep (r=0.27, p<.01), relaxation (r=0.22, p<.01), play (r=0.23, p<.01), positive self statements (r=0.27, p<.01) and travel (r=0.26, p<.01). Continuing education was significantly correlated to supervision (r=0.17, p<.0), nutrition (r=0.27, p<01), relaxation (r=0.19, p<.01), play (r=0.20, p<.01), positive self statements (r=0.29, p<.01), crying (r=0.25, p<.01), mindfulness (r=0.20, p<.01), empathy (r=0.21 p<.01) and creating meaning (r=0.25, p<01). Case consultation as a self-care strategy was significantly correlated to counselors' practicum and internship experiences (r=0.25, p<.01). Self-care strategies such as case consultation (r=0.25, p<.01), balancing caseload (r=0.28, p<.01), positive self statements (r=0.22, p<.01), optimism (r=0.21, p<.01), and creating meaning (r=0.22, p<.01) were positively correlated to participants' current work settings. Although these relationships are statistically significant, all of these effect sizes were small, which demonstrated weak relationships between variables. See Table 9 for a detailed list of correlations between counselor self-care training and implementation.

Table 9

Correlations between Counselor Self-Care Training Format and Implementation

Item	Correlation			
	Counselor coursework	Practicum / Internship	Current work setting	Continuing education
Supervision	**.26 ***	.18	.18	**.17**
Case consultation	**.28 ***	**.25 ***	**.25 ***	.14
Balancing caseload	**.24 ***	.07	**.28 ***	.11
Continuing education	.04	.04	.15	**.54 ***
Maintaining boundaries	.16	.12	.10	.17
Nutrition	**.28 ***	.18	.19	**.27 ***
Exercise	**.23 ***	.16	.14	.13
Sleep	**.27 ***	.15	.11	.04
Medication	.13	.18	.16	.06
Relaxation	**.22 ***	.17	.13	**.19 ***
Play	**.23 ***	.11	.04	**.20 ***
Gardening	.05	-.05	.12	.12
Positive self statements	**.27 ***	.17	**.22 ***	**.29 ***
Inspirational readings	.18	.01	.18	.08
Journaling	.12	.09	.07	.14
Humor	-.04	-.00	-.04	.15
Crying	.13	.04	.01	**.25 ***
Mindfulness	.14	.06	.15	**.20 ***
Optimism	.14	.02	**.21 ***	.17
Empathy	.12	.15	.13	**.21 ***
Self-talk	.19	.15	.17	.18
Spending time with friends and family	.10	.10	.12	.12
Companionship through pets	-.01	.01	.08	.08
Personal counseling	.11	.09	-.02	.06
Travel	**.26 ***	.08	.11	.16
Religious activities	.21	-.01	.01	.12
Meditation	.15	.07	.11	.15
Creating meaning	.15	.04	**.22 ***	**.25 ***

* $p < .01$

Table 10 details correlations between self-care training methods and self-care strategies implemented. Of the 28 self-care strategies offered on the questionnaire, the self-care training method of self reflection was significantly correlated with 21, readings was significantly correlated with 20, and journaling was significantly correlated with 18. The self-care training methods of lecture and role play were significantly correlated with the implementation of 10 self-care strategies, while worksheets and supervision were significantly correlated with 8 self-care strategies. The self-care training methods with the fewest number of significant correlations with self-care strategies were video (7), in-class activities (5) and group projects (3).

These significant correlations ranged from 0.17 to 0.68 ($p<.01$) indicating weak to moderate relationships between variables. All of these significant correlations were positive indicating that for any given training method a participant engaged in, they were more likely to implement a self-care strategy. However, the low to medium effect sizes likely translates to low practical significance.

Table 10

Correlations between Self-Care Training Methods and Strategies Implementation

Item	Lecture	Readings	Worksheets	Video	Role Play	Self Reflection	Journal	Group Projects	In Class Activities	Supervision
Supervision	.04	.17	.13	.19	.22	.28 *	.22*	.20	.25*	.68*
Case consultation	.04	.25 *	.19	.36*	.29 *	.34 *	.33*	.21	.27*	.38*
Balancing caseload	.19	.24 *	.25*	.25	.07	.32 *	.33*	.21	.23	.19
Continuing education	.27*	.33 *	.31*	.39*	.29 *	.28 *	.19	.15	.15	.11
Maintaining boundaries	.17	.27 *	.15	.08	.01	.31 *	.20*	.16	.04	.16
Nutrition	.19*	.27 *	.22	.10	.35 *	.29 *	.22*	.24 *	.18	.15
Exercise	.16	.24 *	.09	-.03	.13	.21 *	.13	.19	.14	.10
Sleep	.19*	.19 *	.03	.10	.15	.21 *	.22*	.02	.09	.05
Medication	.26	.08	.07	.12	-.04	-.04	-.07	-.00	.12	-.01
Relaxation	.23*	.25 *	.20	.24	.24 *	.27 *	.26*	.13	.17	.07
Play	.24*	.22 *	.26*	.38*	.21 *	.35 *	.29*	.23 *	.26*	.24*
Gardening	.25*	.31 *	.30*	.23	.09	.14	.11	.18	.16	-.02
Positive self statements	.31*	.29 *	.23*	.23	.22	.32 *	.20*	.37 *	.24*	.18*
Inspirational readings	.17	.19 *	.15	.22*	.23	.20 *	.20*	.19	.14	-.08
Journaling	.15	.24 *	.13	.10	.18	.29 *	.61*	.21	.15	.12
Humor	.22*	.23 *	.19	.14	.18	.26 *	.32*	.12	.14	.18*
Crying	.17	.14	.15	.19	.27 *	.17	.18	.22	.17	.06
Mindfulness	.15	.31 *	.27*	.31*	.25 *	.40 *	.26*	.19	.15	.12
Optimism	.10	.24 *	.02	.17	.22	.37 *	.30*	.19	.13	.22*
Empathy	.20*	.28 *	.10	.30*	.23	.28 *	.20*	.14	.07	.13
Self-talk	.18	.27 *	.12	.20*	.27 *	.31 *	.25*	.16	.09	.15

