Practicing Counselors, Vicarious Trauma, and Subthreshold PTSD: Implications for Counselor Educators

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The purpose of this study was to gain an understanding of the relationship between vicarious trauma (VT) symptoms and subthreshold post-traumatic stress disorder (PTSD) symptoms among practicing counselors. The researchers determined the frequency of VT symptoms and subthreshold PTSD symptoms experienced among practicing counselors and common contributing factors that participants felt contributed to the development of VT symptoms. Implications are presented for counselor educators to determine how they best can prepare students.

Keywords: **vicarious trauma, subthreshold post-traumatic stress disorder, PTSD, practicing counselors, counselor educators**

Most counselors will likely work with clients addressing trauma (Sommer, 2008; Trippany, White Kress, & Wilcoxon, 2004). Thus, it is important for professional counselors to have an understanding of the dynamics of trauma and interventions to use with clients. Additionally, counselors should be educated on the impact that working with clients can potentially have on them, both personally and professionally. For instance, counselors who work with clients addressing trauma might themselves experience emotional and psychological symptoms, or *vicarious trauma* (VT). VT has been defined as a disruption in schemas and worldview because of chronic empathic engagement with clients. It is often accompanied by symptoms similar to those of post-traumatic stress disorder (PTSD), which occur as a result of secondary exposure to traumatic material that can result in a cognitive shift in the way the therapist experiences self, others, and the world (Jordan, 2010; Michalopoulos & Aparicio, 2012). Although estimates differ, it has been reported that as many as 50% of counselors are at risk of developing VT (National Child Traumatic Stress Network, 2011).

Counseling requires an immense amount of empathetic acceptance on the part of the counselor, which increases the counselor's vulnerability to taking on their clients' traumatic experiences (Finklestein, Stein, Greene, Bronstein, & Solomon, 2015). Empathic acceptance and increased vulnerability on the part of the counselor may increase the counselor's likelihood of developing VT symptoms (Sommer, 2008). VT can have a detrimental effect on all aspects of the counseling process, including both the counselor's professional and personal life. Practicing counselors experiencing VT have been found to leave the profession early and may also experience emotional and physical disorders, suicidal ideation, strained relationships, increased or continuous burnout, anger, and possible substance abuse (Bergman, Kline, Feeny, & Zoellner, 2015; Keim, Olguin, Marley, & Thieman, 2008). VT is highly detrimental to the counseling process and the care provided to clients. A counselor experiencing VT is more likely to make clinical errors, and VT can negatively impact the counseling relationship (Trippany et al., 2004). The negative implications associated with VT make it imperative that counselors and those who work with them (e.g., supervisors and counselor educators) understand all the factors that lead to the development of VT. This can include recognizing

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factors that decrease vulnerability, assessing VT, and intervening (Sommer, 2008). One of the initial components to this process is understanding how VT and related symptoms of subthreshold PTSD develop and the variables or experiences that can contribute to higher levels of vulnerability to VT symptoms. *Subthreshold PTSD* has been defined as the presence of clinically significant PTSD symptoms that fall short of the full *Diagnostic and Statistical Manual of Mental Disorders* PTSD diagnostic criteria (Bergman et al., 2015).

VT and Subthreshold PTSD

As noted, VT can have a detrimental impact on all aspects of the counseling process. A counselor experiencing VT can report many of the symptoms associated with both VT and subthreshold PTSD. VT and subthreshold PTSD have been identified as closely related phenomena. Many counselors who experience VT also meet the criteria for subthreshold PTSD and share similar symptoms (Keim et al., 2008). Counselors who experience VT are in essence experiencing post-traumatic stress symptoms in response to hearing and processing the trauma experienced by their clients (Bercier & Maynard, 2015). Common similar symptoms of VT and subthreshold PTSD include experiencing recurring intrusive thoughts about clients or work, numbing of feelings, hypervigilance or increased anxiety, and a decrease in empathy (Howlett & Collins, 2014; Michalopoulos & Aparicio, 2012; Nelson, 2016).

