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Impact of counselor wellness on positive and negative consequences of COVID-19 shared trauma

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IMPACT OF COUNSELOR WELLNESS ON POSITIVE AND NEGATIVE CONSEQUENCES OF COVID-19 SHARED TRAUMA

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A

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Abstract

IMPACT OF COUNSELOR WELLNESS ON POSITIVE AND NEGATIVE CONSEQUENCES OF COVID-19 SHARED TRAUMA

Monique Lois Raack Rahman

St. Mary's University, 2021

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This study sought to explore how the shared trauma of the COVID-19 pandemic has impacted Texan counselors both positively and negatively, as well as the mediating or moderating effect of counselor wellness. Negative consequences of stress such as secondary traumatic stress, burnout and compassion fatigue were explored, but also positive consequences such as compassion satisfaction and post-traumatic growth. Measures such as the Five Factor Wellness Inventory (FFWEL), the Shared Traumatic and Professional Posttraumatic Growth Inventory (STPPGI), and the Professional Quality of Life Measure (ProQOL) will be utilized in addition to demographic questions and COVID-19 stress related questions mirroring Park et al. (2020). Surprises included the low overall experience of COVID-19 related shared trauma, and overall positive correlations between wellness and negative consequences. Wellness was found to mediate only the relationship between COVID-19 stress and compassion satisfaction. Expected results included the lack of stress surrounding counselor job security as well as the positive correlation between COVID-19 stress and negative consequences and post traumatic growth.
Keywords: shared trauma, wellness, COVID, compassion satisfaction, compassion fatigue, post traumatic growth

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Chapter 1

The increase in anxiety and depression following the global coronavirus (COVID-19) pandemic has been described as a mental health crisis, leaving an increased need for mental health services, difficulty finding available providers, as well as increased burnout for mental health providers (APA, 2020; Caron, 2021). In a survey of 1,787 American psychologists, 74% reported seeing more patients for anxiety disorders since the pandemic and 60% reported seeing more with depressive disorders (APA, 2020). Almost all of the psychologists reported seeing some or all of their patients remotely (96%), and 63% reported finding remote work more challenging than in-person. Through all of these changes, 41% of the psychologists shared they felt burned out, though 66% shared they have still been able to practice self-care and 55% shared they've maintained a positive work-life balance. Over a year since COVID-19 has significantly impacted the world, there has yet to be any research on the impacts on professional counselors. While the impact of the COVID-19 pandemic on the mental health of the general population continues to be studied, it is also important to further investigate the mental health consequences of this stress on mental health providers.

Shared trauma has been defined as occurrences when the counselor and client are simultaneously exposed to the same communal disaster (Baum, 2010). Shared trauma requires the following four criteria: (1) a disaster occurred that has the ability to cause collective trauma, (2), the disaster is recent, (3), the client and counselor are both in the community affected, and (4) counselors are exposed to the trauma through primary, secondary and vicarious means through their roles as a counselor and community member (Baum, 2010). The novel coronavirus (COVID-19) pandemic not only is recent, but has consumed world news for the last year due to its pervasive and deadly impact throughout the entire world. Counselors have been faced not

only with their own personal experiences with COVID-19, but also with witnessing their clients' processes of the same trauma. This life-threatening and life-altering experience has similarities to previously researched shared trauma experiences such as the September 11 terrorist attacks, Hurricane Katrina and the Virginia Tech shooting (Day, et al., 2017).

Researchers have already began investigating the impacts of COVID-19 on stress responses in the general public and some mental health professionals, such as social workers. In Italy, a survey of 381 recovered COVID-19 patients showed that 30.2% had developed post-traumatic stress disorder (Janiri, et al., 2021). A recent study examining emotional well-being during the COVID-19 pandemic found that the sample of social workers exhibited meeting PTSD criteria five times higher than national estimates, and seven times higher than the social workers who self-reported PTSD in 2015 (Holmes, et al., 2021). Though, the prevalence of meeting criteria for PTSD was comparable to the larger sample of general population, suggesting a shared trauma experience. The researchers also found that 99% of the sample reported average to high compassion satisfaction, 63.71% reported average burnout and 49.59% reported average secondary trauma. This study described the experience as collective trauma, acknowledging the widespread threat of illness, death, isolation, loss of employment and lack of resources.

The stress resulting from the COVID-19 experience has been seen worldwide. A Swiss 2-year longitudinal study found increased stress, anger and hopelessness, and lifestyle and economic disruption after the COVID-19 lockdown, with females more likely to experience distress (Shanahan, et al., 2020). A study of healthcare workers in Italy found that females, those without children, those who worked in the frontline, and those who utilized avoidance and social support as coping strategies were more likely to be more stressed (Babore, et al., 2020). A sample of American adults found the most common stressors including hearing about the severity and

contagiousness of COVID-19, uncertainty about the longevity of public safety measures, and daily personal care routine disruption (Park, et al., 2020).

Stay-at-home orders and recommendations from the Centers for Disease Control suggested that during the COVID-19 outbreak, people remained at home as much as possible to limit transmission of the disease. As previously mentioned, this led many mental health providers to move to telehealth services, but impacted many in how they lived their day-to-day lives. Wellness practices such as social gatherings or going to gyms to exercise were limited. Mobility patterns drawn from cellphone data found that those who were less mobile during the stay-at-home recommendations were correlated with less COVID-19 cases, being in more urban areas as well as areas with those with higher socioeconomic status, perhaps due to those people being able to work from home (Levin, et al., 2021). This research also found that Texan residents had similar patterns to other states such as California and Washington state.

Previous research on shared trauma has discovered not only harmful consequences of the trauma, but also positive changes. Research following the impact of September 11 terrorist attacks on mental health professionals found positive consequences such as enhanced self-care, acquiring new skills, positive changes in the therapeutic relationship and increased connectedness with clients (Bauwens & Tosone, 2010). Laumbert and Lawson (2013) surveyed both survivor and responder counselors who treated survivors of Hurricanes Katrina and Rita, finding that those who had survived the hurricanes themselves were more likely to experience higher levels of post-traumatic growth than those who were not personally impacted. Irish counselors who worked with child victims of sexual abuse found rewarding benefits of the traumatic work, including an enhancement of their own attitudes, feeling uplifted within the therapeutic relationship, learning life lessons from children, and experiencing the magical

connection that happens in therapy (Wheeler & McElvaney, 2017). Findings from this study also suggested a struggle to discuss positive impacts of the work. Positive consequences such as feeling more trauma-aware, an increase in workplace support as well as an increase in self-care to cope with increased work demands have resulted from shared trauma (Day, et al., 2015) and vicarious posttraumatic growth from secondary trauma (Manning-Jones, et al., 2016).

Some research has also focused on coping mechanisms through the COVID-19 pandemic. The aforementioned American study found common coping strategies to COVID-19 stress included distraction, active coping, and emotional social support (Park et al., 2020). A Polish study of coping responses to COVID stressors found that basic hope supports meaning in life and life satisfaction, which both work together to lower anxiety and COVID-19 stress (Trzebinski, et al., 2020). Though, there has yet to be investigation into any positive consequences of shared trauma experiences of mental health professionals due to COVID-19. Primarily, it is important to consider how different stressors and counselor behaviors contribute to outcomes of said stressors. An understanding of different types of stress may impact a counselor's response. For example, a counselor may be curious of working from home with their child impacts their stress response. Even more helpful is an understanding of how counselors' wellness practices may impact positive or negative outcomes of stress, as these are behaviors mostly likely in a counselor's control. During the COVID-19 pandemic, many people's lives were turned upside down, and it was often recommended to maintain control over what people could control. It may be helpful to know if a counselor who practices physical wellness would be more likely to experience compassion satisfaction with their clients, and a counselor who lacks coping skills is more likely to experience burnout.

Thus, the purpose of this study is to explore how wellness practices of counselors mediate positive outcomes and moderate negative outcomes of stresses related to COVID-19. Variables indicating positive outcomes will be compassion satisfaction and post-traumatic growth, while variables indicating negative outcomes will be burnout, and secondary traumatic stress. Wellness practices will be measured using the total wellness score of the Five Factor Wellness Inventory. Compassion satisfaction, burnout and secondary traumatic stress will be measured utilizing the Professional Quality of Life Measure (ProQOL). Post-traumatic growth and shared trauma will be measured utilizing the Shared Traumatic and Professional Posttraumatic Growth Inventory (STPPGI). Both a random sample from the Texas Licensed Professional Counselors roster and a non-random sample of Texas counselors solicited via social media will be asked to complete the inventories.

Statement of the Problem

The coronavirus pandemic has created a more stressful environment for counselors. Many mental health providers report increased requests for services, increases in anxiety and depression, and greater challenges providing counseling in telehealth modalities. Many mental health professionals report greater burnout during the pandemic.

In addition, the coronavirus pandemic counselors faced an experience of shared trauma, a traumatic event that the client and counselor are equally affected through direct and secondary means. Research has examined harmful consequences of shared trauma such as separating work and personal life (Day, et al., 2015), not being present during counseling or devaluing their work (Bell & Robinson, 2013). Although research has identified positive consequences of trauma, for example, post traumatic growth (Bell & Robinson, 2013; Laumbert & Lawson, 2013; Manning-Jones, et al., 2016) or improved self-care (Bauwens & Tosone, 2010; Laumbert & Lawson,

2013), no research has examined any positive consequences of the shared trauma experience of COVID-19.

In addition, research is needed to understand what mediates or moderates an individual's response to shared trauma. Some of the studied positive consequences of shared trauma have included improved self-care and professional satisfaction (Laumbert & Lawson, 2013), variables which may relate to similar concepts such as wellness. This begs the question of how wellness practices may moderate or mediate the effect of shared trauma on positive consequences. Similarly, negative consequences such as burnout have continuously been linked to wellness practices (Dupree & Day, 1995; Lent & Schwartz, 2012; Puig, et al., 2012; Van Morkhoven, 1998; Vredenburgh, et al., 1999), begging the question of its moderating effect.

Research has already shown how the COVID-19 pandemic has been stressful for general populations of multiple countries, and some have begun to evaluate experiences of specific career populations such as medical professionals and mental health workers. Though some research has been completed on social workers and psychologists, no research has yet explored the mental health impact of COVID-19 on Licensed Professional Counselors. Multiple studies have indicated that females and those who consume media or news about COVID-19 more frequently have greater COVID-19 related stress, with mixed results regarding the impact of working from home with children. These variables will again be considered to determine their impact on counselors' COVID-19 stress. COVID-19 literature has also found commonalities in coping responses, such as keeping routines, social and emotional support, as well as finding meaning or positive reframing of the stress. These coping strategies relate to wellness areas such as Coping Self, Social Self, and Essential Self from the Five Factor Wellness Inventory, which

will be utilized to understand the mediating or moderating effect of wellness on positive and negative consequences to COVID-19 stress.

Shared trauma research has begun only in the current century, popularizing around the time of the September 11 terrorist attacks. Understanding the difference of the traumatic experience of a mental health professional both experiencing their own primary stress due to a trauma but also secondary stress from working with their client's related trauma has been an important distinction and addition to the field. This shared trauma experience has resulted in consequences to mental health professionals such as trouble balancing work and personal life as well as an inability to process their own stress response while focusing on meeting the needs of their clients. Researchers have found protective factors against negative consequences of shared trauma to include strong boundaries, social support, resiliency, meaning making and practicing mind, body and spiritual wellness with suggestions to practice self-care, insight into readiness to counsel, self-awareness of primary trauma, mindfulness of countertransference, outside supervision and creative strategies (Bell & Robinson, 2013). The same research also mentioned a single positive consequence of shared trauma –increased empathy towards clients—but chose instead to focus on the harmful consequences and suggestions to combat these. Research is still needed to explore the positive consequences of the COVID-19 shared trauma experience, as well as on a larger scale, as most of previous research were qualitative in nature with a smaller sample size.

Wellness as a concept in healthcare has only popularized in the late nineteenth century, with a focus not only on the absence of illness but instead the strive for optimum health. Some research has suggested how wellness practices can be supportive, such as decreasing vicarious traumatization of counselors and increasing emotional regulation of clients. Specific areas of

wellness such as physical wellness has been related to positive outcomes such as avoiding burnout and job stress. Workplace settings of mental health practitioners, such as working for a private practice has related to higher wellness scores, and those who score higher on wellness also seem to have a better balance between work life and personal life. Overall, understanding how wellness practices mediate or moderate reactions to stressors such as shared trauma deserves further investigation.

Part of a counselor's job description is working with clients who have experienced trauma. This is partly why more research has been done to understand the impacts of vicarious trauma from the client to the counselor. However, the experience of shared trauma is much less understood and thus counselors are much less prepared for this experience. However, the COVID-19 pandemic has given an example of how widespread a communal disaster can become, and until now counselors have little guidance on how to move through stressful times such as these. Understanding what counselors can do to reap the most benefits out of a shared traumatic experience or avoid possible harmful consequences can better equip these professionals.

Research Questions

This study is primarily interested in the mediating and moderating effects of wellness on the positive and negative consequences of COVID-19 stress, including shared trauma, and other COVID-19 specific stressors such as working from home with children. The explanatory research questions this study seeks to answer are as follows:

Does increased COVID-19 related stress predict increased negative consequences?

Does increased COVID-19 related stress predict increased positive consequences?

Do wellness practices mediate the relationship between COVID-19 related stress and positive consequences?

Do greater wellness practices moderate the impact of COVID-19 related stress on negative consequences?

Rationale for the Study

Counselors provide mental health care to assist clients in having the resilience and resources they need to move through difficult times in life. However, being to point-person for a caseload of stress and trauma can lead to vicarious trauma or compassion fatigue (Acker, 2011; Adams, et al., 2010; Figley, 2002; Ray, et al., 2013). The stress a counselor feels can be further emphasized when the counselor is experiencing the same stress as a client (Baum, 2010). This study seeks to identify the predictors for both negative and positive consequences of stress when counselors lived through global and national stressors simultaneously with their clients. Implications from the study's results can hopefully suggest best practices for counselors in private practice to maintain wellness in times of shared trauma.

