THE EFFECTS OF PERSONAL TRAUMA HISTORY AND WORKING WITH CLIENTS WITH SIMILAR TRAUMA ON WELL-BEING AMONG MENTAL HEALTH COUNSELORS

by

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ABSTRACT

CORRELATION OF PERSONAL TRAUMA HISTORY, CLIENTS WITH SIMILAR TRAUMA, AND WELL-BEING AMONG MENTAL HEALTH COUNSELORS

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Several studies have researched burnout, compassion fatigue, secondary trauma, vicarious trauma, and shared trauma of practicing mental health professionals. Yet few have focused directly on the impact of personal trauma history on well-being. This study was an online exploratory design investigating the relationships among counselor personal trauma history, well-being, and the effects of seeing clients with similar trauma. Personal trauma history was determined through a demographical survey, and well-being analyzed using the Oxford Happiness Questionnaire (OHQ) and Posttraumatic Stress Disorder Checklist (PCL). The study examined several demographic variables to determine whether a model exits to predict counselor well-being. While the study found that different variables exist for counselors with trauma and those without, posttraumatic stress score was the one common predictor.

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CHAPTER 1

INTRODUCTION

According to the U.S. Department of Labor, Bureau of Labor Statistics (2011), there are currently over 665,500 counselors, 642,000 Social Workers, 170,200 psychologists, and 34,300 psychiatrists in the U.S. These helping professionals, who will be termed counselors for the remainder of this document, are responsible for treating the approximate one-quarter of all U.S. adults that are diagnosed with a mental disorder (Kessler, Chiu, Demler, & Walters, 2005). According to the same source, approximately 3.5% of the U.S. population has post-traumatic stress disorder (PTSD) and 1.3% of the population has severe PTSD. That equates to an approximate 50 thousand counselors, social workers, psychologists and psychiatrists practicing today who may have had PTSD some time in their own lives. And while we are learning more everyday about the effects of PTSD on our military, emergency response personnel, and the general population, we still lack understanding of PTSD's effects on counselors. It is reasonable to assume that, given the nature of practice, these counselors know and are able to implement the strategies needed for self-care for whatever their own trauma may have been. If anything, they should know how to access resources available and seek out treatment for themselves. However, although these counselors may be providing great care for their clients, it is largely unknown if they are taking care of themselves.

Trauma can leave lasting impressions upon individuals that, left untreated, can cause lifelong problems. It can go undiagnosed, misdiagnosed, or under diagnosed with less severity. Of the approximately 3.5% of the U.S. population that meet the criteria for PTSD, 36% of those are considered severe (Kessler, Chiu, Demler, & Walters, 2005). One third of people diagnosed with PTSD are receiving mental health services (Wang et al., 2005), and one third of people with a lifetime history of PTSD fail to recover even after many years (Calhoun, Beckham, & Bosworth,

2002). It is unknown how many of these individuals are counselors seeing clients. Are these counselors currently seeking treatment themselves? Could they fall into part of the population that fails to recover? Furthermore, what effect do the clients have on the counselors' mental health? What is the overall well-being of these counselors while seeing clients? These questions are not only important for keeping counselors healthy, but also for reducing possible harm for their clients. A counselor's personal trauma history could lead to adverse effects such as burnout, compassion fatigue, secondary traumatic stress, or vicarious traumatization which could result in physical, emotional, and behavioral symptoms, work related issues, and interpersonal problems (Trippany, White Kress, & Wilcoxon, 2004). Additionally, if a counselor and a client share the same traumatic event, the therapist is more vulnerable to these adverse effects (Saakvitne, 2002).

Although this may draw initial concern about the effectiveness of any counselor who is providing therapy, it is also very possible that a counselor's personal trauma history can be a factor in the counselor's personal growth (Linley & Joseph, 2007) potentially leading to an increased well-being. If those with personal trauma have undergone therapy and recovered from their trauma, then they may be in a better position to initiate self-care techniques that prevent adverse psychological and professional effects such as burnout. Additionally, the process of teaching coping skills and other therapeutic techniques could be just as beneficial for the counselor as it is for the client. Yet these dynamics and effects are largely unknown due to a lack of research in this specific area. This study intends to explore those dynamics and investigate the connections among a counselor's personal trauma history, their well-being, and the effects of having clients with similar trauma.

1.1 Definitions

- Counselors – Includes all mental health providers, counselors, family therapists, faith-based counselors, social workers, psychologists, psychiatrists, and anyone who provides direct clinical therapy.

- Personal Trauma – The aftermath of a crisis. Crisis is defined by James and Gilliland (2001) as “a perception or experiencing of an event or situation as an intolerable difficulty that exceeds the person’s current resources and coping mechanisms.”

1.2 Prevalence

Using the numbers from U.S. Department of Labor, Bureau of Labor Statistics (2011), there are over 1.5 million counselors in the U.S. As stated earlier, an estimated 3.5% of U.S. population has PTSD. Therefore, it is likely that over 50 thousand counselors, social workers, psychologists, and psychiatrists practicing today may have had PTSD some time in their life. Yet little or no information is available to these counselors on the likelihood of their personal trauma affecting their well-being. This is an important avenue of research because counselors’ personal trauma history could affect up to 80 million adult clients in the United States that meet criteria for a mental disorder (Kessler, Chiu, Demler, & Walters, 2005).

1.3 Purpose Statement

The purpose of this study is to explore the impact of counselors’ personal trauma on their current well-being by collecting and comparing demographic data on practicing mental health counselors.

1.3.1 Research Questions

The primary research question under investigation is: does a counselor’s personal traumatic experience affect well-being while providing therapy to clients?

- Question One: Is there a correlation between overall well-being and severity of posttraumatic stress disorder?
- Question Two: Do counselors who participate in therapeutic self-care interventions have a higher well-being than counselors who participate in other forms of self-care regardless of their trauma experiences or having clients with similar trauma?
    a. for those with trauma, is there a higher well-being for those who participate in therapeutic self-care interventions as compared to those who do not.

b. for those with trauma who see clients with a similar trauma as themselves, is there a higher well-being for those who participate in therapeutic self-care interventions as compared to those who do not?

- Question Three: Does personal trauma impact a counselor's well-being?
    a. when s/he has received mental health therapy?
    b. when s/he is seeing clients with similar trauma?
- Question Four: Does a model exists to predict counselor well-being?

CHAPTER 2

LITERATURE REVIEW

Very little literature exists on the topic of a counselor's personal trauma. If addressed at all, it is only reviewed as a possible subset of the overall concern of burnout. Throughout the literature exists several terms that are sometimes used interchangeably to describe these concerns – the most popular being burnout, compassion fatigue, secondary traumatic stress (STS), and vicarious trauma (VT). Even research among these topics is lacking partially due to confusion among the term definitions (Dunkley & Whelan, 2006). Furthermore, many of the tools used to measure these effects often appear to measure the same thing (Devilly, Wright, & Varker, 2009).

Although these terms can have a slightly different meaning depending upon context and perception (Newell & MacNeil, 2010; Sang Min, Seong Ho, Kissinger, & Ogle, 2010), they all have essentially the same posture in relation to how they regard the counselor's well-being is affected. They all imply that either the client's problems, or the act of dealing with the client's problems, are the source of whichever damaging effect the counselor is experiencing. For example, VT is usually defined as the counselor's secondary traumatic reactions from chronic exposure to a client's trauma (Trippany, White Kress, & Wilcoxon, 2004), not the counselor's personal life experiences. As such, VT does not assume that the counselor has a personal history of trauma, only that the process of seeing so many traumatized clients is traumatic in and of itself (Devilly, Wright, & Varker, 2009). And although VT can be a possible outcome of a counselor's personal trauma, it is not a widespread result. In another example, if a counselor's personal trauma is changing how they treat a client, it is usually defined as an issue of countertransference. Yet even the definition of countertransference lies in that the counselor is projecting a certain adverse effect upon the client; whereas suggested earlier, it is very possible

that a history of personal trauma could have a neutral, or even beneficial, effect upon the client. Countertransference is also an effect during and around the client's session (Trippany, White Kress, & Wilcoxon, 2004), which further lacks explanation of the counselor's overall well-being in and out of session.

Among all these terms used to relate how a counselor is affected within the context of mental health therapy, none accurately define the phenomenon of a counselor's personal trauma affecting their own well-being while providing therapy. In the case of adverse effects, the closest explanation available is actually the simplest: that the client's issues are a trigger for the counselor's own mental illness, and the counselors are solely experiencing symptoms of their own PTSD. But this answer fails to explain the vast differences in counselors' experiences dealing with this issue. It also does not allow for research or programs to accurately confront the issue, leaving counselors without a proper representation of the problem.

Another concept closely related to this research is that of shared trauma. Shared trauma has been defined as "situations in which the helper and helpee, psychotherapist and client, are exposed to the same communal disaster" (Baum, 2010). As Baum suggests, the term "shared trauma" is a somewhat recent name given to better define VT experienced by mental health professionals after the 9/11 attacks, and there still lacks a clear and distinctive definition in any published materials. Since the topic of this thesis looks at "similar trauma," it does not assume that the counselor and client shared the exact same experience, but a relatively comparable one.

Nevertheless, research on burnout, compassion fatigue, secondary traumatic stress, vicarious trauma, and shared trauma are relevant since they contain the closest material to this topic with some of them asking about the respondent's personal trauma history. Therefore, they may be mentioned within this study in the context of referring to other studies that considered personal trauma history. However, for the purposes of this research, their differences will not be examined in depth, and the terms may be used interchangeably.

2.1 Impact of the Problem

Plenty of information is available for practicing counselors on avoiding burnout, stress-reduction techniques, use of social support, and other factors in relation to the possible adverse effects of providing mental health therapy – primarily resources covering the three dimensions of burnout: emotional exhaustion, depersonalization, and personal accomplishment (Halbesleben, 2011; Maslach & Jackson, 1981). Additionally, counselors who have a personal history of trauma are more likely to experience the effect of vicarious trauma (Pearlman & Mac Ian, 1995), and shared trauma increases a counselor's vulnerability to vicarious trauma (Saakvitne, 2002).

Detailed studies of topics such as burnout have helped identify definitions, patterns, and risk factors that have led to the development of policies and programs to address these issues (Sang Min, Seong Ho, Kissinger, & Ogle, 2010). However, without more detailed knowledge of the effects of a counselor's personal trauma in reference to their practice, these tools are limited in their ability to predict or avert potential problems both with the counselor and the client. If a counselor's personal trauma is affecting their own well-being, it is also possible that the client's treatment can be affected. This can have a long-term impact on both the client's and the counselor's mental health, and social perception of counseling as a profession.

2.1.1 Adverse Social Effect

Although beyond the scope of this study, this topic raises question of the effects of a counselor's personal trauma on their clients. Social stigma of PTSD already prevents many clients from pursuing therapy (Hoge et al., 2008), and if these same clients knew about the possibility of their therapist having PTSD, it could prevent even more people from seeking therapy. A potential client many ask, "If the counselor can't take care of himself, how can he take care of me?" Additionally, if a counselor with personal trauma has not fully recovered, then the client's treatment could be adversely affected and potentially result in less than effective treatment, or worse, causing harm to the client.

It could be due to these reasons that few studies have investigated this topic for fear of the social impact of the results. However, that would assume the results to be damaging.

Conversely, it is possible that counselors with personal trauma who have received therapy have a higher well-being than other counselors because of the process of recovery. The results of this study could also show that counselors with personal trauma are more effective counselors overall, but that will never be known if the studies are not conducted.

2.1.2 Adverse Psychological Effect

For counselors with a personal trauma, addressing the issue of their own trauma and its effects on well-being can be challenging and controversial. Due to the social stigma of PTSD, many counselors could fear such a revelation would jeopardize their careers. Unfortunately, this same fear could prevent a counselor from seeking treatment and result in a degradation of their own well-being. It is important for the mental health of counselors with personal trauma that this study investigates the correlation of these factors. If it can be shown that a counselor's well-being is not drastically reduced because of their trauma history, then they may be more willing to disclose and seek treatment.

2.2 Current Attempts to Address the Problem

Within the mental health community there exists a network of materials, classes, and workshops available for practicing counselors that usually involve providing the counselor with tools they can use in their own lives to decrease the chance of adverse effects (Vicarious Trauma Institute, n.d.). Research has suggested methods for dealing with these problems such as more effectively managing caseloads and developing methods for enhancing satisfaction (Figley, 2002). However, issues such as burnout and compassion fatigue are generally understood to be the response to prolonged occupational stress, not necessarily the counselor's personal trauma. Therefore, very little is being done to address this topic directly, and, instead, programs and studies tend to address this indirectly as a subset of providing service to all counselors, not just those who have experienced a personal trauma. For example, three studies on counselor well-being that asked directly about personal trauma history still found the counselor's style, supportive work environment, and time in the profession had a greater influence on well-being

than the personal trauma itself (Adams & Riggs, 2008; Boscarino, Figley, & Adams, 2004; Pearlman & Mac Ian, 1995).

