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# EXPLORING RISK AND PROTECTIVE FACTORS THAT PREDICT SECONDARY TRAUMATIC STRESS IN COUNSELORS-IN-TRAINING

By

Hailey N. Martinez

A dissertation

submitted in partial fulfillment

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RE: regarding study number IRB-FY2016-305: Exploring the Relationship of Risk and Protective Factors in Predicting Secondary Traumatic Stress in Counselors-in-Training

Dear Ms. Martinez:

I agree that this study qualifies as exempt from review under the following guideline: Category 2: Anonymous educational tests, surveys, interviews, or observations. This letter is your approval, please, keep this document in a safe place.

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Sincerely,

Ralph Baergen, PhD, MPH, CIP
Human Subjects Chair

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## ABSTRACT

This study integrated multiple survey instruments to test the effectiveness of the mitigating factors of supervisory working alliance, history of previous trauma, levels of resilience, personal counseling, and mindfulness against Secondary Traumatic Stress. The sample size consisted of 50 counselors-in-training enrolled in masters counselor training programs. The findings showed that there was not a significant relationship between secondary trauma and the mitigating factors of supervisory working alliance, history of previous trauma, levels of resilience, and personal counseling. A significant inverse relationship between secondary trauma and mindfulness practice was found. The implications drawn from this study are primarily linked to counselor educators and supervisors regarding what studies can be helpful in understanding the mitigating factors for secondary trauma in counselors-in-training.

# CHAPTER ONE

## INTRODUCTION

According to the American Counseling Association (ACA) (2016), trauma can result from; a) human-made events (e.g. car accidents, sexual assault or abuse, school shootings, street violence, family violence, war, terrorism, etc.); or b) natural events (e.g. tornadoes, hurricanes, floods, earthquakes, fires, etc.). Trauma results in intense physical and psychological stress reactions; and can refer to a single event, multiple events, or a set of circumstances that can be experienced as physical or emotional harmful or threatening and results in adverse effects that lasts on the individual's well-being: physical, social, emotional, or spiritual (Substance Abuse & Mental Health Services Administration, 2014). A traumatic event can impact a person directly or indirectly. Exposure that is indirect consists of seeing disaster on television or hearing stories about others' experiences, possibly including risk of physical harm or death. Regardless of how the trauma is experienced, intense fear, helplessness, and hopelessness exceed the normal coping skills. Oftentimes, after the traumatic event, people may actively attempt to avoid remembering or feeling things that remind them of the traumatic experience (i.e., talking about the event/experience or visiting the location of the event) (ACA, 2016). The American Psychological Association (2016) defines trauma as an emotional response to an event in which the immediate experiences of shock and denial are typical, while longer term responses may include

unpredictable emotions, flashbacks, strained relationships, and manifestation of physical symptoms. Another definition worth making note of is ACA's description of disaster, which is described as entailing both natural and human-generated disasters, and associated with destruction as well as a loss of loved ones irreplaceable belongings, often overwhelming one's normal coping capacity; also, taking note that disasters stress emotional, cognitive, behavioral, physiological, and religious/spiritual beliefs (Jungersen, Dailey, Uhernik, & Smith, 2013). As much as 8% (24 million) of the U.S. population will experience a traumatic stress response during their lives (Sansbury, Grave, & Scott, 2015).

Given the breadth of experiences that can result in traumatic responses, there is a high likelihood that counselors-in-training (CITs) will be working with survivors of trauma (Trippany, Kress, & Wilcoxon, 2004). Counseling survivors of trauma requires specific skills and knowledge for training standards for crisis and trauma. Trauma competencies have been set forth by the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2016).

Although counselors are required to demonstrate competency in treating trauma survivors, little attention has been given to the potentially harmful psychological effects this work can have on counselors themselves. Known as Secondary Traumatic Stress (STS) (Figley, 1995b), these psychological effects entail the experience of trauma symptoms without experiencing trauma first hand, and can be the result of counselors engaging empathically with clients who are

trauma survivors (Figley, 1995b). Symptoms of STS, as were detailed in the DSM-IV, are identical to the symptoms of counselor's PTSD symptoms (APA, 2013), even though the professional has had no direct experience of the traumatic event (Figley, 1995a).

Secondary Traumatic Stress can lead to the development of negative cognitive changes from the long-term and cumulative exposure to traumatic material. These cognitive changes result in negative schemata and impact relationships, specifically in trust, safety, esteem, intimacy, and control (McCann & Pearlman, 1990b).

The costs of STS can be significant for both the counseling professional and the client. Studies on work-related stress show that professionals who experience secondary trauma have difficulty concentrating and making informed decisions (Shapiro, Shapiro, & Schwartz, 2000), while also experiencing burnout and high turnover (Gellis, 2002). Secondary trauma that has not been acknowledged and treated can also result in an absence of empathy, lack of attention to clients in session, and disruption in relationships (Valent, 2002). Changes within the professional counselor can present harmful consequences for the client and result in re-traumatization (Pearlman & Saakvitne, 1995a). For the purpose of this study, the Secondary Traumatic Stress Scale's (Bride, Robinson, Yegidis, & Figley, 2004) operational definition of STS was used. This definition states STS as "intrusion, avoidance, and arousal symptoms resulting from indirect

exposure to traumatic events by means of a professional helping relationship with a person or persons who have directly experienced traumatic events." (p. 28).

Risk Factors

STS can also impact Counselors-In-Training (CITs), defined in this study as students enrolled in masters counseling programs. CITs present a unique set of factors in comparison to counseling professionals who have years of experience. CITs typically think often about their clients outside of their sessions and can have unrealistic expectations of the amount of time it takes for their clients' to achieve their goals in counseling (Skovholt & Ronnestad, 2003). In addition, CITs face the challenge of setting and maintaining professional and emotional boundaries with their clients (Skovholt & Ronnestad, 2003).

Due to their limited experience, CITs may lack strategies for maintaining personal wellness that can mitigate the impact of hearing about their clients' traumatic experiences. In addition, there are personal factors, outside of training, that may increase a CITs susceptibility to STS. These include personal histories of trauma and low levels of personal resilience. CITs with personal histories of trauma report more secondary trauma than do their peers without such histories (Bride, Jones, & MacMaster, 2007; Cunningham, 2003; Pearlman & Mac Ian, 1995; Slattery & Goodman, 2009). The potential for CITs to be impacted by their work with a client increases when they have a trauma history that has been left unaddressed. The unresolved trauma history places the CIT at higher risk of

developing STS. In addition, lack of personal resilience in CITs may result in secondary trauma. Personal resilience provides CITs with the ability to call on support systems, and to access internal sources of strength when experiencing difficulty within their work with clients. Absence of personal resilience can result in non-beneficial methods of coping with stress and can result in factors of the CIT's experience never being processed (Thompson, Frick, & Trice-Black, 2000).

## Protective Factors

Knowledge of CITs' risk factors is important to consider for counselor educators; however, there exists several protective factors that can be built upon during training to mitigate the impact of STS within CITs. Three protective factors that may be particularly useful in protecting CITS against STS include the supervisory working alliance, personal counseling, and mindfulness. The supervisory working alliance could possibly be a protective factor for addressing secondary trauma in CITs. A supervisory relationship that fosters trust and collaboration serves as a critical component for the growth and development of the supervisee on a personal as well as professional level (Parcover & Swanson, 2013; Ellis, 2006; Bernard & Goodyear, 2004). Research focused on domestic violence and sexual abuse counselors reported that personal feelings shared and processed in supervision assisted in protecting against secondary trauma (Killian, 2008; Sommer & Cox, 2005). Even more, domestic violence advocates were less likely to experience STS when experiencing relationships with their supervisors

that were “engaging, authentic, and empowering” (Slattery & Goodman, 2009, p. 1369). Supervision provides the space for debriefing of specific client related concerns and any possible personalization to be addressed, while also identifying occurrences of countertransference that may impact the client-counselor relationship.

Personal counseling also has the potential to serve as a protective factor in addressing feelings that surface because of the CIT’s work with a traumatized client. Self-awareness is increased through personal counseling (Oden, Miner-Holden, & Balkin, 2009) and assists in the understanding of the emotional impacts on counselors in and out of session. Personal counseling increases awareness of the CIT in being able to notice and identify signs of being negatively impacted by their work with clients and resulting countertransference that may occur (Macran and Shapiro, 1998). Enhanced self-awareness through personal counseling can foster increased self-efficacy in CITs’ belief in their ability to work with people who have experienced trauma. The ability for CITs to have self-awareness and understand how they are impacted by the work they are engaged in is fostered through exploration of this in personal counseling.

Mindfulness has been defined as “the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment by moment” (Kabat-Zinn, 2003, p. 145). Mindfulness has become increasingly popular within the counseling profession as

a means to alleviate symptoms of stress (Brown, Marquis, & Guiffrida, 2013; Decker, Constantine, Brown, Ong, & Stiney-Ziskind, 2015; Richards, Campenni, & Muse-Burke, 2010). Mindfulness practice allows the CITs to be aware of their own thoughts and move into a role of a nonjudgmental observer of what they experience in the moment. This awareness can lead to a deepened sense of understanding of self and the emotional as well as physical impacts of what is occurring in the present moment. As an experience unfolds in present time, intentionality is enhanced as a result of the advancement in deepening one's awareness (Brown et al., 2013). Although supervisor working alliance, personal counseling, and mindfulness practice have been described as protective factors, research is needed to look at the effects these factors have on STS in CITs as serving a part of the trauma work equation. It is important to note that counselors experiencing STS who work with trauma survivors may be less effective or even harmful to their clients unless steps are taken to alleviate its symptoms.

## Importance of the Problem

In order to ensure the quality of care with clients who have experienced trauma, it is critical to protect CITs from the adverse consequences of STS. Knowledge about possible risk factors (i.e., history of personal trauma, lack of resilience) and protective factors (i.e., mindfulness, personal counseling, and supervisory working alliance) can help counselor educators and supervisors identify and support CITs who may need particular assistance in dealing with

secondary trauma. Furthermore, research into risks and protective factors may provide a foundation to develop programs that raise awareness of secondary trauma and provide practical solutions for CITs and supervisors. With this, the research questions for this study are provided below.

## Research Questions

The goal of this study was to explore the relationship between factors that contribute to CITs developing secondary trauma.

The research questions for this study were:

(1) Does a supportive supervisory working alliance predict the impact of secondary trauma within CITs?

(2) Does a history of previous trauma predict the impact of secondary trauma within CITs?

(3) Do low levels of resilience of CITs predict the impact of secondary trauma within CITs?

(4) Does personal counseling predict the impact of secondary trauma within CITs?

(5) Does use of mindfulness practices predict the impact of secondary trauma within CITs?

# CHAPTER TWO

# LITERATURE REVIEW

Counselors face considerable stress and risk of developing psychological symptoms when treating clients who have experienced trauma first hand. These risks to counselors are primarily from secondary traumatic stress (STS). STS has been defined as a natural response in behavior and emotion that results from knowledge about a traumatizing event experienced by another person (Figley, 1999). In the counseling profession, STS is recognized as a consequence of working with a client who has experienced some form of trauma and is characterized by symptoms nearly identical to those of posttraumatic stress disorder (ACA, 2016; Bride, Robinson, Yegidis, & Figley, 2004; Figley, 1999).

The existing literature on STS uses a variety of terms for the phenomenon. Figley (1999) used the term compassion fatigue (CF) in an effort to decrease the stigmatization of describing STS. Vicarious trauma (VT) (Pearlman & Saakvitne, 1995) is another term for the sudden onset of a traumatic reaction to specific client-presented information. Burnout, on the other hand, gradually progresses and is the cumulative result of feeling overloaded secondary to client problems (Trippany, Kress, & Wilcoxon, 2004). For the purpose of this study, STS was the term used to describe CITs' experiences of being traumatically impacted by their client's traumatic experiences. The operational definition used to define STS is the "intrusion, avoidance, and arousal symptoms resulting from indirect exposure

to traumatic events by means of a professional helping relationship with a person or persons who have directly experienced traumatic events." (Bride, Robinson, Yegidis, & Figley, 2004, p. 28).