Table 10, continued

Item	Lecture	Readings	Worksheets	Video	Role Play	Self Reflection	Journal	Group Projects	In Class Activities	Supervision
Spending time with friends and family	.18	.15	.20	.15	.08	.17 *	.23*	.18	.25*	.18*
Companionship through pets	.10	.11	.22	.16	.17	.15	.12	.03	.09	.15
Personal counseling	.13	.11	.27*	.10	-.06	.08	.01	.07	.08	.16
Travel	.25*	.11	.14	.19	-.04	.04	.02	.14	.13	.03
Religious activities	.14	.08	.18	.19	.05	.01	.01	.13	.16	-.12
Meditation	.13	.22 *	.10	.29*	.19	.18 *	.23*	.16	.09	-.01
Creating meaning	.16	.29 *	.25*	.26*	.21 *	.23 *	.14	.11	.16	.22*

* $p < .01$

At the end of the survey, participants were asked to rate the following statement: "Counselors working with trauma victims should make self-care a priority," with responses set on a 7-point Likert scale using strongly agree, moderately agree, mildly agree, neutral, mildly disagree, moderately disagree and strongly disagree. Of the 286 participants, 90% (n=258) selected "strongly agree," 8% (n=23) selected "moderately agree," 1% (n=2) selected "mildly agree," and 1% (n=2) selected "neutral." No participants disagreed to any degree with the statement. The responses to this particular item indicated an overwhelming agreement among participants about the importance of counselor self-care related to trauma work. Table 11 presents the responses to this questionnaire item.

Table 11

Responses to questionnaire item: *Counselors working with trauma victims should make self-care a priority. (n=285)*

Options	Agree				Disagree		
	Strongly	Moderately	Mildly	Neutral	Mildly	Moderately	Strongly
Count	258	23	2	2	0	0	0

The final item on the questionnaire solicited additional general comments regarding self-care and wellness. Following is a sampling of those comments:

> *Counselors working with PEOPLE should make self-care a high priority!* [Participant 031]
>
> *Self-care is an absolute must for any therapist working with trauma survivors. As I see it, the majority of what brings people to therapy is unresolved trauma of one kind of another. Therefore, it is essential that all counselors prioritize their own wellness. Wellness of mind, body, and spirit.* [Participant 080]
>
> *It's critical. Anyone not paying attention to it is being irresponsible.* [Participant 069]

We need to practice what we preach to clients and be examples of self care for them as well, which includes doing things we know we need to do. When we aren't caring for ourselves, we are not being good clinicians. [Participant 164]

Summary of the Findings

The results of the study demonstrated that counselors are receiving some educational preparation concerning self-care strategies related to trauma work, especially in counselor coursework and continuing education formats. And there was a significant relationship between counselor coursework and continuing education with implementation of self-care strategies. This relationship had a small effect size, meaning the relationship is weak. However, the majority of participants reported that no self-care or wellness course was offered in their curriculum and the content that was offered throughout their program was minimal. Participants rated the training they did receive as "somewhat effective." According to participant comments, many counselors choose to independently pursue further training, often in continuing education formats such as workshops and journals.

Participants reported using a wide variety of personal and professional self-care strategies to mitigate the effects of vicarious traumatization. In fact, counselors reported using all of the 29 different strategies included as items on the survey, across five different wellness domains of professional, physical, emotional and mental, relational and spiritual. The most popular self-care activities included spending time with friends and family (n=282, 99.3%), sleep (n=276; 98.2%), empathy (n=277; 98.2%), humor (n=278; 98.2%), and maintaining boundaries (n=280; 98.2%). The least popular activities included medication (56.9%), gardening (42.9%), journaling (29.2%), and personal counseling (27.9%). The results indicated that those self-care strategies implemented by counselors are perceived to be "very effective" overall. Spending time with

family and friends (*M*=1.81, *SD*=0.82), sleep (*M*=1.96, *SD*=1.01), humor (*M*=1.83, *SD*=0.86) and maintaining boundaries (*M*=1.92, *SD*=0.89) were considered "exceptionally effective." Participants commented on the effectiveness of self-care strategies in all five wellness domains.

Pearson product-moment correlation coefficients demonstrated that statistically significant relationships existed between some counselor demographics, self-care training and self-care strategies implemented. And while only weak relationships existed between variables, these correlations indicated that several participant demographics were related to the training received and self-care strategies implemented. These significant relationships were found at the $p < .01$ level, however these relationships should be viewed with caution as many correlational tests of signficance were conducted. There were many significant relationships between self-care training and implementation, which indicates that self-care training is an important, effective piece of counselor education.

Many participants commented in the four free form fields offered throughout the questionnaire. Of the 286 total participants, 173 offered comments or examples regarding their positive and negative self-care training experiences (questionnaire item number 13) and 127 offered comments or examples after being asked about specific self-care training methods (questionnaire item 15). Of the 286 total participants, 150 offered comments or examples of their self-care strategies (questionnaire item 17). And 76 participants offered additional comments regarding self-care and wellness in general (questionnaire item 19). These free form fields yielded substantial in-depth data, which both supported and elaborated on the quantitative findings. The qualitative data allowed participants to explain the quantitative item answers and offer concrete examples of their training experiences as well as their self-care strategies

implemented. The comments about self-care were passionate and enthusiastic about the issue of self-care as well as trauma work.