2.3 Summary of Literature Review

Several studies have been done on burnout, compassion fatigue, secondary trauma, and vicarious trauma of counselors. Of these studies, few have focused on the impact of a counselor's personal trauma on their current state. Even less is known about the well-being of a counselor with trauma who is seeing clients with similar trauma. Instead, the focus is on burnout with personal trauma sometimes being a subset of the study.

Studies controlling for personal trauma history yielded mixes results on whether it affected the outcome of burnout, etc. Some studies found that a history of personal trauma was a factor in the likelihood of a counselor experiencing adverse symptoms (Baird & Kracen, 2006; Ghahramanlou & Brodbeck, 2000; Linley & Joseph, 2007; Salston & Figley 2003; Trippany, 2003). Conversely, other studies found that no link existed between similar factors (Adams, Motto, & Harrington, 2001; Creamer & Liddle, 2005; Schauben & Frazier, 1995). Overall, it is recognized that more research is needed on personal trauma history and how it may contribute to produce adverse symptoms (Adams & Riggs, 2008; Voss, Holohan, Didion, & Vance, 2011).

PTSD does not discriminate against who it will affect, nor are its effects lessened by obtaining a license to practice counseling. Considering the mental health consequences to both the client and the counselors, it is worthwhile to study the effects of the counselor's personal trauma on their own well-being while seeing clients. Understanding these relationships can help new counselors make decisions to take better care of themselves, increase well-being, and decrease burnout.

CHAPTER 3

METHODOLOGY

This study used an online exploratory design to investigate the relationships among a counselor's personal trauma history, their clients' similar trauma, and their current well-being. The personal trauma history of the counselor was determined through demographic data, while their current well-being was analyzed using a standardized happiness scale and PTSD scale. The purpose of this study was to assess the impact of a counselor's personal trauma history on their overall well-being and determine whether a model exits to predict counselor well-being. The survey was designed to be anonymous and confidential. The respondents were provided with information regarding the researcher's contact information in case they had questions or issues pertaining to the survey. Approval to conduct this study was granted by the University of Texas at Arlington (UTA) Institutional Review Board (IRB) on April 13, 2011 (Appendix A). A minor modification to shorten the Facebook message post was approved by IRB on June 9, 2011 (Appendix B). A second minor modification to add additional Facebook groups for recruitment was approved by IRB on July 5, 2011 (Appendix C).

3.1 Sample

The target sample for this study was any mental health provider, counselor, family therapist, faith-based counselor, social worker, psychologist, psychiatrist, and anyone who provides direct clinical therapy. The sample was drawn from professional organizations and online social networking groups targeted toward counselors. Permission to distribute the survey was granted from organization directors and online group administrators via email or through the social networking sites (Appendix D). For a list of organizations and groups contacted see Appendix E.

3.2 Instrumentation

This study used three standardized assessment instruments: the Oxford Happiness Questionnaire (Appendix F), the Posttraumatic Stress Disorder Checklist Civilian (Appendix G), and the Posttraumatic Stress Disorder Checklist Military (Appendix H). These instruments, as well as a demographic questionnaire (Appendix I) containing questions on personal trauma history were delivered using Survey Monkey. The demographic questionnaire included questions that asked about the personal trauma history of the respondent, their self-care activities, history of therapy and medication, and nature of their practice. These questions were checked for face validity by consulting with members of the thesis committee.

3.2.1 Oxford Happiness Questionnaire

The Oxford Happiness Questionnaire (OHQ) is a 29 question scale of general life happiness developed by Hills and Argyle (2002). It is one of the most widely used measures of happiness (Cruise, Lewis, & McGuckin, 2006) and is found to be utilized in a variety of other studies. It addresses nine constructs of happiness: social interest and extraversion, kindness and agreeableness, humor, sense of purpose, awe and aesthetic appreciation, autonomy and locus of control, self-efficacy, perception of physical good health, and self-esteem and self-acceptance. Each question can be answered from 1, strongly disagree to 6, strongly agree. The OHQ has demonstrated high validity and reliability (Cruise, Lewis, & McGuckin, 2006) (Hills & Argyle, 2002), and, with only 29 questions, can be completed in a relatively short period of time. Robbins, Francis, and Edwards (2010) found the OHQ to have a test retest reliability of .78, internal consistency reliability (alpha coefficient) of .92, and good construct validity ($r = .38$ $p < .001$). For the purposed of this study, the OHQ will be used as the sole measure for an individual's well-being since it covers a broad range of constructs, is widely utilized, and does not take a long time to complete.

3.2.2 Posttraumatic Stress Disorder Checklist (Civilian & Military)

The Posttraumatic Stress Disorder (PTSD) Checklist is a 17 question self-report scale designed to measure the potential severity of PTSD symptoms and diagnosis (National Center for

PTSD, n.d.). Each question correlates to the 17 characteristics of PTSD outlined by the current *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM–IV–TR*; American Psychiatric Association, 2000), and each question can be answered from 1, not at all, to 5, extremely. There are three versions of the PTSD Checklist (PCL). Two are standardized and the third can be modified for a specific population or event. The two versions of the PCL administered to counselors in this study were the standardized versions for civilians (PCL-C) and military (PCL-M). Weathers, Litz, Herman, Huska, and Keane (1993) found the PCL to have a test retest reliability of .96 and internal consistency reliability (alpha coefficient) of .97. Convergent validity was determined on the basis of its correlation to four other measures for PTSD. It assessed the correlations among the PCL and the Mississippi scale, the PK scale of the MMPI 2, the Impact of Event Scale, and the Combat Exposure Scale. The correlation for the Mississippi scale was .93, the PK scale of the the MMPI 2 was .77, the Impact of Event Scale was .90, and the Combat Exposure Scale was .46.

3.3 Data Collection

Data collection was conducted through the use of the online survey tool, Survey Monkey, to deliver the survey to respondents. Professional counseling organizations and online social networking sites that targeted counselors were contacted electronically to obtain permission to distribute the survey web link to its members. Once permission was granted, the survey was either posted to the social network site, or sent to members via email. Due to the nature of the study, the survey was designed to be anonymous and confidential to attract more respondents.

Respondents agreed to an informed consent form at the beginning of the survey, and affirmed they provided mental health or social work counseling before they could proceed through to the survey. In order to ensure only respondents that fit inclusion criteria participated, the beginning of the survey asked criteria questions such as, “Are you a practicing social work or mental health counselor?” If a respondent attempting to take the survey did not meet the criteria, the survey would trigger a filter, and the respondent would be thanked for their time and automatically exited from the survey.

3.4 Data Analysis

Data was analyzed using the Statistical Package for Social Sciences (SPSS) version 17. The significance level for this investigation was set at $\alpha = .10$ since a more liberal significance criterion ($p < .10$) is acceptable in exploratory designs (Black, 1999). All demographic variables will be reported. Each hypothesis was measured with an appropriate statistical measure depending on the objective of each hypothesis. The following statistical procedures were used to test the hypotheses:

3.4.1 Question One

Is there a correlation between overall well-being and severity of posttraumatic stress disorder? The procedure used for this question was a bivariate analysis using Pearson correlation between PCL score and OHQ score to measure the strength of the relationship between the two scores.

3.4.2 Question Two

Do counselors who participate in therapeutic self-care interventions have a higher well-being than counselors who participate in other forms of self-care regardless of their trauma experiences or clients with similar trauma? A) for those with trauma, is there a higher well-being for those who participate in therapeutic self-care interventions as compared to those who do not? B) for those with trauma who see clients with a similar trauma as themselves, is there a higher well-being for those who participate in therapeutic self-care interventions as compared to those who do not? The procedure used for this question was an independent samples t-test to assess if the difference between the stated groups is statistically significant.

The demographic question used to identify therapeutic self-care interventions was, “What do you do for self-care?” The options available were: Group Therapy, Hobbies, Physical Exercise, Private Therapy, Social Activities, Stress-Reduction Techniques, Nothing, and Other. The self-care activities that were considered to be “therapeutic self-care interventions” were: Group Therapy, Private Therapy, and Stress-Reduction Techniques. Respondents were grouped into a yes/no category.

The demographic question used to identify counselor/client similar trauma was, “Approximately what percentage of clients have experienced the same trauma you have?” The options available were: Less than 25%, 25% to 50%, 50% to 75%, More than 75%, or None. Respondents were initially grouped into a yes/no category, but there were only five respondents with trauma who responded that none of their clients have the same trauma as themselves compared to 104 who selected some percentage. Therefore, an independent samples t-test was used to compare percentage levels, first comparing over 50% similar, then over 75% similar. All three tests are reported.

3.4.3 Question Three

Does personal trauma impact a counselor’s well-being? Furthermore, does personal trauma impact a counselor’s well-being when a) s/he has received mental health therapy, and b) s/he is seeing clients with similar trauma? The procedure used for this question was an independent samples t-test to assess if the difference between the stated groups is statistically significant. The demographic question used to identify if the respondent received mental health therapy was, “Have you ever received therapy for the trauma previously identified?” The options available were: Individual therapy, Group therapy, or Never received therapy. Respondents were grouped into a yes/no category.

3.4.4 Question Four

Does a model exist to predict counselor well-being? The procedure used for this hypothesis was a regression analysis to explore the relationship between a dependent variable and several independent variables. Because counselors with trauma were statistically significantly different on well-being then their non-trauma counterparts and were asked additional questions pertinent to the regression, separate regression models were tested for the groups. For a list of regression model variables see Table 3.1.

Table 3.1 Regression Model Variables

Trauma Group Variables	**No Trauma Group Variables**
Sex	Sex
Race	Race
Age	Age
Case load	Case load
Number of sessions per client	Number of sessions per client
Supervision frequency	Supervision Frequency
Therapeutic self-care	Therapeutic self-care
Similar trauma as client	PCL score
Past therapy	
Current therapy	
Past medication	
Current medication	
PCL score	

CHAPTER 4

RESULTS

Data was collected online from April 19, 2011 to August 13, 2011. Of the 180 respondents who started the survey, 153 completed. Findings and analysis of the 153 respondents are presented in this chapter and organized by demographic variables and research questions.

4.1 Demographics

The survey asked the respondents to answer several demographic questions. The frequencies and percentages of responses are reported in this section. The demographic variables to be reported are:

- Sex
- Race/Ethnicity
- Age
- Profession
- Licensure
- Nature of practice
- Case Load
- Number of sessions per client
- Supervision frequency
- Trauma status of clients
- Most common trauma of clients
- Primary issue of clients
- Self-care activities
- Personal trauma history

- Most prominent personal trauma
- Percentage of clients with same personal trauma
- Past therapy history
- Current therapy frequency
- Past medications
- Current medications
- Service in U.S. Military
- Combat deployment history
- PCL scores
- OHQ scores

4.1.1 Sex

The majority of the respondents in the study were females (*n* = 103, 67.3%). Males accounted for 32.7% (*n* = 50). The survey also had an option for "Intersex"; however, no one selected this option.

4.1.2 Race/Ethnicity

The ethnicity category with the most respondents was "White" (*n* = 120, 78.4%). There were four other categories of ethnicity: American Indian or Alaskan Native, Asian or Pacific Islander, Black (not of Hispanic origin), or Hispanic. For a list of responses see Table 4.1.

Table 4.1 Race/Ethnicity

	Frequency (*n*=)	**Percent (%)**
American Indian or Alaskan Native	1	.7
Asian or Pacific Islander	2	1.3
Black (not of Hispanic origin)	17	11.1
Hispanic	13	8.5
White (not of Hispanic origin)	120	78.4

4.1.3 Age

The mean age of those who participated in the study was 43.35 (*SD* = 12.30) with a range from 22 to 69 years of age.

4.1.4 Profession

The survey asked respondents to select their profession. The options available were: Counselor, Faith-based Counselor, Psychiatric Nurse, Psychiatrist, Psychologist, Social Worker, or Other. The categories with the most respondents were "Social Workers" (*n* = 73, 47.7%) and "Counselors" (*n* = 58, 37.9%). According to the U.S. Department of Labor, Bureau of Labor Statistics (2011) Social Workers make up 42.5% of all mental health professionals, and counselors, which include family therapists, make up 44%. For a list of responses see Table 4.2. If the respondent selected "Other," they were asked to write in a response. In some cases, responses were grouped into categories when it was clear the response matched the category, but the respondent may have mistakenly missed the option or perhaps misunderstood the question. For a list of all "Other" responses and how they were grouped see Appendix J.