To understand STS, an exploration of the effects of trauma is warranted. Trauma can have chronic and pervasive detrimental effects on multiple developmental areas including social, cognitive, psychological, and biological development across the lifespan (Sansbury, Grave, & Scott, 2015). Experience of a traumatic event leaves the limbic system of the brain in a state of arousal, even in nonthreatening situations (Rothschild, 2000). Traumatic experiences can also impact the formation of memory when traumatic stress is experienced, resulting in the release of hormones that suppress the hippocampus, and result in the explicit memory system being unable to form memory (Rothschild, 2000; Goodman & Calderon, 2012).

While the impact of trauma on clients has been studied extensively, there is a scarcity of research on the impact trauma-specific counseling has on helping professionals (Sansbury, Grave, & Scott, 2015). This is concerning because researchers estimate 15% to 50% of mental health workers experience some form of secondary trauma (Sansbury et al., 2015). The 2009 CACREP standards incorporated trauma training into the eight core curricular areas of counselor training and are also included this in the 2016 standards. Nevertheless, CITs report feeling unprepared to work with trauma survivors (Jones & Cureton, 2014),

which may create a higher potential for the development of STS.

The potential of STS among mental health professionals highlights the importance of addressing secondary trauma with counselors-in-training (CITs). The following sections explore the components of STS in more detail and examine recent literature addressing mitigating factors to STS for professional counselors.

## Review of Relevant Literature

### Trauma and Secondary Trauma

According to the American Counseling Association (2016), trauma can result from; a) human-made events (e.g. car accidents, sexual assault or abuse, school shootings, street violence, family violence, war, terrorism, etc.); or b) natural events (e.g. tornadoes, hurricanes, floods, earthquakes, fires, etc.). Trauma is an emotional response to an event in which the immediate experience of shock and denial are typical (Substance Abuse & Mental Health Services Administration, 2014). Longer term responses may include unpredictable emotions, flashbacks, strained relationships, and physical symptoms. Symptoms of trauma include intrusive thoughts connected to the traumatic material, avoidant responses, physiological arousal, distressing emotions, and functional impairment (Figley, 1995; McCann & Pearlman, 1990a). Additional symptoms include sleep disturbance, nightmares, hyper-vigilance, acute distress, a disrupted sense of safety, and flashbacks (Walker, 2004).

Individuals who have had a traumatic experience often seek counseling to work through their trauma-related emotions and memories. When counselors listen to clients' description of traumatic events, they are repeatedly exposed to the details of the trauma through vivid imagery (Bride, Hatcher, & Humble, 2009). Repeated exposures may increase counselors' susceptibility to experiencing STS, which includes symptoms of Post-Traumatic Stress Disorder (PTSD) (Shoji et al., 2015). Therefore, STS is considered an occupational hazard of clinical mental health work (Figley, 1999; Munroe et al., 1995; Pearlman, 1999). Counselors working with clients who have experienced trauma also experience compassion fatigue and vicarious trauma. An exploration of how these states are similar and dissimilar to STS is found below.

## Compassion Fatigue and Vicarious Trauma

Figley (1995) coined the term compassion fatigue (CF) in an attempt to destigmatize the occurrence of STS in health professionals. Jenkins and Baird (2002) describe CF as consisting of three domains; a) physical symptoms (e.g. sleep disturbance, gastrointestinal disturbance, and other somatic issues); b) emotional changes (e.g. anxiety, excessive irritation, and guilt); c) behavioral components, (e.g. over-eating and substance abuse). Sansbury, Graves, and Scott (2015) observed that the last two domains have particular impacts on counselors' personal and professional relationships due to the isolation that ensues when counselors fail to become aware of their own arousal state and neglect attending

to their self-care. Counselors who face CF are likely to experience tension and be preoccupied with the trauma of their clients through re-experiencing of the traumatic event, resulting in active avoidance of any reminders of the material in the client's story, as well as experiencing ongoing anxiety. A deep physical, emotional, and spiritual exhaustion occur along with emotional pain, which is the result of the counselor having an awareness of the suffering of clients followed with the desire to relieve this suffering (Merriman, 2015).

In addition to CF, counselors are also likely to face vicarious traumatization (VT) when treating clients who have experienced trauma. VT has been used synonymously in the literature to describe the experience of STS; however differences exist between VT and STS. VT is described as a reaction to the detailed information of a traumatic experience as presented by a client (Trippany, Kress, & Wilcoxon, 2004). VT is theorized to be the cumulative transformative effect on the trauma counselor as a result of working with survivors of traumatic life events. These effects specifically impact the identity, worldview, psychological needs, beliefs, and memory system of the counselor (Devilly, Wright, & Varker, 2009).

Constructivist self-development theory (CSDT; McCann & Pearlman, 1990a) and other research suggest counselors experience the impact of VT on both a professional and personal level (Trippany, et al., 2004). VT manifests as changes in memory and impacts the basic needs of safety, dependency, trust,

power, esteem, and intimacy (Dunkley & Whelan, 2006; McCann, Sakheim, & Abrahamson, 1988). Furthermore, in working with survivors of trauma, counselors may experience alterations in identity, worldview, spirituality, self-capacities, ego resources, psychological needs, and the sensory system (Rasmussen, 2005). Like STS and CF, symptoms of VT include anxiety, suspiciousness, depression, somatic symptoms, intrusive thoughts and feelings, avoidance, emotional numbing and flooding, and increased feelings of personal vulnerability (Adams & Riggs, 2008).

However, VT and CF are considered concepts addressing a state and set of symptoms from cumulative exposure, whereas STS may occur in response to a single exposure to clients' traumatic material (Devilly et al., 2009; Jenkins & Baird, 2002; Kadambi & Ennis, 2004). It is concluded that the constructs of CF and VT are closely related phenomenon and have different socially constructed names to basically explain the same phenomenon. Therefore, it is proposed for this research project that the mitigation of STS may also further reduce CF and VT. By reducing the harmful impact of single exposures to clients' traumatic material, the accumulation of these exposures resulting in CF and VT may also be reduced. Finding what contributes to these mitigating factors is the focus of the current study. Below table 1 reviews the terminology used in the literature and distinguishes the differences and similarities of the constructs.

Table 1.

| Term | Components* | Assessment Measures |
|---|---|---|
| Secondary Traumatic Stress (STS) | • Presence of PTSD symptoms<br>• Rapid onset<br>• Driven by fear that arises from a threat to one's personal safety<br>• Stress response; emotional distress<br>• Associated with a particular event | • Secondary Traumatic Stress Scale (STSS) |
| Compassion Fatigue (CF) | • Type of burnout; more pervasive<br>• Rapid onset<br>• Experience a loss of meaning and hope<br>• A result of empathy | • Compassion Fatigue/Satisfaction Self-Test (CFST)<br>• Professional Quality of Life Scale (ProQOL) |
| Vicarious Trauma (VT) | • Less focus on trauma symptoms<br>• Cognitive shifts occur, taking more of the focus<br>• Cumulative exposure<br>• Result of personal trauma | • Traumatic Stress Institute Belief Scale- Revision L (TSI-BSL)<br>• Traumatic Stress Institute Life Events Checklist (TSI-LEC) |

*Nimmo & Huggard, 2013

In an effort to establish effective management of STS counselor educators are tasked with finding ways to infuse these mitigating factors into counseling curricula and within effective supervision of CITs. The purpose of this study is to

specifically determine the relationships between the impact of secondary trauma on CITs and potential risks and mitigating factors associated with counseling student development. Risk factors include a past history of trauma, while mitigating factors include levels of resilience, strength of the supervisory working alliance, involvement in personal counseling, and dispositional mindfulness.

A detailed review of counselor training methods and an exploration of the five predictor variables included within this study can be found below.

## Trauma and Crisis Training Across the Counseling Curriculum

The Council for Accreditation for Counseling and Related Educational Programs (CACREP) requires that CITs receive training in crisis and trauma treatment (CACREP, 2016). Additionally, Culver, McKinney, and Paradise (2011) recommend that, alongside coursework including trauma training, it is important for CITs to have direct counseling experience during internship with trauma survivors. It was hypothesized that CITs working with clients who have experienced trauma will benefit from effective supervision coupled with a strong supervision working alliance (SWA) reducing the impact of STS (Culver, et al., 2011).

However, specific research on the Supervisory Working Alliance (SWA) having an impact on STS in counselor trainees is absent, with limited studies speaking to related constructs of burnout and work-related stress. For instance, Sterner (2009) discovered a significant negative correlation between supervisee

perceptions of the SWA and work-related stress. Therefore, positive perceptions of the supervisees on the SWA reported less work-related stress. Mena and Bailey (2007) performed a study on the influence of the SWA and job satisfaction and BO. Healthy Families America workers (n=80) were surveyed, with results indicating workers' perceptions of rapport within the SWA significantly predicted job satisfaction due to the fact that as workers perceived a greater amount of rapport within the SWA, higher levels of job satisfaction were reported. The SWA did not appear to relate to BO as a whole, however a strong negative correlation between workers' perceptions of SWA rapport and BO constructs of emotional exhaustion and depersonalization. Both studies highlight that the SWA can impact forms of counselor distress, and therefore have the potential of impacting STS.

Slattery and Goodman (2009) studied workplace risk and protective factors in relation to STS in domestic violence advocates (n=148). The Relational Health Index (Liang et al., 2002) was used to assess the quality of the supervisory relationship as a workplace factor. Results showed the quality of the supervisory relationship to be negatively correlated with STS levels. Further, "participants who reported engaging, authentic, and empowering relationships with their supervisors were less likely to experience STS" (Slattery & Goodman, 2009, p. 1369). Slattery and Goodman acknowledged that theirs was one of the first studies to provide empirical support to the assertion that supervision aids in

preventing and alleviating counselor distress (2009).

Supervisory Working Alliance.

Counseling supervision serves the purpose of improving the professional functioning of CITs, monitoring the quality of professional services that are offered to clients, and providing support and encouragement to CITs (Bronson, 2010). The primary focus of supervision is an emphasis on skills and techniques, while attending to CITs personal and professional development (Parcover & Swanson, 2013). Research has stressed the importance of the development of a strong supervisory relationship for the personal and professional growth of the supervisee (Parcover & Swanson, 2013). CITs that experience a strong and supportive supervisory relationship have been shown to be more reflexive and positive within the supervision experience (Martin, 1987). Teaching and learning occur when there is a presence of trust, collaboration, and an emotional investment in the relationship built with the supervisor and CIT (Ellis, 2006; Bernard & Goodyear, 2004). As collaboration and mutual agreement are attained, supervision is able to have a healthy establishment of a productive and secure working relationship. Emphasis on the supervisory relationship provides the supervisor guidelines for how she/he navigates the different roles of support, consultation, instruction, and evaluation.

Supervision can also serve as a protective factor in reducing counselor personalization and assist CITs in identifying countertransference as it arises

(Walsh, 2002). As supervision provides continued growth in a CIT's skill development, it provides an opportunity for further awareness of how working with clients is impacting the supervisee. It is important for supervisors working with CITs that are working with trauma survivors to attend to the supervisory working relationship (Sommer, 2008). Recommendations for supervisors working in a supervisory role with CITs working with survivors of trauma are included below.

Several recommendations exist for supervising CITs working with trauma clients. Etherington (2000) highlighted the importance of supervisors being attentive to CITs' behavior and reactions to clients, potential intrusions of traumatic material into CITs' lives, signs of burnout or feeling overwhelmed, experiencing a withdrawal from the supervisory relationship or counseling, signs of stress, and an inhibited ability to engage in self-care. Rosenbloom, Pratt, and Pearlman (1999) discussed the importance for supervision to "foster an atmosphere of respect, safety, and control for the therapist who will be exploring the difficult issues evoked by the trauma" (p. 77). Pearlman and Saakvitne (1995) suggest that four components are particularly recommended for supervision with counselors working with trauma: (a) a strong theoretical grounding in trauma therapy, (b) attention to both the conscious and unconscious aspects of treatment, (c) a mutually respectful interpersonal climate, and (d) educational components that directly address vicarious traumatization. Thus, a strength-based approach to

supervision is important, which places emphasis on processing the effects of the work and personal feelings surrounding the CIT's experience and provides a focus on the strategies that highlight the CIT's strengths (Sommer & Cox, 2005), therefore increasing awareness of the CIT's resilience. Gnilka, Chang, and Dew (2012) examined the relationship between perceived stress, specific types of coping resources, the working alliance, and the supervisory working alliance among 232 counselor supervisees. Results showed the working alliance and the supervisory working alliance were negatively related to perceived stress and positively related to multiple coping resources. Two regression models showed significant results in predicting the working alliance and supervisory working alliance from perceived stress and specific coping resources.