Although there are limitations in the research on the variables that correspond to the development of VT and subthreshold PTSD among counselors, as well as the factors that address these vulnerabilities, the research has highlighted some areas of concern. Understanding these areas is a critical component of addressing the development, assessment, and intervention for VT and subthreshold PTSD, especially for supervisors and counselor educators who train and work with these counselors. One of these variables is years of experience. Although all practicing counselors are at risk for VT and subthreshold PTSD, novice counselors are at an especially elevated risk (Michalopoulos & Aparicio, 2012; Parker & Henfield, 2012). Novice counselors tend to have limited experience with trauma and often have limited training relevant to working with trauma (Newell & MacNeil, 2010; Parker & Henfield, 2012). Further, novice counselors might have trouble establishing boundaries during the early stages of professional identify development, which can contribute to an increase in vulnerability for developing VT and subthreshold PTSD (Howlett & Collins, 2014). Moreover, beginning counselors' training and personal experiences may not have adequately prepared them for working with individuals dealing with trauma, so in turn they might not have received training on how to address trauma with their clients or identify the development of VT in themselves (Jordan, 2010; Mailloux, 2014; Trippany et al., 2004). It has been recommended that such training should include the key features of trauma, warning signs and symptoms, and strategies to prevent the development of VT and subthreshold PTSD (Newell & MacNeil, 2010).

An essential element of training counselors on strategies to prevent or address the development of VT and subthreshold PTSD includes increasing awareness of the workplace dynamics that may increase vulnerability. Counselors spend a sizeable amount of their time ensuring that others take care of themselves while potentially neglecting their own personal self-care (Whitfield & Kanter, 2014). Neglecting self-care has been found to correspond to an increased rate for developing the negative effects of VT and subthreshold PTSD symptoms (Mailloux, 2014). In an effort to decrease VT and subthreshold PTSD practicing counselors must ensure they are incorporating various types of self-care on a regular basis. Counselors can incorporate self-care activities, such as adequate sleep, social interaction, exercise, a healthy diet, reading, and journaling, into their routine, but all too often practicing counselors let these activities slip (Jordan, 2010; Nelson, 2016).

Related to self-care is helping counselors to understand the importance of seeking support from peers and supervisors. Collaboration and consultation with peers and supervisors at the workplace are vital to minimize the adverse effects of VT and subthreshold PTSD (Jordan, 2010). To address possible VT and subthreshold PTSD, practicing counselors require support from colleagues in relation to case conceptualization and identification of impairment (Newell & MacNeil, 2010; Parker & Henfield, 2012; Whitfield & Kanter, 2014). Additionally, counselors should seek supervision specific to trauma to ensure they are not developing VT symptoms and subthreshold PTSD symptoms (Whitfield & Kanter, 2014). One of the concerns, however, is that for many counselors working at counseling sites with high caseloads related to trauma, there are often low levels of clinical supervision (O'Neill, 2010). These sites also can link to another variable that corresponds to higher levels of VT: the caseload of the counselor. For example, counselors with large caseloads are at increased risk of developing VT or subthreshold PTSD because the counselor may not be able to spend adequate amounts of time on each case and might overextend their time addressing case needs (Whitfield & Kanter, 2014). In addition, counselors with caseloads that deal primarily with trauma are at an increased risk of developing VT and subthreshold PTSD, especially if they have limited clinical experience (Bercier & Maynard, 2015; Newell & MacNeil, 2010; Trippany et al., 2004). Recognizing and understanding the contributors to VT and subthreshold PTSD are essential for counselor educators and supervisors to be aware of as they prepare new counselors to enter the field.

Counselor Educator and Supervisor Implications

When looking at the risk factors associated with VT and subthreshold PTSD, it is clear that a critical component to decrease risk is the training and support provided to counselors. Thus, it is imperative that counselor educators and supervisors be aware of the symptoms and factors that impact the development of VT and subthreshold PTSD. Keim et al. (2008) found that 12% of counselors-in-training (CITs) qualified for a PTSD diagnosis, highlighting the fact that counselor educators and supervisors need to be aware of and educate counselors to recognize the symptoms of VT and subthreshold PTSD. The Council for Accreditation of Counseling and Related Educational Programs (CACREP; 2015) reinforces the importance of this training by specifically requiring that programs educate CITs on trauma-related counseling skills and also engage students in methods to assess and address VT and subthreshold PTSD symptoms in themselves as practicing counselors. To meet this goal, counselor educators and supervisors must more fully understand the causes of VT and subthreshold PTSD (Keim et al., 2008).