CHAPTER V

DISCUSSION

Overview of the Study

Various forms of trauma are regularly reported across the spectrum of counseling settings and the potential negative psychological effects on counselors who are repeatedly exposed to traumatic material are well documented (Adams & Riggs, 2008; Cunningham, 2003; Tehrani, 2007). However, many researchers suggest that vicarious traumatization can be prevented and mitigated with personal and professional self-care strategies (Harrison & Westwood, 2009; O'Halloran & Linton, 2000; Stebnicki, 2007; Trippany, White Kress, & Wilcoxon, 2004). The American Counseling Association (ACA) *Code of Ethics* indicates that it is a professional responsibility for counselors to engage in self-care activities, as efforts to ensure the psychological health of counselors will have a direct effect on their ability to help clients.

The purpose of this descriptive research was to explore what types of educational preparation and training counselors have received regarding self-care, what types of self-care strategies counselors are using, and their perceptions of the effectiveness of the training and strategies. The *Self-Care Training and Implementation Questionnaire (STIQ)*, a 19-item, structured and semi-structured questionnaire developed for this research, was electronically sent to 3000 randomly selected members of ACA. Respondents included 310 responses, 286 of which were deemed appropriate for inclusion in the study. Analyses included descriptive analyses (quantitative data) and content and theme analyses (qualitative data).

Discussion of the Findings

Self-Care Training

Of the 286 participants, only 62 (21.9%) indicated that there was at least one course offered in self-care or wellness in their counselor education program, while 221 (78.1%) indicated there was no such course offered. This finding is consistent with current literature which indicates that self-care or wellness courses are not offered in most counselor curriculums (Roach & Young, 2007; Skovholt, Grier & Hanson, 2001). When asked about any of their self-care or wellness training experiences, 44.6% of participants reported training was not included in their counselor education programs and 35.9% of participants reported training was not included in their practicum and internship experiences. These results suggest that not only do most counselors not take a course specifically devoted to self-care or wellness, but almost half of those counselors had no training at all within their counselor education curriculum.

The comments offered by participants supported the conclusion that no or minimal training is fairly common in counselor coursework, practicum and internship, and current work settings. This finding is consistent with current literature which indicates that self-care training is often lacking in counselor curriculums, and that there is no standard wellness model taught (Roach & Young, 2007; Skovholt, Grier & Hanson, 2001). In a sampling of three universities, Roach and Young (2007) found that 52% of counseling students reported there was no wellness course offered within their program. According to the findings, social, psychological and emotional aspects of counselor wellness were emphasized within the educational programs, while such components as nutrition, exercise or spirituality were not addressed (Roach & Young, 2007). And only one student specifically mentioned stress management as a skill emphasized for personal wellness. Roach and Young (2007) suggested that a wellness model be developed to

provide structure for instruction, and so that students may be more effectively evaluated in the area of wellness. Similarly, Skovholt, Grier and Hanson (2001) discussed how counselor training focused on helping others, with relatively sparse instruction related to helping oneself. The authors attempted to address this one-sided focus by offering a developmental framework for self-care throughout a counselor's professional career.

The findings from the current study are important from the perspective of the Council for Accreditation of Counseling and Related Educational Programs (CACREP) which details requirements for educational programs in counseling, applicable to the academic institution, roles of faculty and staff, curriculum content, and practicum and internship experiences (CACREP, 2009). CACREP outlines program requirements for professional orientation and ethical practice including educational studies that provide an understanding of "self-care strategies appropriate to the counselor role" (CACREP, 2009, p. 10). According to participant responses on the STIQ, counseling programs have failed to consistently incorporate self-care training in their curriculums.

The results demonstrated a decreasing number of "not applicable" responses when asked about the self-care training received as they moved through counseling coursework, practicum and internship, current work setting and continuing education. This finding indicated the possibility of a trend of exposure to self-care training opportunities existing as participants have moved through these four educational and work settings. When asked about any of their self-care or wellness training experiences, 44.6% of participants reported training was not included in their counselor education programs and 35.9% of participants reported training was not included in their practicum and internship experiences. Only 31.5% of participants reported training was not included in their current work settings, and 26.2% of participants reported training was not

included in continuing education formats. Therefore, the majority of participants were introduced to self-care training by the time they were pursuing continuing education. The participant comments reflected that counselors have pursued self-care training in continuing education settings such as conferences and workshops, as well as their own independent studies through peer consultation, journal reading and so forth.

In all four educational and training formats (counselor coursework, practicum and internship, work setting and continuing education), when participants did receive training they reported experiencing training methods such as readings, self reflection, supervision, lecture, journaling and in-class activities. Overall, the participants rated these self-care training methods as just "somewhat effective." These self-care training methods were similar to those found in other research studies (Roach & Young, 2007; Sommer, 2008). Students participating in the Roach and Young (2007) survey reported the following activities as contributing to their knowledge and skills of wellness: (a) group projects, (b) in-class activities, (c) role playing, (d) self-care, (e) personal journals, and (f) supervision. Sommer (2008) recommended several techniques that may be incorporated into counselor education programs to promote student awareness about self-care. The specific practices they suggested included topical presentations, breath work, guided imagery and reflective reading.