Personal Resilience within CITs.

In addition to the protective role of supportive supervision, research has also shown that variability within a CIT's personal resilience has strong correlation to the impact of STS (Cooke, Doust, & Steele, 2013). Personal resilience may be an important factor in explaining the ways in which CITs cope with hearing of traumatic events of their clients; therefore this is further explored in the next section.

Resilience can be defined as the "personal qualities and skills that allow for an individual's successful functioning or adaptation within the context of significant adversity or a disruptive life event" (Lee, Nam, Kim, Kim, Lee, & Lee,

2013, p. 269). Further, resilience is the ability to adapt to changes while finding challenges to be empowering, and discovering how past experiences can be used as a means of confronting and overcoming what is experienced in the present (Lambert & Lawson, 2013; Conner, 2006). Heetkamp and de Terte (2015) studied adolescent hurricane survivors for factors of resilience, trauma, and fear in predicting symptoms of PTSD. They found that high resilience served as a buffer between the level of fear experienced and resulting PTSD symptoms (Heetkamp & de Terte, 2015). These results support the importance of CITs, as well as other helping professionals, to be evaluated for levels of professional resilience throughout their time in training and practice.

Professional resilience entails a "commitment to achieve balance between occupational stressors and life challenges, while fostering professional values and career sustainability" (Fink-Samnick, 2009, p. 331). Professional resilience develops over time, as professionals approach challenges as a means for continued growth (Hodges, Keeley, & Greier, 2005; Lambert & Lawson, 2013). Serving as a protective factor, professional resilience can be utilized when counselors are engaged in empathic connections with clients. When there is a lack of resilience in professional counselors, it can negatively impact their ability to work with traumatized clients and sustain an optimal state of wellbeing. With an absence or lack of resilience having a negative impact on counselors it is possible that professional resilience serves as a protective factor, as demonstrated

in the research discussed next.

Pietrzak, Johnson, Goldstein, Malley, and Southwick (2009) conducted a study of potential protective factors against the development of traumatic stress and depressive symptoms in soldiers returning from Operations Enduring Freedom and Iraqi Freedom. Results showed increased levels of resilience were negatively associated with levels of traumatic stress and depressive symptoms. Huggard, Stamm, & Pearlman (2013) conducted a study that surveyed resident physicians working in New Zealand hospitals, which found a significant negative relationship between compassion fatigue and resilience. These findings suggest that high levels of resilience may be related to low levels of compassion fatigue. As the research demonstrates, professional resilience is likely to be important in serving as a buffer for counselors to the harmful effects resulting from STS. While there is research that focuses on resilience and the protection it provides against risk of harm to mental health and wellbeing, there is a dearth of research looking at the relationship between resilience and secondary traumatic stress in counselors, particularly in CITs (Temitope & Williams, 2015).

Mindfulness.

Mindfulness in the helping professions has gained attention as it has been shown to have an impact in helping to alleviate symptoms of stress on a psychological and physical level (Decker et al., 2015). Mindfulness has been defined as “the awareness that emerges through paying attention on purpose, in

the present moment, and nonjudgmentally to the unfolding of experience moment by moment" (Kabat-Zinn, 2003, p. 145). Awareness means noticing what is occurring in the present moment, on a mental as well as physical level (Brown, Marquis, & Guiffrida, 2013). Brown and Ryan (2003) use the term "dispositional mindfulness" which they describe as an innate ability of intentional awareness (Brown and Ryan, 2003).

As mindfulness has been recognized as an evidence-based approach, it has become increasingly more prevalent within counseling and trauma literature (Brown et al., 2013; Decker et al., 2015; Richards et al., 2010). In Decker et al. (2015), an examination of the relationship between mindfulness and the risk for developing compassion fatigue and the potential for compassion satisfaction was examined among master's level social work student interns. Results showed higher levels of compassion satisfaction to be associated with higher levels of mindfulness, $r = .46$, $n = .92$, $p < .00$. A strong negative relationship between compassion fatigue and mindfulness resulted in higher levels of compassion fatigue associated with lower levels of mindfulness, $r = -.53$, $n = 91$, $p < .00$. Thus, it is suggested that mindfulness may serve as a protective factor for those working within the helping professions (Decker et al., 2015).

Richards, Campenni, and Muse-Burke (2010) explored the link between self-care by mental health professionals and their general wellbeing. Specifically, they examined the direct effect of self-care on self-awareness and mindfulness

and how these associations affect the wellbeing of mental health professionals. Self-awareness and mindfulness were positively correlated and counselors who have developed a mindfulness attitude may attend more to the value they place on their self-care and wellbeing.

Thompson, Amatea, and Thompson (2014) explored how personal resources of mindfulness as well as counselor gender, years of experience, perceived working conditions, use of coping strategies, and compassion satisfaction may predict compassion fatigue and burnout. Results from this study found an inverse relationship between counselor perceptions of positive working conditions and level of compassion fatigue. Additionally, the longer the counselor had worked in the field, the less compassion fatigue and burnout was reported. Thompson, et al. also found that dispositional mindfulness strengthened a counselors' ability to cope with symptoms of exhaustion and to accept, with nonjudgmental awareness, their current mental and emotional state.

Another study by Thieleman and Cacciatore (2014) drew on previous research of compassion fatigue and mindfulness to investigate interactions of these two constructs in professional and non-professional health care employees working with traumatically bereaved clients. A strong positive relationship was found between the Mindful Attention Awareness Scale (MAAS; Thieleman & Cacciatore, 2014) and items on the Professional Quality of Life Scale (PRoQOL; Thieleman & Cacciatore, 2014); compassion satisfaction, a moderately strong but

negative relationship between the MAAS and secondary traumatic stress, and a strong negative relationship between the MAAS and burnout. These results suggest that mindfulness is associated with greater compassion satisfaction scores and lower secondary traumatic stress and burnout scores (Thieleman & Cacciatore, 2014).

Personal Counseling.

Personal counseling is considered a necessary component in the development of CITs (Byrne & Shufelt 2014). The counseling profession actively supports personal wellness in CITs through the recommendation of personal counseling; which serves to significantly improve ability to identify countertransference and act as a preventative to burnout among mental health practitioners (Macran and Shapiro, 1998). Furthermore, within personal counseling, CITs can explore professional boundaries and the impact that boundary setting has on them (Macran, Stiles, and Smith, 1999).

There are a variety of factors that may motivate CITs to enter the counseling profession. A study conducted by Elliott and Guy (1993), examined the prevalence of childhood trauma, family dysfunction, and current psychological distress among female mental health professionals, comparing these rates to the prevalence among women working in other professions. Mental health professionals reported higher rates of physical abuse, sexual molestation, parental alcoholism, psychiatric hospitalization of a parent, death of a family

member, and greater family dysfunction in their families of origin compared to other professionals. However, as adults, the mental health professionals experienced less anxiety, depression, dissociation, sleep disturbance, and impairment in interpersonal relationships compared to the women in other professions outside of mental health (Elliott & Guy, 1993). These results speak to the possibility for people to be motivated by experiences in their lives that moved them towards entering the counseling profession. Additionally, a common occurrence for counselors is to be identified by family, friends, and coworkers as a caregiver in different capacities throughout their life (Hill et al., 2013). As students pursue a career in counseling for a variety of reasons (Hill, 2009), their history may influence their decision and, as a result, makes personal counseling an important part of a CIT's training experience.

Personal counseling also increases CIT's self-awareness (Richards, Campenni, & Muse-Burke, 2010). This self-awareness can assist counselors working with trauma populations as well as other populations (Oden, Miner-Holden, & Balkin, 2009). The increase in awareness suggests counselors' style may be more active with clients and facilitate the expression of empathy as a result of personal counseling (Byrne & Shufelt, 2014; Mackey & Mackey, 1994; Strupp, 1955). CITs receiving personal counseling services can also aid in understanding the complexities of the client-therapist relationship, helping them to become more reflexive, open to personal and professional growth, increased

authenticity of experience, and prolongation of time in personal counseling (Murphy, 2005).

Personal Trauma History.

Research has shown an association of personal trauma history having a negative impact on the CIT. Pearlman and MacIan (1995) found that 60% to 80% of individuals conducting trauma counseling have a history of personal trauma, and the counselor's own memories of personal trauma may be activated during session after hearing traumatic material from a client (McCann & Pearlman, 1990b). Pearlman and Mac Ian's (1995) research suggests that, when working with trauma survivors, counselors with a personal trauma history experienced considerably greater disruptions in their level of safety, trust in their own judgment, trust in others, level of importance, and feeling connected to their client. If the counselor has not addressed their personal trauma history, there is a greater likelihood of intrusive traumatic memories arising during session with a client who is presenting traumatic material (Hesse, 2002).

Although personal history of trauma has been considered a primary risk factor for the development of STS, other research has produced mixed results on the reliability of this factor (Slattery and Goodman, 2009). A study of counselors who had a personal history of sexual trauma and who were working with survivors of sexual violence were found to have no higher levels of distress compared to counselors with no personal history of sexual trauma (Schauben and

Frazier, 1995). However Follette, Polusny, and Milbeck (1994), discovered mental health and law enforcement professionals with a personal history of physical or sexual abuse reported significantly higher levels of trauma-specific symptoms than did professionals reporting no childhood trauma. These contradictory results may be due to specific populations studied and or research designs and call for increased research attention.

## Conclusion

The prevalence of traumatic events in the general population makes it extremely likely that counselors and CITs will be working with trauma survivors. Important and rewarding as this work is, it also places the counselor at high risk for STS. Counselors-in-training may be at a higher risk of STS as a result of limited experience, potentially unrecognized and unresolved personal trauma, and lack of self-awareness.

The current study was designed to look at the risk and protective factors contributing to CITs' development of STS. As counselor education continues to face the reality of CITs working with survivors of trauma, it is imperative for the profession to place emphasis on the factors impacting CITs success or failure throughout training. The results of this study will help contribute to the knowledge base of counselor educators and supervisors to help ensure success of CITs.

# CHAPTER THREE

# METHODOLOGY

The purpose of this study was to determine the relationships between the impact of secondary trauma on counselors in training and potential risk and mitigating factors associated with counseling student development. Risk factors include a past history of trauma, while mitigating factors include levels of resilience, strength of the supervisory working alliance, involvement in personal counseling, and dispositional mindfulness. The following section is divided into four subsections: (a) participants/sampling, (b) instrumentation, (c) data collection/procedures, and (d) data analysis. First, in the participants subsection, I describe the participant criteria. Second in the instrumentation subsection I report the psychometric properties of the measures used within the study. Third, in the data collection/procedures subsection I illustrate the content of the demographics and the data collection procedures for the participants. Lastly, in the data analysis subsection I list the descriptive statistics, power analysis, correlational analyses, and regression analyses that were used for this study.

## Operational Definition of the Variables

Clear operational definitions of the independent and dependent variables are required to understand the results of the study (Heppner, Wampold, & Kivlighan, 2008). It is necessary to determine and provide a rationale for what

specifically is being studied and decide what measures will be used for quantification.

Dependent Variables

For the purpose of this study, the dependent variables or outcome variables were defined as the level of impact of secondary trauma on CITs as measured by the Secondary Traumatic Stress Scale (STSS; Bride, Robinson, Yegidis, & Figley, 2004). Secondary traumatic stress was operationalized as intrusion, avoidance, and arousal as a result of being exposed to a trauma survivor's traumatic experience(s), and resulting in emotional disruption. STS has been defined as "the natural, consequent behavior and emotion that has resulted from knowledge about a traumatizing event experienced by a significant other. It is the stress resulting from helping or wanting to help a traumatized or suffering person" (Figley, 1999, p.10; Bride et al., 2004). Symptoms of STS resemble those of a traumatized person and include PTSD symptomology. The difference with STS is the resulting secondary traumatic impact on an individual after hearing stories from another's traumatic experience and therefore being vicariously affected. The STSS was developed in response to the absence of instruments designed to measure specifically the second hand impact of traumatic experiences and resulting trauma symptoms (Bride et al., 2004).