This study was developed to assess the frequency of VT and subthreshold symptoms among practicing counselors. This included variables that correspond to the development of these symptoms. The data can contribute to our understanding of VT and subthreshold PTSD symptoms among counselors and provide a framework for working with counselors during supervision and in preparing CITs.

Method

Sample

Two hundred and twenty current practicing counselors completed the nationwide survey. Of the 220 participants, 219 participants reported gender; 23 (10.3%) respondents identified as male and 196 (87.9%) respondents identified as female. Of the participants, 217 (98.6%) reported they were over 19 years of age (range 23–65, $M = 39$). Two hundred and fifteen respondents indicated holding a master's degree (97.8%). Thus, exclusion criteria removed five respondents from the data set for not meeting degree requirements —participants must have completed a master's degree in counseling (i.e., school counseling, clinical

mental health counseling, rehabilitation counseling, family and marriage counseling). Current work setting was reported by 207 of the respondents; 137 (62.3%) identified as school counselors, 24 (10.9%) reported working in a community mental health center, 17 (7.7%) reported working in a higher education center, 16 (7.35%) reported working in a private practice, and 13 (5.9%) reported "other," which included settings such as employee assistance programs and crisis centers.

Six respondents (2.7%) reported less than one year of cumulative counseling experience, 50 (22.7%) reported 1–3 years of cumulative counseling experience, 31 (14.1%) reported 4–5 years of cumulative counseling experience, 47 (21.4%) reported 6–10 years of cumulative counseling experience, and 72 (32.7%) reported 10 years or more of cumulative counseling experience. Of the 220 respondents, 12 (5.5%) did not report how many years they have been in their current position, 8 (3.6%) reported being in their current position less than one year, 103 (10.9%) reported 1–3 years, 31 (14.1%) reported 4–5 years, 30 (13.6%) reported 6–10 years, and 36 (16.4%) reported being in their current position 10 or more years.

Instruments

Participants were asked to complete a brief demographic questionnaire and two surveys, the PTSD Checklist for the DSM-5 (PCL-5), developed by Blevins, Weathers, Davis, Witte, and Domino (2015), and the Secondary Trauma Stress Scale (STSS), developed by Bride, Robinson, Yegidis, and Figley (2004). The demographic questionnaire sought to understand the impact that years of experience, number of contributing factors, and preventive measures have on VT and subthreshold PTSD symptoms. Participants in this study also completed a series of measures assessing the rate of VT among practicing counselors, the number of participants who meet the criteria for subthreshold PTSD, and the impact of the types and number of professional supports on practicing counselors.

Demographic measure. A basic demographic survey was developed and utilized to collect data on each respondent's age, gender, current position, years of counseling experience, primary type of clientele served, and any licenses and credentials. Text entry was utilized to understand the type and number of professional supports respondents identified: supervision, peer support, years of experience, training specific to trauma, caseload size, and self-care implementation. The demographic survey collected basic information related to the participants' counseling experience and background to gain an understanding of who chose to participate in the study. Further, the information gained was used to assist in developing implications for counselor educators and supervisors in preparing CITs to recognize VT symptoms and identify the types of professional supports needed.

PTSD Checklist for the DSM-5 (PCL-5). The PCL-5 is a revision of the PTSD Checklist (PCL) that specifically assesses self-report measures of PTSD symptoms as outlined in the DSM-5 (Blevins et al., 2015). The PCL is one of the most widely used measures of PTSD symptoms, and the revised PCL-5 is the only instrument that specifically measures criteria defined in the DSM-5 (Blevins et al., 2015). The PCL-5 is a 20-item survey that corresponds to the 20 PTSD symptoms in the DSM-5 (Bovin et al., 2016). Respondents are asked to rank, from 0–4, how much they have been bothered by the presented symptom within the last month (Bovin et al., 2016). Sample topics include: having difficulty sleeping; feeling jumpy or easily startled; and avoiding memories, thoughts, or feelings related to the stressful event. In a validation study of the PCL-5, Blevins et al. (2015) found high internal consistency (.94), and the measure fell within the recommended range of inter-item correlation of .15 to .50. Test-retest reliability was $r = .82$ with a 95% confidence interval [.71, .89], and paired t-tests were significant ($p < .01$) for the PCL-5 between two test validations (Blevins et al., 2015). Cronbach's alpha for this study indicated high internal consistency (.96) and test-retest reliability of $r = .84$.