Table 4.2 Profession

	Frequency (*n*=)	**Percent (%)**
Counselor	58	37.9
Faith-based Counselor	1	.7
Psychiatric Nurse	2	1.3
Psychiatrist	0	0
Psychologist	16	10.5
Social Worker	73	47.7
Other	3	2.0

4.1.5 Licensure

The survey asked respondents if they practice under a specific licensure. The options available were: LCDC, LPC, LMFT, LMSW/LCSW or other social work licensure, MD/DO,

PhD/PsyD/Ed, RPN/APRN, None, or Other. Respondents were allowed to select multiple options. The category with the most respondents was "LMSW/LCSW or other social work licensure" (*n* = 68, 44.4%). For a list of responses see Table 4.3. If the respondent selected "Other," they were asked to write in a response. In some cases, responses were grouped into categories when it was clear the response matched the category, but the respondent may have mistakenly missed the option or perhaps misunderstood the question. For a list of all "Other" responses and how they were grouped see Appendix J.

Table 4.3 Licensure

	Frequency (*n*=)	**Percent (%)**
LCDC	1	.7
LPC	34	22.2
LMFT	18	11.8
LMSW/LCSW or other social work licensure	68	44.4
MD/DO	0	0
PhD/PsyD/Ed	10.5	22.7
RPN/APRN	1	.7
None	19	12.4
Other	9	5.9

4.1.6 Nature of Practice

The survey asked respondents to select the nature of their practice. The options available were: Private practice, Hospital, Clinic, Faith-based organization, Non faith-based, non-government organization, Government agency, or Other. Respondents were allowed to select multiple options. The The category with the most respondents was "Government Agency" (*n* = 71, 46.4%). For a list of responses see Table 4.4. If the respondent selected "Other," they were asked to write in a response. In some cases, responses were grouped into categories when it was clear the response matched the category, but the respondent may have mistakenly missed

the option or perhaps misunderstood the question. For a list of all "Other" responses and how they were grouped see Appendix J.

Table 4.4 Nature of practice

	Frequency (*n*=)	**Percent (%)**
Private practice	28	18.3
Hospital	29	19
Clinic	24	15.7
Faith-based organization	2	1.3
Non faith-based, non-government organization	14	9.2
Government agency	71	46.4
Other	16	10.5

4.1.7 Case Load

The survey asked respondents to report the approximate number of clients they see each month. The options available were: Less than 20, 20-40, or More than 40. The category with the most respondents was "More than 40" (*n* = 59, 38.6%). For a list of responses see Table 4.5.

Table 4.5 Case load

	Frequency (*n*=)	**Percent (%)**
Less than 20	43	28.1
20-40	51	33.3
More than 40	59	38.6

4.1.8 Number of Sessions Per Client

The survey asked respondents to report the average number of sessions they have with a client before termination. The options available were: Less than 10, 10-20, or More than 20. The category with the most respondents was "10-20" (*n* = 64, 41.8%). For a list of responses see Table 4.6.

Table 4.6 Number of sessions per client

	Frequency (*n*=)	**Percent (%)**
Less than 10	48	31.4
10-20	64	41.8
More than 20	41	26.8

4.1.9 Supervision Frequency

The survey asked respondents to report how often they receive clinical supervision for their cases. The options available were: Weekly, Monthly, Every other month, A few times a year, or Never. The category with the most respondents was "Weekly" (*n* = 65, 42.5%). For a list of responses see Table 4.7.

Table 4.7 Supervision frequency

	Frequency (*n*=)	**Percent (%)**
Weekly	65	42.5
Monthly	39	25.5
Every other month	4	2.6
A few times a year	30	19.6
Never	15	9.8

4.1.10 Trauma Status of Clients

The survey asked respondent if they primarily see clients for trauma-related issues. If the respondent selected "Yes" then they received a follow up question asking them the most common trauma among their clients. If they selected "No" then they received a different follow up question asking them the primary issues for the majority of their clients. The majority of respondents selected "Yes" (*n* = 86, 56.2%).

4.1.10.1 Most Common Trauma of Clients

The respondents who answered “Yes” to the previous question were asked to report the type of trauma that was most common among their clients. The options available were: Combat Trauma, Environmental Disaster, Grief, Physical or Sexual Violence, Traumatic Brain Injury, or Other. The category with the most respondents was “Combat Trauma” (*n* = 51, 33.3%). For a list of responses see Table 4.8. If the respondent selected “Other,” they were asked to write in a response. In some cases, responses were grouped into categories when it was clear the response matched the category, but the respondent may have mistakenly missed the option or perhaps misunderstood the question. Two written in responses contained a combination of the options, so an additional category was added for data analysis. For a list of all “Other” responses and how they were grouped see Appendix J.

Table 4.8 Most common trauma of clients

	Frequency (*n*=)	**Percent (%)**
Combat Trauma	51	33.3
Environmental Disaster	1	.7
Grief	7	4.6
Physical or Sexual Violence	22	14.4
Traumatic Brain Injury	1	.7
Other	2	1.3
Combination	2	1.3

4.1.10.2 Primary Issue of Clients

The respondents who answered “No” to the previous question were asked to report the primary issue for the majority of their clients. The options available were: Adjustment Disorders, Anxiety Disorders, Dissociative Disorders, Eating Disorders, Impulse-Control Disorders, Mood Disorders, Sexual Disorders, Sleep Disorders, Psychotic Disorders, Sexual Dysfunctions, Somatoform Disorders, Substance Disorders, Personality Disorders, or Other. The categories

with the most respondents were “Adjustment Disorders” (*n* = 19, 12.4%) and “Other” (*n* = 19, 12.4%). For a list of responses see Table 4.9. In some cases, responses were grouped into categories when it was clear the response matched the category, but the respondent may have mistakenly missed the option or perhaps misunderstood the question. For a list of all “Other” responses and how they were grouped see Appendix J.

Table 4.9 Primary issue of clients

	Frequency (*n*=)	**Percent (%)**
Adjustment Disorders	19	12.4
Anxiety Disorders	3	2.0
Dissociative Disorders	0	0
Eating Disorders	1	.7
Impulse-Control Disorders	2	1.3
Mood Disorders	18	11.8
Sexual Disorders	0	0
Sleep Disorders	0	0
Psychotic Disorders	1	.7
Sexual Dysfunctions	0	0
Somatoform Disorders	0	0
Substance Disorders	5	3.3
Personality Disorders	1	.7
Other (please specify)	19	12.4

4.1.11 Self-Care Activities

The survey asked respondents to report what they do for self-care. The options available were: Group Therapy, Hobbies, Physical Exercise, Private therapy, Social Activities, Stress-Reduction Techniques, Nothing, and Other. The majority of respondents selected a self-care activity (*n* = 151, 98.7%), with Social Activities being the largest category (*n* = 99, 64.7%). For a list of responses see Table 4.10. Respondents were allowed to select multiple options. Most

respondents selected multiple self-care activities. In some cases, responses were grouped into categories when it was clear the response matched the category, but the respondent may have mistakenly missed the option or perhaps misunderstood the question. For a list of all "Other" responses and how they were grouped see Appendix J.

Table 4.10 Self-care activities

	Frequency (*n*=)	**Percent (%)**
Group Therapy	3	2.0
Hobbies	93	60.7
Physical Exercise	94	61.4
Private Therapy	32	20.9
Social Activities	99	64.7
Stress-Reduction Techniques	67	43.7
Nothing	2	1.3
Other	5	3.3

4.1.12 Personal Trauma History

The survey asked respondents to report if they have personally experienced any type of trauma. The options available were: Combat Trauma, Environmental Disaster, Grief, Physical or Sexual Violence, None, Other. If the respondent selected "Other," they were asked to write in a response. In some cases, responses were grouped into categories when it was clear the response matched the category, but the respondent may have mistakenly missed the option or perhaps misunderstood the question. For a list of all "Other" responses and how they were grouped see Appendix J. Respondents were allowed to select multiple options. The majority of respondents selected a trauma (*n* = 109, 71.2%), with "Grief" being the largest category (*n* = 77, 50.3%). For a list of responses see Table 4.11. Respondents who selected some form of trauma were directed to a second grouping of questions listed in the following subsections.

Table 4.11 Personal trauma history

	Frequency (*n*=)	**Percent (%)**
Combat Trauma	11	7.2
Environmental Disaster	15	9.8
Grief	77	50.3
Physical or Sexual Violence	35	22.9
None	44	28.8
Other	12	7.8

4.1.12.1 Most Prominent Personal Trauma

There were 109 respondents who reported having a personal trauma history. Respondents who reported as having some form personal trauma were asked to report their most prominent personal trauma, i.e. that generates the most invasive memories and stressful symptoms. The options available were: Combat Trauma, Environmental Disaster, Grief, Physical or Sexual Violence, or Other. The category with the most respondents was "Grief" (*n* = 53, 48.6%). For a list of responses see Table 4.12. If the respondent selected "Other," they were asked to write in a response. In some cases, responses were grouped into categories when it was clear the response matched the category, but the respondent may have mistakenly missed the option or perhaps misunderstood the question. For a list of all "Other" responses and how they were grouped see Appendix J.

Table 4.12 Most prominent personal trauma

	Frequency (*n*=)	**Percent (%)**
Combat Trauma	10	9.2
Environmental Disaster	3	2.8
Grief	53	48.6
Physical or Sexual Violence	23	21.1
Other	20	18.3

4.1.12.2 Percentage of Clients with Same Personal Trauma

There were 109 respondents who reported having a personal trauma history. Respondents who reported as having some form personal trauma were asked to report the percentage of clients who have the same trauma as they do. The options available were: Less than 25%, 25% to 50%, 50% to 75%, More than 75%, or None. The majority of respondents selected a percentage (*n* = 105, 95.4%), with "25% to 75%" being the largest category (*n* = 33, 30.3%). For a list of responses see Table 4.13.

Table 4.13 Percentage of clients with same personal trauma

	Frequency (*n*=)	**Percent (%)**
Less than 25%	32	29.4
25% to 50%	33	30.3
50% to 75%	20	18.3
More than 75%	19	17.4
None	5	4.6

4.1.12.3 Past Therapy Occurrence

There were 109 respondents who reported having a personal trauma history. Respondents who reported as having some form personal trauma were asked to report if they have ever received therapy for that trauma. The options available were: Individual therapy, Group therapy, or Never received therapy. Respondents were allowed to select multiple options. The majority of respondents selected a therapy (*n* = 75, 68.8%), with "Individual Therapy" being the largest category (*n* = 66, 60.6%). For a list of responses see Table 4.14.

Table 4.14 Past therapy occurrence

	Frequency (*n*=)	**Percent (%)**
Individual therapy	66	60.6
Group therapy	9	8.3
Never received therapy	41	37.6

4.1.12.4 Current Therapy Frequency

There were 109 respondents who reported having a personal trauma history. Respondents who reported as having some form personal trauma were asked to report if they are currently receiving any form of therapy, and, if so, how often. The options available were: Weekly, Monthly, Every other month, A few times a year, or Not at this time. The majority of respondents selected “Not at this time” (*n* = 89, 81.7%). When combining all frequencies, 18.3% (*n* = 20) of respondents selected some frequency. For a list of responses see Table 4.15.

Table 4.15 Current therapy frequency

	Frequency (*n*=)	**Percent (%)**
Weekly	6	5.5
Monthly	6	5.5
Every other month	2	1.8
A few times a year	6	5.5
Not at this time	89	81.7

4.1.12.5 Past Medications

There were 109 respondents who reported having a personal trauma history. Respondents who reported as having some form personal trauma were asked to report if they have ever taken medication for that trauma in the past. The options available were: Antipsychotics, Antidepressants, Herbal Remedies, Mood stabilizers, Stimulants, Never, and Other. Respondents were allowed to select multiple options.

The category with the most respondents was “None” (*n* = 58, 53.2%). However, when combining all medications, the majority of respondents selected some form of medication (*n* = 68, 62.4%), with “Antidepressants” being the largest medication category (*n* = 44, 40.4%). For a list of responses see Table 4.16. In some cases, responses were grouped into categories when it was clear the response matched the category, but the respondent may have mistakenly missed the

option or perhaps misunderstood the question. For a list of all “Other” responses and how they were grouped see Appendix J.

Table 4.16 Past medications

	Frequency (*n*=)	**Percent (%)**
Antipsychotics	2	1.8
Antidepressants	44	40.4
Herbal Remedies	10	9.2
Mood stabilizers	7	6.4
Stimulants	2	1.8
Never	58	53.2
Other	3	2.8

4.1.12.6 Current Medications

There were 109 respondents who reported having a personal trauma history. Respondents who reported as having some form personal trauma were asked to report if they are currently taking medication for that trauma. The options available were: Antipsychotics, Antidepressants, Herbal Remedies, Mood stabilizers, Stimulants, Never, and Other. Respondents were allowed to select multiple options.

The majority of respondents selected “None” (*n* = 90, 82.6%). When combining all medications, 24% (*n* = 22) of respondents selected some form of medication, with “Antidepressants” being the largest medication category (*n* = 16, 14.7%). For a list of responses see Table 4.17. If the respondent selected “Other,” they were asked to write in a response. In some cases, responses were grouped into categories when it was clear the response matched the category, but the respondent may have mistakenly missed the option or perhaps misunderstood the question. For a list of all “Other” responses and how they were grouped see Appendix J.