Self-Care Implementation

The American Counseling Association *Code of Ethics* (2005) addresses self-care in terms of professional responsibility by stating that counselors should "engage in self-care activities to maintain and promote their emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities" (ACA, 2005, p. 9). Participants reported using all of the 29 different strategies offered as examples on the survey, across five different wellness domains

including professional, physical, emotional and mental, relational and spiritual. The domains are similar to those categories offered by authors for potentially effective self-care strategies (O'Halloran & Linton, 2000; Trippany, White Kress, & Wilcoxon, 2004). The most popular self-care activities included spending time with friends and family, sleep, empathy, humor, and maintaining boundaries. The results indicated that those self-care strategies implemented are perceived by participants to be very effective overall. The least popular self-care strategies included medication, gardening, journaling, and personal counseling.

ACA's Task Force on Counselor Wellness and Impairment (2003) recognized the impact of counselors' fatigue reactions to clients, labeling this as "counselor impairment." Members of the ACA Ethics Committee have explored the idea of self-care in relationship to professional performance (Thomas & Levitt, 2010). The ACA *Code of Ethics* dictates that counselors should monitor their effectiveness and be sensitive to signs of impairment at work (C.2.d, C.2.g). Counselors should engage in activities that promote a healthy lifestyle and mitigate stress, thus achieving a balance that fosters effective work performance. Self-care is viewed as an ethical obligation and preventive tool in this context (Thomas & Levitt, 2010). Participant comments demonstrated that counselors are aware of the impact of self-care on their work with trauma clients. One hundred percent (n=285) of participants agreed that counselors working with trauma victims should make self-care a priority, and 90% (n=258) of those strongly agreed. These results indicated an overwhelming agreement among participants about the importance of counselor self-care related to trauma work. Additionally, 32% (n=76) of those participants who chose to offer general comments regarding self-care and wellness, discussed the importance of counselor self-care regardless of the client population served.

Themes

Qualitative data captured through free form fields on the questionnaire yielded substantial, in depth information regarding self-care training and self-care strategies implemented by counselors. Several themes emerged through qualitative analysis of participant comments using content and thematic analyses in accordance with procedures suggested by Creswell (2009). Responses for each of the four survey items were grouped into four separate sets uniquely, as related to the questionnaire items from which the responses were derived. Within each set, statements were divided into themes and perspectives, and then coded utilizing *in vivo* and open codes. Codes were merged into thematic categories, and then linked to the survey items to provide more in depth information and augment the quantitative data. Themes included minimal self-care training, self-care strategies across all five wellness domains being used and counselors' recognition of the importance of self-care related to their overall health and work.

Minimal Training

Almost half of participants (44.6%) reported that formal self-care training was not included in their counselor education programs, while 31.5% of participants reported that no formal self-care training was offered in their current work setting. According to participant comments, self-care is a topic often only briefly touched upon during counseling coursework and current work settings. Out of 173 comments, 68 (39%) participants indicated they had received no or minimal self-care training in any of the four educational and work settings. When asked to rate the effectiveness of the training they did receive, the average response was "somewhat effective." Out of the same 173 comments, 58 (34%) participants indicated that learning about self-care has been an endeavor pursued independently, outside of education and work settings.

Out of the four training formats included in the study (counselor coursework, practicum and internship, work setting and continuing education), participants reported being exposed to self-care and wellness instruction most often in continuing education formats.

Self-Care Across Five Wellness Domains

Participants reported implementing professional, physical, mental and emotional, spiritual and relational self-care strategies. Professional self-care strategies, especially maintaining boundaries, case consultation and supervision, appeared to be useful for counselors working with trauma clients. Out of 150 participant comments, 46 (31%) mentioned these professional self-care strategies as particularly effective. Participants reported that physical health maintained through exercise, nutrition and sleep, was an important part of self-care. Over one third (35%) of participant comments included references to self-care strategies related to physical health. Empathy, humor, optimism and self-talk were reported as some of the most popular mental and emotional self-care strategies. Participant comments included references to each of these strategies as well as mindfulness, self-awareness, journaling and inspirational readings. Out of 150 comments, 37 participants (25%) described the importance of their spiritual health in overall self-care, noting prayer and religious activities as part of their wellness routine. Finally, relational self-care strategies, especially spending time with family and friends, were found to be helpful for overall counselor wellness. Out of 150 comments, 54 participants (36%) stated that spending time with friends and family, as well as companionship with pets, was a self-care strategy they used to achieve overall wellness.

While there are many popular self-care strategies used by the majority of participants (e.g., spending time with family and friends, sleep, exercise, empathy, humor, etc.), self-care remains a very personalized undertaking as indicated by their comments. Participants offered

their own custom activities including origami, martial arts, acupuncture, being out in nature, hiking, camping, movies, theater, photography, music and so forth. Overall, counselors rated the self-care strategies they used to be very effective, indicating that counselors would not continue to participate in activities which they perceived to be ineffective.

Importance of Counselor Health

The results of the current study indicated that counselors are very aware of the impact of their overall health on their ability to work with trauma clients. This is consistent with Cavanagh and Levitov's (2002) suggestion that the counselor's overall psychological health and functioning will affect his or her ability to be effective with clients within the counseling process. Of 76 participants who chose to offer general comments regarding self-care and wellness, 32% discussed the importance of counselor self-care regardless of the client population served. Participant comments emphasized the idea that counselors are the real tool in counseling and should practice what they preach to clients by making self-care a high priority. The comments offered by participants indicated that counselors are consciously engaging in activities that promote a healthy lifestyle and mitigate stress, thus working toward a balance that fosters effective work performance. In this context, self-care can be viewed as an ethical obligation as well as a preventive care and restorative tool (Thomas & Levitt, 2010). In order to best meet their professional responsibilities, counselors should be equipped with tools to cope with the inevitable consequences of their work. Professional and personal self-care activities that promote better psychological health and overall wellness will ultimately help counselors more effectively serve their clients.

