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Article 28

Trauma and Burnout: Counselors in Training

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Introduction

Exposure to traumatic events, whether directly or indirectly, ranges from 40% to 81% of the U.S. population (Bride, 2007; O'Halloran & O'Halloran, 2001). Due to the high probability of being exposed to traumatic events, the present study assessed burnout, trauma symptoms, and the impact of events among counselor education masters students. Research in this area is critical because those in the helping professions are more likely to have unresolved symptoms of trauma. O'Halloran and O'Halloran (2001) stressed that graduate students, in addition to being exposed to traumatic events, can also be impacted by course content, class discussions, and exposure to client stories. Vicarious trauma, while a student, could result from course information and accounts of child abuse, disasters, terrorism, intimate partner violence, rape and other situations perceived as threatening (Bride; O'Halloran & O'Halloran).

Trauma symptoms can impact attention to classroom learning but also potentially impair counselors' work with clients. To ameliorate symptoms, O'Halloran and O'Halloran (2001) called on faculty to develop teaching strategies for addressing such issues. Additionally, they suggested faculty observe students' affect and

levels of participation when course content is related to traumatic situations. For personal and professional reasons, students must learn to address symptoms of trauma prior to graduating and entering the counseling profession (ACA, 2005; ASCA, 2005).

To understand PTSD, burnout, trauma symptoms, and the impact of events among counselors-in-training, a series of measurements were administered to counselor education masters students who were in pre- and post-clinical stages of their training. The study's rationale, methods, results, discussion, and conclusions follow.

Implications of Vicarious Trauma and Burnout

In addition to being at risk for Post-Traumatic Stress Disorder (PTSD) via personal life experiences, counselors are at risk for vicarious trauma. What counselors hear from clients can impact their beliefs and become too much to handle, cause overwhelming feelings and result in PTSD symptoms (Bride, 2007; Keim, 1999; O'Halloran & O'Halloran, 2001). Several studies indicate that vicarious trauma results when counselors experience trauma-related symptoms while listening to clients' experiences and assuming responsibility for the well-being of their clients (Deighton, Gurriss, & Traue, 2007; Figley, 2002).

In a recent study, Bride (2007) found that social workers experienced vicarious trauma a week after interacting with clients who had experienced trauma. Additionally, 15.2% of the participants met PTSD diagnostic criteria compared with only 7.8% in the general population. Half of the participants reported intrusion symptoms, and 25% reported avoidance and arousal symptoms. Based on this finding, Bride concluded that symptoms related to experiencing trauma vicariously or first-hand are likely to result in prematurely leaving the profession.

In addition to prematurely leaving the profession, emotional and physical disorders, strained interpersonal relationships, burnout, and substance abuse are common. Unfortunately, many mental health professionals are unaware of these problems (Bride, 2007). Other symptoms that have been found to correlate with exposure to traumatic incidents are depersonalization, emotional exhaustion, and

compassion fatigue (Collins & Long, 2003; Deighton et al., 2007; Whealin et al., 2007).

Counselors, who might not experience vicarious trauma symptoms, may experience stress and burnout based on the overall experience of working with clients (Deighton et al., 2007; Whealin et al., 2007). In addition to the stress of working with clients, counselors face continued low funding of agencies, heavy case loads, meeting client contact hour quotas, and perceived levels of efficacy in the success of their work (Deighton et al.; Schauben & Frazier, 1995). Lack of control over quality of services, interpersonal relationships with colleagues and supervisors, and personal history of trauma are other factors in burnout (Deighton et al.).

Whealin et al. (2007) has shown that stress untreated over time can lead to burnout in human service related fields. When burnout is experienced, individuals will begin to alienate themselves from their colleagues and lack a sense of accomplishment while working with clients (Brattberg, 2006; Deighton et al., 2007). Burnout has been shown to impact employee turnover, depression, and anxiety (Vettor & Kosinski, 2000). Brattberg recently found that 52% of individuals sampled who were on long-term sick leave due to burnout, had higher probability of PTSD symptoms.

Counselors have a 50% rate of assault at work, a higher likelihood of attack than employees at convenience stores and gas stations (James & Gilliland, 2001). After traumatic incidents (despite the setting), employees: feel betrayed by their employers; experience depersonalization, emotional exhaustion, and less cohesion in the workplace; and find use of previously successful positive coping mechanisms deteriorates (Whealin et al., 2007). Moreover, counselors who have been traumatized directly or vicariously in their workplace are less trusting of their supervisors and peers (Whealin et al.). Traumatic situations and associated consequences are reasons why Whealin and associates have called for more research examining the associations between traumatic events and potential antecedents and consequences.

This present study sought to clarify relationships between trauma symptoms, the impact of an event and burnout among

counselor education students. Specifically, the following research questions were addressed: 1) Are there relationships between age, sex, and minority status and trauma symptoms? 2) Is there a relationship between where students are in their clinical training and trauma symptoms? 3) What aspects of burnout predict trauma symptoms? and, 4) Does the event's impact predict trauma symptoms?