Secondary Trauma Stress Scale (STSS). The STSS, developed by Bride et al. (2004), was used to understand the number of VT symptoms among practicing counselors as well as to determine the relationship between VT symptoms and subthreshold PTSD symptoms among practicing counselors. The STSS is a 17-item self-report measure designed to assess helping professionals who may have experienced secondary traumatic stress and the frequency of intrusion, avoidance, and arousal symptoms (Bride et al., 2004; Ting, Jacobson, Sanders, Bride, & Harrington, 2005).

The STSS asks that respondents endorse how frequently an item was true for them in the past 7 days (Bride et al., 2004). Responses range from 1 to 5 in Likert form (1 = *never* and 5 = *very often*). Psychometric data for the STSS indicates very good internal consistency reliability with coefficient alpha levels of .93 for the total STSS scale, .80 for the Intrusion subscale, .87 for the Avoidance subscale, and .83 for the Arousal subscale (Bride et al., 2004). Ting et al. (2005) determined in their validation study of the STSS that internal consistency reliability for the 17 total STSS items was very high (.94) and was moderately high for the Intrusion subscale (.79), the Avoidance subscale (.85), and the Arousal subscale (.87), and all three factors were highly correlated with each other (intrusion–avoidance, $r = .96$; intrusion–arousal, $r = .96$; avoidance–arousal, $r = 1.0$), as indicated by a confirmatory factor analysis. Cronbach's alpha for this study confirmed Ting et al.'s findings, as internal consistency reliability for the 17 total STSS items was very high (.94) and was moderately high for the Intrusion subscale (.80), the Avoidance subscale (.86), and the Arousal subscale (.89). Statements on the Intrusion subscale inquire about respondents' intrusion symptomology on a Likert scale with statements such as "My heart started pounding when I thought about my work with clients" and "I had disturbing dreams about my work with clients." The Avoidance subscale asks respondents to respond on a Likert scale to statements such as "I felt emotionally numb" and "I had little interest in being around others." The final subscale, Arousal, asks respondents to respond on a Likert scale to statements such as "I had trouble sleeping" and "I expected something bad to happen."

Procedures

Upon Institutional Review Board approval, participants were recruited via email through listserv solicitation that included the Alabama Counseling Association, the American School Counselor Association, the American Counseling Association, and CESNET. Participants were provided a link to an informed consent document and the research surveys in Qualtrics. Participation was restricted to practicing mental health or school counselors who had a master's degree in counseling and had been a practicing counselor for at least 6 months at the time of the survey.

Design and Statistical Analyses

The purpose of this quantitative study was to investigate the frequency of VT symptoms and subthreshold PTSD symptoms experienced by practicing counselors. This included the relationship of VT symptoms and subthreshold PTSD symptoms with years of experience, work setting and type of clientele, and the number and type of professional supports utilized by practicing counselors. Descriptive analysis was used to determine what symptoms of VT and subthreshold PTSD practicing counselors experience. A linear regression was used to determine the relationship between VT symptoms and subthreshold PTSD symptoms. Linear regressions were utilized to determine the relationship years of experience, work setting and type of clientele, and professional supports have with VT symptoms and subthreshold PTSD symptoms among practicing counselors.

Results

Symptoms of VT and Subthreshold PTSD Experienced by Practicing Counselors

Descriptive statistics based on participants' responses indicated symptoms of VT and subthreshold

PTSD are being experienced by practicing counselors. On the STSS, all symptoms were experienced to some degree by 49.5% of the participants. Symptoms were rated significant if they scored higher than "never" on the STSS, meaning they had experienced the symptom to some degree within the past 7 days.

The most common symptom of VT experienced by participants was thinking about work with clients when not intending to do so (85.5%), as measured by the STSS. Additional symptoms of VT experienced commonly by participants included feeling emotionally numb (80.5%), becoming easily annoyed (79.1%), having difficulty concentrating (75.5%), and feeling discouraged about their future (75.5%). Experiencing disturbing dreams about their clients (49.5%) and feeling jumpy (56.4%) were the least common symptoms experienced by participants, but 49.5% of the participants experienced these symptoms. Table 1 outlines the VT symptoms of participants as measured by the STSS in descending order.