Theoretical Framework

The researcher provides counseling and views life through the lens of Solution Focused Theory. Inherent to the theory is the belief that individuals and systems possess the resources necessary to be well and meet their personal goals (de Shazer, 1982). Similarly, the researcher believes that counselors are capable of maintaining wellness even through difficult times. As with all clients of Solution Focused Therapy, it is important to identify effective and non-productive practices in order to continue what is working. While other counseling theories work deductively from existing theories to determine the cause of client's problems, the founders of Solution Focused theory studied hundreds of hours of therapy to observe what worked (De Jong

& Berg, 2002). As the founders of Solution Focused theory admit, this approach describes more about what is helpful rather than why it is helpful (De Jong & Berg, 2002), just as this research seeks to describe what has been helpful rather than explain why it has worked. As Solution Focused Counseling is collaborative in nature, it appreciates that clients hold their own solutions (de Shazer, 1982). Likewise, the researcher believes that counselors hold their own solution to wellness, it just needs to be identified. Thus, this research project sought to identify what was working well for counselors who were resilient through times of crisis. It is the hope of the researcher that these lessons can help to assist other counselors in their journey for wellness, even through the darkest times. In a time that feels completely uncontrollable, Solution Focused Theory can help people to find what they can control and again feel capable of change.

Methodology

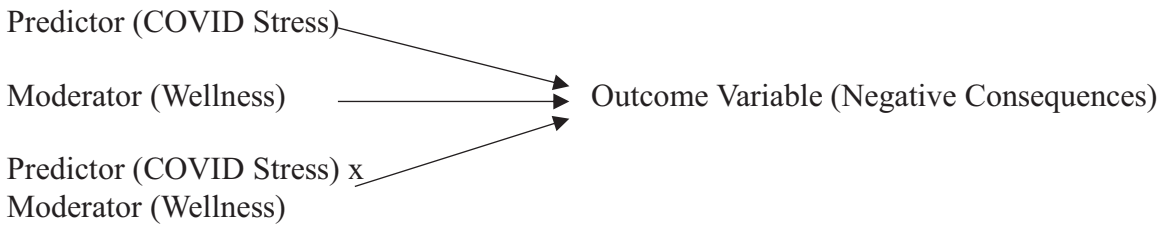
In this study descriptive and inferential statistical analyses such as frequencies, t-tests and correlations will assist in answering the research questions. Two more complicated statistical analyses will be utilized, a moderation analysis and a mediation analysis. A moderation analysis will be utilized to understand the moderating effect of wellness on the relationship between stress and negative outcomes such as burnout and secondary traumatic stress. In other words, this study will examine if wellness practices adjust the strength of the relationship between COVID-19 related stress and harmful outcomes such as burnout. A mediation analysis will be utilized to understand the mediating effect of wellness on the relationship between stress and positive consequences such as compassion satisfaction and post-traumatic growth. In this case, the study will test if wellness practices explain the positive consequences as a result of the COVID-19 related stress. More specifically, a Moderator or Mediator model (Baron & Kenny, 1986; Hayes, 2018) will be utilized for statistical methods. Though in the past “moderator” and “mediator” has

been used interchangeably, Baron and Kenny described the important differentiation of these terms.

Moderation tests whether the prediction of an outcome variable from a predictor variable differs across levels of a third variable (Fairchild & MacKinnon, 2009). The moderator model defines a moderator as a variable that affects the direction or strength of the relationship between an independent or predictor variable and the dependent or criterion variable (Baron & Kenny, 1986). While there may be main effects of predictor and moderator variables on outcome variables independently of one another, the moderator hypothesis is supported if the interaction between the moderator variable and predictor variable is significant. That is, the relationship between the predictor variable and criterion variable changes as a function of the moderator variable. Multiple regression analyses are utilized to compare how the relationship between the predictor and outcome variables change at differing levels of the moderator variable.

Figure 1

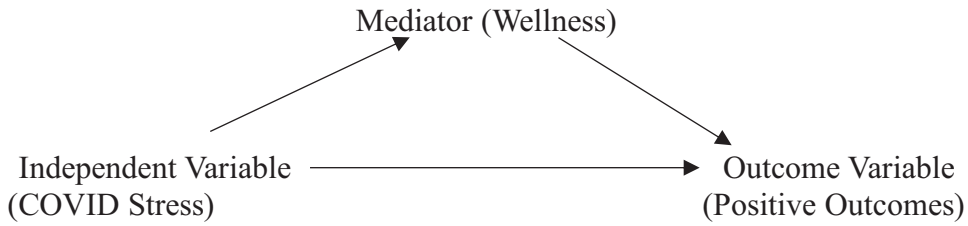
Moderation Analysis Relationship Pathways



Mediation explores if two variables are related by a third mediating variable (Fairchild & MacKinnon, 2009). The mediator model is described when considering if a mediating variable is significantly contributing to the relationship between predictor and outcome variables. This model assumes there are two causal paths towards the outcome variable: the impact of the independent variable and the impact of the mediator. There is also a path from the independent

variable to the mediator. The mediation model seeks to understand the direct and indirect effects of the independent variable on the dependent variable. The direct effect is considered to be the effect of the independent variable on the dependent variable when the mediator is removed, where the indirect effect considers the mediator. A variable is considered a mediator when: (a) variations in levels of the independent variable significantly account for variations in the presumed mediator, (b) variations in the mediator significantly account for variations in the dependent variable, and (c) when the prior two relationships are controlled, a previous significant relation between the independent and dependent variables is no longer significant, with the strongest demonstration of mediation occurring with this path is zero or significantly decreased. To test for mediation it is recommended that three regression equations are conducted: regressing the mediator on the independent variable; second, regressing the dependent variable on the independent variable; and third, regressing the dependent variable on both the independent variable and on the mediator. Separate coefficients for each equation is encouraged to be estimated and tested, with no need for hierarchical or stepwise regression. Successful mediators are caused by the independent variable and cause the dependent variable.

Figure 2



Limitations

Because this research was conducted during a global pandemic, the researcher determined that conducting an online self-report survey would be a safe and efficient methodology. However, self-report surveys come with risks of bias, and online surveying restricts participants to those who have access to the internet. As many mental health professionals along with the larger society moved towards online work, this limitation was hoped to be minimized. Though random sampling methods are intended to be utilized, it is possible that the population will be surveyed through convenience sampling, which while not as generalizable as random sampling was the average sampling method in related research. A final consideration is the timing of this research, as a larger portion of the United States and Texas population had been vaccinated against COVID and thus may have a sense of hope that the pandemic may be towards its' end.

Definitions of Terms

The research questions in this study explore grouped variables. The grouped variables, more specific terms and their definitions in the scope of this study are as follows:

COVID-19 related stress (CRS)

This grouped variable is defined as the resulting score of Shared Trauma as well as indications of COVID-19 related stress from the measure used in Park et al. (2020).

Shared Trauma (ST)

This term refers to the score from the technique-specific shared trauma subscale of the Shared Traumatic and Professional Posttraumatic Growth Inventory (STPPGI). This is meant to identify the extent to which a participant feels they experienced a shared trauma from COVID-19 with their clients.

Personal Trauma (PT)

This term refers to the score from the personal trauma subscale of the Shared Traumatic and Professional Posttraumatic Growth Inventory (STPPGI). This is meant to identify the extent to which a participant feels they experienced a personal trauma from COVID-19.

Burnout

This term refers to the score from the burnout subscale of the Professional Quality of Life Measure (ProQOL).

Secondary Traumatic Stress (STS)

This term refers to the score from the secondary traumatic stress subscale of the Professional Quality of Life Measure (ProQOL).

Positive consequences (PC)

The grouped variable of Positive Consequences is defined as the resulting scores of the subscales of Compassion Satisfaction (CS) and Post-Traumatic Growth (PTG) from their respective instruments.

Compassion Satisfaction (CS)

This term refers to the score from the compassion satisfaction subscale of the Professional Quality of Life Measure (ProQOL).

Posttraumatic Growth (PTG)

This term refers to the score from the professional posttraumatic growth subscale of the Shared Traumatic and Professional Posttraumatic Growth Inventory (STPPGI).

Wellness practices (WP)

Each of the below factors represent different areas of wellness on the inventory.

Creative Self This term refers to the score from the Creative Self second-order factor in the Five Factor Wellness Inventory (FFWEL), which explores the subscales of Thinking, Emotions, Control, Work, and Positive Humor. Myers and Sweeney (2004) defined the Creative Self factor as the combination of attributes that each person forms to create a unique place in their social interactions and to positively interpret their world. The Thinking subscale was defined as being mentally active or open-minded, Emotions subscale defined as being in touch with one's feelings, Control subscale defined as beliefs about competence, confidence and mastery, Work subscale defined as being satisfied with one's work, and Positive Humor subscale defined as being able to laugh at one's own mistakes or events.

Coping Self This term refers to the score from the Coping Self second-order factor in the Five Factor Wellness Inventory (FFWEL), which explores the subscales of Leisure, Stress Management, Self Worth and Realistic Beliefs. Myers and Sweeney (2004) defined the Coping Self factor as the combination of factors that regulate our responses to life events and help transcend their negative effects. The Leisure subscale was defined as satisfaction in free time activities, Stress Management subscale defined as general perception of self-regulation, Self Worth subscale defined as accepting one's own qualities, and Realistic Beliefs subscale defined as understanding perfection is impossible.

Social Self This term refers to the score from the Social Self second-order factor in the Five Factor Wellness Inventory (FFWEL), which explores the subscales of Friendship and Love. Myers and Sweeney (2004) defined the Social Self factor as social support through connections with friends, family and intimate relationships. The Friendship subscale was defined as social relationships that involve connections with others who do not have marital, sexual or familial

commitment that can be trusted and provide support. The Love subscale was defined as the ability to be intimate, trusting and self-disclosing with another person.

Essential Self This term refers to the score from the Essential Self second-order factor in the Five Factor Wellness Inventory (FFWEL), which explores the subscales of Spirituality, Gender Identity, Cultural Identity and Self-Care. Myers and Sweeney (2004) defined the Essential Self factor as a person's essential meaning-making processes in relation to others, self and life. The Spirituality subscale was defined as personal beliefs and behaviors practiced as recognition of being more than material aspects of mind and body, Gender Identity subscale defined as satisfaction with one's gender, Cultural Identity subscale defined as satisfaction with one's cultural identity, and Self-Care subscale defined as taking responsibility for wellness through preventative self-care habits.

Physical Self This term refers to the score from the Physical Self second-order factor in the Five Factor Wellness Inventory (FFWEL), which explores the subscales of Exercise and Nutrition. Myers and Sweeney (2004) defined the Physical Self factor as the biological and physiological aspects of development and functioning. The Exercise subscale was defined as engaging in physical activity to keep in good physical condition, while the Nutrition subscale defined as eating a nutritionally balanced diet.

Contextual Wellness This term refers to the four context scores from the Five Factor Wellness Inventory (FFWEL), including Local Context, Institutional Context, Global Context and Chronometrical Context. Local Context is defined as the perceived safety in systems such as families, neighborhoods and communities. Institutional Context is defined as social and political systems that affect daily functioning. Global Context is defined as factors that connect us to others around the world such as politics, culture and global events. Chronometrical Context is

defined as growth, movement and change in the time dimension that is perpetual, of necessity, positive and purposeful.

Life Satisfaction Index This term refers to the validity index Myers and Sweeney (2004) define as the extent to which one is satisfied with one's life, overall.

Overall Wellness This term refers to the sum of all items on the FFWEL, and is described as a measure of one's general wellbeing or total wellness.

Chapter 2

Literature Review

The Coronavirus 2019 (COVID-19) created a shared stressful experience around the globe. This shared trauma extended to counselors and their clients. Research on past shared trauma experiences such as the September 11 attacks or Hurricane Katrina have begun to explore their effects on mental health providers trying to process their own response in addition to their clients'. Research on responses to trauma have typically been focused on harmful or negative consequences, with less focus on positive consequences such as compassion satisfaction or post-traumatic growth. The counseling field is separated from other mental health professions by its primary focus on strengths and wellness. Some literature has explored how wellness negatively relates to harmful consequences such as burnout, though more research is required on how wellness predicts helpful consequences.

COVID-19 Pandemic

In March 2020, The World Health Organization declared the Coronavirus 2019 (COVID-19) a global pandemic. In April 2021, the United States had lost more than 550,000 lives to COVID-19, and more than 30 million cases have been diagnosed (Centers for Disease Control and Prevention, 2021). The Centers for Disease Control (2021) acknowledged that feeling stress during the COVID-19 pandemic is natural, and recognized that healthcare measures such as social distancing may increase isolation, loneliness and stress. Parents of young children have had to manage concern for the future as well as balancing work and childcare from home, leading to higher stress levels (Sahithya, et al., 2020).

Past worldwide pandemics have also caused significant consequences. During the last global pandemic, the Spanish Flu of 1918, the United States saw an increase in suicides

(Wasserman, 1992). Beyond a high mortality rate, many who lost their lives to the influenza pandemic were between the ages of twenty and forty, leaving many widows and parentless children, compounding economic stress (Mamelund, 2017). The physical and mental health consequences of pandemics of this magnitude are clear.

Some research has already been conducted regarding the stress impact of the COVID pandemic. A longitudinal cohort study in Switzerland followed up on participants who were 20 years of age in 2018 and 22 in their fourth and fifth weeks of lockdown to compare stress and health measures (Shanahan, et al., 2020). The authors found an overall increase in stress and anger, with a predictor for emotional distress during COVID-19 being emotional distress in the previous study, as well as lifestyle and economic disruption and hopelessness. Similar to other literature, the results of this study suggested females were more likely to experience distress both prior to and during COVID-19. Finally, keeping a daily routine, engaging in physical activity and positive reframing were associated with lower distress. In Italy, where some of the strictest and quickest lockdown measures were taken in wake of COVID-19, 595 healthcare workers were surveyed regarding their stress, coping and demographics (Babore, et al., 2020). The authors found that females, those without children, those who worked in the frontline, and those who utilized avoidance and social support as coping strategies were more likely to be more stressed, and having a positive attitude was the strongest protective factor against distress. In April 2020, 317 participants in Poland were recruited to understand how different constructs related to stress levels, finding through mediation analyses that basic hope supports meaning in life and life satisfaction, which both work together to lower anxiety and COVID-19 stress (Trzebinski, et al., 2020). A systematic review of 19 cross-sectional studies and 93,569 participants on psychological wellbeing during the COVID-19 pandemic found that participants from eight

countries showed relatively high rates of anxiety, depression, PTSD, psychological distress and stress in the general populations, with risk factors including the female gender, younger age (less than or equal to 40), presence of chronic or psychiatric illnesses, unemployment, student status and frequent exposure to media regarding COVID-19 (Xiong, et al., 2020).