Methods

Participants

Participants were 51 counselor education students from a University in the Southwestern United States. The criterion for selection was enrollment in a CACREP accredited counselor education program. The research was approved by the institutional review board of the participating university. In accordance with ACA standards, participation was voluntary with no benefits or adverse consequences experienced based on participation or non-participation. The participation rate was 78.4%. Participants completed a demographic questionnaire, the Maslach Burnout Inventory-Human Services Survey, the Impact of Events Scale and the LA Symptom Checklist.

The demographic questionnaire included items regarding: sex, ethnicity, age, education, career goals and place in their graduate training. The majority of participants were female (80.4%) with 19.6% male. The self-reported racial composition of the sample was 54.9% Caucasian, 2% American Indian, 31.4% Hispanic, and 11.7% other. Of participants, 45.9% were between ages of 20 and 30; 27.1% were between 31 and 40; 16.7% were between 41 and 50; and 10.4% were over 51 years of age.

Instruments

The Maslach Burnout Inventory – Human Services Survey (MBI-HSS; Maslach, Jackson, & Leiter, 1996) assesses emotional exhaustion, depersonalization and personal accomplishment. The test developers report reliability as follows: emotional exhaustion (= .90), depersonalization (= .79), and personal accomplishment (= .71). The

22-item instrument is scored on a Likert-scale ranging from 0 (never) to 6 (everyday).

The Impact of Events Scale (IES) is a 15-item Likert-scale instrument ranging from 0 “not at all” to 3 “often” and was developed by Horowitz, Wilner, and Alvarez (1979). The instrument contains two scales, intrusion, ($\alpha = .78$) and avoidance ($\alpha = .82$). The Intrusion scale measures the level of dreams, feelings, and intrusive thoughts regarding a traumatic event. The Avoidance scale focuses on denial: the avoidance of memories and discussion associated with a traumatic event.

The Los Angeles Symptom Checklist (LASC) assesses three PTSD areas (King, Leskin & Foy, 1995). The instrument is Likert-scaled from 0 (no problem) to 4 (extreme problem). The first scale focuses on symptoms of PTSD and consists of 17 items with higher scores indicating more symptoms. The second scale indicates whether a participant qualifies for the DSM-IV-TR, PTSD diagnosis based on items checked with higher scores. In aggregate all 43 items are considered a measure of overall distress, with higher scores indicating greater distress. Reliabilities for the subscales and total scores as assessed with coefficient alpha have ranged from .88 to .94, indicating acceptable reliability.

Procedures and Analysis

Participants were provided with the survey instrument following announcement of the project. A cover letter informed participants of their rights as human participants and that data was confidential. Participants completed the survey during their own time and deposited the completed survey in a secured box at a centralized location. Completion of the instruments took approximately 15 minutes.

Results

Data analysis consisted of hierarchical multiple regressions to explore predictors of the PTSD symptoms (Cohen, Cohen, West, & Aiken, 2003). The first block included demographic characteristics as predictors of PTSD (age, sex and minority status), the second block

included program status (clinical vs. pre-clinical), the third block included measures of burnout, and the fourth block added intrusiveness and avoidance of factors associated with the event. Change in explained variance was assessed at the inclusion of each block of predictors and significant predictors in the final model were interpreted. All model results are reported in Table I.

The first block of predictors focused on relationships between age, sex and minority status and the dependent variable of trauma symptoms. The resultant regression equation did not account for a statistically significant amount of variance, $F(3, 46) = 2.27$, $p = .09$, and $R^2 = .129$. The second block examined the relationship of clinical experience with trauma symptoms. After accounting for the variance associated with demographic characteristics, clinical experience was a significant negative predictor of trauma symptoms, $F_C(1, 45) = 5.196$, $p = .02$ and $R^2_C = .09$. The total simultaneous regression was also significant with $F(4, 49) = 3.13$, $p = .02$ and $R^2 = .21$. The third block of predictors ascertains whether the burnout scales of emotional exhaustion, depersonalization and personal accomplishment were predictors of trauma. The addition of these predictors did not result in a significant change in variance accounted for in trauma symptoms and will not be further discussed, $F(3, 42) = 1.05$, $p = .37$ and $R^2_C = .05$. The final block of predictors investigated whether the addition of the Impact of Event subscales (avoidance and intrusion) significantly predict variance in trauma symptoms after accounting for the aforementioned variables; with the expectation being that they would positively predict variance in trauma symptoms. The change in R^2 was statistically significant with $F_C(2, 40) = 10.45$, $p < .001$, and $R^2_C = .24$. In addition, the complete model was statistically significant with $F(9, 40) = 4.87$, $p < .001$, and $R^2 = .52$.