Table 1

STSS Symptom Distribution

Items in Descending Order	*n* (%)
I thought about my work with clients when I didn't intend to.	188 (85.5%)
I felt emotionally numb.	177 (80.5%)
I was easily annoyed.	174 (79.1%)
I felt discouraged about the future.	166 (75.5%)
I had trouble concentrating.	166 (75.5%)
I had trouble sleeping.	165 (75.0%)
I wanted to avoid working with some clients.	162 (73.6%)
I was less active than usual.	156 (70.9%)
Reminders of my work with clients upset me.	155 (70.5%)
My heart started pounding when I thought about my work with clients.	155 (70.5%)
I had little interest in being around others.	149 (67.6%)
It seemed as if I was reliving the trauma(s) experienced by my client(s).	133 (60.5%)
I expected something bad to happen.	132 (60.0%)
I avoided people, places, or things that reminded me of my work with clients.	126 (57.3%)
I noticed gaps in my memory about client sessions.	126 (57.3%)
I felt jumpy.	124 (56.4%)
I had disturbing dreams about my work with clients.	109 (49.5%)

Participant responses to the PCL-5, utilized to measure subthreshold PTSD symptoms, suggested practicing counselors are experiencing subthreshold PTSD symptoms. Symptoms were rated as significant if they scored higher than "not at all," indicating they had experienced the symptom to some degree within the past month. The most common symptom reported to have been experienced by all participants (100%) was repeated, disturbing, or unwarranted memories of the stressful experience. Other symptoms that were reported to have been experienced commonly by practicing counselors included having trouble falling or staying asleep (71.4%), having difficulty concentrating (70.9%), feeling distant or cut off from other people (68.2%), and feeling very upset when something

reminded them of the stressful experience (66.8%). Taking too many risks or doing things that could cause personal harm (36.8%); feeling or acting as if the stressful experience were actually happening again (42.7%); and experiencing repeated, disturbing dreams of the stressful experience (49.1%) were experienced least commonly by participants. Table 2 outlines the VT symptoms of participants as measured by the PCL-5 in descending order.

Table 2

PCL-5 Symptom Distribution

Items in Descending Order	*n* (%)
Repeated, disturbing, and unwanted memories of the stressful experience?	220 (100%)
Trouble falling or staying asleep?	157 (71.4%)
Having difficulty concentrating?	156 (70.9%)
Feeling distant or cut off from other people?	150 (68.2%)
Feeling very upset when something reminded you of the stressful experience?	147 (66.8%)
Irritable behavior, angry outbursts, or acting aggressively?	139 (63.2%)
Avoiding memories, thoughts, or feelings related to the stressful experience?	139 (63.2%)
Having strong negative feelings such as fear, horror, anger, guilt, or shame?	134 (60.9%)
Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	130 (59.1%)
Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	127 (57.7%)
Being "superalert" or watchful or on guard?	125 (56.8%)
Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	125 (56.8%)
Loss of interest in activities that you used to enjoy?	123 (55.9%)
Blaming yourself or someone else for the stressful experience or what happened after it?	121 (55.0%)
Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	119 (54.1%)
Feeling jumpy or easily startled?	116 (52.7%)
Trouble remembering important parts of the stressful experience?	113 (51.4%)
Repeated, disturbing dreams of the stressful experience?	108 (49.1%)
Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	94 (42.7%)
Taking too many risks or doing things that could cause you harm?	81 (36.8%)

Relationship Between VT Symptoms and Subthreshold PTSD Symptoms

Linear regression models determined the relationship between VT symptoms and subthreshold PTSD symptoms among practicing counselors. In a backward regression, the PCL-5, measuring subthreshold PTSD symptoms, was entered as the dependent variable, and the subscales of the STSS, measuring VT symptoms, were entered as the independent variables. Results indicated that the more