Table 4.17 Current medications

	Frequency (*n*=)	**Percent (%)**
Antipsychotics	1	0.9
Antidepressants	16	14.7
Herbal Remedies	2	1.8
Mood stabilizers	2	1.8
Stimulants	0	0
None	90	82.6
Other	3	2.8

4.1.13 Service in U.S. Military

The majority of respondents in the study did not serve in the U.S. Military. Respondents who identified as having served in the U.S. Military (*n* = 53, 34.6%) were directed to a second question asking about their deployment history.

4.1.13.1 Combat Deployment History

There were 53 respondents who reported as having served in the U.S. Military. These respondents were asked to report if they have ever deployed to a combat zone and, if so, how long. The options available were: Never deployed to combat zone, Less than one year, One to two years, More than three years. The majority of respondents selected “Never deployed to combat zone” (*n* = 30, 56.6%). For a list of responses see Table 4.18.

Table 4.18 Combat deployment history

	Frequency (*n*=)	**Percent (%)**
Never deployed to combat zone	30	56.6
Less than one year	1	1.9
One to two years	4	7.5
More than three years	18	34

4.1.14 All PCL Scores

The mean of all PCL scores was 26.76 (*SD* = 11.42). The minimum PCL score was 17 and the maximum was 71. The PCL distribution was positively skewed (2.00, *SE* = .20). The distribution has a positive excess kurtosis (3.81) appearing leptokurtic. Taking the standard error of the kurtosis statistic (.49) and multiplying by 2 to construct the range of normality (-0.78 to 0.78), the distribution is non-normal because the value for the PCL kurtosis (3.81) falls outside the range of -0.78 to 0.78. For a histogram of all PCL scores see Figure 4.1.

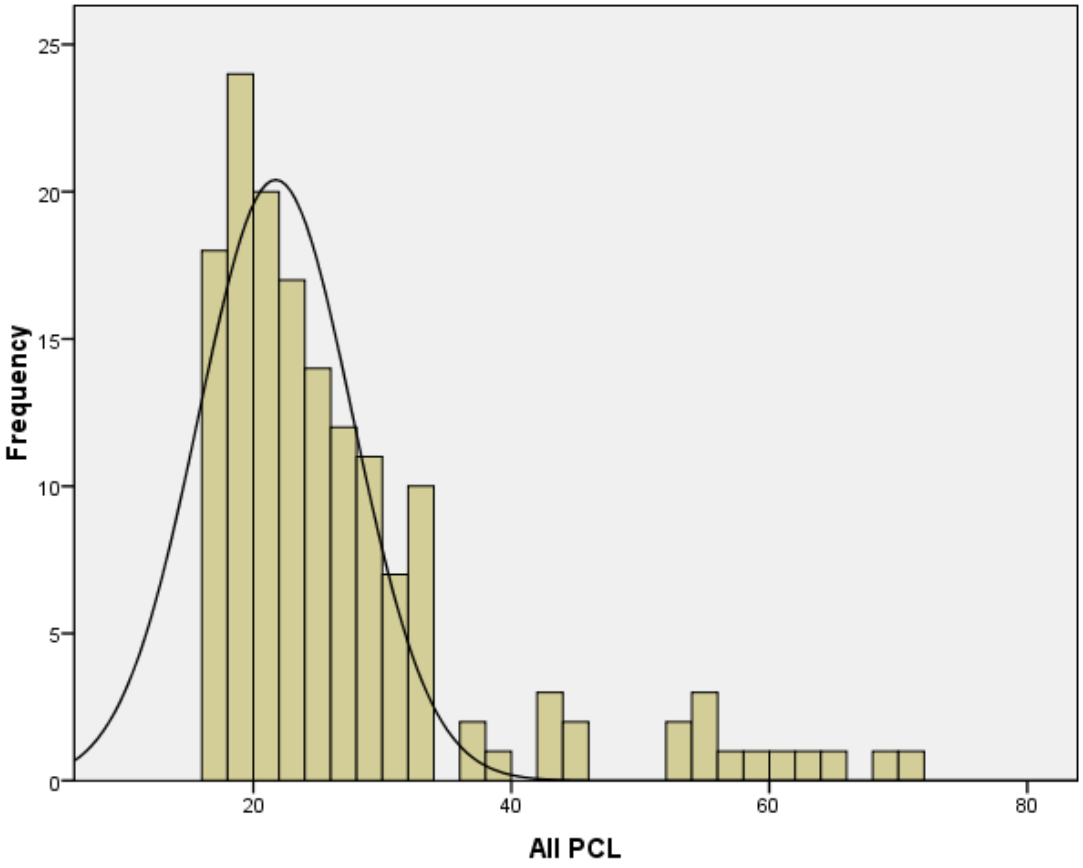

Figure 4.1 Histogram of All PCL Scores

4.1.15 PCL-C Scores

The 100 respondents who reported as not having served in the U.S. Military were directed to the civilian version of the PCL. The mean PCL-C score was 25.16 (*SD* = 7.60). The minimum PCL-C score was 17 and the maximum was 58. The PCL-C distribution was positively skewed (2.26, *SE* = .24). The distribution has a positive excess kurtosis (6.71) appearing leptokurtic. Taking the standard error of the kurtosis statistic (.48) and multiplying by 2 to construct the range of normality (-0.96 to 0.96), the distribution is non-normal because the value for the PCL-C kurtosis (6.71) falls outside the range of -0.96 to 0.96. For a histogram of PCL-C see Figure 4.2.

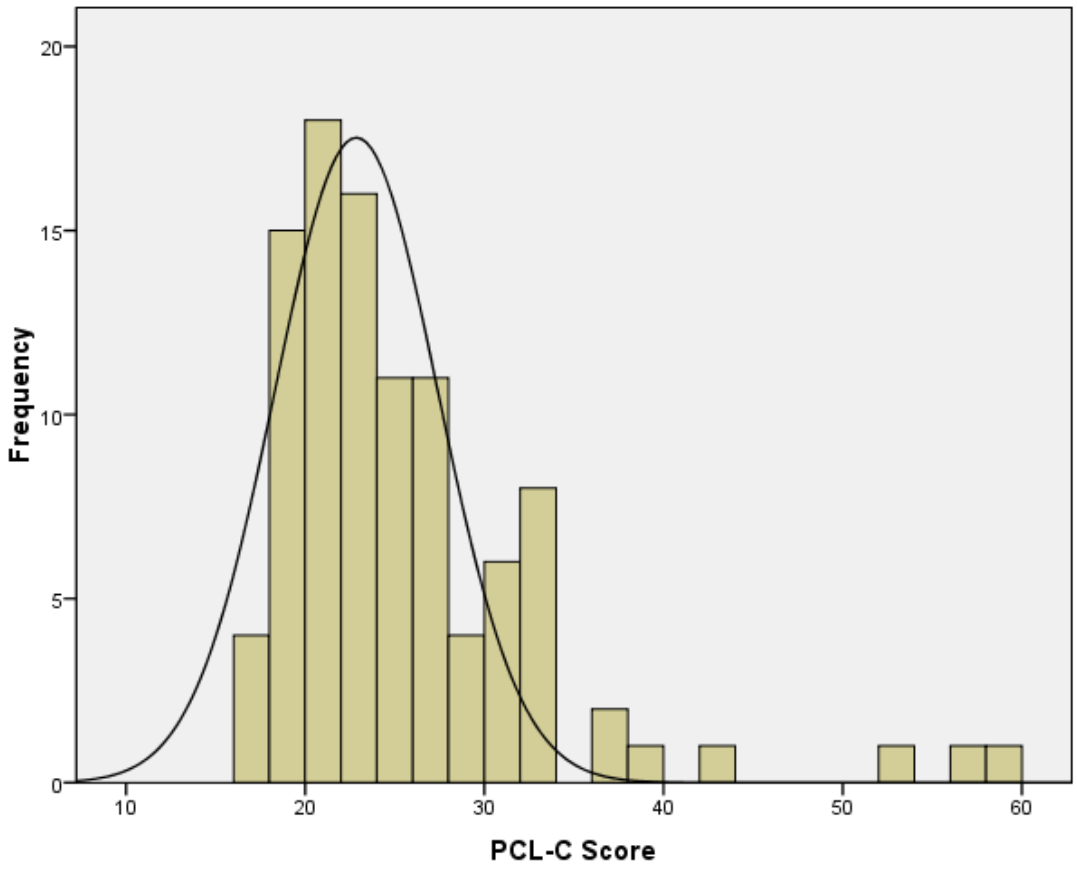

Figure 4.2 Histogram of PCL-C

4.1.16 PCL-M Scores

The 53 respondents who reported as having served in the U.S. Military were directed to the military version of the PCL. The mean PCL-M score was 29.77 (*SD* = 16.03). The minimum PCL-M score was 17 and the maximum was 71. The PCL-M distribution was positively skewed (1.25, *SE* = .33). The distribution has positive excess kurtosis (.32) appearing leptokurtic. Taking the standard error of the kurtosis statistic (.64) and multiplying by 2 to construct the range of normality (-1.29 to 1.29), the distribution approaches normality because the value for the PCL-M kurtosis (.32) falls within the range of -1.29 to 1.29. For a histogram of PCL-M see Figure 4.3.

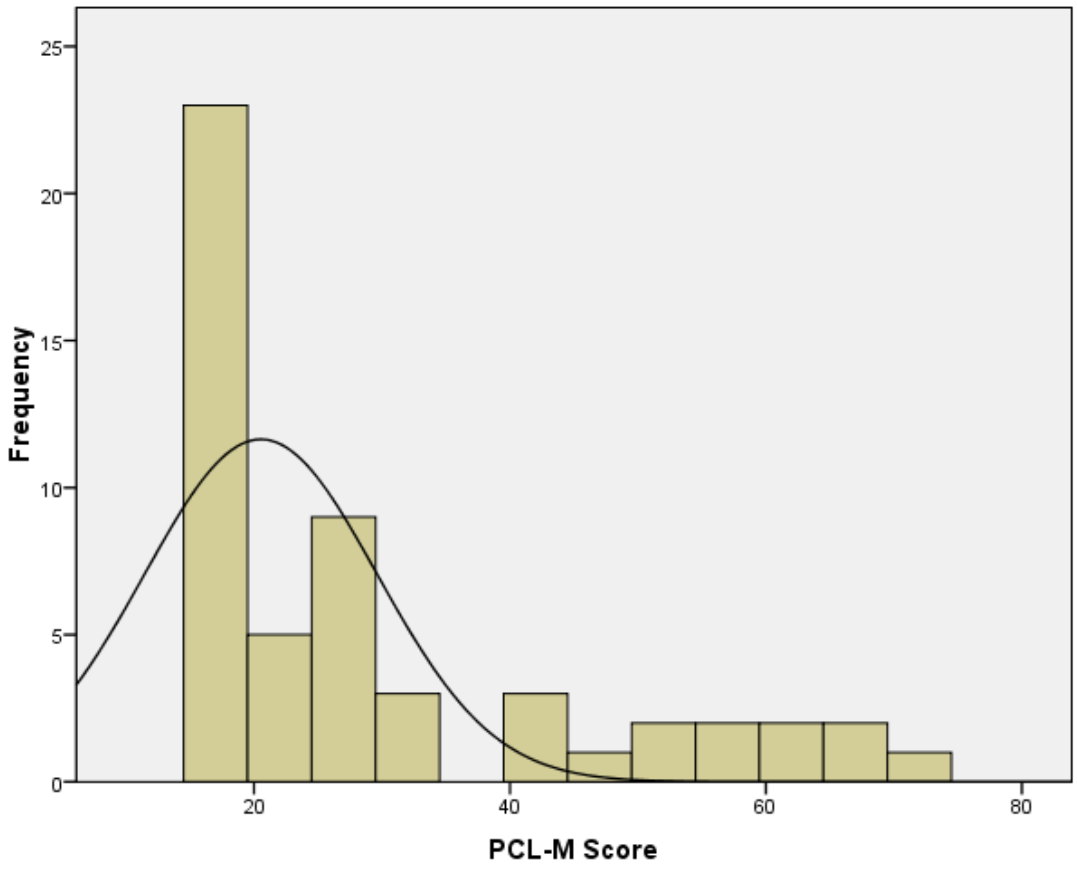

Figure 4.3 Histogram of PCL-M

4.1.17 OHQ Scores

All 153 respondents completed the OHQ. The mean OHQ score was 4.38 (*SD* = .71). The minimum OHQ score was 2.21 and the maximum was 5.59. The OHQ distribution was negatively skewed (-.88, *SE* = .20). The distribution has positive excess kurtosis (.62) appearing leptokurtic. Taking the standard error of the kurtosis statistic (.39) and multiplying by 2 to construct the range of normality (-0.78 to 0.78), the distribution approaches normality because the value for the OHQ kurtosis (.62) falls inside the range of -0.78 to 0.78. For a histogram of OHQ see Figure 4.4.