Significant predictors in the final model were as follows: majority status = .29 and $p = .02$; clinical status = -.27 and $p = .02$; and intrusive memories = .52 and $p < .001$ (all reported s are standardized). Gender, = -.20 and $p = .09$, was marginally significant. Due to the size of the sample ($N = 51$), which resulted in limited statistical power, and to the convergence of the result with other research findings, gender will be further discussed as a predictor of interest. In

summary, these results suggest that: 1) Anglos and females on average tend to report experiencing a greater number of traumatic symptoms, 2) those who have begun seeing clients (post-clinical) on average report fewer trauma symptoms relative to those students who have not seen clients (pre-clinical participants), and 3) that as the intrusiveness of traumatic event memories increase so do symptoms of trauma.

Discussion

The first research question examined ethnic and gender differences in the reporting of trauma symptoms on the LASC. Significant differences in PTSD symptoms based on ethnicity were found, with Anglos reporting a greater number of symptoms than minority status participants. In addition, males were found to have fewer symptoms than females. It is possible that males resolve their trauma symptoms quicker than females, or are less likely to report their trauma symptoms. However, consistent with Brattberg (2006) it is possible that this result reflects lower exposure to sexual assault and/or intimate partner violence in the male population. If females are more likely to be victimized, it follows that they would be more likely to have trauma symptoms; a more sensitive investigation of this hypothesis is needed.

The second research question examined the relationship of level of graduate training and trauma symptoms: pre-clinical (not having seen clients in practica/internship) vs. post-clinical (having started practica/internship). Our results, similar to O'Halloran and O'Halloran (2001), suggest that pre-clinical participants self-reported significantly more trauma symptoms. Therefore, the present study indicates that individuals may resolve issues associated with their traumatic experiences during the course of graduate training. Further study of specific program characteristics could be fruitful in identifying program components that are protective factors.

The third research question explored significant relationships between the MBI-HSS scales and trauma symptoms. Personal Accomplishment, Emotional Exhaustion and Depersonalization were not statistically significant predictors of trauma symptoms. However,

the size of the sample may have been inadequate to ascertain whether these factors were predictors of trauma symptoms.

The last research question explored the relationship between the event (IES) and trauma symptoms. This study found that as intrusive memories from the event increase so do other symptoms associated with PTSD. According to Cohen and associates (2003), this relationship is quite large, with a standard deviation increase in intrusive memories resulting in a half-standard deviation increase in trauma symptoms. This suggests that as memories become intrusive the overt symptoms associated with trauma are more likely to be experienced. This finding is problematic as it indicates that intrusive memories may interfere with recovery from traumatic events. Moreover, intrusive traumatic memories may interfere with listening to clients, attending to course work and benefiting from clinical supervision.

Conclusions

Among the general population, 8% qualify for a diagnosis of PTSD during their lifetime (American Psychiatric Association, 2000). Among participants of this research 12% qualify for a PTSD diagnosis based on self-reported symptoms on the LASC. Additionally, 12.5% indicated an experience with a client was a source of traumatic stress, 41.7% indicated a personal event, and 45.8% indicated an event with friend or family member.

It is difficult to fully understand the sources of PTSD symptoms that counselors experience. Trauma symptoms can be due to vicarious trauma and a counter transference reaction, a counselor's unresolved personal issues that relate to the client's issues, and/or trauma in the counselor's life that is unrelated to clients. For example a heightened startle response could be tied to the counselor's client who was raped, a re-emergence of the counselor's traumatic childhood issues, or tied to a car accident the counselor had. For purposes of our work we are concerned with any traumatic symptoms experienced by counselor education students and view it as critical that faculty prepare students to address trauma symptoms from all sources mentioned.

Of concern to counselor educators is the number of students in programs qualifying for a PTSD diagnosis and who express that their most traumatic event involved a client. In conclusion, it is ethically and morally critical, in our opinion, that faculty address these issues with students via class discussions about experienced and vicariously experienced trauma while counseling individuals. Rather than only responding when something happens, programs should proactively address ways of preventing burnout and trauma symptoms. Counselor self-care can be addressed via supervision, counseling courses, and practical/internships. Examples of content include increasing student awareness of safety issues when working with clients, normalizing the occurrence of vicarious trauma, focusing on coping strategies, and having students develop self-care plans.

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Table I. Hierarchical Regression of Trauma Symptoms

Explanatory Variable	Model 1	Model 2	Model 3	Model 4
Demographics				
<i>Gender (male = 1)</i>	-.240	-.260*	-.240*	-.203*
<i>Race (majority = 1)</i>	.281*	.312**	.271**	.293**
<i>Age</i>	.012	.005	.110	-.112
Education				
<i>Place in Program (Clinical = 1)</i>		-.302**	-.242*	-.272**
Burnout				
<i>Emotional Exhaustion</i>			.250	.136
<i>Depersonalization</i>			.067	.085
<i>Personal Accomplishment</i>			-.137	-.091
Impact of Events Scale				
<i>Avoidance</i>				.011
<i>Intrusion</i>				.506***
R² Change		.090**	.050	.249***
R²	.129*	.219**	.274**	.523***

Note: Standardized Beta Coefficients Reported.

* p < .10

**p < .05

***p < .01