VT symptoms were experienced by practicing counselors, the more subthreshold PTSD symptoms were experienced. There was a significant relationship between results from the PCL-5 and all three STSS subscales. The relationship between subthreshold PTSD symptoms and the Intrusion subscale was significant ($r = .676$, $p < .001$). There also was a significant relationship between subthreshold PTSD symptoms and avoidance symptoms ($r = .759$, $p < .001$), and between subthreshold PTSD symptoms and arousal symptoms ($r = .790$, $p < .001$). Avoidance VT symptoms and arousal VT symptoms were the most predictive variables associated with developing subthreshold PTSD symptoms as evidenced in the restricted model regression summary. In the backward regression model, the Intrusion subscale of the STSS was eliminated as the least significant variable, which indicates the more arousal and avoidance symptoms were experienced as VT, the more subthreshold PTSD symptoms were experienced by the practicing counselors. In the full regression model (R^2 Full = .656, $F = 103.4$, $p < .001$), results suggested a significant relationship, indicating that the more VT symptoms were experienced by practicing counselors, the more subthreshold PTSD symptoms were experienced. Through the restricted regression model (R^2 Restricted = .655, $F = 155.75$, $p < .001$) and the F change test, results indicated that the restricted model is not worse than the full model because the observed F (.00000892; $p = .647$) does not exceed the critical F ($df = 1,163$), which is 3.94.

Relationship Among Demographics and Type of Professional Supports Among Practicing Counselors on VT

A backward linear regression model was utilized to determine the relationship between VT symptoms and years of experience, work setting and type of clientele, and type of professional supports among practicing counselors. There were two significant relationships within this regression in the restricted model of the regression. There was a significant negative correlation between VT symptoms and having a manageable caseload, indicating the more manageable caseload the counselor has, the fewer VT symptoms they have. In addition, there was a significant negative correlation between VT symptoms and having adequate supervision, indicating the more supervision received, the fewer VT symptoms experienced. Overall, the two variables (caseload and supervision) correlate with the dependent variable, VT symptoms ($r = .273$, $R^2 = .074$). This overall correlation is unlikely due to chance ($F = 8.159$, $p < .001$). The F change test indicated the observed F (2.008; $p = .158$) does not exceed the critical F ($df = 1, 202$), which is 3.89. The semi-partial correlation between caseload and VT symptoms was -.173, while the semi-partial correlation between supervision and VT symptoms was -.150. The semi-partial correlation indicates the uniqueness of the relationship. The squared semi-partial correlation for supervision was $(-.173)^2 = .029$, and the squared semi-partial correlation for caseload was $(-.150)^2 = .02$., $^*p < .05$.

Relationship Between Demographics and Type of Professional Supports Among Practicing Counselors on Subthreshold PTSD Symptoms

A backward linear regression model was utilized to determine the relationship between subthreshold PTSD symptoms and years of experience, work setting and type of clientele, and the number and type of professional supports among practicing counselors. With subthreshold PTSD symptoms as the dependent variable and years of experience, work setting and type of clientele, and type of professional supports as the independent variables, a backward linear regression was run to understand the relationship between the variables in the restricted model of the regression. Results indicated a significant relationship between subthreshold PTSD symptoms and those counselors who work primarily with adolescents or with sexual assault/domestic violence survivors. Overall, the two variables (adolescents and sexual assault/domestic violence) correlate with our dependent variable, subthreshold PTSD symptoms ($r = .242$, $R^2 = .059$). This overall correlation is unlikely due to chance ($F = 5.080$, $p = .007$). The F change test indicated the observed F (2.255; $p = .135$) does not exceed the critical F ($df = 1,162$), which is 3.94. The semi-partial correlation between adolescents and

subthreshold PTSD symptoms was .159, while the semi-partial correlation between sexual assault/domestic violence and subthreshold PTSD symptoms was .187. The semi-partial correlation indicates the uniqueness of the relationship. The squared semi-partial correlation for adolescents was $(.159)^2 = .025$, and the squared semi-partial correlation for sexual assault/domestic violence was $(.187)^2 = .03$. This data indicates that work setting and the type of clientele served by the counselor can influence risk for developing subthreshold PTSD symptoms.

Limitations

One limitation for this study was the high percentage of participating school counselors (62.3%). This could have possibly skewed results as the type of clientele that the practicing counselors primarily worked with exhibited the most influence on symptoms of VT and subthreshold PTSD (i.e., adolescents). Additionally, this large percentage of school counselors could make the implications suggested in this study not as applicable for counselors in higher education settings.

An additional limitation of this study was the lack of demographics available to identify if counselors were in a rural setting or urban setting. Although the implications suggested are applicable to all counselors, demographic location could serve as an additional barrier to implementing the professional supports suggested.