Independent Variables

For the intent of this study, the independent variables or predictor variables were defined as: a) past history of trauma, b) level of resilience, c) strength of the supervisory working alliance, d) involvement in personal counseling, and e) mindfulness practices.

The first predictor variable of past history of trauma was defined as a CIT's first-hand experience of a traumatic event in their life, and self-identified as being traumatic. History of past trauma was measured using the Trauma History Questionnaire (THQ; Green, 1996). For the intent of the current study, past history of trauma encompassed experiencing an event related to crime, general disaster, and trauma, or physical or sexual trauma for which the impact was significant and resulted in the individual experiencing high stress. The second predictor variable, level of resilience, was defined as the qualities and skills that make up a person and allow for a healthy level of functioning when presented with a stressful life event. The level of resilience was measured using the Brief Resilience Scale (BRS; Smith et al., 2008). The third predictor variable of strength of the supervisory working alliance (SWA) looked at the supervisory relationship between the CIT and supervisor and was defined as the perceived support experienced by the CIT of the supervisory working relationship. SWA was measured using the Supervisory Working Alliance Inventory- Trainee Form (SWAI-T; Efstation, Patton, & Kardash, 1990). A fourth predictor variable,

personal counseling was defined as actively attending individual counseling with a licensed clinical professional. Personal counseling consisted of binominal data of yes or no responses. The last predictor variable, dispositional mindfulness, is defined as the awareness given to one's thoughts, feelings, and behaviors in the present moment. Mindfulness was measured using the Mindful Attention Awareness Scale (MAAS; Brown & Ryan, 2003).

## Participants

A convenience sample was used for this study. Participants were sampled from Council for Accreditation of Counseling and Related Educational Programs (CACREP) and Non-CACREP accredited counselor education programs with counselors-in-training (CITs) from various Association of Counselor Education and Supervision (ACES) regions across the United States. These regions include the Rocky Mountain, Western, Southern, Mid-Western, Northeastern, and Eastern ACES Regions.

This study sampled CITs, who were enrolled in a counseling practicum or internship course. Selecting students enrolled in practicum and internship ensured the CIT had been serving clients through counseling, as well as having worked with a supervisor on a regular basis. Exclusion criteria for this study consisted of participants with zero direct client hours, or CITs that had not completed the survey packet to completion.

## Sampling Plan

The proposed study was submitted to the Human Subjects Research Committee for IRB approval. Once approval was granted, the process of sending out e-mail invitations to the identified counselor education programs was initiated. I solicited participation through internship site coordinators. To ensure confidentiality, all forms including consent of participation and the survey data did not include any identifying information such as; name, student identification number, or student email addresses.

Demographic data were collected from the participants, including age, gender, ethnicity, specialization of master's program, level of training received in relation to trauma work semesters or quarters in the program, and status of CACREP accreditation for program. The demographic variables for this study were chosen to help the researcher better understand the sample of participants.

Initial contact with counselor education departments was made by email to the department's internship coordinator and entailed a follow up telephone call to secure distribution of assessments to CITs via email.

Responses were collected through Qualtrics, an online research survey program. Participation in this study was voluntary and could be discontinued at any time with no penalty to the participant.

It was important to allow for a significant amount of time for the completion of surveys. There were anticipated rounds of data collection

beginning with a one-month timeline that was extended based on the progress of the collection of surveys for this study. The anticipated length of time the assessment took to complete was noted in the invitation to participate. Assurance of participant's confidentiality was of top priority and questions regarding this study and one's concern of confidentiality were welcomed. There are a variety of 'rules of thumb' when considering a minimum sample size, with the most common being that you should have at least 10-15 data points per predictor parameter model (Field et al., 2012). For example, for this study, five predictors were used (i.e. past history of trauma, level of resilience, strength of the supervisory working alliance, involvement in personal counseling, and mindfulness practice), which results in a minimum sample size of 50 to 75 participants. For regression models, k predictors recommend a minimum sample size of 50 + 8k in order to sufficiently test the model overall, and 104 + k to sufficiently test each of the predictors in a model (Green, 1991). Cohen's (1988) benchmark statistical power of 0.8 and the use of three predictors in the regression model would consist of: a large effect size (> 0.5) and require a minimum sample size of 40 experimental units; where a medium effect size would require a sample size of 80; while a small effect size requires a sample size 600 (Miles & Shevlin, 2001; Feld et al., 2012).

## Instrumentation

The instruments that were used to measure the outcome and predictor variables are discussed within this section. The outcome variable, impact of secondary trauma, was assessed using the (a) Secondary Traumatic Stress Scale. (Bride, Robinson, Yegidis, & Figley, 2004). The predictor variables were assessed using the (b) Supervisory Working Alliance Inventory – Trainee Form (SWAI-T; Efstation, Patton, & Kardash, 1990), (c) Brief Resilience Scale (BRS, add citation), and (d) Mindful Attention Awareness Scale (MAAS; Brown & Ryan, 2003).

### Secondary Traumatic Stress.

The Secondary Traumatic Stress Scale (STSS) is a measure of secondary traumatic stress symptomatology in individuals who have been affected by their work with traumatized clients. The scale consists of 17-item, Likert-type scale items ranging from 1-5, and is a self-report instrument designed to assess the frequency of intrusion, avoidance, and arousal symptoms associated with secondary traumatic stress (STS). STS includes the indirect exposure to trauma. Participants are instructed to read each item and indicate how frequently the item was true for them in the past 7 days, using a five-choice, Likert-type response format ranging from 1 (never) to 5 (very often). The STSS is comprised of three subscales: Intrusion (items 2, 3, 6, 10, 13), Avoidance (items 1, 5, 7, 9, 12, 14, 17), and Arousal (items 4, 8, 11, 15, 16). Scores for the full STSS (all items) and

each subscale are obtained by summing the items assigned to each. The STSS differs from other measures of PTSD in that the instruction wording and the stems of stressor-specific items (items 2, 3, 6, 10, 12, 13, 14, 17) were designed so the traumatic stressor was identified as exposure to clients. Consistent with the DSM-IV criteria for PTSD, items that are not stress-specific (items 1, 4, 5, 7, 8, 9, 11, 15, 16) are characteristics of the negative aspects of traumatic stress. Means, standard deviations, and internal consistency values for the STSS and its subscales is as follows. Full STSS ($M = 29.49$, $SD = 10.76$, $\alpha = .93$), Intrusion ($M = 8.11$, $SD = 3.03$, $\alpha = .80$), Avoidance ($M = 12.49$, $SD = 5.00$, $\alpha = .87$), and Arousal ($M = 8.89$, $SD = 3.57$, $\alpha = .83$) (Bride, Robinson, Yegidis, & Figley, 2004). The STSS has good internal consistency reliability ($\alpha = .93$). The scale also has a high rate of comorbidity among traumatic stress, depression, and anxiety (Bride et al., 2004). Confirmatory factor analysis supports a three-factor model (i.e., intrusion, avoidance, and arousal) (Bride et al., 2004).

Supervisory Working Alliance.

The Supervisory Working Alliance Inventory- Trainee (SWAI-T) (Efstation et al., 1990) is a 19-item self-report measure designed to measure the relationship within counselor supervision. The SWAI-T consists of the set of interactions used by both supervisor and supervisee within the supervisory relationship. Thus, consisting of 36 items that are measured on a 7-point Likert-type scale ranging from Never (1) to Always (7). There are three subscales, with

each comprised of 12 items, addressing Agreement on Tasks, Agreement on Goals, and Emotional Bonds. Sample items include "I feel that (supervisor) appreciate me" and "I am worried about the outcome of our supervision sessions." Summing of the three subscale scores resulted in total scores ranging from 36 to 252. Stronger alliances are represented by higher scores, following the reversal scoring of the fourteen negatively-worded items. Supervisor and Trainee versions of the SSI scales were found to have high internal consistency estimates from ($\alpha$ = .70 to .93). Two-week test-retest reliability coefficients ranged from (r = .78 to .94) for the total inventory and each scale (Efstation, Patton, & Kardash, 1990).

Past Trauma History

The Trauma History Questionnaire (THQ; Green, 1996) is a 24-item self-report instrument designed to gather information from general community and clinical populations about lifetime exposure to a range of potentially traumatic events. The questions developed for the THQ were based on a structured "high magnitude" stressor events interview (the Potential Stressful Events Interview, or PESI; Falsetti, Resnick, Kilpatrick, & Freedy, 1994; Kilpatrick et al., 1998; and Hooper, Stockton, Krupnick, & Green, 2011). General recommendations of the THQ items contend that studies should elicit information of the presence or absence of each specific event instead of asking open-ended questions of traumatic exposure. Therefore, neutral language of behavioral responses has been used. The THQ consists of 24 yes/no questions addressing a range of traumatic

events in three areas: (a) crime-related events (e.g., robbery, mugging), (b) general disaster and trauma (e.g., injury, disaster, witnessing death), and (c) unwanted physical and sexual experiences (Hooper et al., 2011). An additional item is an "other" response (Have you experienced any other extraordinary traumatic stressful situation or event that is not covered? If yes, please specify.). This allows for the participant to report additional experiences that were not covered in the other response items. The self-report format takes approximately 10 to 15 minutes to complete. Test-retest reliability revealed results to reporting specific traumatic events were fair to excellent. Stability coefficients ranged from ($r = .51$ to $.91$). The correlation for a number of items endorsed across administrations was (.70) (Green, 1996; Hooper et. al., 2011). Scores were summed adding each of the categories and then dividing the total score with the number of items within the category.

### Brief Resilience Scale

Levels of resilience was measured using the Brief Resilience Scale (BRS; Smith et al., 2008). Resilience is defined as the ability to bounce back or return to a previous level of functioning (Smith et al., 2008). The BRS consists of six items; with items 1, 3, and 5 being positively worded, and items 2, 4, and 6 being negatively worded. The BRS requires reverse coding of items 2, 4, and 6 and finding the mean of the six items. The BRS was created to assess the ability to bounce back or recover from stress. Psychometric characteristics were studied

within four samples. Results from these samples included a one-factor solution that account for 55-67% of the variance. Internal consistency was good, with Cronbach's alpha range from .80-.91. Two samples were given in the BRS with a test-retest reliability of .69 for one month of 48 participants from sample 2 and .62 for three months in 61 participants from sample 3 (Smith, 2008).

Mindfulness Awareness Attention Scale

The trait Mindfulness Awareness Attention Scale (MAAS) was designed to measure a core characteristic of mindfulness, specifically, an open state of mind where attention is informed by careful awareness of what is occurring in the present moment by simply noticing, nonjudgmentally. The MAAS had high test-retest reliability, discriminant and convergent validity, known-groups validity, and criterion validity. Trait mindfulness is operationalized by the 15-item unidimensional Mindfulness Attention Awareness Scale (MAAS). Internal consistency ($\alpha = .82$) and 4-week test-retest reliability (interclass $r = .81$) and is positively correlated with number of years of meditation practice ($r = .36$, $p < .05$), which is specific to a technique aiming to increase mindfulness (Brown & Ryan, 2003). MAAS scores were also significantly higher among meditation practitioners relative to non-practitioners (Brown and Ryan, 2003). While a different study reported MAAS scores to be significantly correlated with other psychometrically sound measures of mindfulness (with Freiburg Mindfulness Inventory $r = .31$, $p < .01$; with Kentucky Inventory of Mindfulness Skills $r = .51$,

$p < .01$; with Cognitive Affective Mindfulness Scale $r = .51$, $p < .01$; with Mindfulness Questionnaire $r = .38$, $p < .01$ (Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006; Black, Sussman, Johnson, & Milam, 2012).

## Data Collection Procedures

Data for this research was obtained from CITs who were currently in their first, second, or third year of training in a CACREP or Non-CACREP masters in counseling program.

Procedures began with initial contact of the CACREP and Non-CACREP accredited masters training programs for counselors via email, requesting the email be forwarded to CITs and asking for voluntary participation in this study. The email request entailed a description of the study (see Appendix A). Following contact with the counselor education departments and obtaining consent from participants; participants will go online and complete the survey via the link provided in the email. Completion of this research study, included questionnaires and instruments, that took approximately 10-20 minutes. After the initial contact email, a reminder email was sent out, along with an email thanking participants for their time in completing the study (See Appendix B).