Findings from the current study can contribute to a better understanding of a counselor's unique work, especially the way in which a counselor's personal and professional lives are

interrelated. Shallcross (2011) discussed the complex nature of counselor identity in an article regarding counselor self-care. Shallcross explored the topic through an interview with Lawson, chair of the ACA Task Force on Counselor Wellness and Impairment, who remarked that it was impossible to separate who he was as a counselor from the work that he did. Venart, a task force member, emphasized the importance of the counselor-client relationship in counseling outcomes, stating that "Since the self of the counselor is an essential component of effective counseling, it is vital that we nourish our own wellness. When we are well, we are better able to connect with our clients, more attentive and creative in our work, and less likely to make clinical errors or violate boundaries" (Shallcross, 2011). The results of this study show that participants are aware of the professional need to pursue personal wellness. The current findings also indicated that educational programs sometimes serve as a base for introducing the notion of self-care to counselors, but are not formally integrated into the curriculum; therefore, counselors must educate themselves on the matter through various continuing education opportunities.

Limitations and Delimitations

A significant limitation in all survey research is that participants are self-selected, and therefore may not represent an accurate sampling of the population (Creswell, 2005). The sample may be skewed in that participants who choose to complete the survey may have strong ideas about trauma work or self-care, and those counselors who do not have strong ideas will opt not to participate in the survey. It is possible that counselors who are or were victims of vicarious traumatization may not be fully aware of the situation, or may not acknowledge this. Additionally, those who have experienced vicarious traumatization may not be practicing and may be unavailable to take the survey. It is also possible that the topic was too personal for those counselors suffering from vicarious traumatization, and therefore the sample was comprised of

self-selected, healthy counselors. From a practical standpoint, counselors may have opted to not participate in the survey simply related to the time demands of their work. These sampling biases may result in a misrepresentation of the general counselor population. In an effort to ensure an adequate representation from the population, study participants were recruited from a randomly selected list of members of the American Counseling Association (ACA). Once data were collected, it was determined by visual inspection how closely the sample resembled the known demographics of this counselor population by comparing sample demographics to membership demographics. Both ACA members and sample participants were predominantly Caucasian women with master's degrees. Both groups reported a myriad of specialties and employment in a variety of work settings including agencies, private practices, schools and colleges. However, the most current membership report available for ACA (2010) includes demographic information for only 16,885 members, which is representative of only 38% of total membership.

Another important assumption of this type of research is that participants who choose to complete the survey will answer questions and admit problems honestly. However, participants may want to provide socially desirable responses to survey items regarding self-care training and implementation. Also, participants may have difficulty answering items that could be embarrassing or have a stigma attached to them. These are common problems associated with all survey research, but risk for these biases was reduced with the randomized sample selection from a national population of ACA members. Additionally, the anonymity of an electronic, web-based survey should have helped minimize these limitations.

A delimitating factor is that the survey was distributed only to members of ACA, therefore, the findings are generalizable only to this membership population. In order to

generalize the results of the study to the population being studied, a high response rate was needed (Creswell, 2005). A response rate is simply the percentage of questionnaires completed and returned to the researcher (Creswell, 2005). Response rates to electronic questionnaires fluctuate based on many variables, including the research topic being studied and timing. After the initial email was sent to solicit survey participation, a second follow-up email reminder was sent as well as a final email requesting participation which may have helped increase response rates. Out of 3000 surveys sent, 310 completed surveys were received; therefore the response rate was approximately 10%. Response rates to electronic questionnaires fluctuate based on many variables including the research topic being studied, timing and so forth, but this was an acceptable response rate.

Study Implications

The research findings have clear implications for counselor education, practice and policy. Although self-care is emphasized within the curriculum of CACREP-accredited educational programs and included in the ACA *Code of Ethics*, there is still much room for improvement in self-care training for counselors. The results of this study could be used to inform a more purposeful and systematic inclusion of self-care training in educational and training formats. The development of a uniform wellness model inclusive of five domains, but able to be customized by counselors, might be helpful for teaching purposes. It is also clear that continued assessment of the effectiveness of these training methods is necessary in order to measure training outcomes. Self-care should be emphasized in educational and work settings in order to address impairment issues with students and coworkers.

Assessment tools such as those offered through ACA might be emphasized and more thoroughly publicized so that counselors could engage in effective self evaluation and continue

to proactively take care of themselves. The organization offers the following materials for counselors interested in managing their own self-care: (a) self-care assessment worksheet, (b) self-care strategies worksheet, (c) self-care life pie worksheet, and (d) self-care social support worksheet. As empirical knowledge about self-care implementation increases, other instruments could be developed to more effectively evaluate counselor self-care. Access to these tools may help guide counselors in developing personalized wellness plans.

The significance of the study could impact those in administrative or supervisor positions in mental health work settings as they might examine the way in which self-care concerns are handled in their work place. Policies, resource management, funding and morale issues which affect counselor wellness could be explored to ensure a better work environment for mental health providers.

Suggestions for Future Research

Numerous studies have documented the profound negative psychological effects associated with helping clients cope with trauma, also known as vicarious traumatization (e.g., Adams & Riggs, 2008; Cunningham, 2003; Tehrani, 2007). Personal and professional self-care strategies often are suggested to prevent or mitigate the effects of vicarious traumatization (Harrison & Westwood, 2009; O'Halloran & Linton, 2000; Stebnicki, 2007; Trippany, White Kress, & Wilcoxon, 2004). The results of this study demonstrate what type of self-care training counselor are receiving, and subsequently what type of self-care strategies counselors are implementing. In addition, the study explored counselor perceptions of the efficacy of the training received and strategies used. The results of this study indicated that there are many relationships between counselor demographics, self-care training and self-care implementation. Although many of these relationships were weak in strength, the findings constitute a knowledge

gain that can be built upon with future research. It may be helpful to further explore some of these relationships in order to more fully understand them.