One of the first studies capturing the CDC guideline adherence, stress and coping response in an American population due to the COVID-19 pandemic was done by Park, Russell, Fendrich, Finkelstein-Fox, Hutchison and Becker (2020). Utilizing an online survey method surveying Amazon MTurk workers, 1015 participants' responses were included in the analysis with a sample of 53.9% (n = 547) women and 82.4% (n = 836) White participants with an average age of 38.9 years (SD = 13.5, range = 18-88). Participants reported most commonly utilizing distraction, active coping, and emotional social support as coping strategies. The results of the study included indications that the most commonly experienced stressors were reading or hearing about the severity and contagiousness of COVID-19 (96.6%), uncertainty about how long public safety measures such as quarantining and social distancing would go on (88.3%), changes in social routines (83.7%) and daily personal care routines (80.1%). The stressors endorsed as most stressful (with 1 indicating "not at all stressful" and 5 indicating "extremely stressful") were loss of job security or income (M = 4.09, SD = 0.96) and risk of a loved one's illness (M = 3.65, SD = 1.01). Overall, women rated experiences significantly more stressful than men in stressors such as: infection-related risk, change to daily activities, and resource insecurity. Caregivers, defined as a primary caregiver for a dependent, also reported higher stress in infection-related risk. The majority of participants reported adhering to CDC guidelines such as avoiding going out to eat and visiting nursing homes, social distancing and practicing healthy hygiene, though women, older adults and those with financial security were more likely.

Shared Trauma

Shared trauma has been defined as having the following four criteria: (1) a disaster occurred that has the ability to cause collective trauma, (2), the disaster is recent, (3), the client and counselor are both in the community affected, and (4) counselors are exposed to the trauma through primary, secondary and vicarious means through their roles as a counselor and community member (Baum, 2010). In the case of the COVID-19 virus, literature continues to demonstrate the stressful impact of the global pandemic. As the virus was first named in 2019 and became widespread in the entire world in 2020, it meets the recent requirement as well as the affected membership requirement. This study seeks to better understand the primary, secondary and vicarious exposures to possible COVID-19 related trauma.

The DSM 5 defines trauma as exposure to actual or threatened death or serious injury, experienced in one of four ways: (1) directly to oneself, (2) witnessed, (3) learning of its occurrence to family or friends, or (4) via repeated exposure to details of traumatic events. Texas has a population of about 29 million people (U.S. Census Bureau, 2019). As of April 2021, in Texas, there have been about 2.84 million cases of COVID-19 and 49,605 deaths (The New York Times, 2021). This roughly averages to about 1 in 10 Texans who have been diagnosed with COVID-19 personally, not accounting for those who were never tested. As the majority of Texans have probably known someone, if not themselves, who have had COVID-19, there has been exposure to actual or threatened death or serious injury. Those who are struggling with trauma seek mental health care, leaving mental healthcare workers repeatedly exposed to and witnessing trauma. Beyond counselors' work with clients, they may also be exposed to the reactions of their friends and family. News coverage in the United States of COVID has focused on risk, and frequent exposure to COVID-19 news was found to be positively associated with

depressive symptoms (Olagoke, et al., 2020). This relationship between news exposure and depressive symptoms was found to also be mediated by perceived vulnerability (Olagoke, et al., 2020).

Shared trauma, also referred to as collective trauma, describes occurrences when the counselor and client are simultaneously exposed to the same communal disaster (Baum, 2010). In contrast, previous literature has referred to terms such as vicarious trauma or secondary trauma as the experience of those indirectly exposed to trauma, such as a counselor being exposed to their client's trauma in session (McCann & Pearlman, 1990). The term *shared trauma* became popular following the September 11 terrorist attacks as well as utilized after Hurricane Katrina and the Virginia Tech shootings (Day, et al., 2017). These events called for moving beyond secondary trauma, or clinician's experience of listening to their clients' experience of trauma, into the combination of secondary and primary trauma. What separates shared trauma from experiences such as those where a counselor has a history with a similar trauma to a client is the simultaneous nature of experience of the same traumatic situation. For example, a counselor who has a history with domestic violence treating a client who also experienced domestic violence would not be an example of shared trauma, as those traumas were not simultaneous and from the same event.

The COVID-19 Pandemic and Emotional Well-Being Study was utilized to examine the mental health impact of COVID-19 on first responders, essential workers and the public. Within this, a study was done measuring how the COVID-19 pandemic has impacted social workers' mental health, focusing on PTSD, grief, burnout and secondary trauma (Holmes, et al., 2021). Results suggested the sample of social workers exhibited PTSD prevalence five times higher than national estimates, and seven times higher than social workers who self-reported PTSD in

2015, though comparably to the whole sample of participants from the overarching study, suggesting a collective trauma experience. More than 99% of the sample reported average to high compassion satisfaction, 63.71% reported average burnout and 49.59% reported average secondary trauma. Researchers solicited participation through social media and email listservs, sampling a total of 181 people from 27 states who identified as employed in the social work field with a bachelor or master's level education. Participants were asked to complete demographic questions including questions about COVID experience, PTSD checklist (PCL-5), grief measure (Adult Attitude to Grief Scale), measure on compassion satisfaction and fatigue (ProQOL) as well as a developed scale to address organizational support (Indirect Trauma Organizational Capacity Index). This study will be utilized as a comparison to the current study's counselor sample in regards to the ProQOL and PCL-5 responses, though it does not consider positive outcomes such as wellness.

Bell and Robinson (2013) reviewed the literature on the concept of shared trauma in comparison to secondary or vicarious trauma. The authors made recommendations that practitioners can do prior to and after a community trauma, as well as identified warning signs of shared trauma. Protective factors included: strong emotional boundaries, social support, ability to reframe, resiliency, establishing a professional network, meaning-making and practicing mind, body and spiritual wellness. Early warning signs of shared trauma included: distancing from social situations, becoming avoidant of client's trauma material, not being present during counseling, devaluing work, emotional or physical exhaustion, decreased empathy, and anger towards clients. Suggested self-care strategies included: positive self-care through all four realms, self-awareness and treatment of primary trauma, mindfulness of countertransference, seeking out client resilience, outside supervision, creative strategies and posttraumatic growth.

Day, Lawson and Burge (2015) completed a qualitative study that interviewed eight people who provided clinical or supervisory services after the Virginia Tech shooting. Positive and negative impacts were explored, including a changed perspective on those who experienced the shared trauma and work impact. Clinicians discussed avoiding watching coverage on the news, putting their own processing on hold in order to be available for their clients, and having a difficult time separating work from personal life. In respects to growth, clinicians discussed feeling more trauma-aware, an increase in workplace support as well as an increase in self-care to cope with increased work demands. The authors recommended clinicians to practice self-care, remain insightful on ability to work, seek support, supervision and personal counseling, and to discuss the concept of shared trauma in training or school. Though this study had a limited sample size, the implications are in alignment with other similar studies. The scope of this shared trauma was more isolated to a specific community, making the draws to the global experience of COVID-19 more difficult.

Bauwens and Tosone (2010) sent surveys by mail to social workers in New York approximately 6 years post-9/11, with a total of 481 reviewable responses but only 201 who provided the open-ended response to "add any additional comments you choose related to your personal and professional September 11 experiences". The qualitative study's results support similar findings that shared trauma results in both positive and negative changes, growth and pain both personally and professionally. They also found that clinicians who were better able to relate to their clients were more satisfied with work and experienced more growth, similar to related research (Linley & Joseph, 2007; Tosone 2006; as cited in Bauwens & Tosone, 2010). The largest limitation to this study is the gap of six years time between shared trauma and reflection on experience, leaving room for rumination effects.

Another qualitative study of the impacts of 9/11 on mental health clinicians with only indirect exposure who had engaged in 9/11 related work with clients (Pulido, 2012). Utilizing an availability sample, 26 clinicians were interviewed. Themes included clinicians feeling new to disaster work, being challenged by the cumulative effect of repeatedly listening to similar stories, painful emotional impacts, and the impacts of clinical support and supervision. Overall, clinicians in this sample experienced significant secondary traumatic stress reactions despite only having an indirect shared trauma. Again, this study was completed two years post-9/11, and as the author pointed out other crises such as the NYC black-out and the Iraq war also occurred by the time of the interviews.

Dekel, Nuttman-Shwartz and Lavi (2016) analyzed three focus groups of 30 mental health professionals who worked with clients in southern Israel experiencing many missile strikes. Content analysis was utilized through a boundary theory lens, with a central theme of the conflict between professional and personal boundaries and the resulted segmentation of the clinician's lives. Participants shared experiences of feeling the need to choose between protecting their family or assisting their clients, and segmenting or focusing on just one world or the other. The authors likened this response to dissociation, while other participants were able to integrate and described bringing their humanness to their clinical work. This study was completed in a completely different culture and language, with a more apparent dangerous crisis than the COVID-19 pandemic, limiting the implications to the current study.

Negative Consequences of Trauma

Experiences such as burnout and secondary traumatic stress are well-known in the mental health profession as possible consequences to the demanding nature of the work. Part of the demand of working as a mental health professional includes being repeatedly exposed to others'

trauma experiences. Though these are just two possible consequences of exposure to trauma, they also foreshadow other consequences such as declines in physical health, leisure time and job performance.

In the 1970s, researchers Maslach and Freudenberger began to recognize the impact of burnout on those in the helping career field due to the emotionally exhausting nature of their work (Pines & Maslach, 1978). Burnout was later defined as a syndrome of emotional exhaustion, depersonalization and a reduced sense of personal accomplishment in response to chronic job-related stress (Maslach & Jackson, 1986). The three dimensions of burnout were found to often follow one another, beginning with the physical and emotional exhaustion response to job-stress, moving to the cynicism or detached response to the job, and finally an inefficacy response related to a feeling of incompetence and lack of achievement at work (Maslach & Leiter, 2017). Though research began with understanding the experience of the individuals, such as their symptoms or relationships, it later shifted to understanding the job context in fields beyond the social services (Maslach, et al., 2001). With further research, burnout was found not to be a problem of individuals but instead of the work environment (Maslach & Leiter, 2017).

Studies were conducted to better understand the discriminate validity of burnout and related concepts such as depression, finding burnout to be an experience specific to the workplace and depression a more pervasive condition (Bakker et al., 2000, Glass & McKnight 1996, Leiter & Durup 1994 as cited in Maslach, et al., 2001). Burnout has been associated with declines in physical health, job performance, and morale and increases in turnover and mental illness (Maslach & Leiter, 2017). Through the years, there has also come the conclusion that relationships within the workplace, such as between a person and their clients, coworkers or

supervisors also has an important relationship to burnout. (Maslach & Leiter, 2017). However, Maslach and Leiter (2017) discuss consequences to the psychological individualistic approach to understanding burnout, including a sense that burnout is a failure of an individual rather than a workplace. In other words, the approach to burnout until recently has been focused on the symptoms of the experience, such as individuals' reactions, rather than the root of the issue, the system the individuals work in.

Counselors may be at a heightened risk for burnout due to their personalities, demanding caseloads and experience with trauma. It has been argued that qualities foundational to counselors, such as empathy and compassion, leave counselors vulnerable to burnout (Lawson, et al., 2007; Pines & Maslach, 1978; Thompson, et al., 2014). Again, this is coming from the perspective of what makes a person more likely to experience burnout rather than what makes an environment more likely to produce burnout. The trauma-engulfed field of counseling undeniably has emotional stress that comes with the job territory. Morse, et al. (2012) found that between 21 and 67% of mental health professionals may experience high levels of burnout. Similarly, mental health professionals are likely to experience compassion fatigue due to working frequently with others' trauma (Acker, 2011; Adams, et al., 2010; Figley, 2002; Ray, et al., 2013). In a study of mental health providers at the VA, providers who felt they had too much clinical work to complete were more likely to experience burnout (Garcia, et al., 2014). Similarly, one who is too busy with their work may have less time for avocation. One group of researchers found that the Deterioration in Personal Life burnout sub scale was negatively related to the Leisure, Stress Management, and Self-Worth domains in the Coping Self wellness subscale, supporting the idea that when a counselor's personal life is struggling, so may their leisure time, stress levels and self-worth (Puig, et al., 2012).

Secondary Traumatic Stress (STS) has been defined as the natural consequences of behaviors and emotions resulting from knowing about a significant others' traumatizing event (Figley, 1995). Similar to burnout, it has been studied as a helper's stress response to working with a client. Although burnout and STS can promote similar behavioral responses, STS more similarly resembles post-traumatic stress disorder (Figley, 1995). While burnout is a consequence of occupational stress, STS is an emotional response to traumatic stress (Alkema, et al., 2008 as cited in Hotchkiss & Lesher, 2018).

Hotchkiss and Lesher (2018) surveyed 534 chaplains utilizing the Mindful Self-Care Scale (MSCS) and the Professional Quality of Life (ProQOL) scale to understand the relationship between self-care practices and the professional quality of life of chaplains, recognizing their work in helping people navigate emotional distress such as grief, anxiety, depression and loneliness. Secondary traumatic stress was found to increase burnout risk, and was most strongly protected against by mindful self-awareness, self-compassion and purpose, and supportive structure (e.g. professional boundaries, manageable work hours and being able to say "no" to inappropriate requests). The results of this survey indicated that the strongest protective factors against burnout were self-compassion and purpose, supportive structure, mindful self-awareness, mindful relaxation, supportive relationships and physical care. Place of work somewhat predicted risk of burnout, with those working in a hospital being slightly more at risk.

Manning-Jones, de Terte and Stephens (2016) surveyed 365 New Zealand healthcare professionals likely to treat traumatized individuals in order to better understand predictors of secondary traumatic stress (STS), vicarious post traumatic growth (VPTG), and how each career field compared. The researchers found STS to be negatively related to self-care and social

support from family and friends and found humor, self-care and peer support to be positively related to VPTG. Counselors were found more likely to practice self-care than doctors, nurses and social workers. This study utilized the following relevant measures: The Secondary Traumatic Stress Scale (STSS), The Posttraumatic Growth Inventory (PTGI), The Social Support Scale (SSS), The Self-Care Utilization Questionnaire (SCUQ). This study did not, however, measure any differences in workplace settings, which has consistently shown a relationship to variables such as STS, burnout, compassion satisfaction and wellness.

Overall, although burnout and secondary traumatic stress (STS) can predict harmful consequences, they can also tell a story of what helps predict healthier responses to stress. Self-care and support from others appear to relate to better outcomes such as post-traumatic growth and less burnout and STS. These variables begin to explore possible positive outcomes of experiencing either first or second-hand trauma.

Positive Consequences of Trauma

Although much reporting has justly focused on understanding the harmful impacts of trauma experience on counselors, understanding any positive consequences is also important. Helping counselors see benefit in their demanding mental health treatment work may also contribute to job satisfaction. As stated in aforementioned shared trauma studies, positive consequences such as feeling more trauma-aware, greater job satisfaction, greater empathy towards clients, an increase in workplace support as well as an increase in self-care to cope with increased work demands (Bauwens & Tosone, 2010; Day et al., 2015) have resulted from shared trauma or vicarious posttraumatic growth from secondary trauma (Manning-Jones, et al., 2016). Overall, compassion satisfaction and posttraumatic growth continue to appear as positive consequences of shared or secondary trauma experiences.