## Data Analysis/Design

This study used three types of statistical analyses. First, descriptive statistics reported the means, standard deviations, for the outcome variable and predictor variables. Descriptive statistics were also provided for the demographic

variables. Second, Pearson Product-Moment correlation analysis assessed the relationships between variables of past trauma history, personal counseling, levels of resilience, supervisory working alliance, and mindfulness. Last, standard multiple linear regression analysis was used for analyzing the data and determining how predictor variables account for the variance of the outcome variable. IBM® SPSS™ Statistics version 24.0 was used.

Multiple regressions consist of several types (e.g., standard, hierarchical, forced entry, stepwise). Standard regression is considered the most basic form of regression, where all predictor variables are entered into the equation concurrently (Tabachnick & Fidell, 1983). This type of regression answers research questions such as, "What is the degree of the overall relationship between secondary trauma and level of resilience and supervisory working alliance?" Each predictor variable is evaluated by its prediction of the criterion variable above and beyond what the other predictor variables offered. A limitation to this model is the predictor variable's association to the criterion variable may be limited to the entry of various predictor variables at the same time.

Hierarchical regression predictors are selected based on previous work and is decided by the researcher of the order to the order of predictors into the model (Field, 2013). Predictors thought to be most important need to be entered into the model first. Forced entry is a method where all predictors are simultaneously forced into the model. Similar to hierarchical, sound theoretical reasoning for

using chosen predictors is necessary; there is no decisions made by the researcher on the order variables are entered. This method is looked at as an acceptable way for testing theory.

Stepwise regression includes predictors that are entered into the model based on a mathematical criterion. The forward method begins with a model containing the constant, after which predictors that best predict the outcome variable are chosen. Stepwise method is identical to the forward method, with the difference being that each time a predictor is added, a removal test is made with the least useful predictor. The backward method consists of the computer begins by taking all predictors and calculating the contribution of each one by looking at the significance value of the t-test for each predictor (Field, 2013).

The research methodology for this study was a standard regression analysis. The outcome variable was secondary traumatic stress. There were a total of five predictor variables: (a) past history of trauma, (b) personal counseling, (c) levels of resilience, (d) mindfulness, and (e) supervisory working alliance. Standard multiple regression analysis was used to determine the predictive value for these five variables on secondary traumatic stress.

The predictor variables were entered into the standard regression equation into a specific order based on previous knowledge of these variables based within the existing literature, the causal priority principle, and the research relevance principle. Past history of trauma was entered first, based on previous research

findings. Emphasis has been placed on the effects of a counselor's past history of trauma in impacting one's work in the role of counselor. This theoretical stance is consistent with the causal priority principle, stating that if a predictor variable (past history of trauma) is thought to be influential to another predictor variable (supervisory working alliance and personal counseling), the assumed influential variable (past history of trauma) needs to be entered first. Personal counseling was entered second based on the principle of research relevance. As discussed previously, the relationship between histories of past trauma, personal counseling, and levels of resilience were investigated. Levels of resilience were entered third.

In summary, three types of statistical analyses were used for this study. First, descriptive statistics reported the means and standard deviations for the outcome and predictor variables. Descriptive statistics, including mean and standard deviation were also provided for the demographic variables. Second, Pearson Product-Moment correlation analysis assessed the correlations between past history of trauma, personal counseling, and level of resilience, mindfulness, and supervisory working alliance. Third, standard multiple regression analysis was used to determine how the five predictor variables predicted variance within the outcome variable. Chapter four presents the results of the study.

# CHAPTER FOUR

# RESULTS

The purpose of this study was to determine if there was a relationship between mitigating and protective factors that contribute to the development of secondary traumatic stress in Counselors-in-Training (CITs). This chapter includes a summary of the statistical analyses used for this study. The descriptive statistics presented first describe the sample of participants. Correlates of the study's variables were then presented for personal counseling, supervisory working alliance, trauma history, brief resilience, and mindfulness. Finally, the results of the multiple regression analysis are reported.

## Descriptive Statistics

This section includes the means and standard deviations. First, the primary variables of personal counseling, supervisory working alliance, trauma history, resilience, and mindfulness are presented. Second, the demographic variables of gender, age, race, ethnicity, region of training program, accreditation status of training program, year in program, specialty track, practicum or internship status, types of current mindfulness practices, number of clients with history of trauma, and type(s) of trauma training received are presented.

## Demographic Variables

The demographic variables for this study are found in Table 1.

Table 1

Descriptive Statistics of the Primary Variables for Counselors-in-Training (n=50)

| Variable | Response | Percentage |
|---|---|---|
| Gender: | | |
| Male | 6 | 12% |
| Female | 41 | 82% |
| Transgender | 2 | 4% |
| Choose not to disclose | 1 | 2% |
| Age: | M = 31.43; SD = 9.62 | Range: 22-56 |
| Race & Ethnicity: | | |
| Caucasian/White | 49 | 98% |
| African American | 0 | 0% |
| Hispanic | 0 | 0% |
| Asian American | 0 | 0% |
| Native American | 0 | 0% |
| Pacific Islander | 1 | 2% |
| Other | 0 | 0% |
| Region of Training | | |
| Program: | 9 | 18% |
| North Atlantic | 5 | 10% |
| North Central | 11 | 22% |
| Southern | 21 | 42% |
| Rocky Mountain | 4 | 8% |
| Western | | |
| Accreditation Status: | | |
| CACREP accredited | 49 | 98% |
| Non-CACREP accredited | 1 | 2% |
| Years in Program: | 2 | 100% |
| Specialty Track: | | |
| Clinical Mental Health | 30 | 60% |
| Marital, Couple, and | 8 | 16% |
| Family | 11 | 22% |
| School | 1 | 2% |
| Student Affairs | 0 | 0% |
| Other | | |
| Status: | | |
| Practicum | 17 | 34% |
| Internship | 33 | 66% |
| Mindfulness Practices: | | |

| | | |
|---|---|---|
| Yoga | 14 | 30% |
| Sitting Meditation | 24 | 51% |
| Breath Work | 33 | 70% |
| Transcendental Meditation | 0 | 0% |
| Other | 8 | 17% |
| None | 3 | .06% |
| Mean Number of Clients with Trauma History: | M = 11.76 SD = 12.22 | Range : 0-50 |
| Trauma Training: | | |
| Workshop (>3 hours) | 14 | 30% |
| Online training/webinar | 12 | 26% |
| Seminar/conference presentation (<3 hours) | 11 | 23% |
| Infused into degree curriculum | 30 | 64% |
| Single course as part of degree | 24 | 51% |

This study included 41 females, 6 males, 2 transgender, and 1 participant who chose not to disclose. Age was reported as having a minimum age of 22 and a maximum of 56 with an average of 31. Race and ethnicity of participants were reported as 49 Caucasian/white and 1 Pacific Islander. The age of the participants ranged between 22 and 56 with a mean of M = 31 years and a standard deviation of SD = 9.72. The region in which the program was located was as follows: North Atlantic (N = 9); North Central (N = 5); Southern (N = 11); Rocky Mountain (N = 21); and Western (N = 4). The accreditation status of the masters counseling program was 49 CACREP accredited programs, and 1 Non-CACREP accredited program. While years in the master's program averaged 2 years with a maximum of 5 years, and a standard deviation of SD = .93. Specialty tracks

included: Clinical Mental Health (N = 30); Marital, Couple, and Family (N = 8); School (N = 11); and Student Affairs (N = 1). The CITs included N = 17 completing Practicum and N = 33 completing Internship. Mindfulness practices included Yoga (N = 14); sitting meditation (N = 24); breath work (N = 33); while CITs reported other practices (N = 8): "awareness of daily activities, sitting meditation, and breath work; various forms of self care; none; visualization, daily reminders, etc.; art; walking meditation; and prayer." A small number of participants reported having no mindfulness practices (N = 3). The reporting of clients with a trauma history included a maximum of 50 with an average of 11. 76, and a standard deviation of SD = 12.22. The amount and type of trauma education and training included: workshop (N = 14); online training/webinar (N = 12); seminar/conference presentation (N = 11); infusion into degree curriculum (N = 30); and single course as a part of degree (N = 24). CITs who were currently receiving personal counseling had an N = 37, with 13 participants reporting not receiving personal counseling; standard deviation of SD = .44. Participants were contacted through purposeful sampling of counselor training programs.

## Primary Variables

Means and standard deviations of the predictor variable and outcome variables are presented in Table 2.

Table 2

Basic Descriptive Statistics of Model Variables

| Variable | M | SD |
|---|---|---|
| STSS | 29.58 | 9.72 |
| SWAI-T | 108.96 | 28.34 |
| THQ | 28.92 | 2.71 |
| BRS | 32.97 | .294 |
| MAAS | 3.91 | .875 |
| Frequency | | |
| | In Counseling | Not in Counseling |
| COUN | 37 | 13 |

The basic descriptive statistics for Secondary Traumatic Stress Scale (STSS) reported a mean of M = 29.58 and a standard deviation of SD = 9.72. For the Supervisory Working Alliance Inventory- Trainee (SWAI-T) reported a mean of M = 29. 58 and a standard deviation of SD = 28. 34. The Trauma History Questionnaire (THQ) reported a mean of M = 28. 92 and a standard deviation of SD = 2. 71. The Brief Resilience Scale (BRS) reported a mean of M = 32. 97 and a standard deviation of SD = .294. The Mindfulness Attention Awareness Scale (MAAS) reported a mean of M = 3.91 and a standard deviation of SD = .875. Last, personal counseling scores for CITs found 37 who were currently receiving

counseling and 13 CITs who were not in counseling. Basic descriptive statistics of model variables are presented in table 2.

## Correlational and Regression Statistical Analyses

Pearson Product-Moment Correlation was used to estimate the relatedness of the predictor variables, and to assess if any correlations were above r = .80. Correlations above this range suggest a risk for multicollinearity (Field, 2013). No variables were significantly correlated above r = .80. The correlation between predictor variables of STSS and SWAI-T was found to be r = -.150; STSS and THQ was found to be r = .105; STSS and BRS was found to be r = .158; STSS and personal counseling (COUN) was found to be r = -.116; and STSS and MAAS was found to be r = -.502. Correlation between predictor variables of SWAI-T and STSS was found to be r = -.150; SWAI-T and THQ was found to be r = -.100; SWAI-T and BRS was found to be r = .121; SWAI-T and COUN was found to be r = .181; and SWAI-T and MAAS was found to be r = -.109. Correlation between predictor variables THQ and STSS was found to be r = .105; THQ and SWAI-T was found to be r = -.100; THQ and BRS was found to be r = -.256; THQ and COUN was found to be r = -.389; and THQ and MAAS was found to be r = .068. The correlation between the predictor variables BRS and STSS was found to be r = .158; BRS and SWAI-T was found to be r = .121; BRS and THQ was found to be r = -.256; BRS and COUN was found to be r = -.070; BRS and MAAS was found to be r = -.102. The correlation between variables COUN

and STSS was found to be r = -.116; COUN and SWAI-T was found to be r = .181; COUN and THQ was found to be r = -.389; COUN and BRS was found to be r = -.070; and COUN and MAAS was found to be r = .005. Predictor variables MAAS and STSS was found to have a correlation of r = -.502; MAAS and SWAI-T was found to be r = -.109; MAAS and THQ was found to be r = .068; MAAS and BRS was found to be r = -.102; MAAS and COUN was found to be r = .005. Correlations between the predictor variables are presented in Table 3.

Table 3

Pearson Product-Moment Correlation Between Predictor Variables (N=50)

| | STSS | SWAI-T | THQ | BRS | COUN | MAAS |
|---|---|---|---|---|---|---|
| STSS | 1.00 | -.150 | .105 | .158 | -.116 | -.502* |
| SWAI-T | -.150 | 1.00 | -.100 | .121 | .181 | -.109 |
| THQ | .105 | -.100 | 1.00 | -.256* | -.389* | .068 |
| BRS | .158 | .121 | -.256* | 1.00 | -.070 | -.102 |
| COUN | -.116 | .181 | -.389* | -.070 | 1.00 | .005 |
| MAAS | -.502* | -.109 | .068 | -.102 | .005 | 1.00 |

* $p < .05$.