A qualitative study may be able to explore more in depth how counselors are impacted by their work with trauma victims and how their self-care strategies work to prevent and mitigate vicarious traumatization. Also, it may be worthwhile to explore how counselors experience the negative effects of trauma work by interviewing practitioners who have experienced vicarious traumatization. It may be interesting to explore how various counseling variables impact a counselor's susceptibility to vicarious traumatization. For instance, the type of trauma, type of intervention, clinician's trauma history, clinician's experience or educational level, a clinician's resilience level and their workload have all been found to act as risk and protective factors for vicarious traumatization.

There are few tools available to measure the effectiveness of counselor self-care, and none specifically designed to address their work with trauma clients. Future research may build upon the results of this study and elicit more information that can be used to develop such instruments. Effectively evaluating counselor self-care could be useful to counselors as well as their clients.

Significance of the Study

Various forms of trauma are reported on a daily basis in sessions across the spectrum of counseling settings (Culver, McKinney, & Paradise, 2011). The potential negative psychological effects on mental health professionals who are repeatedly exposed to traumatic material are well documented (Adams & Riggs, 2008; Cunningham, 2003; Tehrani, 2007). As a result of vicarious traumatization, counselors may become less effective with clients and may leave the mental health field altogether, leading to a lack of qualified counselors to treat trauma victims

(Fahy, 2007). Personal and professional self-care strategies often are suggested to prevent or mitigate the effects of vicarious traumatization (Harrison & Westwood, 2009; O'Halloran & Linton, 2000; Stebnicki, 2007; Trippany, White Kress, & Wilcoxon, 2004). Thus, there is a substantial need to educate counselors in preparation for counseling practice, to prevent contamination in the counseling process, to maximize self-care strategies for counselors, and ultimately to retain qualified, experienced counselors to treat trauma victims.

However, there is little evidence regarding training provided to counselors with respect to self-care strategies, and how effective this training might be. It is also unclear which self-care strategies are being used by counselors currently working with trauma victims, and which are perceived to be the most effective strategies when implemented. The results of this study contribute to the knowledge base concerning counselor self-care training and implementation. Counselors should be adequately trained to treat trauma victims and should be equipped with tools to cope with the inevitable personal and professional consequences of this work (Trippany et al., 2004). All of these efforts to ensure the psychological health of counselors will have a direct effect on their ability to help clients. Mental health professionals who may be interested in this study include (a) practitioners such as counselors, social workers, psychologists, psychiatric nurses and nurse practitioners; (b) educators including faculty and researchers; and (c) agency directors, school administrators, clinical and administrative supervisors, and policy makers.

Pearlman and Saakvitne (1995) have suggested that a lack of formal, trauma-specific coursework may contribute to a counselor's susceptibility to trauma-related symptomology. Results of several other studies supported the idea that education and training could substantially contribute to mental health professionals more effectively coping with difficult client cases (Alpert & Paulson, 1990; Chrestman, 1995; Follette, Polusny, & Milbeck, 1994). "Students need

substantial trauma-specific training in the context of a full semester of coursework or multiple intensive workshops in order to protect themselves against the potential negative impact of trauma counseling" (Adams & Riggs, 2008, p. 32). The course could address various treatment methods for working with trauma victims, potential impacts on counselors, and self-care strategies. Counselor educators and supervisors should help students prepare for the inherent risks of trauma work through trauma-specific training including self-care strategies that may help prevent and ameliorate vicarious traumatization (Sommer, 2008).

Working with clients who experience trauma is commonplace for counseling professionals, crossing their educational program, practica, internships (Pearlman & Mac Ian, 1995). Therefore, students, counselors and supervisors should be educated about the warning signs of vicarious traumatization so that they may be equipped to cope with the symptoms (Sommer, 2008; Trippany, 2004). Otherwise, not only will counselors suffer from the effects of working with trauma victims, but also they may potentially cause harm to their clients and negatively affect counseling outcomes. Counselors may encourage their clients to avoid traumatic material in session, or may be unable to be fully present with their clients because of the effects of vicarious traumatization (Munroe, 1999). Additionally, counselors may leave the mental health field altogether, resulting in a lack of qualified professionals to work with clients (Sommer, 2008).

Conclusions

The current study adds to the literature concerning counselor self-care training and implementation. The study explored self-care training formats, methods and efficacy as well as self-care strategy implementation and efficacy. After thorough examination of the data, it was determined that counselors receive minimal self-care training in their counseling coursework and

practicum and internship experiences. However, there is a relationship between self-care training exposure and implementing self-care strategies. Participant comments indicated that learning about self-care was often an individual pursuit taken on by themselves. The results point to a need for formalized self-care training in order to better prepare counselors for their work with trauma clients.

The findings demonstrate that counselors are proactively engaging in self-care in order to work toward overall wellness. It is clear that self-care is an issue which counselors embrace and view as important. One hundred percent (n=285) of participants agreed that counselors working with trauma victims should make self-care a priority, and 90% (n=258) of those strongly agreed. These results indicated an overwhelming agreement among participants about the importance of counselor self-care related to trauma work. Additionally, 32% (n=76) of those participants who chose to offer general comments regarding self-care and wellness, discussed the importance of counselor self-care regardless of the client population served.