Bauwens and Tosone (2010) surveyed clinicians in Manhattan regarding the shared traumatic experience of the September 11 terrorist attacks by sending mailed surveys to a research agency's list of National Association for Social Workers (NASW) members. Though they sent over 1200 surveys, there was a response rate of 39% and 26 responses were excluded to to the participants being retired social workers. A total of 481 surveys were received but only 201 clinicians were included in this study as they were the only ones to answer the open-ended questions included. This cross-sectional research study utilized the Post 9/11/01 Quality of Professional Practice Survey (PQPPS) to capture professional demographics and professional experiences after September 11. Two open-ended questions were also included, and the one question this study was focused on requested participants to "add any additional comments you choose related to your personal and professional September 11 experiences." Content analysis was utilized on the open-ended question responses, finding the following themes: collective and personal vulnerability, past traumas, trauma responses, blurred roles, professional and clinical growth, and professional pain. Though many themes focused on negative consequences of the shared experience, some found positive consequences such as enhanced self-care, acquiring new skills, positive changes in the therapeutic relationship, political activism, preparation for future traumas and increased connectedness with clients.

Laumbert and Lawson (2013) surveyed professional counselors who provided services to those affected by Hurricane Katrina and Rita. The sample, solicited from an announcement to American Counseling Association members, consisted of counselors who were simply volunteers and others who also were impacted by the hurricanes themselves. Participants were asked to complete a self-care assessment, demographic questions and three measures: K6+ screening for severe mental illness, the Posttraumatic Growth Inventory, and the Professional Quality of Life

Scale (ProQOL). The resulting data indicated a modest positive relationship between practicing self-care and post-traumatic growth, and a modest negative relationship with burnout, compassion fatigue and vicarious traumatization. Contrary to the researchers' hypothesis, the counselors who survived the hurricanes themselves had higher levels of posttraumatic growth than those who were volunteers. Although this research study does not mention the concept of shared trauma, the results support the notion that those who experience shared trauma may have more positive consequences than those who experience secondary trauma.

A qualitative study of nine female Irish therapists conducted an unstructured interview regarding their specialist work in childhood sexual abuse. Both interviewers had personal experience with counseling children who had been affected by sexual abuse, and one of those interviewers had worked with the participants in the past. This study utilized purposive and convenience sampling with a sample that was entirely female, ranged in age from 36 to 65 years, and ranged in length of time employed in the organization from 1 to 20 years. An inductive thematic analysis was utilized to identify four themes: the struggle to talk about the positive impact, professional satisfaction from helping children, learning life lessons from children, and the magical connection that happens in therapy. The interviewers noticed that each participant struggled to focus on the positive aspects of their work, some spoke to it only after probing, and half of the therapists acknowledged the novelty of focusing on the positive impacts. Eight of the therapists described either loving their work or feeling satisfied by the positive effect of therapy on their clients. Every one of the therapists described learning lessons from their clients, including positive impacts on their philosophy of life or personality, or learning how to deal with adverse circumstances. Finally, seven of the nine therapists described cherishing the relationship between therapist and client, including recognizing the magic or joy in working with children.

Though this study was not focused on shared trauma, it does point to the lack of research and implications of positive consequences of trauma.

Wellness

The concept of wellness is foundational to the counseling field. In 1989, once the American Association for Counseling and Development (AACD) but now the American Counseling Association (ACA) adopted the resolution entitled *The Counseling Profession as Adovicates for Optimum Health and Wellness*, clearly subscribing to and advocating for wellness in society (Myers & Sweeney, 2008). Though the concept of wellness can be traced as far as Aristotle, the concept of thinking holistically about health did not emerge in the medical field until the end of the 20th century (Myers & Sweeney, 2008). In 1958, the World Health Organization (WHO) adopted the definition of health to include "a state of complete physical, mental, and social well-being and not merely the absence of disease" (p. 1). It was not until the early 1990s that a wellness model based in counseling was created (Myers & Sweeney, 2008) which eventually went on to inform the Five Factor Wellness (FFWEL) inventory.

Wellness has been defined as the "optimum state of health and well-being that each individual is capable of achieving" (Myers, et al., 2000, p. 252). Of health practitioners, counselors are unique in that they strive to value wellness for both the client and professional (Venart, et al., 2007). Though, this shift towards focus on counselor wellness has been a recent one. In their literature review in 2008, Myers & Sweeney found only eight studies measuring wellness in professional counselors, counselors-in training, and counselor educators with the Five Factor Wellness Inventory. Though, research in counselor wellness has since become more popular. The Council for Accreditation of Counseling and Related Educational Programs (CACREP) 2016 standards calls for the notion of wellness to permeate throughout the education

of a counselor. The American Counseling Association's code of ethics (2014) also calls for counselors to attend to their wellness by monitoring for signs of impairment. The American Counseling Association created a task-force to assist in addressing issues of wellness among counselors, eventually advocating for educational programs, treatment options and efforts to decrease the stigma in counseling-for-counselors (Baggs et al., 2012).

Researchers have utilized the FFWEL to understand wellness in the general population and professional counselors, and the measure continues to be supported as evidenced-based and psychometrically sound (Myers & Sweeney, 2008; Shannonhouse, et al., 2020) and is the gold-standard in wellness research. In a cross-sectional study of 179 participants from alcohol and drug treatment sites in the southeastern United States, total wellness was found to have a significant negative correlation to emotional regulation, supporting previous research findings (Clarke, et al., 2020). A survey of 68 professional counselors addressed the relationship between wellness and vicarious traumatization, finding that counselors with higher levels of wellness who had exposure to client trauma exhibited a significantly lower level of vicarious traumatization (Foreman, 2018).

Though many researchers have explored contributors to harmful consequences of stress, other studies have focused on positive consequences of wellness practices. Lawson (2007) found counselors who had a higher level of wellness endorsed a balance between personal and professional life and a sense of control over work responsibilities. As burnout is often associated with the work environment (Maslach, 2003), counselors who have described a greater satisfaction with work have been found to be less likely to experience burnout (Lent & Schwartz, 2012; Thompson, et al., 2014). Relatedly, counselors who reported greater compassion satisfaction and higher mindfulness attitudes reported less burnout (Thompson, et al., 2014).

Previous research has suggested that mental health practitioners in private practice are more likely to score higher on wellness (Rupert & Kent, 2007) and less likely to experience burnout (Dupree & Day, 1995; Lent & Schwartz, 2012; Van Morkhoven, 1998; Vredenburgh, et al., 1999) than their peers in other work environments. Furthermore, while some research findings suggest that counselors are less likely than psychologists to endorse utilizing clinical supervision or peer support (Lawson, 2007), others have found that relying on supervisors and coworkers have helped to prevent burnout (Ducharme, et al., 2008; Maslach, et al., 2001; Woo, et al., 2018).

Mental health professionals' increased physical health has been related to lower levels of job stress (Hamberger & Stone, 1983; Leighton & Roye, 1984; Lowenstein, 1991; MacBride, 1983; Meir, et al., 1990; Patrick, 1984; Ross, 993; as cited in Puig et al., 2012). More specifically, job burnout was found to negatively relate to mental health professionals' exercise and nutrition, though directional causality could not be determined allowing the possibility that those who maintained healthy exercise and nutrition may be less likely to experience burnout (Puig, et al., 2012). Thus, one of the most common recommendations to avoid burnout is focusing on physical health by improving nutrition and exercise (Maslach & Leiter, 2017).

While the literature on wellness is often intertwined with prevention of more negative outcomes of stress, there are still suggestions about how wellness practices can be helpful, such as decreasing vicarious traumatization and increasing emotional regulation. Commonly, practicing physical wellness is suggested to have positive outcomes such as avoiding burnout and job stress. Workplace setting, such as working for a private practice has oftentimes predicted higher wellness scores, and those who score higher on wellness also seem to have a better

balance between work life and personal life. Overall, understanding how wellness practices mediate or moderate reactions to stressors such as shared trauma deserves further investigation.

Chapter 3

Methods

As the COVID-19 global pandemic has been a novel experience for the entire world, it's consequences are yet to be fully understood. Within the mental health field, the shared traumatic experience of COVID-19 as a shared trauma simultaneously experienced by both the counselor and client requires further understanding. Furthermore, understanding how wellness plays a part in counselors experiencing helpful and hurtful consequences of this stress will help provide suggestions for counselors as they continue to manage this shared stress.

Research Design

The purpose of this study is to understand how variables such as stress related to COVID-19, wellness, and positive (compassion satisfaction, posttraumatic growth) and negative consequences (burnout, secondary traumatic stress) are related. This research is a cross-sectional, non-experimental design that seeks to understand the relationship between variables. Explanatory in nature, this research hopes to explain the relationship between stress and positive and negative consequences such as post-traumatic growth and burnout. Frequency data can also help from an exploratory perspective in describing the novel Coronavirus experience in Texas counselors, as no research has yet to do. A constructivist paradigm underlies this research as the variables have been socially constructed and interpreted.

Participants

Participants will be solicited utilizing the contact information provided from Texas' Behavioral Health Executive Council (BHEC) and the Licensed Professional Counselors board. Ideally, random sampling will be utilized to support greater generalizability. Because the contact list provided by BHEC contains a multitude of contact information that does not include emails,

the researcher will mail links to an online survey. Online recruitments such as social media and listservs may be utilized as an alternative convenience sampling method in line with similar studies sampling methods. Inclusion criteria includes current Professional Counselor licensure in the state of Texas and practice of counseling during the COVID-19 pandemic. The only exclusion criteria is a mailing address that is outside of Texas, seeking to limit participants to those who live in and practice in Texas.

Measuring Instruments

This study is primarily interested in COVID-19 related stressors, positive and negative consequences of said stressors, and wellness. COVID-19 related stressors include the experience of COVID-19 related shared trauma and stress response scores to a COVID-19 experience measure based on Park et al. (2020). Positive consequences include compassion satisfaction and post-traumatic growth. Negative consequences include burnout and secondary traumatic stress. These variables will be measured utilizing the scores resulting from the following instruments.

Five Factor Wellness Inventory (FFWEL)

This instrument is a 91 item, 4 point Likert scale rating measurement with an average completion time of 20-25 minutes. A preferred measure of wellness among wellness researchers is the Five Factor Wellness Inventory (FFWEL), which measures overall wellness and five second order factors as well as seventeen subscales. This measure has continued to be considered psychometrically sound with internal consistency and construct validity (Shannonhouse, et al., 2020). The factors (and subscales) measured are as follows: Creative Self (Thinking, Emotions, Control, Work, Positive Humor), Coping Self (Leisure, Stress Management, Self Worth, Realistic Beliefs), Social Self (Friendship, Love), Essential Self (Spirituality, Gender Identity, Cultural Identity, Self-Care), and Physical Self (Exercise, Nutrition). The FFWEL also includes

two scales to acknowledge context and overall life satisfaction: Contextual Variables (Local Context, Institutional Context, Global Context, Chronometrical Context) and Life Satisfaction Index. The researcher chose this measure in part due to it's wide-acceptance as a scale that produces valid results, but also as it considers variables that previous literature has linked to burnout, shared trauma and post-traumatic growth as well as the contextual variables such as the COVID-19 pandemic. Overall wellness, measured by the total score from the instrument, will be primarily utilized in data analyses. Subscale scores will be utilized for post-hoc analyses to further understand impacts of specific wellness practices.

Professional Quality of Life Measure (ProQOL)

The ProQOL was chosen as it is a less-demanding 30-item scale that captures relevant concepts such as compassion satisfaction, burnout as well as secondary traumatic stress. The compassion satisfaction subscale will be utilized as a positive consequence measure, and the burnout and secondary traumatic stress subscales will be utilized as negative consequence measures. In addition, the researcher would like to understand the of secondary traumatic stress (STS) and its relationship to shared trauma as captured in the STPPGI.

Shared Traumatic and Professional Posttraumatic Growth Inventory (STPPGI)

The STPPGI is a 14-item five point Likert-scale used to understand the shared trauma experience. In the past, shared trauma was measured utilizing PTSD symptom scales and the compassion fatigue/STS sub scales of the ProQOL. Tosone, Bauwens and Glassman (2014) created the Shared Traumatic and Professional Posttraumatic Growth Inventory (STPPGI) to measure the shared traumatic experience of social workers who along with their clients experienced Hurricane Katrina personally, finding evidence of internal and external validity when compared to similar measures. This instrument consists of three subscales: technique-

specific shared trauma, personal trauma, and professional posttraumatic growth. This study seeks to utilize the same scale but change language from “Hurricane Katrina” to “COVID-19 pandemic” (e.g. “My work with Hurricane Katrina-related clients facilitated my grieving about the event” to “My work with COVID-19 pandemic-related clients facilitated my grieving about the event”). Though this scale has limited generalizability, it was chosen as the best scale of growth from shared trauma. A frequently used scale of post traumatic growth, the Post-Traumatic Growth Inventory did not completely capture the experience of vicarious post-traumatic growth (Abel, et al., 2014) and thus is suspected not to accurately capture growth from shared trauma. As the STPPGI is designed specifically for shared trauma, it was chosen as the most appropriate scale. The professional posttraumatic growth subscale score will be utilized as a positive consequence variable. The other two subscales, technique-specific shared trauma and personal trauma will be considered COVID-19 related stress variables.

COVID-19 Related Stress

To understand how COVID-19 may have impacted the participants’ stress, questions such as if they have experienced risk of catching COVID-19 or transmitting illness to others. These questions will mirror the Park et. al (2020) questions utilized with American adults to recognize COVID-19 related stress. This measure asks participants to respond if they (yes or no) had experienced a multitude of COVID-19 related stressors. If participants selected “yes”, they are then asked to rate how stressful they found the experience on a scale of 1 (not at all stressful) to 5 (extremely stressful). In order to represent each participant, those who select “no” to the initial experience question will be coded as 0 on the following stress rating. The total score from the Park et al. measure will be calculated by totaling the stress ratings for each question. This variable will be labeled as [COVTOT] and was considered a stress variable.

Demographic Questions

For generalizability purposes, demographic questions such as sex, race or ethnicity and age will be requested. To understand variability of the sample, the participants will also be asked to identify their employment status as well as their workplace setting (e.g. agency or private practice).

Procedures

This study will be conducted via an internet survey consisting of a few instruments. Participants will be randomly selected from the entire roster of Licensed Professional Counselors in Texas and mailed a solicitation including a link and QR code to the online survey. Demographic questions, COVID-19 stress questions pulled from prior COVID-19 related research, and the chosen instruments (FFWEL, ProQOL, STPPGI) will then be listed on the online survey. Simultaneously, a non-random social media and email list-serv solicitaitons will be sent out in the case of a small response rate from the random sampling method.