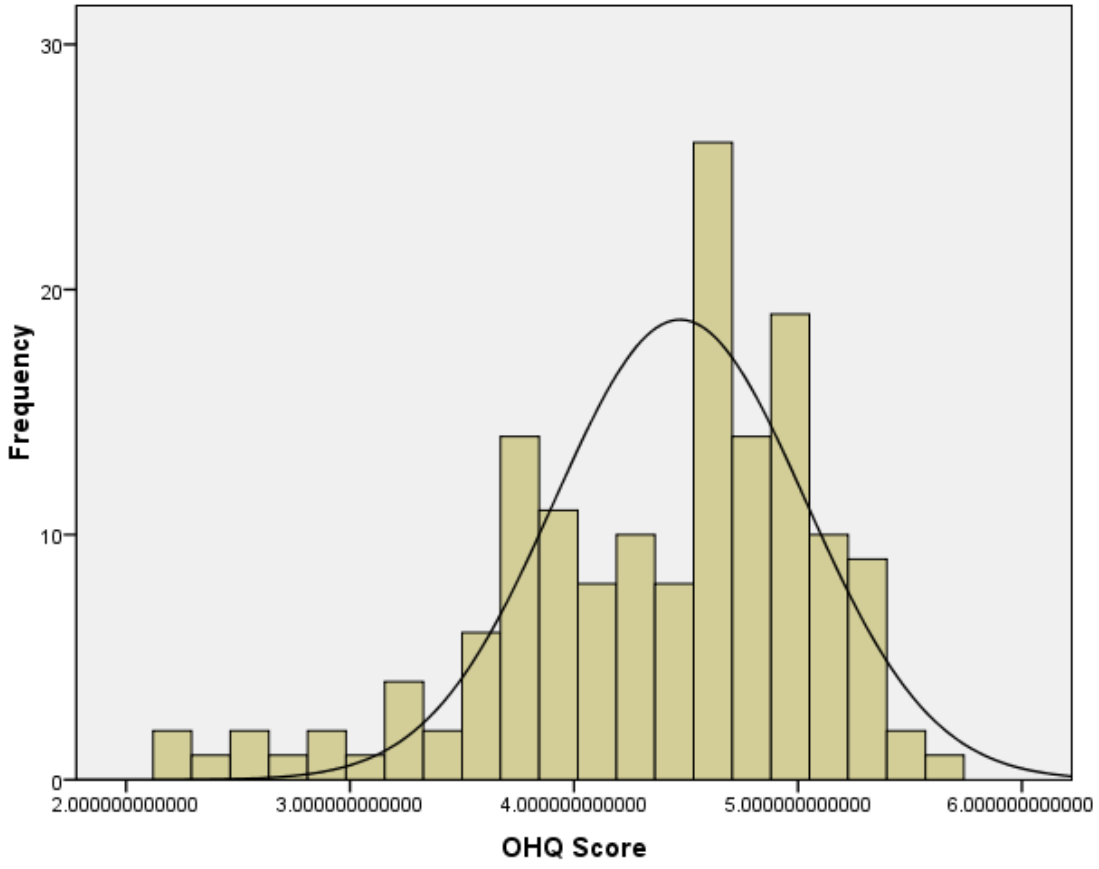

Figure 4.4 Histogram of OHQ

4.2 Questions Analysis

4.2.1 Question One

The first question asked if there is a correlation between overall well-being and severity of posttraumatic stress disorder. Pearson's correlation was used to measure the strength of the relationship between the PCL score and OHQ score. Between all PCL scores and OHQ, Pearson's correlation indicated a strong, negative correlation, and the correlation was statistically significant (r = -.58, p < .01). Between PCL-C and OHQ, Pearson's correlation indicated a strong, negative correlation, and the correlation was statistically significant (r = -.40, p < .01). Between PCL-M scores and OHQ, Pearson's correlation indicated a strong, negative correlation, and the correlation was statistically significant (r = -.70, p < .01).

4.2.2 Question Two

The second question asked if counselors who participate in therapeutic self-care interventions have a higher well-being than counselors who participate in other forms of self-care regardless of their trauma experiences or having clients with similar trauma. It also asked the same question for those with trauma, and for those who see clients with trauma similar to theirs.

The t-test indicated that those who used therapeutic self-care interventions were not significantly different than those who did not in terms of overall well-being, t(151) = -.69, p = .49. For those without trauma, the t-test indicated that those who used therapeutic self-care interventions were not significantly different than those who did not in terms of overall well-being, t(42) = .82, p = .42). For those with trauma, the t-test indicated that those who used therapeutic self-care interventions were not significantly different than those who did not in terms of overall well-being, t(107) = -1.36, p = .18). For those with trauma who see clients with similar trauma, the t-test indicated that those who used therapeutic self-care interventions were not significantly different than those who did not in terms of overall well-being regardless of the percentage of clients who have similar trauma as themselves (see Table 4.19).

Table 4.19 T-Test Output of Question 2-B

Similar Trauma	**Independent Samples T Test**
Any percentage	$t(102) = -.98$, $p = .33$
50% to 75%	$t(107) = .30$, $p = .76$
More than 75%	$t(107) = .68$, $p = .50$

4.2.3 Question Three

The third question asked if personal trauma impacts a counselor's well-being. It also asked if personal trauma impacts a counselor's well-being when a) s/he has received mental health therapy, and when b) s/he is seeing clients with similar trauma. The t-test indicated that those with a history of personal trauma were significantly different than those without a history of personal trauma in terms of overall well-being, $t(151) = 2.31$, $p = .02$). The mean OHQ score for counselors with a personal trauma history was 4.29, and the OHQ score for counselors without a personal trauma history was 4.58.

For those with trauma, the t-test indicated that those who received mental health therapy were not significantly different than those who did not in terms of overall well-being, $t(107) = -.55$, $p = .58$). Also, for those with trauma, the t-test indicated that those who see clients with similar trauma were not significantly different than those who do not in terms of overall well-being, $t(107) = -.68$, $p = .50$).

4.2.4 Question Four

The fourth question asked if a model exists to predict counselor well-being (OHQ Score) based on selected demographic variables. Separate regression models were tested for counselors with trauma and those without due to statistically significance between the groups and additional predictors to be used in the regression for counselors with trauma. These additional predictors stem from additional questions asked of the counselors with trauma who responded to the survey.

For counselors with trauma, the variables tested were: sex, race, age, number of sessions per client, case load, supervision frequency, therapeutic self-care, similar trauma as client, past therapy, current therapy, past medication, current medication, and PCL score. The initial model tested contained all 13 variables identified above and was found to be statistically significant, $F(13, 94) = 7.30$, $p < .001$, but not all of the predictors were significant, so the variable with the highest probability value was excluded and the model was tested again. This was repeated until a model was found with the highest adjusted R-squared value and least number of predictors.

See Table 4.20 for a list of excluded predictors, and Table 4.21 for a list of final predictors. The final model was statistically significant, $F(4, 103) = 24.90$, $p < .001$. No tolerances were close to zero, so there was no collinearity issue. The model had an adjusted R square value of .47, which accounts for 47% of the variance.

Table 4.20 Excluded Predictors for Trauma Regression

	Predictor Excluded	**Significance (*p*=)**
First model	Past medication	.90
Second model	Number of sessions per client	.85
Third model	Race	.74
Fourth model	Sex	.71
Fifth model	Age	.72
Sixth model	Supervision frequency	.74
Seventh model	Case load	.52
Eight model	Current therapy	.45
Ninth model	Past therapy	.45

Table 4.21 Final Predictors for Trauma Regression

	Beta (β=)	**Significance (*p*=)**	**Tolerance**
Therapeutic self-care	.13	.07	.98
Similar trauma as client	.11	.13	.96
Current medication	-.10	.20	.81
PCL Score	-.64	.00	.80

For counselors without trauma, the variables tested were: sex, race, age, number of sessions per client, case load, supervision frequency, therapeutic self-care, and PCL score. Two outliers (defined as PCL scores equal to or greater than 33, identified as outliers by an SPSS stem and leaf plot) were excluded from analysis (See Figure 4.5). The initial model tested contained all eight variables identified above and was found to be statistically significant, $F(8, 33) = 1.87$, $p = .01$, but not all of the predictors were significant, so the variable with the highest probability value was excluded and the model was tested again. This was repeated until a model was found with the highest adjusted R-squared value and least number of predictors. See Table 4.20 for a list of excluded predictors, and Table 4.21 for a list of final predictors. The final model was statistically significant, $F(3, 38) = 5.32$, $p = .004$. No tolerances were close to zero, so there was no collinearity issue. The model had an adjusted R square value of .24, which accounts for 24% of the variance.

```
Frequency    Stem &  Leaf

   16.00        1 .  7777778889999999
   17.00        2 .  00001112333333334
    7.00        2 .  5667789
    2.00        3 .  11
    2.00 Extremes    (>=33)

Stem width:         10
Each leaf:       1 case(s)
```

Figure 4.5 PCL Stem and Leaf Plot

Table 4.22 Excluded Predictors for Non-Trauma Regression

	Predictor Excluded	**Significance (*p*=)**
First model	Sex	.96
Second model	Race	.95
Third model	Therapeutic self-care	.84
Fourth model	Age	.77
Fifth model	Case Load	.39

Table 4.23 Final Predictors for Non-Trauma Regression

	Beta (β=)	**Significance (*p*=)**	**Tolerance**
Number of session per client	.27	.06	.95
Supervision Frequency	.34	.02	.91
PCL Score	-.40	.01	.88

CHAPTER 5

DISCUSSION

The purpose of this study was to explore the impact of counselors' personal trauma on their current well-being by collecting and comparing demographic data on practicing mental health counselors. The findings of this thesis are important to provide counselors with research that directly addresses the impact of personal trauma history on practice. A review of the literature found that other research surrounding issues of burnout, compassion fatigue, secondary traumatic stress, and vicarious trauma lacked specific research into counselor personal trauma, influence on well-being, and effects of seeing clients with similar trauma. These specific topics were addressed in an attempt to help counselors make decisions to take better care of themselves, increase well-being, and decrease burnout. For counselors with a history of personal trauma, the variables recognized as predictors of well-being were: use of therapeutic self-care, seeing clients with similar trauma, currently taking medication, and severity of posttraumatic stress disorder. For counselors without a history of personal trauma, the variables recognized as predictors of well-being were: number of sessions per client, clinical supervision, and severity of posttraumatic stress disorder. Counselors can benefit from future research into these predictors and how they affect overall well-being. This chapter will discuss practical interpretation of findings, limitations of the study, implications for practice, and future recommendations.

5.1 Question One

The first question asked if there is a correlation between overall well-being and severity of posttraumatic stress disorder. Cutoff scores for PTSD diagnosis through the Posttraumatic Stress Disorder Checklist vary depending upon different factors such as setting and population. The recommended cutoff score is 50 for veterans (Weathers, Litz, Herman, Huska, & Keane, 1993) and 30 for civilians (Walker, Newman, Dobie, Ciechanowski, & Katon, 2002). Using these cutoff

scores, 16.9% (*n* = 9) of veteran respondents would be diagnosed with PTSD, and 21% (*n* = 21) of civilian respondents would be diagnosed with PTSD.

Pearson's correlation was used to measure the strength of the relationship between overall well-being and severity of posttraumatic stress, with separate tests for civilian and military respondents. In all tests conducted it was found that overall well-being and severity of posttraumatic stress were inversely correlated – meaning that as one goes up, the other goes down. This is generally to be expected since a high severity of posttraumatic stress would indicate that an individual is suffering from PTSD due to traumatic experiences and is not happy or in a state of good well-being.

5.2 Question Two

The second question asked if counselors who participate in therapeutic self-care interventions have a higher well-being than counselors who participate in other forms of self-care regardless of their trauma experiences or having clients with similar trauma. It also asked the same question for those with trauma, and for those who see clients with trauma similar to theirs. The results indicated that, in terms of well-being, counselors who used therapeutic self-care interventions were not significantly different than those who did not for all groups compared.

5.3 Question Three

The third question asked if personal trauma impacts a counselor's well-being. It also asked if personal trauma impacts a counselor's well-being when a) s/he has received mental health therapy, and when b) s/he is seeing clients with similar trauma. Comparing the two groups found that a counselor's personal trauma does affect well-being. The results indicated that counselors with a personal trauma history have a lower well-being score than counselors without a personal trauma history.

The second part of this question explored if receiving mental health therapy plays a part in terms of well-being. The results indicated that counselors who received mental health therapy were not significantly different than those who did not. The third part of the question explored if counselors who see clients with similar trauma are affected in terms of well-being. The results

indicated that counselors who see clients with similar trauma were not significantly different than those who do not.

5.4 Question Four

A series of regression models were created for analysis in search of a model useful in predicting counselor well-being. Separate regression models were tested for counselors with trauma and those without due to statistical significance between the groups and additional questions asked of counselors with trauma.