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Appendix A

Self-Care Training and Implementation Questionnaire

SELF-CARE TRAINING AND IMPLEMENTATION QUESTIONNAIRE (STIQ)

I. DEMOGRAPHIC INFORMATION

1. Sex

Male
Female

2. Age

1-99

3. Ethnicity

White/Caucasian
Black/African American
American Indian
Alaska Native
Asian Indian
Chinese
Filipino
Japanese
Korean
Vietnamese
Native Hawaiian
Guamanian
Samoan
Other Asian
Other Pacific Islander
Other

4. Highest education level. Check highest degree and program level attained.

Baccalaureate Degree
Masters in Social Work
Masters in Counseling
Masters in Psychology
Ph.D. in Social Work
Ph.D. in Counseling
Ph.D. in Psychology
Other

5. Professional license and certification. Check all that apply.

LPC
LMFT
LSW
LMHPC
Licensed Psychologist
NCC
NCSC
None
Other

6. Present employment position. Check the one most prominent position.

Agency counselor
School counselor
In patient facility counselor
Educator
Administrator
Researcher
Private practice
Other

7. How many years have you worked in the mental health field?

1-60

8. Do you work with trauma victims? According to the American Psychiatric Association (2000), trauma is often associated with exposure to a situation that involves threatened or actual death, or serious injury to self or others. For the purposes of this study, trauma can include loss, physical or sexual assault, childhood sexual abuse, domestic violence, natural and man-made disasters, as well as school and work-related violence.

Yes
No

9. Please estimate the total number of clients you counsel, on average each week, including intakes and ongoing clients.

1-60

10. Please estimate the number of clients with trauma histories you counsel, on average each week, including intakes and ongoing clients.

1-60

II. SELF-CARE TRAINING

11. In your counselor educational program, was there at least one course offered specifically regarding self-care or wellness?

Yes
No

12. Please rate the effectiveness of the self-care or wellness training you received in each of the following educational and work settings. Please select "not applicable" if you did not receive any training in that particular format.

Format	Exceptionally Effective	Very Effective	Somewhat Effective	Neutral	Somewhat Ineffective	Very Ineffective	Not Effective At All	Not Applicable
Counselor Coursework	o	o	o	o	o	o	o	o
Practicum/ Internship	o	o	o	o	o	o	o	o
Current work setting	o	o	o	o	o	o	o	o
Continuing education	o	o	o	o	o	o	o	o

13. Please comment and/or provide examples of your positive and/or negative self-care training experiences.

Free form field.

14. Please rate the effectiveness of each self-care or wellness training method which you experienced. Please select "not applicable" if you did not receive any training in that particular format.

Format	Exceptionally Effective	Very Effective	Somewhat Effective	Neutral	Somewhat Ineffective	Very Ineffective	Not Effective At All	Not Applicable
Lecture	o	o	o	o	o	o	o	o
Readings	o	o	o	o	o	o	o	o
Worksheets	o	o	o	o	o	o	o	o
Video	o	o	o	o	o	o	o	o
Role play	o	o	o	o	o	o	o	o
Self reflection	o	o	o	o	o	o	o	o
Journaling	o	o	o	o	o	o	o	o
Group projects	o	o	o	o	o	o	o	o
In-class activities	o	o	o	o	o	o	o	o
Supervision	o	o	o	o	o	o	o	o

15. Please comment and/or provide examples of your training experiences.

Free form field.

III. SELF-CARE IMPLEMENTATION

16. Please rate the effectiveness of each of the following self-care strategies that you use or have used to prevent and/or mitigate the effects of working with trauma victims. Rate only those that apply to your own experience. Please select "not applicable" if you have not used the strategy.

Strategies	Exceptionally Effective	Very Effective	Somewhat Effective	Neutral	Somewhat Ineffective	Very Ineffective	Not Effective At All	Not Applicable
Professional								
Supervision	o	o	o	o	o	o	o	o
Case consultation	o	o	o	o	o	o	o	o
Balancing caseload	o	o	o	o	o	o	o	o
Continuing education	o	o	o	o	o	o	o	o
Maintaining boundaries	o	o	o	o	o	o	o	o
Physical								
Nutrition	o	o	o	o	o	o	o	o
Exercise	o	o	o	o	o	o	o	o
Sleep	o	o	o	o	o	o	o	o
Medication	o	o	o	o	o	o	o	o
Relaxation	o	o	o	o	o	o	o	o
Play	o	o	o	o	o	o	o	o
Gardening	o	o	o	o	o	o	o	o
Emotional and Mental								
Positive self statements	o	o	o	o	o	o	o	o
Inspirational readings	o	o	o	o	o	o	o	o
Journaling	o	o	o	o	o	o	o	o
Humor	o	o	o	o	o	o	o	o
Crying	o	o	o	o	o	o	o	o
Mindfulness	o	o	o	o	o	o	o	o
Optimism	o	o	o	o	o	o	o	o
Empathy	o	o	o	o	o	o	o	o
Self-talk	o	o	o	o	o	o	o	o
Setting boundaries	o	o	o	o	o	o	o	o
Relational								
Spending time with friend and family	o	o	o	o	o	o	o	o
Companionship through pets	o	o	o	o	o	o	o	o
Personal	o	o	o	o	o	o	o	o

Strategies	Exceptionally Effective	Very Effective	Somewhat Effective	Neutral	Somewhat Ineffective	Very Ineffective	Not Effective At All	Not Applicable
counseling								
Travel	o	o	o	o	o	o	o	o
Spiritual								
Religious activities	o	o	o	o	o	o	o	o
Meditation	o	o	o	o	o	o	o	o
Creating meaning	o	o	o	o	o	o	o	o

17. Please comment and/or provide examples of your self-care strategies.

Free form field.

18. Please rate the following statement.

	Strongly Agree	Moderately Agree	Mildly Agree	Neutral	Mildly Disagree	Moderately Disagree	Strongly Disagree
Counselors working with trauma victims should make self-care a high priority.	o	o	o	o	o	o	o

19. Any additional comments regarding self-care and wellness are welcome.

Free form field.