Analysis

SPSS will be utilized to conduct analyses. Univariate analyses such as descriptive statistics will also be utilized to report data such as frequencies of STS and shared trauma. Inferential statistics will be utilized for research questions regarding relationships, including correlations and t-tests. In addition, a Moderator and Mediator model (Baron & Kenny, 1986; Hayes, 2018) will be utilized for the last two research questions. Both a moderator analysis and mediator analysis will be utilized where appropriate. While moderator variables are usually seen where there is a weak relationship between predictor and criterion variables, mediators are best done when there is a strong relationship between the two.

COVID-19 stress referred to two variables: the total score on the STPPGI measure as well as a total score derived from the COVID-19 related measure from Park et al. (2020). The total score from the Park et al. measure will be calculated by totaling the stress ratings for each question and labeled as [COVTOT]. Principal components analysis will be used to identify and compute a composite score that summarized [COVTOT] and STPPGI total score. This component variable will then be labeled as [COVSTRESS] and utilized for the mediation and moderation analyses.

In the case of the variables in this research study, literature has suggested a strong relationship between stress and negative consequences such as burnout and secondary traumatic stress (Acker, 2011; Ducharme, et. al, 2008; Dupree et. al, 2005; Garcia, et. al, 2015), recommending a moderator model of analysis. Moderator variables help explain a relationship, and the independent variable predicts both the moderator and outcome variable. The following conditions will need to be met in order to support moderation: stress significantly influences the negative consequences as well as wellness practices, and wellness practices significantly influence negative consequences. Moderation will be assumed if there is a significant relationship between the interaction of stress and wellness on negative consequences such as burnout and secondary traumatic stress. Multiple regression analyses are utilized to compare how the relationship between the predictor and outcome variables change at differing levels of the moderator variable. The regression analysis of the interaction between the predictor and moderator variables on the outcome variable will determine moderation.

As the mediation model helps test if a relationship between a predictor and outcome variable is explained by a third variable, it is appropriate to utilize in the case of the positive consequences outcome variable. In other words, the mediation analysis will help understand if

positive consequences such as compassion satisfaction and post-traumatic growth are explained by wellness practices. In this case, stress is presumed to contribute to the positive consequences while wellness may better explain the relationship. The researcher hypothesizes that wellness practices may better explain the relationship between COVID-19 stress and the positive consequences of compassion satisfaction and post traumatic growth. Mediation will be assumed if the relationship between stress and positive consequences is zero or significantly smaller when wellness is controlled for. The mediation effect may reverse if the causal direction is flipped, in the case that positive consequences cause stress. The direction of causal relationship as stress causing positive consequences is such because common sense would suggest that positive consequences such as compassion satisfaction or post-traumatic growth would not cause a negative experience such as stress.

To test for mediation it is recommended that three regression equations are conducted: regressing the mediator (wellness) on the independent variable (stress); second, regressing the dependent variable (positive consequences) on the independent variable (stress); and third, regressing the dependent variable (positive consequences) on both the independent variable (stress) and on the mediator (wellness).The regression analyses of the indirect effect of both the predictor and mediator variables on the outcome variable will show if mediation has occurred.

Chapter 4

Results

Although research has shown the COVID-19 pandemic has affected mental health professionals, no research has examined how wellness factors can moderate or mediate the stress from the pandemic. Additionally, while previous research on stress has shown positive consequences such as post traumatic growth and compassion satisfaction, there has been no investigation into the positive consequences of COVID-19 related stress or its impact on professional counselors, specifically. This study utilized an online survey, composed of multiple measures of COVID-19 related stress, wellness, positive and negative outcomes as well as demographic questions, to answer questions about how the COVID-19 pandemic has impacted Texas counselors.

Drawing from the roster of Texas Licensed Professional Counselors obtained through the Texas LPC Board, 750 mailed postcard solicitations were sent to a random selection of licensees. In eight weeks, only 43 participants who responded to the survey were solicited by the mailed solicitations. As the research questions in this study benefitted by a prompter response due to the nature of the everchanging COVID-19 pandemic, a simultaneous non-randomized sampling method was also enacted. Online solicitations through social media and listservs, primarily through Texas LPC focused groups on Facebook were posted. There were 41 of the 43 mailed participants who completed the survey, and 118 of the 139 social media participants finished the entire survey, giving a total of 182 participants. Oftentimes the participants who dropped out discontinued their participation once completing a measure and beginning a new one. The author decided to utilize the data of the completed measures when appropriate.

Table 1

Demographic Characteristics of Samples, with tests of homogeneity of samples

	Random sample		Internet sample		Combined sample		Homogeneity
Variable	Freq	%	Freq	%	Freq	%	χ^2=
Age							
18-24	0	0.0	1	0.7	1	0.6	0.013*
25-34	9	20.9	48	34.8	57	31.5	
35-44	6	14.0	43	31.2	49	27.1	
45-54	16	37.2	27	19.6	43	23.8	
55-64	8	18.6	13	9.4	21	11.6	
over 65	4	9.3	6	4.3	10	5.6	
Gender							
Male	11	25.6	10	7.2	21	11.6	<.001*
Female	31	72.1	128	92.8	159	87.8	
Non-binary	1	2.3	0	0.0	1	0.6	
Culture/Ethnicity							
African American	6	14.0	5	3.6	11	6.1	0.005*
Caucasian	26	60.5	89	64.5	115	63.5	
Hispanic/Latinx	7	16.3	35	25.4	42	23.2	
Other	3	7.0	6	4.3	9	5.1	
Prefer not to answer	1	2.3	3	2.2	4	2.2	
Marital Status							
Married	28	65.1	102	74.5	130	72.2	0.342
Single	10	23.3	22	16.1	32	17.8	
Divorced	3	7.0	11	8.0	14	7.8	
Other	2	4.6	2	1.4	4	2.3	

NOTE: a significant χ^2 statistic indicates that categorical data are different between samples.

Demographic Variables

Demographic variables of age, gender, culture and marital status were used to compare homogeneity of the sampling groups (Table 1). The chi-square analysis demonstrated that there was a significant difference between groups among the variables of age, gender and culture. Because the sample size of the random sample was small, both samples were combined for the rest of the analyses.

Table 2

Demographic Work Characteristics of Sample

Variable	Frequency	Percentage
Employment Status		
Employed FT	139	76.4
Employed PT	31	17.0
Unemployed	1	0.5
Retired, PT work	3	1.6
Student, employed	8	4.4
Education Level		
Master's	160	87.9
Doctorate	22	12.1
Work Setting		
Agency/Nonprofit	51	22.6
Career	2	0.9
Hospital	9	4.0
Legal/Correctional	3	1.3
Private Practice	115	50.9
Rehab/Detox	6	2.7
Religious	3	1.3
Residential	2	0.9
School, K-12	9	4.0
College/University	14	6.2
Other	12	5.1

The majority of participants endorsed working full-time, most commonly in the private practice or agency setting (Table 2). Though there is no data source to know the exact amount of LPCs in each type of work setting, many LPCs may work in concurrent settings. For this reason, the survey participants were able to select multiple work settings as well as enter "other" settings, which included responses of: department of veteran affairs, EAP/hotline, federal healthcare, insurance, mobile crisis responder, online, and private agency. Interestingly, only one participant reported being unemployed but looking for work. Although COVID-19 has led to many losing their jobs, this sample appears to represent what other studies (APA, 2020; Caron,

2021) have found in that mental health professionals have been in-demand through the pandemic.

Internal Reliability of Measures

Table 3

Chronbach's Alpha Reliability for Measures

Measure	# of Items	α
COVID-19	22	0.741
PROQOL	30	0.713
STPPGI	13	0.808
FFWEL	91	0.963

NOTE: COVID-19 refers to the COVID-19 stress measure modeled form Park et al. (2020), PROQOL refers to the Professional Quality of Life measure, the STPPGI refers to the Shared Traumatic and Professional Post Traumatic Growth Inventory, and the FFWEL refers to the Five Factor Wellness Inventory.

Chronbach's alpha was utilized to determine the internal reliability of each of the measures (Table 3). Cortina (1993) indicates that an alpha coefficient above 0.70 is acceptable while above 0.80 is preferred. The COVID-19 questionnaire that sought to understand how stressful the participant's experience and the Professional Quality of Life scale (PROQOL) were found to be reliable. The Shared Traumatic and Professional Posttraumatic Growth Inventory (STPPGI) and The Five Factor Wellness Inventory (FFWEL) were found to be highly reliable.

Descriptive Statistics

Descriptive statistics were run on each of the major variables (Table 4). Total Wellness was defined as the total wellness score from the Five Factor Wellness Inventory (FFWEL). Secondary Traumatic Stress (STS) and Compassion Satisfaction were both subscale scores from the Professional Quality of Life Measure (PROQOL). Post Traumatic Growth (PTG) and Personal Trauma were both subscale scores from the Shared Traumatic and Professional Post

Traumatic Growth Inventory (STPPGI), with the total measure score referring to the Shared Trauma variable. Finally, the COVID-19 Stress variable was determined as the total score from the COVID-19 questionnaire modeled from the Park et al. (2020) study. Predictor variables included both the overall STPPGI score and the total COVID-19 stress score from the Park et al. (2020) study. The Total Wellness score served as both the moderator and mediator variables. Outcome variables described as negative consequences were secondary traumatic stress (STS) and burnout. The outcome variables described as positive consequences were compassion satisfaction and post traumatic growth.

Table 4

Descriptive Statistics

Variable	N	Min	Max	Mean	SD	Skew	Kurtosis
Predictor Variables							
COVID-19 Stress	147	1	5	3.44	1.0	-0.121	-0.648
Shared Trauma	166	13	57	36.70	8.1	-0.280	0.678
Moderator/Mediator Variable							
Total Wellness	147	27	73	46.71	8.8	0.005	-0.308
Outcome Variables							
Compassion Satisfaction	170	17	50	39.35	6.3	-0.317	-0.035
Burnout	171	10	39	23.23	6.3	0.138	-0.452
Secondary Traumatic Stress	172	11	46	21.00	6.7	0.983	1.068*
Post Traumatic Growth	168	1	5	3.28	0.8	-0.702	0.849
Other Variables (Post-Hoc)							
Personal Trauma	169	1	5	1.76	0.9	1.061*	0.265

NOTE: COVID-19 refers to the COVID-19 stress measure modeled from Park et al. (2020), Shared Trauma, Post Traumatic Growth and Personal Trauma are from the Shared Traumatic and Professional Post Traumatic Growth Inventory (STPPGI), Total Wellness is from the Five Factor Wellness Inventory (FFWEL) and Burnout, Secondary Traumatic Stress and Compassion Satisfaction are from the Professional Quality of Life measure (PROQOL)

In this sample, the personal trauma subscale of the STPPGI was significantly skewed, while the secondary traumatic stress subscale (STS) of the PROQOL showed significant kertosis. When determining normal distributions, skewness greater than positive one or below negative one is considered skewed, and kurtosis above positive one is considered too peaked while below negative one is considered too flat (Hair, et al., 2017). As the personal trauma subscale had the significant skew and a low mean (1.76) on a 5 point scale, the only analysis this measure was utilized for was descriptive in nature. Because the secondary traumatic stress histogram revealed it as leptokurtic due to the large frequency of responses at a score of 17 (N=19), a transformation (Templeton, 2011) was completed to create a normalized distribution.

As the only measure for shared trauma, STPPGI scores do not have predetermined levels as the measure has yet to be widely used and defined. Of a total of 166 valid participant scores on the STPPGI measure, there was an average total score of 36.7 (SD = 8.1), with a skewness of -0.28 and kurtosis of 0.68. It is important to note that one question was accidentally omitted from the STPPGI measure, so total scores may be lower than expected. Participants reported a mean response of 2.84 (SD = 1.12) where 1 = strongly disagree and 5 = strongly agree. The STPPGI measured the construct of shared trauma and contained three different subscales. The total STPPGI score represented the variable of Shared Trauma, while the subscale of Post Traumatic Growth was considered an outcome variable for positive consequences. Technique Specific Shared Trauma sought to understand if the counselors adjusted their treatment boundaries in response to the shared COVID-19 experience. The Posttraumatic Growth subscale focuses on more of a positive side effect of the shared experience, capturing if there was growth including a greater empathy, search for more knowledge or professional development and an appreciation for the profession. Finally, the third subscale, Personal Trauma sought to capture the personal impact

of sharing the COVID-19 experience with clients. On the Technique Specific Shared Trauma sub scale, there was a mean response of 2.97 (SD = 0.80), endorsing an average slight disagreement to changes in treatment due to the shared COVID-19 experience. On the Professional Posttraumatic Growth (PTG) sub scale there was a mean response of 3.28 (SD = .76), suggesting a neutrality or slight agreement that the shared experience of COVID-19 had resulted in PTG. And in the Personal Trauma subscale there was a mean response of 1.76 (SD = 0.90), conveying a stronger disagreement that the shared COVID-19 experience had resulted in personal trauma.

All PROQOL subfactors including compassion satisfaction and STS are considered low for scores 22 or less, moderate for scores between 23 and 41, and high for scores above 42. Only one participant (N=1, 0.6%) scored "high" on the secondary traumatic stress (STS) sub scale of the PROQOL. There were 67 participants (39.0%) who scored a moderate level of STS, and 104 who scored a low level of STS (60.5%). It was also interesting to note that there were no participants who scored "high" on the burnout sub scale, 96 who scored moderate (56.1%) and 75 who scored a low level of burnout (43.9%). On a more positive variable, 63 participants (37.1%) scored a high level of compassion satisfaction, 106 participants (62.4%) scored a moderate level, and only one participant (0.6%) scored a low level of compassion satisfaction.

Responses (Table 5) from the COVID-19 risk experiences measure utilized from Park et al. (2020) described a variety of perceived risk levels. Although 100% of participants felt informed about the severity and contagiousness of COVID-19, 20% felt they were not at risk of being infected, 12.6% felt their loved ones were not at risk and 54.9% felt they were not at risk of infecting others. Participants were asked to identify if they had experienced several consequences related to COVID-19, and if answered in the affirmative were then asked to rate how stressful they found said experience. Another almost unanimous response with a higher

stress rating was the experience of uncertainty about how long quarantine or social distancing requirements will last. Supporting the employment demographic responses, the lowest endorsement rate was to the prompt of loss of job security or income.