For counselors with trauma, of the 13 variables tested, nine were removed until a useful model for predicting overall well-being was discovered. This thesis found that sex, race, age, case load, number of sessions per client, supervision frequency, past therapy history, current therapy frequency, and past medication history are not significant predictors of well-being. However, use of therapeutic self-care, seeing clients with similar trauma, currently taking medication, and severity of posttraumatic stress disorder explain 47.2% of the variance in well-being scores – meaning that almost half of the change in happiness can be explained by these predictors. See Table 5.1 for a list of significant and non-significant predictors of well-being for counselors with trauma.

Table 5.1 Predictors of well-being for counselors with trauma

Non-Significant Predictors	**Significant Predictors**
Sex	Therapeutic self-care
Race	Similar trauma as client
Age	Current medication
Case load	Severity of Posttraumatic Stress Disorder
Number of session per client	
Supervision Frequency	
Past therapy	
Current therapy	
Past Medication	

For counselors without trauma, of the eight variables tested, five were removed until a useful model for predicting overall well-being was discovered. This thesis found that sex, race, age, therapeutic self-care, and case load are not significant predictors of well-being. However, number of sessions per client, supervision frequency, and severity of posttraumatic stress disorder explain 24% of the variance in well-being scores. See Table 5.2 for a list of significant and non-significant predictors of well-being for counselors without trauma.

Table 5.2 Predictors of well-being for counselors without trauma

Non-Significant Predictors	**Significant Predictors**
Sex	Number of session per client
Race	Supervision Frequency
Age	Severity of Posttraumatic Stress Disorder
Therapeutic self-care	
Case load	

5.5 Limitations

The findings of this study should be interpreted with caution for several reasons. Threats to internal and external validity are listed and discussed, as well as other observations that may have impacted the research.

Initially, there was difficulty obtaining respondents to join the study. The original sample of online groups did not generate a large response. This led to a minor IRB modification (Appendix C) to add additional groups for recruitment. Even still, the response was not as large as originally expected. This may be due to only a certain type of counselor who is willing to take an online survey. This is discussed further in the selection bias portion of threats to internal validity.

Another limitation was the disproportionate number of respondents (71.2%) who self-reported as having a history of personal trauma. It is unknown how representative this number is

of the general population of counselors. Again, this may relate to certain types of counselors willing to participate in online surveys.

Whether or not a counselor participated in self-care was an important factor in the study, and of the 153 respondents, only two (1.3%) did not select some form of self-care. This study compensated for this by grouping the self-care responses into a yes/no category, with “Group Therapy,” “Private Therapy,” and “Stress-Reduction Techniques” being considered therapeutic self-care interventions. Nevertheless, the fact that the response was so disproportionate indicates a limitation of the original question.

5.5.1 Threats to Internal Validity

5.5.1.1 Selection Bias

The online survey was a not a random sample, and that may have caused a sampling bias. Not everyone is guaranteed to have internet access, and even if they do, they may not be part of, or actively engaged in the online membership groups where the survey was distributed. For this same reason an online survey is subject to self-selection bias (Duda & Nobile, 2010), and, while all respondents were required to affirm they were mental health professionals, some may not have been. Additionally, not everyone is online in the first place, and the experiences and attitudes of counselors who use the internet may be different than those who do not. Due to self-selection and exclusion of those without access to the internet, an online survey is effectively a double bias (Duda & Nobile, 2010).

5.5.1.2 Attrition/Mortality

Of the 180 individuals who started the survey, 153 finished. Eight of the 27 who did not finish were not counselors and did not make it past the informed consent page. The other 19 left the survey at mostly random points throughout the survey with the exception of nine who left right at, or during, the PTSD checklist portion.

The length of the survey and time required to finish may have contributed to individuals leaving early. Also, the survey was online, thus not allowing the respondents to ask clarifying questions.

5.5.1.3 Ambiguous Temporal Precedence

Several questions were asked about the counselors' personal trauma history, clients, and well-being. However, there were not any questions about the counselors' life outside of work, such as their family, friends, finances, or non-traumatic stressors from the past or present. The questions that were not asked could impact a counselor's well-being enough to alter the data.

5.5.2 Threats to External Validity

5.5.2.1 Interaction Effects of Selection Biases

Many of the same selection biases threats to internal validity are also threats to external validity. Because the survey was a not a random sample, the results of this survey are not necessarily representative of the general population. The generalizability of the results is also limited to counselors who have internet access, counselors who are members of, and participate in, online groups, and counselors who are likely to self-select and complete an online survey.

5.5.2.2 Reactive Effects of Experimental Arrangements

The fact that the survey is taken online is a reactive effect since the internet is not a natural setting. Also, because of the requirement of informed consent, all respondents knew the details of the study, thus making them prone to the Hawthorne Effect – that the respondents may change their answers because they know they are part of a research study.

5.6 Implications and Recommendations

The regression analysis for counselors with trauma indicated that if counselors and clients shared the same traumatic event, then the well-being score for the counselor increased. This may indicate that counselors find a sense of happiness and personal satisfaction when helping clients who have experienced a similar situation.

The regression analysis for counselors without trauma indicated that the more sessions counselors provide to clients the higher the counselors' well-being score. This may indicate that counselors feel a greater sense of accomplishment when they are able to dedicate more time and care to a client. For the same group, the more a counselor participates in supervision the higher

their well-being score. This supports the idea that supervision is a significant factor in job satisfaction and burnout (Hyrkäs, Appelqvist-Schmidlechner, & Haataja, 2006).

It would appear from the data that certain predictor variables suspected as influential (e.g. case load, supervision frequency, and therapeutic self-care) were not universally significant or even identified as a predictor. However, it is important to take into account that posttraumatic stress severity was the most significant predictor, and its effects may be overshadowing the other predictors. Also affecting this may be other personal or clinical factors. Therefore, predictors that were significant for counselors without trauma (e.g. number of sessions per client and supervision frequency) may still be significant for counselors with trauma.

Counselors, supervisors, researchers, and students can benefits from this research by learning to be more sensitive to these predictors when they appear in practice. For example, a supervisor can adjust their supervisory plans and evaluation when working with a counselor known to have a personal trauma history. It is notable that 71.2% of counselors self-identified as having a history of personal trauma, and 19.6% (n = 30) of all respondents who participated in the survey met the criteria for PTSD according to the PTSD Checklist. Also, the age of the counselor was not a predictor, implying that time alone is not enough to change the results. These findings show the prevalence of counselors with a personal trauma history and reflect the importance of developing models and strategies for effective supervision and self-care.

The main contributions to the counselor well-being literature are the results of the regression analysis. It found four predictors of well-being for counselors with a personal trauma history, and three predictors of well-being for counselors without a personal trauma history. While the study found that different variables exist for predicting counselor well-being between those with trauma and those without, posttraumatic stress severity was the one common predictor. This will allow future research on counselor well-being to focus on only those predictors that are found to be statistically significant, and develop intervention models that target specific populations of counselors.

APPENDIX A

IRB #2011-0332 EXPEDITED APPROVAL OF HUMAN SUBJECT RESEARCH WITH WAIVER/ALTERATION TO INFORMED CONSENT

April 19, 2011

THE UNIVERSITY
OF TEXAS
AT ARLINGTON

Office of Research Administration
Box 19188
202 E. Border St., Suite 214
Arlington, Texas
76019-0188

T 817.272.3723
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http://www.uta.edu/research
Expertise at UT Arlington
http://www.uta.edu/expertise

Joel Chaverri
Dr. Regina Aguirre
The University of Texas at Arlington
School of Social Work
Box 19129

EXPEDITED APPROVAL OF HUMAN SUBJECT RESEARCH WITH WAIVER/ALTERATION TO INFORMED CONSENT

IRB No.: 2011-0332
TITLE: *Correlation of personal trauma, nature of practice, and well-being among mental health counselors*
Effective Date: April 13, 2011
Expiration Date: April 12, 2012

Approved Number of Participants: 500 **(Do not exceed without prior IRB approval).**

The University of Texas Arlington Institutional Review Board (UTA IRB) has made the determination that this research protocol involving human subjects is eligible for expedited review in accordance with Title 45 CFR 46.110(a)-(b)(1), 63 FR 60364 and 63 FR 60353, category (7). The IRB Chairman (or designee) approved this protocol effective April 13, 2011. IRB approval for the research shall continue until April 12, 2012.

APPROVED NUMBER OF PARTICIPANTS:
This protocol has been approved for enrollment of a maximum of 500 participants and is not to exceed this number. If additional data are needed, the researcher must submit a modification request to increase the number of approved participants **before** the additional data are collected. Exceeding the number of approved participants is considered an issue of non-compliance and will result in the destruction of the data collected beyond the approval number and will be subject to deliberation set forth by the IRB.

WAIVER/ALTERATION OF INFORMED CONSENT
The above referenced study also qualifies for a waiver of the requirement to obtain documentation of written Informed Consent under the federal guidelines for the protection of human subjects as referenced at Title 45 CFR 46.117 (c). An IRB may waive the requirement for the investigator to obtain a signed consent form for some or all subjects if it finds that:

1. That the only record linking the subject and the research would be the consent document and the principal risk would be potential harm resulting from a breach of confidentiality. Each subject should be asked whether the subject wants documentation linking the subject with the research, and the the subject's wishes must govern.

AND/OR

2. Pursuant to §46.117(c)(2), the research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context.

MODIFICATION TO AN APPROVED PROTOCOL:
Pursuant to Title 45 CFR 46.103(b)(4)(iii), investigators are required to, "promptly report to the IRB ***any*** proposed changes in the research activity, and to ensure that such changes in approved research, during the period for which IRB approval has already been given, are **not initiated without prior IRB review and approval** except when necessary to eliminate apparent immediate hazards to the subject." Modifications include but are not limited to: Changes in protocol personnel, number of approved participants, and/or updates to the protocol procedures or instruments and must be submitted via the electronic submission system. Failure to obtain approval for modifications is considered an issue of non-compliance and will be subject to review and deliberation by the IRB which could result in the suspension/termination of the protocol.

ANNUAL CONTINUING REVIEW:
In order for the research to continue beyond the first year, a Continuing Review must be completed via the online submission system within 30 days preceding the date of expiration indicated above. A reminder notice will be forwarded to the attention of the Principal Investigator (PI) 30 days prior to the expiration date. Continuing review of the protocol serves as a progress report and provides the researcher with an opportunity to make updates to the originally approved protocol. Failure to obtain approval for a continuing review will result in automatic ***expiration of the protocol*** all activities involving human subjects must cease immediately. The research will not be allowed to commence by any protocol personnel until a new protocol has been submitted, reviewed, and approved by the IRB. Per federal regulations and UTA's Federalwide Assurance (FWA), there are no exceptions and no extensions of approval granted by the IRB. The continuation of study procedures after the expiration of a protocol is considered to be an issue of non-compliance and a violation of federal regulations. Such violations could result in termination of external and University funding and/or disciplinary action.

ADVERSE EVENTS:
Please be advised that as the principal investigator, you are required to report local adverse (unanticipated) events to The UT Arlington Office of Research Administration; Regulatory Services within 24 hours of the occurrence or upon acknowledgement of the occurrence.

HUMAN SUBJECTS TRAINING:
All investigators and key personnel identified in the protocol must have documented Human Subjects Protection (HSP) training or CITI Training on file with The UT Arlington Office of Research Administration; Regulatory Services. Completion certificates are valid for 2 years from completion date.

COLLABORATION:
If applicable, approval by the appropriate authority at a collaborating facility is required prior to subject enrollment. If the collaborating facility is *engaged in the research*, an OHRP approved Federalwide Assurance (FWA) may be required for the facility (prior to their participation in research-related activities). To determine whether the collaborating facility is engaged in research, go to: http://www.hhs.gov/ohrp/humansubjects/assurance/engage.htm

CONTACT FOR QUESTIONS:
The UT Arlington Office of Research Administration; Regulatory Services appreciates your continuing commitment to the protection of human research subjects. Should you have questions or require further assistance, please contact Robin Dickey at robind@uta.edu or you may contact the Office of Regulatory Services at 817-272-3723.

Sincerely,

Patricia Turpin

Digitally signed by Patricia Turpin
DN: o=The University of Texas System, ou=The University of Texas at Arlington CA, ou=www.verisign.com/repository/CPS Incorp. by Ref.LIAB.LTD(c)99, cn=Patricia Turpin, email=pturpin@uta.edu
Date: 2011.05.05 23:18:32 -05'00'

Patricia Turpin, Ph.D., RN, NEA, BC
Clinical Associate Professor
UT Arlington IRB Chair

APPENDIX B

IRB #2011-0332 MINOR MODIFICATION APROVAL LETTER 1

THE UNIVERSITY
OF TEXAS
AT ARLINGTON

Office of Research
Administration
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76019-0188

T 817.272.3723
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Expertise at UT Arlington
http://www.uta.edu/expertise

June 9, 2011

Joel Chaverri
Dr. Regina Aguirre
School of Social Work
The University of Texas at Arlington
Box 19129

IRB No.: **2011-0332**

RE: Minor Modification Approval Letter

Title: *Correlation of personal trauma, nature of practice, and well-being among mental health counselors*

The UT Arlington Institutional Review Board (UTA IRB) Chair (or designee) reviewed and approved the modification(s) to this protocol on **June 6, 2011** in accordance with Title 45 CFR 46. 110(b)(2). Therefore, you are authorized to conduct your research. The modification(s), indicated below, was/were deemed minor and appropriate for expedited review.