Appendix B

IRB Approval Letter

University Committee for the Protection of Human Subjects in Research
University of New Orleans

Campus Correspondence

Principal Investigator:	Louis V. Paradise
Co-Investigator:	Leslie M. Culver
Date:	December 3, 2010
Protocol Title:	"Counselor Perceptions of the Efficacy of Training and Implementation of Self-Care Strategies Related to Trauma Work"
IRB#:	03Dec10

The IRB has deemed that the research and procedures described in this protocol application are exempt from federal regulations under 45 CFR 46.101category 2, due to the fact that the information obtained is not recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects.

Exempt protocols do not have an expiration date; however, if there are any changes made to this protocol that may cause it to be no longer exempt from CFR 46, the IRB requires another standard application from the investigator(s) which should provide the same information that is in this application with changes that may have changed the exempt status.

If an adverse, unforeseen event occurs (e.g., physical, social, or emotional harm), you are required to inform the IRB as soon as possible after the event.

Best wishes on your project.
Sincerely,

Robert D. Laird, Ph.D., Chair
UNO Committee for the Protection of Human Subjects in Research

Appendix C

First Electronic Message

First Electronic Message

Dear Counselor,

I am conducting a study for my dissertation research entitled, *Counselor Perceptions of the Efficacy of Training and Implementation of Self-Care Strategies Related to Trauma Work*. I have developed a survey (Self-Care Training and Implementation Questionnaire or STIQ) that is designed to measure what types of self-care training counselors receive as well as how effective counselors perceive this training to be. In addition, the survey asks about what self-care strategies counselors use and how effective these strategies are when implemented. I plan to use the data collected from this survey to better understand self-care training in counselor education formats. I intend to share the information through scholarly presentation and publication.

The survey is composed of 19 items and will take about 10 to 15 minutes to complete. All information provided is anonymous as there will be no way to identify you once you have submitted your answers. Your participation in this study is entirely voluntary and you may withdraw your consent and terminate participation without consequence at any time. The risks associated with this study are minimal.

Please click the following link to begin the survey. Completion and electronic submission of the STIQ will indicate your consent for participation in this study. If you are not connected automatically, simply cut and paste the URL into your browser and press enter.

[Insert survey link]

Please direct any questions or concerns about this study to the principal investigator, Leslie M. Culver (lmidtbo@uno.edu), the faculty advisor, Dr. Louis V. Paradise (lparadis@uno.edu), or the Office of Human Subjects Research at the University of New Orleans (unoirb@uno.edu).

Thank you in advance for your participation. Your time is greatly appreciated.

Leslie M. Culver, MS, NCC
PhD Candidate
University of New Orleans
Bicentennial Education Building, Room 348
2000 Lakeshore Drive
New Orleans, LA 70148

Appendix D

Second Electronic Message

Second Electronic Message

Dear Counselor,

If you have already completed the *Self-Care Training and Implementation Questionnaire (STIQ)*, thank you again for your participation in this study.

If you have not had the opportunity to participate, please take approximately 10-15 minutes to complete this brief 19-item survey.

I am conducting a study for my dissertation research entitled, *Counselor Perceptions of the Efficacy of Training and Implementation of Self-Care Strategies Related to Trauma Work.* The survey is designed to measure what types of self-care training counselors receive as well as how effective counselors perceive this training to be. In addition, the survey asks about what self-care strategies counselors use and how effective these strategies are when implemented. I plan to use the data collected from this survey to better understand self-care training in counselor education formats. I intend to share the information through scholarly presentation and publication.

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Thank you in advance for your participation. Your time is greatly appreciated.

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New Orleans, LA 70148

Appendix E

Final Electronic Message

Final Electronic Message

Dear Counselor,

This is a final reminder for those of you who have not had the opportunity to participate in my dissertation research entitled, *Counselor Perceptions of the Efficacy of Training and Implementation of Self-Care Strategies Related to Trauma Work.* **If you have already completed the Self-Care Training and Implementation Questionnaire (STIQ), thank you again for your participation in this study. If you have not had the opportunity to participate, please take approximately 10-15 minutes to complete this brief 19-item survey.**

The survey is designed to measure what types of self-care training counselors receive as well as how effective counselors perceive this training to be. In addition, the survey asks about what self-care strategies counselors use and how effective these strategies are when implemented. I plan to use the data collected from this survey to better understand self-care training in counselor education formats. I intend to share the information through scholarly presentation and publication.

All information provided is anonymous as there will be no way to identify you once you have submitted your answers. Your participation in this study is entirely voluntary and you may withdraw your consent and terminate participation at any time without consequence. The risks associated with this study are minimal.

Please click the following link to begin the survey. Completion and electronic submission of the STIQ will indicate your consent for participation in this study. If you are not connected automatically, simply cut and paste the URL into your browser and press enter.

[Insert survey link]

Please direct any questions or concerns about this study to the principal investigator, Leslie M. Culver (lmidtbo@uno.edu), the faculty advisor, Dr. Louis V. Paradise (lparadis@uno.edu), or the Office of Human Subjects Research at the University of New Orleans (unoirb@uno.edu).

Thank you in advance for your participation. Your time is greatly appreciated.

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Vita

The author is a native New Orleanian. She obtained her Bachelor's degree in English Literature from Loyola University New Orleans in 2001, her Master's degree in Counseling from Loyola University New Orleans in 2008, and her PhD in Counselor Education from the University of New Orleans in 2011. She looks forward to a career within the counseling field that will include practicing, teaching, research and service.