Table 5

COVID-19 Risk Experiences

Have you experienced…	Yes	%	No	%	Mean Rating	SD
Risk of becoming infected	147	80.8	34	18.7	2.77	1.64
Self monitoring of symptoms	135	74.2	47	25.8	2.16	1.62
Risk of loved ones becoming infected	159	87.4	21	11.5	3.31	1.62
Risk of unintentionally infecting others	80	44.0	100	54.9	1.68	2.03
Read/heard about severity/contagiousness of COVID-19	182	100	0	0.0	3.52	1.11
Shame/stigma related to quarantine or working in high-risk	52	28.6	129	70.9	1.02	1.72
Shame/stigma related to being a certain age group	62	34.1	120	65.9	0.96	1.49
Uncertainty about how long quarantine/ social distancing will last	166	91.2	15	8.2	3.22	1.40
Changes to daily personal care routines	153	84.1	27	14.8	2.66	1.49
Changes to work routines	117	64.3	65	35.7	2.37	1.97
Changes to education routines	93	51.1	88	48.4	1.60	1.81
Changes to social routines	166	91.2	13	7.1	3.22	1.41
Changed responsibilities for dependents (e.g. childcare, eldercare)	74	40.7	104	57.1	1.58	2.03
Cancellation of planned celebrations/trips	171	94.0	8	4.4	3.26	1.33
Cancellation of meaningful rituals (e.g. funerals, religious services)	111	61.0	67	36.8	2.13	1.93
Inability to travel	160	87.9	20	11.0	2.98	1.47
Increased contact with others	107	58.8	67	36.8	1.86	1.78
Pressure to “make the most of” COVID-19	112	61.5	65	35.7	1.83	1.75
Loss of job security or income	51	28.0	127	69.8	1.16	1.94
Loss of job training opportunities or education benchmarks	43	23.6	134	73.6	0.79	1.56
Potential changes to the national or global economy	67	36.8	109	59.9	1.32	1.84
Difficulty accessing important resources for daily life	58	31.9	119	65.4	1.15	1.79
Inadequate access to reliable information about COVID-19	67	36.8	110	60.4	1.38	1.89

NOTE: Each question answered “yes” was then asked to rate on a 1-5 Likert scale how stressful they found that experience, with those who answered no coded as 0

Wellness Factor Relationships

Descriptive statistics were run to understand the general responses to the FFWEL's subfactors, hoping to better understand which wellness areas were most utilized (Table 6). The wellness areas with the highest means were Coping Self-Realistic Beliefs, and each of the Physical Self subfactors. Coping Self-Realistic Beliefs refers to the ability to perceive reality accurately, separating rational from irrational thoughts. The Physical Self factor refers to the biological and physiological processes that make up our physical development, including the subfactors of exercise or engaging in sufficient physical activity, as well as nutrition or eating a balanced diet. The wellness area with the lowest mean was the Social Self-Love subfactor, which refers to the ability to have an intimate and trusting relationship with another person.

Pearson correlation analysis was utilized to understand the relationship between the FFWEL's wellness factors and both shared trauma and secondary traumatic stress (Table 7). The total STPPGI score, representing shared trauma, had a significant relationship with the FFWEL's total wellness score, the life satisfaction index, the creative self emotions subfactor, the physical self nutrition subfactor, the coping self composite score and each coping self subfactor. The PROQOL's secondary traumatic stress score had a significant relationship with almost every FFWEL second order factor and their sub scales. The STS scores also had significant relationships with the FFWEL's local context and chronometrical context scales, as well as the life satisfaction index and the total wellness score. The only four sub scales that did not have significant relationships with STS score were creative self positive humor, essential self cultural identity, physical self exercise and essential self spirituality.

When examining the relationship between total wellness scores from the FFWEL and the STS scores from the PROQOL, there was a statistically significant relationship (r= 0.363, p

< .001). When examining the relationship between total wellness scores from the FFWEL and the burnout scores from the PROQOL, there was a statistically significant relationship (r = 0.649, p < .001). When examining the relationship between total wellness scores from the FFWEL and the compassion satisfaction scores from the PROQOL, there was a statistically significant relationship (r = -0.573, p < .001). When examining the relationship between total wellness scores from the FFWEL and the PTG scores from the STPPGI, there was not a statistically significant relationship (r = 0.153, p =.067). Cases were deleted pairwise for each of these analyses.

When examining the relationship between total wellness scores from the FFWEL and the total scores from the STPPGI, there was a statistically significant relationship (r = 0.224, p <.01). A total score of the COVID-19 stress response questions was computed, with a 0 score for those questions that respondents shared they had not experienced that type of stress. The COVID stress score [COVTOT] had a significant relationship with the total wellness score (r(145) = .19, p <.05) 95% C.I. [.030, .342].

Table 6

Five Factor Wellness Inventory Descriptive Statistics

Wellness factor	N	Min	Max	Mean	SD
Creative Self					
Thinking	157	25.00	65.00	40.80	9.85
Emotions	159	25.00	68.75	44.69	10.51
Control	158	25.00	75.00	42.99	11.35
Work	158	25.00	80.00	48.29	12.60
Positive Humor	159	25.00	68.75	44.97	11.84
Composite	156	25.00	65.48	44.43	8.78
Coping Self					
Leisure	157	25.00	100.00	49.95	14.03
Stress Management	158	25.00	93.75	48.69	12.12
Self Worth	158	25.00	93.75	43.79	13.56
Realistic Beliefs	156	25.00	95.00	56.54	12.76
Composite	151	25.00	85.53	50.08	10.79
Social Self					
Friendship	157	25.00	87.50	40.33	13.88
Love	159	25.00	75.00	33.29	11.59
Composite	157	25.00	71.88	36.72	11.55
Essential Self					
Spirituality	158	25.00	100.00	52.03	22.47
Gender Identity	157	25.00	100.00	45.90	13.64
Cultural Identity	157	25.00	100.00	47.29	15.34
Self Care	160	25.00	81.25	38.83	11.35
Composite	155	25.00	76.56	46.33	12.18
Physical Self					
Exercise	159	25.00	100.00	56.04	18.82
Nutrition	159	25.00	100.00	55.94	16.69
Composite	158	25.00	97.50	55.97	16.36
Contextual Variables					
Local Context	159	25.00	65.00	38.30	10.80
Institutional Context	160	25.00	87.50	51.33	12.01
Global Context	160	25.00	75.00	49.84	12.52
Chronometrical Context	160	25.00	75.00	44.92	11.13
Life Satisfaction Index	160	25.00	100.00	45.94	17.26
Total Wellness Score	147	27.20	73.63	46.71	8.82

Table 7

Pearson Correlations between wellness factors, shared trauma and secondary traumatic stress

	Shared Trauma			Secondary Traumatic Stress		
Wellness factor	N	*r*	*p*	N	*r*	*p*
Creative Self						
Thinking	154	.148	0.068	156	.214	*.007
Emotions	155	.184	*.022	158	.257	*.001
Control	154	.093	0.252	157	.254	*.001
Work	154	.103	0.202	157	.355	*<.001
Positive Humor	155	.072	0.373	158	.133	.096
Composite	153	.154	0.057	155	.323	*<.001
Coping Self						
Leisure	153	.328	*<.001	156	.396	*<.001
Stress Management	154	.333	*<.001	157	.484	*<.001
Self Worth	154	.183	*.023	157	.279	*<.001
Realistic Beliefs	153	.409	*<.001	155	.430	*<.001
Composite	148	.394	*<.001	150	.479	*<.001
Social Self						
Friendship	153	.040	0.626	156	.197	*.014
Love	155	.156	0.053	158	.253	*.001
Composite	153	.097	0.232	156	.235	*.003
Essential Self						
Spirituality	154	.073	0.370	157	.103	0.201
Gender Identity	153	.042	0.610	156	.276	*<.001
Cultural Identity	153	-.036	0.661	156	.076	.345
Self Care	156	.145	0.072	159	.189	*.017
Composite	151	.078	0.342	154	.206	*.011
Physical Self						
Exercise	155	.076	0.345	158	.112	0.160
Nutrition	155	.192	*.017	158	.279	*<.001
Composite	154	.141	0.082	157	.201	*.012
Contextual Variables						
Local Context	155	.156	0.052	158	.288	*<.001
Institutional Context	156	.008	0.925	159	.159	*.045
Global Context	156	-.024	0.770	159	-.073	.361
Chronometrical Context	156	.088	0.272	159	.179	*.024
Life Satisfaction Index	156	.220	*.006	159	.272	*<.001
Total Wellness Score	144	.224	*.007	146	.363	*<.001

NOTE: * denotes significance

COVID-19 Stress

Stress variables were defined as the total score on the STPPGI measure as well as a total score derived from the COVID-19 related measure from Park et al. (2020). The total score from the Park et al. measure was calculated by totaling the stress ratings for each question and labeled as [COVTOT]. Principal components analysis was used to identify and compute a composite score that summarized [COVTOT] and STPPGI total score. The component that was extracted explained 64.856% of the variance and loaded at a .805 level with both the total STPPGI score and the total score from the COVID-19 stress responses based on Park et al. (2020). Only one component was extracted (Table 8). The solution could not be rotated. All items were loaded on this component. The two scales equally contributed to the component (Table 9). This component variable was then labeled as [COVSTRESS] and utilized for the mediation and moderation analyses.

Table 8

Principal Component Analysis

	Initial Eigenvalues		
Component	Total	% of Variance	Cumulative %
1	1.30	64.85	64.85
2	0.70	35.15	100.00

NOTE: Extraction method was Principal Component Analysis

Table 9

Component Matrix

Scale	Component 1
STPPGI	0.805
COVID	0.805

NOTE: STPPGI represents the total score from the Shared Traumatic and Professional Posttraumatic Growth Inventory, COVID refers to the total score of stress scale responses from the Park et al. (2020) COVID measure

Regression Analyses

There were four research questions this study sought to answer, varying in nature of analysis. Some keywords within the research questions refer to multiple variables. Positive consequences refer to both the compassion satisfaction and post traumatic growth variables and negative consequences refer to both the burnout and secondary traumatic stress (STS) variables. The following research questions were examined.

Does increased COVID-19 related stress predict increased negative consequences?

Does increased COVID-19 related stress predict increased positive consequences?

Do wellness practices mediate the relationship between COVID-19 related stress and positive consequences?

Do greater wellness practices moderate the impact of COVID-19 related stress on negative consequences?

Does increased COVID-19 related stress predict increased negative or positive consequences?

A simple linear regression was calculated to predict secondary traumatic stress (STS) based on COVID-19 stress. Another simple linear regression was calculated to predict burnout based on COVID-19 stress. COVID-19 stress was found to significantly predict both secondary

traumatic stress (STS) and burnout (Table 7). The precondition for the moderation analysis of COVID-19 stress predicting both STS and Burnout was met.

A simple linear regression was calculated to predict Post Traumatic Growth (PTG) based on COVID-19 stress. Another simple linear regression was calculated to predict Compassion Satisfaction based on COVID-19 stress. COVID-19 stress was found to significantly predict PTG but not Compassion Satisfaction (Table 10). The precondition for the mediation analysis of COVID-19 stress predicting PTG was met but not Compassion Satisfaction.

Table 10

Regression Analyses of COVID-19 stress as predictor

Variable	*B*	*SE*	***β***	*t*	*p*
Secondary Traumatic Stress	3.382	0.431	0.524	7.845	*<.001
Burnout	2.081	0.487	0.317	4.271	*<.001
Post Traumatic Growth	0.533	0.042	0.702	12.608	*<.001
Compassion Satisfaction	-0.988	0.508	-0.151	-1.945	0.054

NOTE: *signifies statistically significant

Is there a moderating effect of wellness on the relationship between stress and negative consequences?

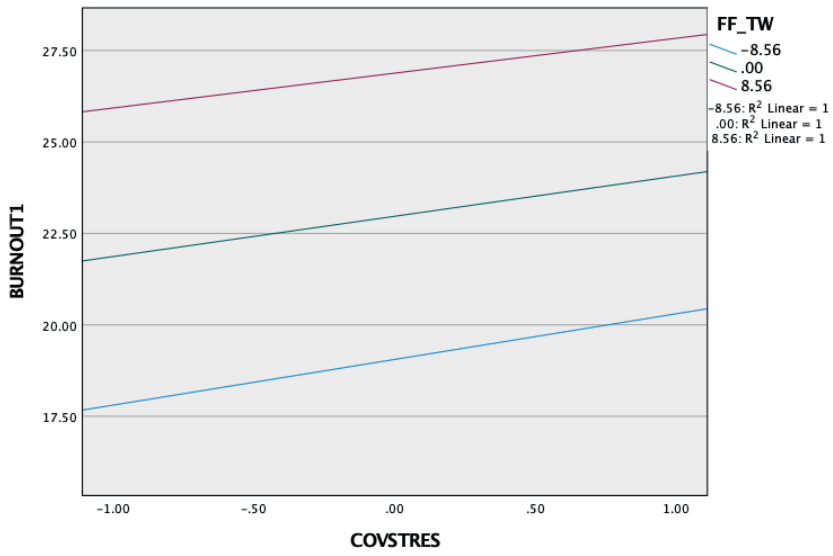
To investigate if there was a moderating effect of wellness on the relationship between COVID-19 stress and negative consequences (burnout and secondary traumatic stress), simple moderator analyses were performed using PROCESS model 1 (Hayes, 2018). This programmed syntax developed by Hayes (2018) utilizes SPSS to run the multiple regression analyses necessary for the moderation analysis.

The first analysis measured the relationship between the predictor variable COVID-19 stress, the moderation variable of Wellness, defined as the total wellness score from the FFWEL, and the outcome variable of Burnout, as measured from the subscale score of the PROQOL. The

interaction between COVID-19 stress and wellness was not found to be statistically significant (b = -.017, SE = .043, p =.691). Figure 3 displays similar slopes of the relationship between Burnout and COVID-19 Stress at different levels of Wellness, supporting this conclusion. While COVID-19 stress was a significant predictor of Burnout, Wellness did not moderate that relationship.