A standard multiple linear regression was calculated to predict the impact of Secondary Traumatic Stress (STSS) on counselors in training based upon

supervisory working alliance (SWAI-T), history of previous trauma (THQ), levels of resilience (BRS), personal counseling, and mindfulness (MAAS). A significant regression equation was found ($F(5,44) = 4.462$, $p < .002$), with an $R^2$ of .336. The model predicted that secondary traumatic stress is equal to 26.315 + -.073 not significant (supervisory working alliance) + .581 not significant (history of previous trauma) + 5.679 not significant (levels of resilience), + .004 not significant (personal counseling), + -5.767 significant (mindfulness). A report of the results can be found in Table 4.

Table 4

Standard Multiple Linear Regression of Mitigating and Protective Factors of Secondary Trauma reported by Counselors in Training (N = 50)

| Variable | B | SE B | β |
|---|---|---|---|
| Constant | 26.31 | 24.63 | -- |
| SWAI-T | -.073 | .043 | -.212 |
| THQ | .581 | .502 | .162 |
| COUN | .004 | 3.032 | .000 |
| MAAS | -5.767 | 1.381 | -.519* |

*p < .05

## Analysis of Statistical Assumptions

As the researcher, I plotted the histogram of residuals and examined it for normality. The plot appeared to adhere to a normal distribution meeting this

assumption. I utilized the Durbin-Watson test statistic (d = 2.185) to assess if the distribution of errors was normal. Normal ranges for this test statistic range between 0.0 and 4.0, with scores nearer to 2.0 suggesting uncorrelated variables. It was determined that the error terms of the model were independent of each other. Homoscedasticity was investigated by plotting the residuals. Visual investigations of the plots revealed a consistent variance of the residuals, meeting the assumption of homoscedasticity. Examining the scatterplot between the predictor variables and the outcome variable assessed linearity. The scatterplot revealed a mostly linear relationship. Examining the tolerance values of each predictor variables assessed multicollinearity. All tolerance values were within the normal range set forth by guidelines within (Field, 2013), indicating no risk of multicollinearity.

In conclusion, this study intended to determine if there was a relationship between mitigating and protective factors that contributed to the development of secondary traumatic stress in Counselors-in-Training (CITs). Statistical analyses used for this study included correlational and regression analyses. The descriptive statistics presented first described the sample of participants; followed by correlates of the study's variables being presented for personal counseling, supervisory working alliance, trauma history, brief resilience, and mindfulness. Finally, the results of the multiple regression analysis were reported. The final chapter provides a discussion of the results, limitations of the study,

recommendations for future research and implementation of the significant findings in counselor education and supervision.

# CHAPTER FIVE

# DISCUSSION, SUMMARY, AND RECOMMENDATION

## Introduction

In this chapter, I discuss the results of this study. First, I briefly discuss the participant demographics. Second, I discuss the analysis of the findings of my research questions. Third, I discuss the limitations of the current study. Fourth, I describe the implications and recommendations for future research. Fifth, I discuss the future research initiatives. Last, I provide a conclusion of the study.

## Summary of Participant Demographics

The preliminary analyses consisted of descriptive statistics, correlations, and a standard multiple regression to describe my sample and explore relationships among variables. Demographic data entailed 50 counselors in training, with six (12%) males, forty-one (82%) females, two (4%) transgender, and one (2%) that chose not to disclose. This is compared to CACREP's Annual Report (2015) of master's students' gender as: 17.40% males, 82.54% females, 0.06% alternative identity. For both the current study and CACREP's annual report, there were a higher percentage of females than males and only a small percentage was represented as identifying as transgender or alternative identity. The race and ethnicity of participants in this study were reported as: forty-nine (98%) Caucasian, and one (2%) Pacific Islander. As compared to CACREP's report of students' racial and ethnic demographics as: 60.22% Caucasian, 18.63%,

8.39% Hispanic/Latino/Spanish American, 2.09% Asian American, 2.06% Multiracial, 0.90% Nonresident Alien, 0.61% American Indian/Native Alaskan, 0.14% Native Hawaiian/Pacific Islander, and 6.96% Other/Undisclosed (2015). Race and ethnicity for this study and CACREP reported a majority of the participants/students identified as Caucasian. There was no representation from the African American, Hispanic, Asian American, Native American, or other communities in the current study; whereas CACREP's report showed a small percentage as identifying as these other communities. The regions of the country in which the participants represented were reported as: nine (18%) North Atlantic; five (10%) North Central; eleven (22%) Southern; twenty-one (42%) Rocky Mountain; and four (8%) Western. The varying regions the participants are located speaks to the sampling method used. As I personally emailed programs in the rocky mountain region and then elsewhere based on the spreadsheet created of a list of master's counselor training programs. Forty-nine (98%) participants attended CACREP accredited programs, and one (2%) participant attended a Non-CACREP accredited program. These results could be explained by the method used for sampling, as I was more successful in finding CACREP accredited master's counselor training programs as compared to Non-CACREP accredited master's counselor training programs. Participants' years in their master's program were reported as an average of 1.90 (years) and a maximum of 5.00 (years). The amount of years in their program reflects on the standard amount of

time it takes to complete a master's counselor training program. The specialty track in the participants' Master's programs were reported as: thirty (60%) Clinical Mental Health; eight (16%) Marital, Couple, and Family; eleven (22%) School; and one (2%) Student Affairs. CACREP's report of program areas were as follows: 3 Addiction; 10 Career; 185 Clinical Mental Health; 7 College; 73 Community; 63 Counselor Ed. & Supervision; 1 Gerontological; 42 Marriage, Couple, & Family; 26 Mental Health; 247 School; 13 Student Affairs; 12 Student Affairs & College; 2 Dually-accredited Clinical Rehabilitation/Clinical Mental Health (2015). The specialty tracks reported in this study roughly reflect the reportings of CACREP accredited program areas across the nation. The participants included seventeen (34%) completing Practicum, and thirty-three (66%) completing Internship. Participants reported mindfulness practices as including: fourteen (29.79%) yoga; twenty-four (51.06%) sitting meditation; thirty-three (70.21%) breath work; and eight (17.02%) reported "other" practices, such as: "awareness of daily activities, sitting meditation, and breath work; various forms of self care; none; visualization, daily reminders, etc.; art; walking meditation; and prayer." The report of mindfulness practices among the participants supports the significant negative correlation I found in mitigating the effect of STS. Thus, meaning participant's mindfulness practices served as a possible protective factor for their work with clients and prevented the development of STS. The reporting of clients with a trauma history included a

maximum of 50 with a mean of M=11.76, and a standard deviation of SD=12.22. This shows high occurrence for participants to be working with clients who have had some form of trauma in their lives, which speaks to the prevalence of trauma in the general population that CITs will be working with. Thus, highlighting the high probability for our CITs to be working with clients with a trauma history. Participants' amount and type of trauma education and training included: fourteen (29.79%) workshop; twelve (25.53%) online training/webinar; eleven (23.40%) seminar/conference presentation; thirty (63.83%) infusion into degree curriculum; and twenty-four (51.06%) single course as a part of degree. Receiving training and education in trauma work may result in CITs feeling more prepared to work with clients with trauma histories while those who have less exposure to trauma training, for example, those who do not experience the inclusion of trauma work across their curriculum, are more prone to feel less prepared in working with trauma populations. The prevalence of some form of training in trauma work for participants may have contributed to the results of the STSS, finding low scores of STS.

Thirty-seven (74%) participants were currently receiving personal counseling, and thirteen (26%) reported not receiving personal counseling. The high percentage of participants that were currently engaging in personal counseling may contribute to serving as that buffer against STS.

## Analyses of Findings

This section provides a review of the major findings derived from the study. The purpose of this study was to determine if there was a relationship between mitigating and protective factors that contribute to the development of secondary traumatic stress in Counselors-in-Training (CITs).

The results of this study showed a significant negative correlation among STS and mindfulness practice. These results support Thieleman and Cacciatore's (2014) conclusions that as mindfulness increased, compassion fatigue decreased. A CIT's wellness is one of many factors that contribute to the performance and success in their clinical training and professional careers. Attending to wellness includes self-care practices and commitment to maintaining it in various areas within a person's life. Different self-care practices can help in attending to this wellness component, and the counseling profession encourages these practices for all counselors. One method self-care includes mindfulness, which has been described in detail in the previous chapters. As mindfulness is an approach to self-care and can be utilized in a variety of settings within a counselor's life, it is especially useful in preventative practices against burnout, compassion fatigue, and secondary trauma. This is borne out by this study's finding that participants with high mindfulness scores reported lower scores on the measurement for secondary trauma.

The literature has shown the effectiveness of supervision to serve as a protective factor to developing secondary trauma in mental health professionals (Harrison & Westood, 2009; Sommer & Cox, 2005; Slattery & Goodman, 2009; Dunkley & Whelan, 2006; Pearlman & Mac Ian, 1995). However, the results of this study suggest that Supervisory Working Alliance (SWA) was not a significant predictor of secondary traumatic stress ($p = .102$). This contradicts the findings in other studies such as, DelTosta (2014) and Fama (2003), in which SWA was found to significantly prevent vicarious trauma as well as STS. The participants' rating on the SWA-T showed scores in the higher range of the measure indicating that the majority of participants perceived their supervision as supportive, yet there was an nonsignificant correlation to STSS ($r = -.150$), suggesting no underlying relationship between the two constructs for the current study's participants.

Prior trauma history was not found to be a significant predictor of secondary trauma in this study. This contradicts a previous study by Goodpaster (2014) which found a trauma history as having a significant impact on trainees. In that study, trainees' personal trauma history contributed to secondary trauma on the Trauma Attachment and Belief Scale (TABS) vicarious trauma, but not to secondary traumatic stress (STS) (Goodpaster, 2014). In addition, other research has shown that professionals' work with clients with traumatic backgrounds has the potential for activating the clinician's memories of their own trauma (McCann

& Pearlman, 1990b) and lead to clinicians experiencing secondary trauma (Hesse, 2002). In the current study, the results of the THQ showed participants having experienced traumatic life events, although the scores were low. This characteristic of the current study's participants may explain the lack of significant results.

Participants' resilience levels were not predictive of secondary trauma among CITs in this study. These results contradict the findings in other studies that have shown personal resilience to serve as a protective factor against the negative impact of traumatic stress or second hand impact of compassion fatigue (Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009; Huggard, Stamm, & Pearlman, 2013). The current study's results for the BRS showed medium to high resilience in the participants' responses which could reduce the potential for risk of STS as a result of their work with clients with trauma histories. However, in this study resilience the CIT has developed was not predictive measure in protecting the CIT from STS in their future work with clients.

Personal counseling was not shown to predict the impact of secondary trauma among this study's participants. Literature has noted the prevalence of mental health professionals with histories and family histories of mental health challenges and impairment in various aspects of their life (Elliott & Guy, 1993). Other research has acknowledged the positive impact that personal counseling has had on professionals and trainees (Byrne & Shufelt, 2014; Mackey & Mackey,

1994; Macran & Shapiro, 1998; Macran, Stiles, & Smith, 1999; Murphy, 2005; Oden, Miner-Holden, & Balkin, 2009; Strupp, 1955). As personal counseling may be a measure the CIT is engaging in even before entering their counselor training program, this study found no significant prediction for this to be a protective measure against development of STS while in their training program.

In conclusion, the hypotheses of the study were: (1) A supportive supervisory working alliance predicted the impact of secondary trauma within CITs. This first hypothesis was found to have no significance. (2) A history of trauma predicted the impact of secondary trauma within CITs. This second hypothesis was found to have no significance, as well. (3) Low levels of resilience in CITs would predict the impact of secondary trauma within CITs. This third hypothesis was found to have no significance. (4) Personal counseling would predict the impact of secondary trauma within CITs. This fourth hypothesis was found to have no significance. Last, (5) Use of mindfulness practices would predict the impact of secondary trauma within CITs. This last hypothesis found mindfulness practices predict the impact, and may serve as a protective factor against secondary trauma within CITs.

## Limitations

The sample size of the current study was considered a limitation. For this regression model, the preferred number of participants was following a general rule of thumb of a minimum of 50 to 75 (Field et al., 2012). The number of

participants for this study was 50, the lower range of the preferred minimum. With a larger sample size it is possible that more of the predictor variables could have been found to be significant predictors of secondary traumatic stress. Another limitation to the results found in this study is for a potential difference to be found if there would have been more specificity in the questions surrounding the amount of clinical experience the counselor had. It may be possible that counselors with more clinical experience and time working in the field may not consider a strong SWA as important in mitigating STS. It may be that there are other more fitting constructs to within supervision that would speak to the mitigating factor to help prevent STS. More so, the timing of this study may have had a possible effect on the type of participants we were able to gather results for. Distributing this survey during the fall or early spring months may have pulled from participants who had spent less time working with clients in their clinical practicum or internship training.