Discussion

The purpose of this study was to develop an understanding of the frequency and characteristics of VT symptoms and subthreshold PTSD symptoms among practicing counselors, which was answered by the first research question. The most common VT symptom experienced by participants (85.5%) was thinking about their work with clients when they did not intend to outside of work. This finding is significant for counselor educators and supervisors as it indicates that VT symptoms are being experienced by the majority of the counselors in this study. All VT symptoms, as measured by the STSS, were experienced by 49.5% of the participants, indicating all 17 VT symptoms measured had been experienced to some degree by the counselors that participated in this study. This study adds to the current literature reported by Bride (2007) that 50% of child welfare counselors experience traumatic stress symptoms within the severe range. In addition, Cornille and Meyers (1999) reported 37% of their sample of child protection service workers reported clinical levels of emotional distress associated with secondary trauma, and Conrad and Kellar-Guenther (2006) reported 50% of child protection workers suffered "high" to "very high" levels of compassion fatigue.

In addition to measuring VT symptoms, the first research question was developed to acquire an understanding of the frequency of subthreshold PTSD symptoms experienced by counselors. Subthreshold PTSD symptoms were measured by the PCL-5 and results suggest practicing counselors are experiencing subthreshold PTSD symptoms. Of the 20 items in the PCL-5, all but three were experienced by at least 50% of the participants. All 220 (100%) of participants reported experiencing repeated, disturbing, and unwanted memories of the stressful experience. This finding is similar to that found by the STSS in that over 85% of participants had unwanted thoughts about experiences with clients outside of work. Furthermore, over 70% of participants reported having trouble sleeping and having difficulty concentrating in both the STSS and PCL-5 as symptoms of VT and subthreshold PTSD. Understanding the symptoms of VT and subthreshold PTSD experienced by participants was important, as previous studies have indicated that those who experience VT symptoms also experience subthreshold PTSD symptoms (Jordan, 2010). Additionally, the literature has reported VT symptoms and subthreshold PTSD symptoms as being one and the same (Finklestein et al., 2015).

The second research question was developed to gain an understanding of the relationship between VT symptoms and subthreshold PTSD symptoms. A linear backward regression with the PCL-5 measuring subthreshold PTSD symptoms was entered as the dependent variable, and the subscales of the STSS, measuring VT symptoms, were entered as the independent variables. Results from this regression model indicated that the more VT symptoms were experienced by practicing counselors, the more subthreshold PTSD symptoms were experienced. In the backward regression model, the Intrusion subscale of the STSS was eliminated as the least significant variable, which indicated that the more arousal and avoidance symptoms were experienced as VT, the more subthreshold PTSD symptoms were experienced by the practicing counselors, with the Intrusion scale not being significant. This finding is consistent with the extant literature that has reported VT symptoms being analogous to PTSD symptoms (Keim et al., 2008). Furthermore, this finding also is consistent with prior literature that reported counselors who experience VT symptoms also experience PTSD symptoms (Bercier & Maynard, 2015), as found in Bride's (2007) study in which 34% of child welfare workers met the PTSD diagnostic criteria because of VT.

In an effort to answer the second research question, which was interested in the relationship between VT symptoms and subthreshold PTSD symptoms and years of experience, work setting and type of clientele, and the number and type of professional supports, two backward linear regression models were established. The first linear regression model was interested in the relationship between VT symptoms and years of experience, work setting and type of clientele, and the number and type of professional supports among practicing counselors. In this backward linear regression model, the STSS served as the dependent variable with years of experience, work setting and type of clientele, and the number and type of professional supports serving as the independent variables. Results indicate a significant relationship between VT symptoms and having a manageable caseload as well as between VT and utilizing supervision. A negative correlation between VT symptoms and having a manageable caseload indicates that the more manageable a counselor's caseload, the less likely they were to experience VT symptoms. This finding is consistent with prior studies that indicate a manageable caseload as being a protective factor for counselors that can decrease their chance of developing both VT symptoms and subthreshold PTSD symptoms (Trippany et al., 2004). Additionally, there was a negative correlation between supervision as a professional support and the development of VT symptoms among counselors. Adequate supervision has been identified as a protective factor against the development of VT (Harrison & Westwood, 2009). Both of these findings are important implications for counselor educators and supervisors as they can be initiated in the classroom while CITs are preparing for a career in the counseling profession.