Figure 3

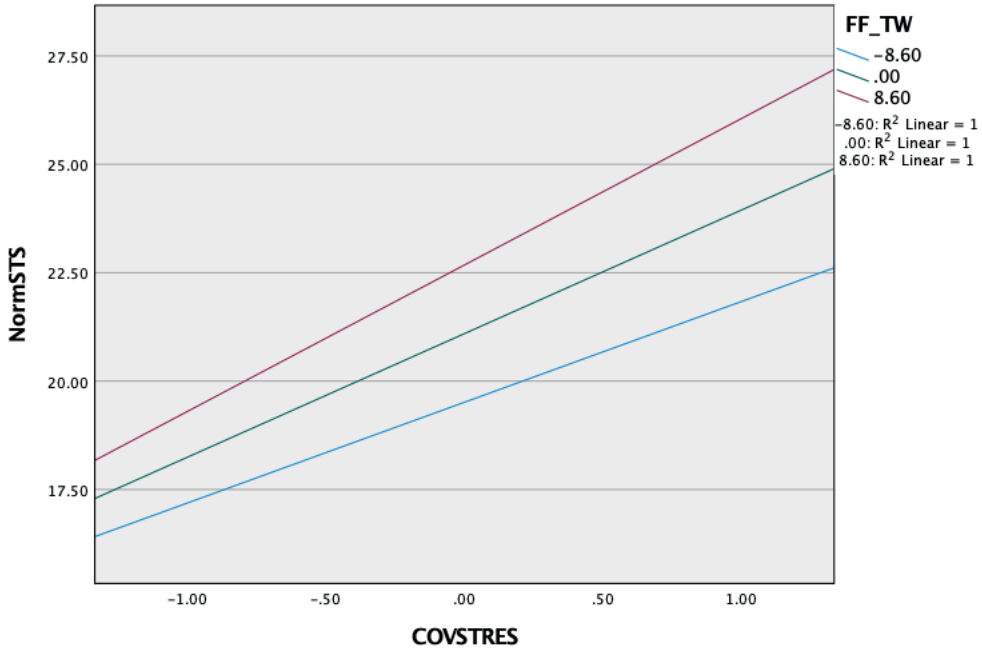
Moderation Effect of Wellness on relationship COVID-19 and Burnout



The second analysis measured the relationship between the predictor variable COVID-19 stress, the moderation variable of Wellness, defined as the total wellness score from the FFWEL, and the outcome variable of Secondary Traumatic Stress, as measured from the subscale score of the PROQOL. The interaction between COVID-19 stress and wellness was not found to be statistically significant (b = -.061, SE = .043, p =.158). Figure 4 displays similar slopes of the relationship between Secondary Traumatic Stress and COVID-19 Stress at different levels of Wellness, supporting this conclusion. While COVID-19 Stress was a significant predictor of Secondary Traumatic Stress (STS), Wellness did not moderate that relationship.

Figure 4

Moderation Effect of Wellness on relationship COVID-19 stress and Secondary Traumatic Stress



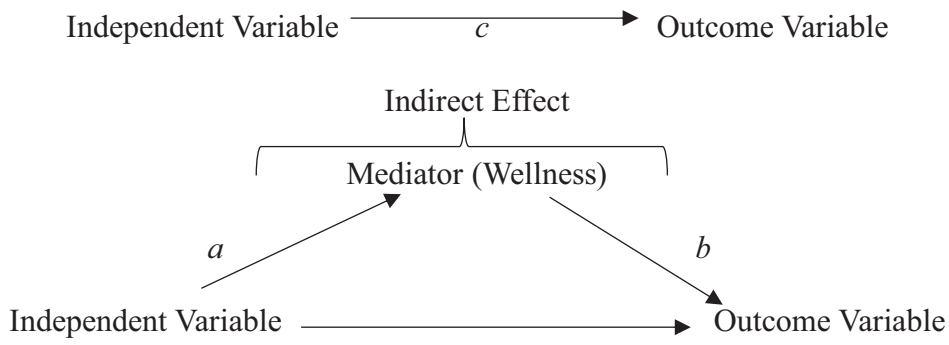
Is there a mediating effect of wellness on the relationship between stress and positive consequences?

To investigate if there was a mediating effect of wellness on the relationship between stress (total of stress responses to COVID-19 questions and total STPPGI score) and positive consequences (compassion satisfaction and post traumatic growth), simple mediation analyses were performed using PROCESS model 4 (Hayes, 2018). Traditionally, the model proposed by Baron & Kenny (1986) suggested that many pathways through the mediation model had to be significant for mediation to occur. This included first supporting that the independent variable predicts the dependent variable, noted as path *c* in the Mediation Analysis Pathways (see Figure 5). The independent variable also needed to predict the mediating variable, seen as path *a* in the Mediation Analysis Pathways (see Figure 5). And finally, both the independent and mediating

variables together needed to predict the dependent variable, concluded both by the mediating variable predicting the dependent variable and the independent variable prediction on the dependent variable decreasing or ceasing when considering the mediating variable. However, contemporaries have suggested that this is not supported and weight must be placed on the indirect effect of mediation without needing all paths to be significant (Hayes, 2018; Rucker, et al., 2011). This study will assess mediation with the contemporary method, paying specific attention to the results of the indirect effect regression analysis in the PROCESS model 4 output.

Figure 5

Mediation Analysis Pathways



stress, the mediation variable of Wellness, defined as the total wellness score from the FFWEL, and the outcome variable of Compassion Satisfaction, as measured from the subscale score of the PROQOL. Although COVID-19 stress alone did not predict Compassion Satisfaction, the indirect effect of COVID-19 stress and Wellness on Compassion Satisfaction was found to be statistically significant (Effect = -1.07, 95% C.I. [-1.72, -.42]), suggesting a mediating effect of wellness on the relationship between COVID-19 stress and compassion satisfaction.

The second mediation analysis measured the relationship between the predictor variable of COVID-19 stress, the mediation variable of Wellness, defined as the total wellness score from the FFWEL, and the outcome variable of Post Traumatic Growth, as measured from the subscale score of the STPPGI. The indirect effect of COVID-19 stress on post traumatic growth was not found to be statistically significant (Effect = -.006, 95% C.I. [-.038, .021]), concluding that Wellness does not mediate the relationship between COVID-19 stress and Post Traumatic Growth.

Post Hoc Analyses

Babore and colleagues (2020) found that those with children were more likely to be more stressed during COVID-19, presumably due to the changed responsibilities when caring for dependents. One question on the Park et al. (2020) COVID-19 stress questionnaire was "Have you experienced changed responsibilities to care for dependents (e.g., childcare, eldercare)?" Post hoc analysis assessed if having a change in dependent care created a significant difference in COVID-19 stress, wellness, compassion satisfaction, secondary traumatic stress, burnout or post traumatic growth. To assess these relationships, independent samples T-Tests were utilized. The results suggested that a change in dependent care affected two variables, COVID-19 stress and Wellness (see Table 11). Those with a change in dependent care reported higher COVID-19 stress and higher Wellness than those without a change in dependent care.

Table 11

Difference between those with and without changes to dependent care

	Yes		No		t-test		
Variable	Mean	SD	Mean	SD	t	df	p
COVID stress	58.99	19.52	40.49	18.10	6.50	176	*<.001
Total wellness	48.52	8.59	45.49	8.76	2.07	143	*0.040
Compassion Satisfaction	38.84	6.52	39.88	6.03	-1.06	166	0.291
Burnout	23.96	5.71	22.54	6.56	1.46	167	0.145
Secondary Traumatic Stress	21.56	6.91	21.28	6.26	0.27	167	0.784
Post Traumatic Growth	3.40	0.78	3.42	0.80	1.61	165	0.175

NOTE: Categories refer to answering "yes" or "no" to if they have experienced changes in childcare

Multiple studies have found that females were also more likely to experience a higher level of stress related to COVID-19 (Babore, et al., 2020; Shanahan, et al., 2020). To test if being female also had an impact on stress consequences in this sample, an independent samples T-Test was completed. There were no significant differences in means between females and males in COVID-19 stress scores, total wellness scores, compassion satisfaction, burnout, STS, or PTG (Table 12).

Table 12

Difference between Females and Males in stress consequences

	Females		Males		t-test		
Variable	Mean	SD	Mean	SD	t	df	p
COVID stress	47.24	19.40	52.62	29.09	0.82	22.39	0.419
Total wellness	46.32	8.66	49.36	9.66	1.41	145	0.161
Compassion Satisfaction	39.54	6.17	38.25	7.33	-0.86	167	0.393
Burnout	23.06	6.41	24.25	5.47	0.79	168	0.429
Secondary Traumatic Stress	21.27	6.57	22.24	6.07	0.62	168	0.536
Post Traumatic Growth	3.27	0.76	3.42	0.80	0.84	165	0.405

A correlational analysis was run to determine if demographic variables had a significant relationship with wellness, positive consequences or negative consequences. There was a

significant relationship between age and total wellness score ($r(147) = -.172$, $p < .05$) as well as age and compassion satisfaction ($r(170) = .162$, $p < .05$). There was not a significant relationship between age and burnout ($r(171) = -.115$, $p = .134$) or age and STS ($r(171) = -.048$, $p = .531$).

Because participants were allowed to choose multiple work settings, it was not possible to compare directly between groups of work settings. However, due to literature supporting a relationship between work in a private practice setting and wellness and stress outcomes, a group was created signifying if participants worked in private practice (N = 115) or not (N = 67). An independent samples t-test was completed to determine if there was a difference between those who did and did not work in private practice and outcome variables of COVID-19 stress responses, total wellness, compassion satisfaction, burnout, PTG and STS. No significant differences occurred (Table 13).

Table 13

Difference between those in private practice and those who are not

	Private Practice		Other Settings		t-test		
Variable	Mean	SD	Mean	SD	t	df	p
COVID-19 stress	47.14	20.82	49.36	20.59	-0.70	180	0.487
Total Wellness	46.86	8.91	46.44	8.73	0.28	145	0.780
Compassion Satisfaction	39.25	6.50	39.52	6.00	-0.26	168	0.795
Burnout	22.92	6.52	23.75	5.94	-0.85	169	0.399
Secondary Traumatic Stress	21.40	6.66	21.43	6.25	-0.03	169	0.976
Post Traumatic Growth	3.32	0.76	3.21	0.76	0.94	166	0.347

NOTE: Categories refer to answering "yes" or "no" to if they work in private practice

Overall, there were surprising findings in these results. The STPPGI results suggest there was not much of a shared trauma experience for counselors, and no overwhelming impact on counselor's treatment or post-traumatic growth. The majority of participants experienced moderate to low secondary traumatic stress, moderate burnout and moderate to high compassion satisfaction. Counselor wellness had a significant impact on both STPPGI scores and PROQOL

scores, including specific impacts on STS and burnout scores. This sample appears to continue the trend of wellness impacting consequences of stress, including burnout and secondary traumatic stress.

Chapter 5

Summary, Implications, and Recommendations

Some research has already begun on understanding the impact of COVID-19 on the general population and mental health professionals, though none have yet examined Licensed Professional Counselors. It was additionally important to understand how COVID-19 related to the concept of shared trauma, when both the counselor and client experience the same trauma at the same time. This construct only recently began being studied after the September 11 terrorist attacks twenty years ago, and has only been studied in a few shared trauma incidents in the last two decades. Furthermore, understanding not only the negative consequences of trauma but also the positive consequences helps to create a fuller picture of the impact. There has yet to be research on positive consequences to COVID-19 stress. Additionally, another goal of this research was to understand if wellness moderated or mediated a counselor's response to shared trauma, as wellness has previously been linked to positive consequences (Laumbert & Lawson, 2013) and inversely to negative consequences such as burnout and STS (Dupree & Day, 1995; Lent & Schwartz, 2012; Puig, et al., 2012; Van Morkhoven, 1998; Vredenburgh et al., 1999).

Results

When participants responded to questions about their experiences and stress related to COVID-19, there were some interesting differences. Although 100% of participants felt they heard about the severity and contagiousness of COVID-19, 20% felt they were not at risk of being infected, 12.6% felt their loved ones were not at risk of becoming infected and 54.9% felt they were not at risk of infecting others. For context, the participant responses were collected

between July 12, 2021 and August 23, 2021, a time with COVID-19 infection rates in Texas were high and growing due to a new variant of the disease (CDC, 2021; Texas DSHS, n.d.).

When comparing to the original Park et al. (2020) sample of American adults on COVID-19 stress, there were some similarities and differences with the current sample. Both studies found the most commonly experienced stressors were hearing about the severity and contagiousness of COVID-19, uncertainty about how long public safety measures such as quarantining and social distancing would go on, and changes in social routines, but this study found the second largest experienced stressor to be cancellation of planned celebrations or trips.

The literature and general public have suggested that mental health professionals have been in higher demand throughout the COVID-19 pandemic, leading to more study on the consequences of this additional stress. Although COVID-19 has led to many losing their jobs, this sample appears to represent what other studies have found in that mental health professionals have been in-demand through the pandemic, with only one participant sharing they were unemployed and looking for work. When rating stressfulness of COVID-19 experiences, the lowest endorsement rate was to the prompt of loss of job security or income, although this was ranked as the most stressful experience in the original Park et al. (2020) study.

Although previous research had found females to be more likely to be stressed during COVID-19 (Babore, et al., 2020; Park et al., 2020; Shanahan et al., 2020), this study found no significant relationship between the female gender and COVID-19 stress scores, secondary traumatic stress, burnout, or more positive consequences such as total wellness scores, compassion satisfaction or post traumatic growth (Table 6). Prior studies found that those with children were more likely to be more stressed during COVID-19 (Babore et al., 2020; Park et al., 2020; Sahithya et al., 2020), presumably due to changes in care for dependents including day-

cares closing and an increase in working from home. Within this study, those who had changes in caring for their dependents had significantly higher COVID-19 related stress scores, but also higher total wellness scores.

Experiencing a shared trauma has been associated with enhanced self-care and positive changes in the therapeutic relationship (Bauwens & Tosone, 2010; Day, et al., 2015) as well as post-traumatic growth (Laumbert & Lawson, 2013). Additionally, life satisfaction was found to have a significant relationship with COVID-19 stress response (Trzebinski et al., 2020). When examining the COVID-19 shared trauma STPPGI scores, there was a significant relationship with FFWEL subfactors including total wellness scores, the life satisfaction, the creative self-emotions subscale, the physical self-nutrition subscale, the coping self-composite and each coping self-subfactor of leisure, stress management, self-worth, and realistic beliefs.

In Holmes et al. (2021) study of the impact of COVID-19 on social workers, 99% of the sample reported average to high compassion satisfaction, 63.71% reported average burnout and 49.59% reported average secondary trauma. This led to asking what frequency of Texan LPCs would experience high secondary traumatic stress (STS). Only one participant scored "high" on the secondary traumatic stress (STS) sub scale of the PROQOL, 67 participants (39.0%) who scored a moderate level of STS, and 104 who scored a low level of STS (60.5%). This suggested an overall lower level of STS in this sample of Texas LPCs when compared with the Holmes et al. (2021) social worker sample. It was also interesting to note that there were no participants who scored "high" on the burnout sub scale, 96 who scored moderate (56.1%) and 75 who scored a low level of burnout (43.9%), again scoring slightly lower on burnout than the social worker sample. However, when considering compassion satisfaction, 63 participants (37.1%)

scored high, 106 participants (62.4%) scored a moderate level, and only one participant (0.6%) scored a low level of compassion satisfaction, again scoring lower than the social worker sample.