- Shortening of posts to be used on the Study's facebook page

Pursuant to Title 45 CFR 46.103(b)(4)(iii), investigators are required to, "promptly report to the IRB ***any*** proposed changes in the research activity, and ensure that such changes in approved research, during the period for which IRB approval has already been given, **are not initiated without IRB review and approval** except when necessary to eliminate apparent immediate hazards to the subject."

The modification approval will additionally be presented to the convened board on June 14, 2011 for full IRB acknowledgment [45 CFR 46.110(c)]. All investigators and key personnel identified in the protocol must have documented Human Subjects Protection (HSP) training, *CITI* Training, or other approved training on file with the UT Arlington Office of Research Administration; Regulatory Services.

The UT Arlington Office of Research Administration appreciates your continuing commitment to the protection of human research subjects. Should you have questions or require further assistance, please contact Robin Dickey at robind@uta.edu or you may contact the Office of Regulatory Services at 817-272-3723.

Sincerely,

Judy R. Wilson

Dr. Judy R. Wilson
Associate Professor
UT Arlington IRB Vice-Chair

APPENDIX C

IRB #2011-0332 MINOR MODIFICATION APROVAL LETTER 2

THE UNIVERSITY
OF TEXAS
AT ARLINGTON

Office of Research
Administration
Box 19188
202 E. Border St., Suite 214
Arlington, Texas
76019-0188

T 817.272.3723
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Expertise at UT Arlington
http://www.uta.edu/expertise

July 5, 2011

Joel Chaverri
Dr. Regina Aguirre
School of Social Work
The University of Texas at Arlington
Box 19129

IRB No.: **2011-0332**

RE: Minor Modification Approval Letter

Title: *Correlation of personal trauma, nature of practice, and well-being among mental health counselors*

The UT Arlington Institutional Review Board (UTA IRB) Chair (or designee) reviewed and approved the modification(s) to this protocol on **June 26, 2011** in accordance with Title 45 CFR 46. 110(b)(2). Therefore, you are authorized to conduct your research. The modification(s), indicated below, was/were deemed minor and appropriate for expedited review.

- ADD additional facebook groups for recruitment.

Pursuant to Title 45 CFR 46.103(b)(4)(iii), investigators are required to, "promptly report to the IRB ***any*** proposed changes in the research activity, and ensure that such changes in approved research, during the period for which IRB approval has already been given, **are not initiated without IRB review and approval** except when necessary to eliminate apparent immediate hazards to the subject."

The modification approval will additionally be presented to the convened board on July 12, 2011 for full IRB acknowledgment [45 CFR 46.110(c)]. All investigators and key personnel identified in the protocol must have documented Human Subjects Protection (HSP) training, *CITI* Training, or other approved training on file with the UT Arlington Office of Research Administration; Regulatory Services.

The UT Arlington Office of Research Administration appreciates your continuing commitment to the protection of human research subjects. Should you have questions or require further assistance, please contact Robin Dickey at robind@uta.edu or you may contact the Office of Regulatory Services at 817-272-3723.

Sincerely,

Patricia Turpin

Digitally signed by Patricia Turpin
DN: postalCode=76019, o=The University of Texas at Arlington, street=701 South Nedderman Drive, st=TX, l=Arlington, c=US, cn=Patricia Turpin, email=pturpin@uta.edu
Date: 2011.07.08 17:28:00 -05'00'

Patricia Turpin, Ph.D., RN, NEA, BC
Clinical Associate Professor
UT Arlington IRB Chair

APPENDIX D

MESSAGE TO DIRECTORS AND ADMINISTRATORS

Introduction Message

Hello, my name is Joel Chaverri, and I am a Social Work graduate student at the University of Texas in Arlington. I am working on my thesis, and am writing to request permission to post a survey URL to your Facebook group: (Group Name). This IRB approved study is designed to explore potential stressors of the counseling profession, and counselor's personal coping skills. The survey does not request any identifiers, so the information will be anonymous. Below is a short explanatory paragraph with a link to the survey that can be posted to the wall. Thank you for your consideration.

Original Facebook Message

Practicing Counselors! Please participate in this survey on the well being of professional social work and mental health counselors: http://www.surveymonkey.com/s/JWBW6ZZ
This survey is intended to collect information on counselors, their personal coping skills, and traumatic experiences (if any). This survey contains questions about your experience managing the potential stressors of the counseling profession. The survey data will be kept anonymous and confidential, and you will not be asked to identify yourself in any way. This survey is part of a study being conducted by Joel Chaverri at the University of Texas at Arlington in partial fulfillment of thesis requirements. IRB approval has been granted. If you have any questions or concerns regarding this survey please contact Joel Chaverri (joel.chaverri@mavs.uta.edu). If you choose to participate in this survey, please go to http://www.surveymonkey.com/s/JWBW6ZZ.

Shortened Facebook Message from IRB Modification

Counselors! Please participate in this survey on the well-being of practicing mental health counselors: http://www.surveymonkey.com/s/JWBW6ZZ. This IRB approved survey is anonymous and confidential and contains questions about your experience managing the potential stressors of the counseling profession. If you have any questions or concerns regarding this survey please contact Joel.Chaverri@mavs.uta.edu

APPENDIX E

ORGANIZATIONS AND GROUPS CONTACTED

1. Name: Counselors
Category: Common Interest - Health & Wellness
Description: Group for Licensed Professional Counselors, Provisionally Licensed Professional Counselors, and students planning on becoming L.P.C.'s. Members will benefit from networking, as well as the exchange of information about various resources.
Privacy Type: Open: All content is public.
Members: 353
http://www.facebook.com/group.php?gid=2226745586

2. Name: Counseling Military Families
Category: Business - General
Description: This is a network of counselors, social workers, and family therapists who work with military service members and their families.
Privacy Type: Open: All content is public.
Members: 26
http://www.facebook.com/group.php?gid=57769636562

3. Name: Facebooks National Association of Social Workers
Category: Common Interest - Beliefs & Causes
Description: This group is for Social Workers, National and International, who are interested in making a positive change in the world. Social Workers in this group MUST adhere to the NASWs guidelines, rules, and regulations.....(even if you are not a paying member).
Privacy Type: Open: All content is public.
Members: 7,762
http://www.facebook.com/group.php?gid=2205023439

4. Name: Licensed Professional Counselors
Category: Business - General
Description: Networking group for LPC's in private practice. Building a sustaining a strong client base through marketing and advertising.
Privacy Type: Open: All content is public.
Members: 85
http://www.facebook.com/group.php?gid=60348752649

5. Name: Licensed Professional Counselors (and or MHSP's)
Category: Organizations - Professional Organizations
Description: A website for those who have graduated, passed the NCE, NMHCE, and the Juris Prudence exams and are now licensed professional counselors in their state. A place for LPC's to meet, have discussions, and share ideas or events with each other.
Privacy Type: Open: All content is public.
Members: 139
http://www.facebook.com/group.php?gid=3312310093

6. Name: Licensed Professional Counselors Association of North Carolina
Category: Organizations - Professional Organizations
Description: For members of the LPCANC - the only professional counseling association in North Carolina dedicated exclusively to the advocacy, education and professional needs of LPCs
Privacy Type: Closed: Limited public content. Members can see all content.
Members: 186
http://www.facebook.com/group.php?gid=87710988485

7. Name: LMSWs and MSWs of Georgia Society for Clinical Social Work!
Category: Organizations - Professional Organizations

Description: This group is a way for new social workers (MSWs and LMSWs) with a clinical focus in Georgia to connect, exchange information, network, and learn more about the Georgia Society for Clinical Social Work (GSCSW)!! Here we'll post events that GSCSW hosts specifically for new social workers like you! These include networking events, meetings on various relevant clinical topics (ex. Eating Disorders, Starting a Private Practice, and more!).
Privacy Type: Open: All content is public.
Members: 75
http://www.facebook.com/group.php?gid=144040415624274

8. Name: Marriage and Family Therapists
Category: Common Interest - Families
Description: This is a place for practitioners, interns, clients, or anyone interested in discussing the field of marriage and family therapy. If you've got systemic thinking, we're for you!
Privacy Type: Open: All content is public.
Members: 150
http://www.facebook.com/group.php?gid=10025224359

9. Name: Marriage and Family Therapists
Category: Common Interest - Families
Description: Mental Health Students and Professionals
MFT focus
Privacy Type: Open: All content is public.
Members: 336
http://www.facebook.com/group.php?gid=2338440759

10. Name: Marriage and Family Therapists
Category: Organizations - Professional Organizations
Description: This group was created for marriage and family therapists and students, for the purpose of networking (i.e., sharing job opportunities, profession-related news, resources) and socializing!
Privacy Type: Open: All content is public.
Members: 912
http://www.facebook.com/group.php?gid=2224825059

11. Name: MARRIAGE AND FAMILY THERAPY
Category: Common Interest - Health & Wellness
Description: Therapists and Students of MFT
Privacy Type: Open: All content is public.
Members: 227
Name: MARRIAGE AND FAMILY THERAPY Category: Common Interest - Health & Wellness
Description: Therapists and Students of MFT
Privacy Type: Open: All content is public.

12. Name: Military Social Work
Category: Common Interest - Beliefs & Causes
Description: This group is for all those who take care of our active duty military and their families - but is focused on our military social workers. This is a place for military and non-military medical, medical service corps and nurse corps members and civilian counterparts scattered around the universe - to gather, talk freely and share ideas. This is a place to discuss the work we're doing, the work we want to do and to air opinions. This is a place to connect and re-connect with some pretty cool military medical types. OK - maybe this is just an excuse for me to get all my favorite people together.
Privacy Type: Closed: Limited public content. Members can see all content.

Members: 429
http://www.facebook.com/group.php?gid=10263737567

Name: Military Social Work Interest Group (MilSWIG)

13. Category: Student Groups - General

Description: The Military Social Work Interest Group promotes the welfare, social interests, education, outreach, and support of military service members and veterans, their families, and their communities.
Privacy Type: Open: All content is public.
Members: 129
http://www.facebook.com/group.php?gid=124491104241111

14. Name: National Association of Social Workers - California

Category: Organizations - Advocacy Organizations
Description: The Official Facebook group for the California chapter of the National Association of Social Workers
Privacy Type: Open: All content is public.
Members: 578
http://www.facebook.com/group.php?gid=136902889359

15. Name: National Association of Social Workers - NASW

Category: Organizations - Non-Profit Organizations
Description: The Official Facebook group of NASW, National Association of Social Workers. Representing the Social Work Profession on Facebook.
Privacy Type: Open: All content is public.
Members: 13,071
http://www.facebook.com/group.php?gid=10886145903

16. Name: National Association of Social Workers, DC Metro Chapter

Category: Organizations - Professional Organizations
Description: This is the Facebook Group for the National Association of Social Workers, DC Metro Chapter! For more information on our chapter, or to join, email the Office Manager at dcmetrochapter@naswdc.org. Don't forget to visit our website at www.naswmetro.org!
Privacy Type: Open: All content is public.
Members: 355
http://www.facebook.com/group.php?gid=18238584236

17. Name: Navy Clinical Psychology

Category: Organizations - Professional Organizations
Description: Navy Psychologists care for service members and their families, consult to the military and conduct research. We are a diverse group spread throughout the world while serving the military. The purpose of this group is to enhance communication and camaraderie for all Navy Clinical Psychologists. The group is open only to active duty Navy Psychology trainees and active duty, reserve, civilian psychologists, and federal consulting psychologists working in Navy sites and treatment facilities.
Privacy Type: Closed: Limited public content. Members can see all content.
Members: 111
http://www.facebook.com/group.php?gid=115996937866

18. Name: NC Licensed Professional Counselors

Category: Common Interest - Current Events
Description: This is for mental health counselors licensed in NC. Discussion of current issues, trainings, networks.