The second linear regression model focused on the relationship between subthreshold PTSD symptoms and years of experience, work setting and type of clientele, and the number and type of professional supports among practicing counselors. In this backward linear regression model, the PCL-5 served as the dependent variable with years of experience, work setting and type of clientele, and the number and type of professional supports serving as the independent variables. Results indicated a significant relationship between subthreshold PTSD symptoms and counselors who primarily work with adolescents and sexual assault/domestic violence survivors. These findings are consistent with prior literature that has indicated sexual assault counselors report more VT symptoms and subthreshold PTSD symptoms. For instance, Bride (2007) reported 65% of domestic violence and sexual assault social workers reported at least one symptom of VT, while Lobel (1997) reported over 20 years ago that 70% of sexual assault counselors experienced VT. Additionally, Schauben and Frazier (1995) reported that counselors who work with a higher percentage of sexual assault survivors report more disrupted beliefs about themselves and others, more subthreshold PTSD symptoms, and more VT than counselors who see fewer sexual assault survivors.

Implications for Counselor Educators and Supervisors

The results of this study provide counselor educators and supervisors with information to prepare CITs to have an increased awareness of VT and subthreshold PTSD symptoms. This study established evidence that practicing counselors are experiencing numerous VT symptoms and subthreshold PTSD symptoms. In fact, this study found that all VT symptoms measured were experienced by 49.5% of the participants, and 17 of the 20 PTSD symptoms measured were experienced by all participants. Further, in an open-ended question in the brief demographic survey, participants provided the researcher with ideas they felt would increase awareness of VT and subthreshold PTSD and decrease VT and subthreshold PTSD symptoms. Over 40% of responses indicated a desire for more education on VT symptoms and subthreshold PTSD symptoms. With 49.5% of participants reporting VT symptoms and subthreshold PTSD symptoms, it is evident that additional education is needed related to these symptoms among practicing counselors. Keim et al. (2008) suggested educational trainings and workshops be provided to CITs proactively to increase awareness of VT and subthreshold PTSD and to decrease VT symptoms and subthreshold PTSD symptoms among practicing counselors. Counselor educators and supervisors can provide trainings on the signs and symptoms of VT and subthreshold PTSD experienced by counselors to raise awareness of these symptoms and ways to recognize and alleviate them before causing harm to the counselor or client.

This study denoted that counselors who work primarily with adolescents and sexual assault/domestic violence survivors are experiencing more subthreshold PTSD symptoms than counselors that do not work specifically with these populations. As counselor educators prepare CITs for practicum, internship, and employment as counselors, it is vital for counselor educators to acknowledge the unique challenges that may stem from working with adolescents and survivors of sexual assault/domestic violence. It is imperative that counselor educators and supervisors integrate specific educational material through coursework related to these populations to best prepare CITs. Evidence-based practices that are effective for counseling these populations should be implemented within counselor education programs, supervision, workshops, and trainings outside of the degree program (e.g., at conferences; Alpert & Paulson, 1990; Mailloux, 2014; Whitfield & Kanter, 2014).

Education on the significance of professional supports, such as adequate supervision and manageable caseloads, is fundamental for CITs to be prepared to lessen the hazard of developing VT symptoms and subthreshold PTSD symptoms. By providing sufficient supervision during practicum and internship, counselor educators and supervisors can prepare CITs for coping with VT symptoms and subthreshold PTSD symptoms should they develop. In addition, through modeling appropriate supervision, CITs will comprehend the supervisory process and seek post-degree supervision.

Directions for Future Research

Future studies on VT symptoms and subthreshold PTSD symptoms need to focus solely on clinical mental health counselors or school counselors to develop implications specific to counseling sites. Further research devoted to the development of workshops and trainings to educate counselors on VT and subthreshold PTSD is needed.

A future study that compares counselors in rural settings and urban settings will be important to understand barriers to coping with and addressing VT symptoms and subthreshold PTSD symptoms. For example, in a rural setting, the counselor may not have adequate supervision and may be overloaded with cases, which can decrease the amount of self-care they are able to implement. It will be important for future research to explore what barriers to professional supports counselors face in these different demographic communities.

Because of this study's finding that working primarily with adolescents and individuals who have experienced sexual assault or domestic violence increases counselors' chances of experiencing VT symptoms and subthreshold PTSD symptoms, a qualitative or mixed-methods study focused on VT among counselors working with these populations is desirable. In an effort to best prepare students who will work with these populations, an understanding of exactly which aspects of working with these clients increase VT symptoms and subthreshold PTSD symptoms is essential.

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