The researcher also wanted to understand how the sample would respond to the STPPGI measure of shared trauma, and results suggested a minor experience of shared trauma. On the Technique Specific Shared Trauma sub scale, participants endorsed an average slight disagreement to changes in treatment due to the shared COVID-19 experience. On the Professional Posttraumatic Growth (PTG) sub scale the participants suggested a neutrality or slight agreement that the shared experience of COVID-19 had resulted in PTG. Finally, the Personal Trauma subscale results conveyed a stronger disagreement that the shared COVID-19 experience had resulted in personal trauma. Overall, the shared trauma experience appears to be limited in this sample.

Wellness subfactors of Coping Self-Realistic Beliefs and each Physical Self subfactors had the highest reporting levels, suggesting that they were the most utilized wellness methods. This sample of Texas counselors subjectively reported the ability to balance realistic or logical thinking with illogical thoughts. Participants also reported a high level of physical wellness practices such as exercise and healthy nutrition practices. The lowest response was to the Social Self-Love subfactor, which referred to the ability to form intimate, trusting relationships with another. Perhaps the social distancing requirements made forming intimate relationships difficult, and challenged those relationships that were already in existence with limited separation time.

The relationship between wellness factors and shared trauma or secondary traumatic stress was also questioned. There were many statistically significant relationships, though no particularly strong correlations. The shared trauma scale's total score had a significant positive correlation with total wellness, life satisfaction and many wellness subfactors, with the strongest

relationships found with the coping-self composite score and the subfactors of realistic beliefs, leisure and stress management. Though, the significant relationships were not necessarily strong. Similarly, the PROQOL's secondary traumatic stress score had a significant positive correlation with almost every wellness subfactor, though none had particularly strong relationships. The strongest relationship was found between STS and coping self's stress management and realistic beliefs subfactors, as well as the coping-self composite score.

The researcher also wanted to understand the relationship between wellness and positive and negative consequences. There were significant positive correlations between total wellness and both negative consequences of STS and burnout and a significant negative correlation with the positive consequence of compassion satisfaction. There was not a significant relationship between total wellness and post traumatic growth. These results were unexpected, suggesting that higher wellness scores correlated with higher negative consequences of burnout and secondary traumatic stress, as well as a lower positive consequence of compassion satisfaction. It is possible that those who experienced more burnout or secondary traumatic stress felt a need to compensate with better wellness practices.

The relationship between counselor wellness and stress variables was also examined. Both the total COVID-19 stress score and total shared trauma STPPGI score had statistically significant positive correlations with the counselor's total wellness score. These relationships were weak and unexpected. A possible explanation again may be that the more stress a counselor experienced, the more they felt the need to compensate with better wellness practices.

Similarly questioned was if wellness, positive or negative consequences shared a relationship with demographic variables. Age had a significant but weak negative correlation with total wellness, suggesting younger counselors had higher levels of wellness. Age also had a

positive but weak correlation with compassion satisfaction, suggesting older counselors had higher rates of compassion satisfaction. Contrary to prior research findings suggesting a relationship between working in private practice and wellness or stress responses, in this sample those who did and did not work in private practice did not differ across COVID-19 stress responses, total wellness scores, compassion satisfaction, burnout, PTG or STS.

Research questions

The first research questions wondered how positive and negative consequences related to the COVID-19 stress variables. COVID-19 stress was found to significantly predict secondary traumatic stress, burnout and post traumatic growth, but not compassion satisfaction. These results follow a logic that the more stress the counselor experienced due to COVID-19, the more burnout and secondary traumatic stress they may experience. Similarly, in order to experience post traumatic growth (PTG), a person must first experience a trauma, which could contribute to the explanation of the relationship between a higher COVID-19 stress level and higher PTG. Though compassion satisfaction has been seen as a result of a shared trauma experience, it is also logical that a counselor may be experience higher compassion satisfaction at lower levels of stress.

Finally, the last two research questions wondered how wellness played a part in the relationship between COVID-19 stress and the positive and negative consequences of stress. A participant's wellness score appeared to have a mediating effect on the relationship between COVID-19 stress on compassion satisfaction. Wellness was not found to moderate the relationship between COVID-19 stress on negative consequences, nor on the positive consequence of PTG.

Discussion

Overall, the results both supported and refuted the researcher's original hypotheses. Surprises included the low overall experience of COVID-19 related shared trauma, and overall positive correlations between wellness and negative consequences. Rather than wellness practices acting as protective factors against negative consequences and stress as hypothesized, perhaps wellness practices increased as a result of negative consequences and stress. Another confusing result included the negative correlation between total wellness scores and compassion satisfaction, suggesting those with higher wellness scores experienced less compassion satisfaction. Wellness having a mediating effect between COVID-19 stress and compassion satisfaction was expected. Expected results included the lack of stress surrounding counselor job security, the positive correlation between COVID-19 stress and negative consequences and post traumatic growth. The researcher also found it interesting that Texas LPCs scored lower average scores on burnout, secondary traumatic stress and compassion satisfaction than the previously studied social workers, though still at levels that are worth noting.

Research Implications and Clinical Applications

Though the stressful impact of COVID-19 on Texas LPCs was not as significant as the researcher expected, it was still meaningful. A large portion of participants appear to be experiencing a moderate level of burnout and secondary traumatic stress. Encouragingly, all but one participant scored moderate to high compassion satisfaction levels. It was also important to note that work setting of being in private practice or not did not affect any stress, negative or positive consequence variables.

This sample of counselors showed a positive correlation between stress related to COVID-19 and the negative consequences of burnout and STS. This relationship was expected,

and concluded that those who were more stressed about COVID-19 also experienced more burnout and secondary traumatic stress. Directionality of the relationship or causality cannot be determined, but there are implications of similarity in stress responses across variables. More hopefully, there was also a positive correlation between COVID-19 stress and post traumatic growth, suggesting these counselors were also experiencing helpful benefits of experiencing these stressors.

The relationship between total wellness scores on the FFWEL and the negative consequence variables was surprising in that wellness was not related to STS or burnout as a protective factor, but perhaps instead as a consequence. As perhaps evidenced by the researcher's personal experience of seeing an increase in advertisements related to wellness and mental health since the COVID-19 pandemic, it is curious if wellness practices have increased as the stress related to COVID-19 has increased. Similarly, perhaps this sample of counselors increased their wellness practices as a result of feeling more burnout or secondary traumatic stress.

Limitations

The primary limitation of this study is the lack of generalizability and representativeness of this sample to the larger population of Texas Licensed Professional Counselors. Though the researcher hoped to solicit a random sample using the Texas LPC roster, responses were not sufficient and had to be supplemented by non-random sampling. If in the future the Texas LPC roster includes emails of participants, it may be more cost-effective to be able to send multiple solicitations in order to increase the response in this sampling method. With the roster as it is, a future researcher may choose to supplement a mailed solicitation with a phone call as phone numbers were also available. The two solicitation methods sample sizes were also so different that comparing homogeneity was also difficult.

Recommendations

The researcher hopes that this research study will recommend that people do not forget to check on their counselor colleagues and friends. It is easy to overlook those in the helper role when crisis and stress occur, though this study supports that they may be impacted similar to the general population. This sample of Texas LPCs showed stress responses to the COVID-19 pandemic experience, both positive and negative. It is important that counselors reflect not only on the difficult impacts of this stressful experience, but also how they may have grown or been positively affected.

Future Research

As previous research on shared trauma has suggested, the timing of research with the experienced trauma is important. The COVID-19 experience has been different than previous ones in that it has been ongoing for a much longer time period than events such as the September 11 terrorist attacks or Hurricane Katrina. Previous research has suggested that helpers are able to focus more on their own experience after a crisis has resolved, and that during a crisis they are more focused on their clients. This research was able to capture the experience of this sample of Texas LPC counselors approximately 16 months into an unresolved global pandemic. It would be interesting to compare results at a future date, when COVID-19 is no longer widely experienced and hospitals and intensive care units are not full of affected patients. Furthermore, examining professional counselors in other states may show differing results. Additionally, a qualitative or mixed-methods study may help explain the experience of professional counselors in a way this quantitative analysis was unable to. This may provide an opportunity for participants to explain their experience or results rather than the onus being on the researcher to interpret meaning. Finally, it is the researcher's hope that studies will continue to examine positive consequences to

stressful experiences. Helpful effects are an important part of the story that is often left out, and without which a pessimistic picture is painted. People, especially counselors, can be resilient people who are capable of growth from struggle.

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Appendix A

IRB Approval Letter

ST MARY'S UNIVERSITY

July 12, 2021

Monique Raack Rahman
Dept. of Counseling
St. Mary's University

DELIVERED BY EMAIL TRANSMISSION

Dear Ms. Rahman:

The IRB has approved the study, Rahman (Ratliff, Faculty sponsor) Impact of Counselor Wellness on Positive & Negative Consequences of COVID-19 Shared Trauma. If research participants have any questions about their rights as a research subject or concerns about this research study please contact the Chair, Institutional Review Board, St. Mary's University at 210-436-3736 or email at IRBCommitteeChair@stmarytx.edu.

Dan Ratliff, Ph.D.
IRB Chair
St. Mary's University

The proposal is determined to meet criteria for exemption under 45 CFR 46.104(d)(2), the use of survey procedures, with de-identified, minimal risk data. You may collect data from human subjects according to the approved research protocol. The approval stamp must appear on any Information Form or Informed Consent Form approved by the IRB (jpeg file attached).

If, at any time, you make changes to the research protocols that affect human participants, you must file a "Changes to Approved IRB Protocol and/or Unanticipated Problems" form. Changes must be reviewed and approved by IRB before proceeding with data collection.

Good work on an interesting approach to counselor education. I look forward to seeing your results.

Dan Ratliff, Ph.D.
IRB Chair
Attachment: IRB Approval Stamp jpeg file

IRB Policy states, "No individual involved in the conduct and/or supervision of the research project shall participate in its review." This certifies that Dr. Ratliff, the faculty sponsor, did not participate in the IRB review. After the IRB members reached their determination, Dr. Ratliff only assisted with the preparation of the documents.

Priscilla Vasquez

Priscilla Reyna, Ph.D.
IRB Area Representative, Counseling Dept.

DEPARTMENT OF COUNSELING AND HUMAN SERVICES ■ ONE CAMINO SANTA MARIA ■ SAN ANTONIO, TEXAS 78228-8527
OFFICE: (210) 438-6400 ■ FAX: (210) 438-6441

Appendix B

Informed Consent

The IRB has approved the study, Rahman (Ratliff, Faculty sponsor) Impact of Counselor Wellness on Positive & Negative Consequences of COVID-19 Shared Trauma. If research participants have any questions about their rights as a research subject or concerns about this research study please contact the Chair, Institutional Review Board, St. Mary's University at 210-436-3736 or email at IRBCommitteeChair@stmarytx.edu.

Dan Ratliff, Ph.D.
IRB Chair
St. Mary's University

Welcome to the research study!

We are interested in understanding the experience of Texas Licensed Professional Counselors (LPCs) during the COVID-19 pandemic. Questions will be asked regarding COVID-19 related stress, professional quality of life and wellness practices. Please be assured that your responses will be kept completely confidential and we will not ask for any identifying information.

The study may take you around thirty minutes to complete, depending on the speed of your responses. Your participation will be assisting in furthering knowledge in the counseling field. Your participation in this research is voluntary. You have the right to withdraw at any point during the study, for any reason, and without any prejudice. If you would like to contact the Principal Investigator in the study to discuss this research, please e-mail Monique Raack at mraack@mail.stmarytx.edu.

By clicking the button below, you acknowledge that your participation in the study is voluntary, you are 18 years of age, you are a Licensed Professional Counselor (LPC) in Texas, and that you are aware that you may choose to terminate your participation in the study at any time and for any reason.

Please note that this survey will be best displayed on a laptop or desktop computer. Some features may be less compatible for use on a mobile device.

If you have any questions about your rights as a research subject or concerns about this research study please contact the Chair, Institutional Review Board, St. Mary's University at 210-436-3736 or email at IRBCommitteeChair@stmarytx.edu. ALL RESEARCH PROJECTS THAT ARE CARRIED OUT BY INVESTIGATORS AT ST. MARY'S UNIVERSITY ARE GOVERNED BY THE REQUIREMENTS OF THE UNIVERSITY AND THE FEDERAL GOVERNMENT.

- ◯ I consent, begin the study
- ◯ I do not consent, I do not wish to participate

→

Appendix C

PRO-QOL

PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)

COMPASSION SATISFACTION AND COMPASSION FATIGUE
(PROQOL) VERSION 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some-questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1=Never	2=Rarely	3=Sometimes	4=Often	5=Very Often

_____ 1. I am happy.
_____ 2. I am preoccupied with more than one person I *[help]*.
_____ 3. I get satisfaction from being able to *[help]* people.
_____ 4. I feel connected to others.
_____ 5. I jump or am startled by unexpected sounds.
_____ 6. I feel invigorated after working with those I *[help]*.
_____ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
_____ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
_____ 9. I think that I might have been affected by the traumatic stress of those I *[help]*.
_____ 10. I feel trapped by my job as a *[helper]*.
_____ 11. Because of my *[helping]*, I have felt "on edge" about various things.
_____ 12. I like my work as a *[helper]*.
_____ 13. I feel depressed because of the traumatic experiences of the people I *[help]*.
_____ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
_____ 15. I have beliefs that sustain me.
_____ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
_____ 17. I am the person I always wanted to be.
_____ 18. My work makes me feel satisfied.
_____ 19. I feel worn out because of my work as a *[helper]*.
_____ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
_____ 21. I feel overwhelmed because my case [work] load seems endless.
_____ 22. I believe I can make a difference through my work.
_____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
_____ 24. I am proud of what I can do to *[help]*.
_____ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
_____ 26. I feel "bogged down" by the system.
_____ 27. I have thoughts that I am a "success" as a *[helper]*.
_____ 28. I can't recall important parts of my work with trauma victims.
_____ 29. I am a very caring person.
_____ 30. I am happy that I chose to do this work.

Appendix D

Curriculum Vita

Monique is a Licensed Professional Counselor (LPC) and new Counselor Educator at her alma mater of the University of Houston-Victoria (Katy). Monique is passionate about working with both those in a mental health crisis and as well as those who are working towards prevention of mental illness. Monique hopes to focus on the mental wellness of everyone, including counselors. This has included working towards advanced training in play therapy in order to best serve young clients in their journey for mental wellness. Monique has been grateful of her support of her growing and multicultural family, and is excited to welcome a baby daughter due in December.