Expanding the dependent variable through the use of additional instruments that measure for secondary trauma as well as vicarious trauma, burnout, and compassion fatigue, may provide more depth of understanding in what is occurring within the development of secondary traumatic stress (STS) in CITs. Also, the singular use of self-report data collection resulted in a mono-method bias (Shadish, Cook, & Campbell, 2002). The results of this study relied upon CITs' subjective responses to the survey materials, therefore having the

possibility to portray parts of self that are desirable for the study, yet possibly not accurately capturing their experience.

## Implications and Recommendations

This study supports the finding that mindfulness practices of CITs can help to mitigate the risk of developing secondary trauma symptoms. It was hypothesized that supervisory working alliance, previous trauma history, and levels of resilience would also mitigate secondary trauma, however the study failed to produce evidence that these factors were related to secondary trauma. Although results were not found to be significant for these factors, other investigations have shown significance that these other variables do indeed mitigate for secondary traumatic stress. With this, the entirety of this research base will be used in order to inform the implications for this study.

An initial implication is that counselor educators and supervisors need to give special attention to the training CITs are receiving in order to help mitigate the effects of student's work with trauma clients. With CITs learning clinical skills through their work with clients, it is not a question of if but when they will experience the emotional impact of their counseling work. Therefore, classroom discussions regarding how the CIT's clinical work impacts the self is an important aspect of counselor education.

A second implication is the need for counselor educators and supervisors be aware of CITs' susceptibility to developing STS and help to build awareness

through the conversation around the risks of working with clients. One way the awareness building can be facilitated is by discussing self-care practices with CITs that will serve in attending to wellness. The mindfulness survey (MAAS) administered in this study is one example of a self care practice that can serve to developing CITs' awareness of how they are impacted by their work with clients.

Developing and implementing a mindfulness component across the CACREP core areas of curriculum would help model the importance of developing a mindfulness practice for CITs. Providing a time and space for the practice of mindfulness in attendance to self-care can help to prepare the CIT for lifelong attendance to maintaining optimal wellness by engaging in self-care practices. This could take the form of opening each classroom meeting with a mindfulness exercise in which CITs could engage in grounding and centering mindfulness practices.

Another recommendation is for counselor education to establish within their supervision practices an exploration of the supervisory working alliance by using instruments such as the SWAI-T to gain a better understanding of the CIT's perception of the supervisory working relationship. Placing emphasis on self-care practices within supervision is also recommended. For example, providing a time at the beginning of every supervision meeting for the supervisor and supervisee to engage in a mindfulness practice. By setting this intention through a created space for a mindfulness practice in supervision will foster the CIT's wellness, and

model a form of self-care that the CIT can develop, whether practicing alone or implementing it into their work with clients.

For counselor education programs at the doctoral level, including mindfulness training and practice for clinical supervision with an emphasis on building the supervisory working relationship is recommended. This could look like the basic skills class master's level CITs are required to take as a part of their curriculum requirements, and instead be focused on the supervision element and incorporating their clinical identities into their supervisor identities through the practice of different supervision models. Given the significant importance supervision has on the CIT's development of clinical skills, this shows again how emphasis on the relationship is essential. Also, creating an ongoing open dialogue as to the risks of secondary trauma and check-in during the mindfulness practice to discuss any stress or impact the CIT's work with clients is having on them is necessary. These practices, coupled with trauma focused-supervision can aid in the CIT's growth and development in helping to ensure that all necessary measures are taken in order to educate and provide tools to help them in their clinical work. Attending to the relationship in order to address what is occurring for the CIT in their work with clients, while considering the trauma experience of their work are aspects of what is included in a trauma-focused supervision (Wells, Trad, & Alves, 2003). An ongoing dialogue regarding the trauma work and how it is impacting the CIT, and addressing signs of secondary trauma are all aspects

of trauma-focused supervision. It is necessary for supervisors to have ongoing training in trauma work to stay current in their supervision in relation to trauma work.

Results of this study showed a higher percentage of the participants rated their supervisory working alliance experience as being beneficial to their growth as a CIT. A beneficial supervisory working alliance serves the CIT in helping to maintain professional relationships, mitigate reactions to traumatic material brought in by clients, and explore how one finds a balance in developing and maintaining boundaries within the therapeutic relationship (Savicki & Cooley, 1982).

With a high number of CITs reporting current involvement in personal counseling, one recommendation can be to make it highly encouraged for CITs to receive a certain amount of sessions of personal counseling. This attends to the ethical responsibility counselor educators and supervisors assume to protect the wellbeing of students and their clients. Serving in this role as a gatekeeper is vital to the counseling profession in order for decisions to be made regarding a CIT's developmental readiness for clinical responsibilities.

## Future Research Initiatives

Drawing upon these findings and continuing to integrate various factors into the study of mitigating factors on secondary trauma will provide counselor educators and supervisors with additional direction that is grounded in best

practices for the CIT's professional development and success throughout one's career. The direction of this research has the potential to take on many different forms that employ quantitative and qualitative methodology.

The first area of future research could be the continuation of this study to increase the sample size. The small sample size gained for this study did not allow for a significant effect size to be observed. The continuation of this research would entail recruiting additional CITs to complete the survey in Qualtrics online during the fall or early spring semesters.

With a larger number of participants, it could be possible to change the design of future research to a mixed methods approach. The results of this study indicated there is a significant inverse relationship between mindfulness and secondary trauma. The use of a mixed methods approach could allow for a more in depth exploration into the type and level of mindfulness practice in using a blend of qualitative and quantitative data. Exploring each of the mitigating factors could shed new light as to how these specifically impact the individual. For example, what specific factors contribute to the efficacy of the supervisory working alliance in helping to alleviate symptoms of STS? Second, how does the training in crisis and trauma work CITs receive impact the potential of developing STS? Third, how are mindfulness practices implemented within the counseling program and clinical training? Fourth, how does resilience serve the CIT within

their clinical training? And last, how does one's lived experience contribute to the CIT's capability in their program?

A major implication of this study was the need for conversations to be had throughout CIT's clinical experience on the risks of developing STS, burnout, and compassion fatigue over time. Space could be made within the classroom and across the core areas for these types of conversations. Such conversations could help CITs to share their inherent knowledge regarding self-care as well as learn from each other methods of self-care, and the impact of work with clients. More so, exploration of different constructs that are considered to be of significant importance within the supervision experience is a possible avenue for research, looking at if these help in mitigating factor to help prevent STS.

Future research on this topic utilizing qualitative methodology would offer important information to counselor educators and CITs undergoing their clinical training. A phenomenological inquiry into the lived experience of CITs in their lives before entering their counselor-training program and during their program may offer information as to how and which different factors serve to lessen the negative impacts of their work with clients. A grounded theory inquiry could also be used to explore the process that is undergone in training CITs in crisis and trauma coursework, while attending to the impact the work is having on the individual. Thus, using qualitative methodologies are recommended to help provide insight as to the possible mitigating factors for CITs developing STS, and

what helps to prevent or contribute to this development. Also, researchers may find that variables contributing to STS for CITs will vary. Themes found through qualitative methods can be used in larger studies that could generalize results to the larger population of counselor trainees. These results may help counselor educators and supervisors understand what variables are important and why they are important for CITs.

## Conclusion

The purpose of this study was to determine what relationship there is between mitigating factors with secondary trauma among CITs. Contrary to the existing literature, this study's results on the mitigating factors of supervisory relationship, levels of resilience, personal counseling, and trauma history were not supported. However, these results found mindfulness practice to be the single predictive factor to help in the mitigation of STS in CITs. The potential for developing a mindfulness practice may have a significant effect on students' awareness and development of STS.

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# APPENDIX A

Date

Dear Counselor-In-Training,

Hello. This is a letter to invite you to participate in the study, "Exploring Risk and Protective Factors that Predict Secondary Traumatic Stress in Counselors-in-Training." You are asked to participate in a research study conducted by Hailey N. Martinez, doctoral candidate at Idaho State University under the supervision of Dr. Judith Crews because you have been identified as a Counselor-in-Training (CIT) for a CACREP/Non-CACREP counseling program. I am looking to conduct a quantitative study using hierarchical multiple regression analysis to view the relationship between predictor variables and scores on the Secondary Traumatic Stress Scale (STSS). Through interpretation of this data, I hope to increase counselor educator's understanding on the necessity for attending to the training of CITs and the impact of the supervisory working alliance on helping to mitigate the effects of secondary trauma.

The purpose of this quantitative study is to measure the relationship between past history of trauma, level of resilience, strength of the supervisory working alliance, involvement in personal counseling, and mindfulness practices and scores on the STSS.

If you consent to the research, you will be asked to commit to completing a demographic questionnaire along with the STSS, SWAI-T, THQ, and the MAAS surveys through online access. This will take approximately 10-20 minutes. Upon completion of the online questionnaire and survey, you will be finished with your commitment to the study.

Survey link: https://isudhs.az1.qualtrics.com/SE/?SID=SV_eP3mzW9Zq0FSQYJ

If you are interested in participating in this study, please review the informed consent by clicking on the survey link above prior to completing the survey. I welcome any questions about the research and I value your contributions. If you decide to participate, you are free to withdraw your consent and discontinue participation at any time.

Thank you so much for your consideration in participating in this study.

Sincerely,
Hailey N. Martinez, M.Coun, LPC, NCC

# APPENDIX B

Date

Dear Counselor-In-Training,

Hello. This is a letter to thank you for your participation in the study, "Exploring the Relationship of Risk and Protective Factors in Predicting Secondary Traumatic Stress in Counselors-in-Training." Your participation in this research study is valuable as it helps to increase counselor educator's understanding of the necessity for attending to the training of CITs and understanding the impact of the supervisory working alliance on helping to mitigate the effects of secondary trauma.

If you have any questions about the research please do not hesitate to contact me. I value your contributions.

Thank you so much for your time and participation in this study.

Sincerely,

Hailey N. Martinez, M.Coun, LPC, NCC

# APPENDIX C

## Exploring the Relationship of Risk and Protective Factors in Predicting Secondary Traumatic Stress in Counselors-in-Training
## Demographic Questionnaire

1. Please indicate your gender:

    - Male
    - Female
    - Transgender
    - Choose not to disclose

2. What is your age? (please slide the ruler below to your age)

3. Please indicate your race:

    - African American
    - Asian
    - Hispanic
    - Caucasian
    - Native American
    - Pacific Islander
    - Other: _____

4. Please indicate your ethnicity:

    - African American
    - Asian
    - Hispanic
    - Caucasian
    - Native American
    - Pacific Islander
    - Other: _____

5. Please indicate in which region of the country your program is located within:

    - North Atlantic (yellow)
    - North Central (orange)
    - Southern (red)
    - Rocky Mountain (green)
    - Western (purple)

6. What is the accreditation status of your program?

    - CACREP Accredited Program
    - NON-CACREP Accredited Program

7. Approximately how long have you been in your counseling program?

    Years in master's program: 0 1 2 3 4 5

8. Please indicate your specialty track in Master's program:

    - Clinical Mental Health
    - Marital, Couple, and Family
    - School
    - Student Affairs
    - Other (please specify)_____

9. What is your status?

    - Practicum
    - Internship

10. What type(s) of mindfulness practices do you currently participate in? (select all that apply)

    - Yoga
    - Sitting meditation
    - Breath work
    - Transcendental meditation
    - Other (please specify)_____

11. How many clients with a history of trauma are you currently working with or have worked with in your practicum or internship?

    Number of clients with a trauma history:

    0 10 20 30 40 50

12. Please describe the type of trauma training you have received (check all that apply)

    - Workshop (> 3 hours)
    - Online training/webinar
    - Seminar/Conference Presentation (< 3 hours)
    - Infused into degree curriculum
    - Single course as part of degree

13. Have you or are you currently receiving personal counseling?

    - Yes
    - No

# APPENDIX D

Secondary Traumatic Stress Scale (STSS)

The following is a list of statements made by persons who have been impacted by their work with traumatized clients. Read each statement then indicate how frequently the statement was true for you in the past seven (7) days by circling the corresponding number next to the statement.

NOTE: "Client" is used to indicate persons with whom you have been engaged in a helping relationship. You may substitute another noun that better represents your work such as consumer, patient, recipient, etc.

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never | Rarely | Occasionally | Often | Very Often |

1. I felt emotionally numb

1 2 3 4 5

2. My heart started pounding when I thought about my work with clients

1 2 3 4 5

3. It seemed as if I was reliving the trauma(s) experienced by my client(s)

1 2 3 4 5

4. I had trouble sleeping

1 2 3 4 5

5. I felt discouraged about the future

1 2 3 4 5

6. Reminders of my work with clients upset me

1 2 3 4 5

7. I had little interest in being around others

1 2 3 4 5

8. I felt jumpy

1 2 3 4 5

9. I was less active than usual

1 2 3 4 5

10. I thought about my work with clients when I didn't intend to

1 2 3 4 5

11. I had trouble concentrating

1 2 3 4 5

12. I avoided people, places, or things that reminded me of my work with clients

1 2 3 4 5

13. I had disturbing dreams about my work with clients

1 2 3 4 5

14. I wanted to avoid working with some clients

1 2 3 4 5

15. I was easily annoyed

1 2 3 4 5

16. I expected something bad to happen

1 2 3 4 5

17. I noticed gaps in my memory about client sessions

1 2 3 4 5



Intrusion Subscale (add items 2, 3, 6, 10, 13) Intrusion Score _____

Avoidance Subscale (add items 1, 5, 7, 9, 12, 14, 17) Avoidance Score _____

Arousal Subscale (add items 4, 8, 11, 15, 16) Arousal Score _____

TOTAL (add Intrusion, Arousal, and Avoidance Scores) Total Score _____

Bride, B.E., Robinson, M.R., Yegidis, B., & Figley, C.R. (2004). Development and validation of the Secondary Traumatic Stress Scale. *Research on Social Work Practice*, 14, 27-35.

# APPENDIX E

Supervisory Working Alliance Inventory: Trainee (SWAI-T) Form

Instructions: Please indicate the frequency with which the behavior described in each of the following items seems characteristic of your work with your supervisee. After each item, check (X) the space over the number corresponding to the appropriate point of the following seven- point scale:

1 2 3 4 5 6 7

Almost Never Almost Always

I feel comfortable working with my supervisor.

___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7

My supervisor welcomes my explanations about the client's behavior.

___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7

My supervisor makes the effort to understand me.

___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7

My supervisor encourages me to talk about my work with clients in ways that are comfortable for me.

___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7

My supervisor is tactful when commenting about my performance.

___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7

My supervisor encourages me to formulate my own interventions with the client.

___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7

My supervisor helps me talk freely in our sessions.

___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7

My supervisor stays in tune with me during supervision.

___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7

I understand client behavior and treatment technique similar to the way my supervisor does.

___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7

I feel free to mention to my supervisor any troublesome feelings I might have about him/her.

___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7

My supervisor treats me like a colleague in our supervisory sessions.

___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7

In supervision, I am more curious than anxious when discussing my difficulties with clients.

___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7

In supervision, my supervisor places a high priority on our understanding the client's perspective.

___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7

My supervisor encourages me to take time to understand what the client is saying and doing.

___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7

My supervisor's style is to carefully and systematically consider the material I bring to supervision.

___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7

When correcting my errors with a client, my supervisor offers alternative ways of intervening with that client.

___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7

My supervisor helps me work within a specific treatment plan with my clients.

___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7

My supervisor helps me stay on track during our meetings.

___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7

I work with my supervisor on specific goals in the supervisory session.

___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7

Efstation, J. E, Patton, M. J., & Kardash, C. M. (1990). Measuring the working alliance in counselor supervision. *Journal of Counseling Psychology*, 37, 322 32.

# APPENDIX F

Brief Resilience Scale (BRS)

Please respond to each item by marking one box per row:

BRS 1

I tend to bounce back quickly after hard times.

| Strongly Disagree | Disagree | NeutralAgree | Agree | Strongly Agree |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

BRS 2

I have a hard time making it through stressful events.

| Strongly Disagree | Disagree | NeutralAgree | Agree | Strongly Agree |
|---|---|---|---|---|
| 5 | 4 | 3 | 2 | 1 |

BRS 3

It does not take me long to recover from a stressful event.

| Strongly Disagree | Disagree | NeutralAgree | Agree | Strongly Agree |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

BRS 4

It is hard for me to snap back when something bad happens.

| Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |
|---|---|---|---|---|
| 5 | 4 | 3 | 2 | 1 |

BRS 5

I usually come through difficult times with little trouble.

| Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

BRS 6

I tend to take a long time to get over set-backs in my life.

| Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |
|---|---|---|---|---|
| 5 | 4 | 3 | 2 | 1 |

Scoring: Add the responses varying from 1-5 for all six items giving a range from 6-30. Divide the total sum by the total number of questions answered.

My score: _____ item average / 6

Smith, B. W., Dalen, J., Wiggins, K., Tooley, E., Christopher, P., & Bernard, J. (2008). The brief resilience scale: assessing the ability to bounce back. *International Journal of Behavioral Medicine,* 15(3), 194-200.

# APPENDIX G

## Trauma History Questionnaire (THQ)

The following is a series of questions about serious or traumatic life events. These types of events actually occur with some regularity, although we would like to believe they are rare, and they affect how people feel about, react to, and/or think about things subsequently. Knowing about the occurrence of such events, and reactions to them, will help us to develop programs for prevention, education, and other services. The questionnaire is divided into questions covering crime experiences, general disaster and trauma questions, and questions about physical and sexual experiences.
For each event, please indicate (circle) whether it happened, and if it did, the number of times and your approximate age when it happened (give your best guess if you are not sure). Also note the nature of your relationship to the person involved, and the specific nature of the event, if appropriate.

### Crime-Related Events

1. Has anyone ever tried to take something directly from you by using force or the threat of force, such as a stick-up or mugging?

No _____ Yes _____

2. Has anyone ever attempted to rob you or actually robbed you (i.e. stolen your personal belongings)?

No _____ Yes _____

3. Has anyone ever attempted to or succeeded in breaking into your home when you weren't there?

No _____ Yes _____

4. Has anyone ever tried to or succeeded in breaking into your home while you were there?

No _____ Yes _____

General Disaster and Trauma

5. Have you ever had a serious accident at work, in a car or somewhere else?

No _____ Yes _____

6. Have you ever experienced a natural disaster such as a tornado, hurricane, flood, major earthquake, etc., where you felt you or your loved ones were in danger of death or injury?

No _____ Yes _____

7. Have you ever experienced a "man-made" disaster such as a train crash, building collapse, bank robbery, fire, etc., where you felt you or your loved ones were in danger of death or injury?

No _____ Yes _____

8. Have you ever been exposed to dangerous chemicals or radioactivity that might threaten your health?

No _____ Yes _____

9. Have you ever been in any other situation in which you were seriously injured?

No _____ Yes _____

10. Have you ever been in any other situation in which you feared you might be killed or seriously injured?

No _____ Yes _____

11. Have you ever seen someone seriously injured or killed?

No _____ Yes _____

12. Have you ever seen dead bodies (other than at a funeral) or had to handle dead bodies for any reason?

No _____ Yes _____

13. Have you ever had a close friend or family member murdered, or killed by a drunk driver?

No _____ Yes _____

14. Have you ever had a spouse, romantic partner, or child die?

No _____ Yes _____

15. Have you ever had a serious or life-threatening illness?

No _____ Yes _____

16. Have you ever received news of a serious injury, life-threatening illness or unexpected death of someone close to you?

No _____ Yes _____

17. Have you ever had to engage in combat while in military service in an official or unofficial war zone?

No _____ Yes _____

Physical and Sexual Experiences

18. Has anyone ever made you have intercourse, oral or anal sex against your will?

No _____ Yes _____

19. Has anyone ever touched private parts of your body, or made you touch theirs, under force or threat?

No _____ Yes _____

20. Other than incidents mentioned in Questions 18 and 19, have there been any other situations in which another person tried to force you to have unwanted sexual contact?

No _____ Yes _____

21. Has anyone, including family members or friends, ever attacked you with a gun, knife or some other weapon?

No _____ Yes _____

22. Has anyone, including family members or friends, ever attacked you without a weapon and seriously injured you?

No _____ Yes _____

23. Has anyone in your family ever beaten, "spanked" or pushed you hard enough to cause injury?

No _____ Yes _____

24. Have you experienced any other extraordinarily stressful situation or event that is not covered above?

No _____ Yes _____

# APPENDIX H

Mindful Attention Awareness Scale (MAAS), trait version characteristics of the scale:

The trait MAAS is a 15-item scale designed to assess a core characteristic of mindfulness, namely, a receptive state of mind in which attention, informed by a sensitive awareness of what is occurring in the present, simply observes what is taking place. This is in contrast to the conceptually driven mode of processing, in which events and experiences are filtered through cognitive appraisals, evaluations, memories, beliefs, and other forms of cognitive manipulation.

Across many studies conducted since 2003, the trait MAAS has shown excellent psychometric properties. Factor analyses with undergraduate, community and nationally sampled adult, and adult cancer populations have confirmed a single factor scale structure (Brown & Ryan, 2003; Carlson & Brown, 2005). Internal consistency levels (Cronbach's alphas) generally range from .80 to .90. The MAAS has demonstrated high test-retest reliability, discriminant and convergent validity, known-groups validity, and criterion validity. Correlational, quasi-experimental, and experimental studies have show that the trait MAAS taps a unique quality of consciousness that is related to, and predictive of, a variety of emotion regulation, behavior regulation, interpersonal, and well-being phenomena. The measure takes 5 minutes or less to complete. A validated, 5-item state version of the MAAS is also available in Brown and Ryan (2003) or upon request.

MAAS norms to date:

Normative information on the trait MAAS is available for both community adults and college students, as follows:

> Community adults (4 independent samples): N = 436; MAAS M = 4.20, SD = .69.
> College students (14 independent samples): N = 2277; MAAS M = 3.83, SD = .70.

Appropriate validity references for the trait MAAS:

Brown, K.W. & Ryan, R.M. (2003). The benefits of being present: Mindfulness and its role in psychological well-being. *Journal of Personality and Social Psychology*, 84, 822-848.

Carlson, L.E. & Brown, K.W. (2005). Validation of the mindful attention awareness scale in a cancer population. *Journal of Psychosomatic Research*, 58, 29-33.

Day-to-Day Experiences

Instructions: Below is a collection of statements about your everyday experience. Using the
1-6 scale below, please indicate how frequently or infrequently you currently have each
experience. Please answer according to what really reflects your experience rather than
what you think your experience should be. Please treat each item separately from every
other item.

| 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|
| Almost Always | Very Frequently | Somewhat Frequently | Somewhat Infrequently | Very Infrequently | Almost Never |

I could be experiencing some emotion and not be conscious of it until some time

later.

1 2 3 4 5 6

I break or spill things because of carelessness, not paying attention, or thinking of something else.

1 2 3 4 5 6

I find it difficult to stay focused on what's happening in the present.

1 2 3 4 5 6

I tend to walk quickly to get where I'm going without paying attention to what I experience along the way.

1 2 3 4 5 6

I tend not to notice feelings of physical tension or discomfort until they really grab my attention.

1 2 3 4 5 6

I forget a person's name almost as soon as I've been told it for the first time.

1 2 3 4 5 6

It seems I am "running on automatic," without much awareness of what I'm doing.

1 2 3 4 5 6

I rush through activities without being really attentive to them.

1 2 3 4 5 6

I get so focused on the goal I want to achieve that I lose touch with what I'm doing right now to get there.

1 2 3 4 5 6

I do jobs or tasks automatically, without being aware of what I'm doing.

1 2 3 4 5 6

I find myself listening to someone with one ear, doing something else at the same time.

1 2 3 4 5 6

I drive places on 'automatic pilot' and then wonder why I went there.

1 2 3 4 5 6

I find myself preoccupied with the future or the past.

1 2 3 4 5 6

I find myself doing things without paying attention.

| | | | | | |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 |

I snack without being aware that I'm eating.

| | | | | | |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 |

MAAS Scoring

To score the scale, simply compute a mean (average) of the 15 items. Higher scores reflect higher levels of dispositional mindfulness.