Privacy Type: Open: All content is public
Members: 67
http://www.facebook.com/group.php?gid=15820219478

19. Name: Psychologists
Category: Common Interest - Science
Description: A group for psychologists around the world!
Privacy Type: Open: All content is public.
Members: 588
http://www.facebook.com/group.php?gid=2242509248

20. Name: The Soldier Project
Category: Organizations - Non-Profit Organizations
Description: The Soldiers Project is a private, non-profit, independent group of volunteer licensed mental health professionals including psychiatrists, psychologists, social workers, and marriage and family therapists. We provide free counseling and support to military service members who have served or who expect to serve in the Iraq and/or Afghanistan conflicts and to veterans of those conflicts. We see active duty as well as members of activated Reserve or Guard units. In addition, our services are available to the families and other loved ones of service members. We provide help to service members and families struggling with issues related to the overwhelming trauma of war including the cycle from pre-deployment to deployment to homecoming and re-entry to civilian life. Our services are entirely free of charge. We do not report to any government agency.
Privacy Type: Open: All content is public.
Members: 61
http://www.facebook.com/group.php?gid=142756582128

Groups Added in IRB Modification

1. Name: American Association for Marriage and Family Therapy (AAMFT)
Description: The American Association for Marriage and Family Therapy (AAMFT) is the professional association for the field of marriage and family therapy. We represent the professional interests of more than 50,000 marriage and family therapists throughout the United States, Canada and abroad.
Members: 50,000
http://www.aamft.org

2. Name: American Association of Spinal Cord Injury Psychologists and Social Workers
Description: ASCIP is a not for profit incorporated association comprised of 4 professional sections: American Paraplegia Society (APS), Association of Spinal Cord Injury Nurses (ASCIN), Psychologists and Social Workers (PSW) and Therapy Leadership Council (TLC).
Members: Unknown
http://www.academyscipro.org

3. Name: American Association of Suicidology
Description: The goal of the American Association of Suicidology (AAS) is to understand and prevent suicide.
Members: 111
http://www.suicidology.org

4. Name: American Counseling Association
Description: The ACA promotes the counseling profession through work in advocacy, research and professional standards.

Members: Unknown
http://www.counseling.org/

5. Name: American Mental Health Counselors Association
Description: The American Mental Health Counselors Association (AMHCA) is a growing community of almost 6,000 mental health counselors. Together, we make a critical impact on the lives of Americans. AMHCA succeeds in giving a voice to our profession nationwide and in helping to serve you and your colleagues in your state.
Members: 6,000
http://www.amhca.org/

6. Name: American Psychiatric Association
Description: A professional organization of psychiatrists and trainee psychiatrists in the United States. The association publishes various journals and pamphlets, as well as the Diagnostic and Statistical Manual of Mental Disorders, or DSM. The DSM codifies psychiatric conditions and is used worldwide as a key guide for diagnosing disorders.
Members: 38,000
http://www.psych.org/

7. Name: American Psychological Association
Description: Based in Washington, D.C., the American Psychological Association (APA) is a scientific and professional organization that represents psychology in the United States. With more than 154,000 members, APA is the largest association of psychologists worldwide.
Members: 154,000
http://www.apa.org/

8. Name: Association for Death Education and Counseling
Description: The Association for Death Education and Counseling is an international, professional organization dedicated to promoting excellence and recognizing diversity in death education, care of the dying, grief counseling and research in thanatology. Based on quality research, theory and practice, the association provides information, support and resources to its international, multicultural, multidisciplinary membership and to the public.
Members: Unknown
http://www.adec.org

9. Name: Association for Specialists in Group Work
Description: The Association for Specialists in Group Work is a division of the American Counseling Association. As Counseling Professionals who are interested in and specialize in group work, we value the creation of community; service to our members, their clients, and the profession; and leadership as a process to facilitate the growth and development of individuals and groups.
Members: Unknown
http://www.asgw.org/

10. Name: Catholic Social Workers National Association
Description: Catholic Social Workers National Association is a Professional Membership Association that was formed on the belief that professional associations should support not only your profession, but also your beliefs, values, and your faith. CSWNA has been established for social workers who are faithful to the teachings of the church and are looking for support and direction within their profession based upon church teachings.
Members: Unknown
http://www.cswna.org/

11. Name: Clinical Social Work Association
Description: Clinical social workers are the most recognized practitioners of mental health services in the nation. A profession is only as vibrant as is its leadership. The Clinical Social Work Association is the leading organization ensuring the efficacy, stability and viability of clinical social work. Through our clinical offerings, legislative advocacy and practice related alerts, we keep clinical social workers well informed and prepared to make a difference in our client's lives.
Members: Unknown
http://www.clinicalsocialworkassociation.org/

12. Name: Department of Defense
Description: The U.S. federal department allocated the largest level of budgetary resources and charged with coordinating and supervising all agencies and functions of the government relating directly to national security and the United States armed forces.
Members: 700,000
http://www.dod.gov/

13. Name: Department of Veterans Affairs
Description: To provide veterans the world-class benefits and services they have earned - and to do so by adhering to the highest standards of compassion, commitment, excellence, professionalism, integrity, accountability, and stewardship.
Members: 275,000
http://www.va.gov/

14. Name: International Federation of Social Workers
Description: The International Federation of Social Workers (IFSW) is a global federation of national organizations of social workers (unions or associations). It is striving for social justice, human rights and social development through the development of social work, best practices and international cooperation between social workers and their professional organizations. Individuals and other organizations may support the Federation by joining as Friends.
Members: 48,000
http://www.ifsw.org/

15. Name: Mental Health America
Description: With over a century of advocacy, public education, and the delivery of programs and services, Mental Health America is the country's leading nonprofit dedicated to helping all people live mentally healthier lives.
Members: Unknown
http://www.nmha.org/

16. Name: National Association of Black Social Workers
Description: The National Association of Black Social Workers, Inc., comprised of people of African ancestry, is committed to enhancing the quality of life and empowering people of African ancestry through advocacy, human services delivery, and research.
Members: Unknown
http://www.nabsw.org

17. Name: National Association of Perinatal Social Workers
Description: The National Association of Perinatal Social Workers was incorporated in 1980 for the purpose of promoting, expanding, and enhancing the role of social work in perinatal health care.
Members: Unknown
http://www.napsw.org/

18. Name: National Association of Social Workers
Description: NASW has several State specific NASW pages. These pages represent the National Association of Social Workers on Facebook for their specific State
Members: 150,000
https://www.socialworkers.org

19. Name: National Institute For Social Work (UK)
Description: The National History for Social Work provides a vast range of services that are aimed at achieving the highest standards in practice and management in social work and care.
Members: Unknown
http://www.nisw.org.uk/

20. Name: North American Association of Christians in Social Work
Description: NACSW equips its members to integrate Christian faith and professional social work practice.
Members: Unknown
http://www.nacsw.org

21. Name: School Social Work Association of America
Description: The School Social Work Association of America is dedicated to promoting the profession of school social work and the professional development of school social workers in order to enhance the educational experience of students and their families.
Members: Unknown
https://www.sswaa.org

22. Name: Society for Social Work Leadership in Health Care
Description: The Society for Social Work Leadership in Health Care is an association, 1200 members strong, dedicated to promoting the universal availability, accessibility, coordination, and effectiveness of health care that addresses the psychosocial components of health and illness
Members: 1,200
http://www.sswlhc.org/

APPENDIX F

OXFORD HAPPINESS QUESTIONAIRE

Oxford Happiness Questionnaire

The Oxford Happiness Questionnaire was developed by psychologists Michael Argyle and Peter Hills at Oxford University.

Instructions
Below are a number of statements about happiness. Please indicate how much you agree or disagree with each by entering a number in the blank after each statement, according to the following scale:

1 = strongly disagree
2 = moderately disagree
3 = slightly disagree
4 = slightly agree
5 = moderately agree
6 = strongly agree

Please read the statements carefully, some of the questions are phrased positively and others negatively. Don't take too long over individual questions; there are no "right" or "wrong" answers (and no trick questions). The first answer that comes into your head is probably the right one for you. If you find some of the questions difficult, please give the answer that is true for you in general or for most of the time.

The Questionnaire

1. I don't feel particularly pleased with the way I am. (R) _____
2. I am intensely interested in other people. _____
3. I feel that life is very rewarding. _____
4. I have very warm feelings towards almost everyone. _____
5. I rarely wake up feeling rested. (R) _____
6. I am not particularly optimistic about the future. (R) _____
7. I find most things amusing. _____
8. I am always committed and involved. _____
9. Life is good. _____
10. I do not think that the world is a good place. (R) _____
11. I laugh a lot. _____
12. I am well satisfied about everything in my life. _____
13. I don't think I look attractive. (R) _____
14. There is a gap between what I would like to do and what I have done. (R) _____
15. I am very happy. _____
16. I find beauty in some things. _____
17. I always have a cheerful effect on others. _____
18. I can fit in (find time for) everything I want to. _____
19. I feel that I am not especially in control of my life. (R) _____
20. I feel able to take anything on. _____
21. I feel fully mentally alert. _____
22. I often experience joy and elation. _____
23. I don't find it easy to make decisions. (R) _____
24. I don't have a particular sense of meaning and purpose in my life. (R) _____
25. I feel I have a great deal of energy. _____
26. I usually have a good influence on events. _____
27. I don't have fun with other people. (R) _____
28. I don't feel particularly healthy. (R) _____
29. I don't have particularly happy memories of the past. (R) _____

Calculate your score

Step 1. Items marked (R) should be scored in reverse:
For example, if you gave yourself a “1,” cross it out and change it to a “6.”
Change “2″ to a “5″
Change “3″ to a “4″
Change “4″ to a “3″
Change “5″ to a “2″
Change “6″ to a “1″

Step 2. Add the numbers for all 29 questions. (Use the converted numbers for the 12 items that are
reverse scored.)

Step 3. Divide by 29. So your happiness score = the total (from step 2) divided by 29.

Your Happiness Score: _____

APPENDIX G

PTSD CHECKLIST – CIVILIAN

PTSD Checklist – Civilian Version (PCL-C)

Instructions: Below is a list of problems and complaints that individuals sometimes have in response to stressful life experiences. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem *in the last month*.

No.	Response:	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?					
2.	Repeated, disturbing dreams of a stressful experience from the past?					
3.	Suddenly *acting* or *feeling* as if a stressful experience *were happening again* (as if you were reliving it)?					
4.	Feeling *very upset* when *something reminded* you of a stressful experience from the past?					
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful experience from the past?					
6.	Avoid *thinking about* or *talking about* a stressful experience from the past or avoid *having feelings* related to it?					
7.	Avoid *activities* or *situations* because *they remind you* of a stressful experience from the past?					
8.	Trouble *remembering important parts* of a stressful experience from the past?					
9.	Loss of *interest in things that you used to enjoy?*					
10.	Feeling *distant* or *cut off* from other people?					
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?					
12.	Feeling as if your *future* will somehow be *cut short*?					
13.	Trouble *falling* or *staying asleep*?					
14.	Feeling *irritable* or having *angry outbursts*?					
15.	Having *difficulty concentrating*?					
16.	Being *"super alert"* or watchful on guard?					
17.	Feeling *jumpy* or easily startled?					

APPENDIX H

PTSD CHECKLIST – MILITARY

PTSD Checklist – Military Version (PCL-M)

Instructions: Below is a list of problems and complaints that veterans sometimes have in response to stressful military experiences. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem *in the last month*.

No.	Response:	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Repeated, disturbing memories, thoughts, or images of a stressful military experience?					
2.	Repeated, disturbing dreams of a stressful military experience?					
3.	Suddenly *acting* or *feeling* as if a stressful experience *were happening again* (as if you were reliving it)?					
4.	Feeling *very upset* when *something reminded* you of a stressful military experience from the past?					
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful military experience?					
6.	Avoid *thinking about* or *talking about* a stressful experience from the past or avoid *having feelings* related to it?					
7.	Avoid *activities* or *situations* because *they remind you* of a stressful military experience?					
8.	Trouble *remembering important parts* of a stressful military experience?					
9.	Loss of *interest in things that you used to enjoy?*					
10.	Feeling *distant* or *cut off* from other people?					
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?					
12.	Feeling as if your *future* will somehow be *cut short*?					
13.	Trouble *falling* or *staying asleep*?					
14.	Feeling *irritable* or having *angry outbursts*?					
15.	Having *difficulty concentrating*?					
16.	Being *"super alert"* or watchful on guard?					
17.	Feeling *jumpy* or easily startled?					

APPENDIX I

SURVEY

1. Informed Consent

PRINCIPAL INVESTIGATOR NAME:
Joel Chaverri

TITLE OF PROJECT
Correlation of personal trauma, nature of practice, and well-being among mental health counselors

INTRODUCTION
You are being asked to participate in a research study. Your participation is voluntary. Please ask questions by emailing Joel Chaverri (joel.chaverri@mavs.uta.edu) if there is anything you do not understand.

OBJECTIVE
The objective of this quantitative research study is to explore the impact of counselor's personal experiences and nature of their practice on their current well being. The design is an online exploratory survey that collects information on counselors, their personal coping skills, and personal traumatic experiences, if any.

DURATION
This survey will take approximately 15 to 20 minutes to complete depending upon your answers which may increase how many questions you are asked.

PROCEDURES

The procedures, involving you as a research participant, include you completing an online survey. You are being asked to answer questions regarding your profession, personal trauma, and behavior. The number of questions you are asked depends on your personal experiences. For example, if you indicate a particular experience of interest, you may be asked additional questions about that experience that someone who did not have that experience would not be asked.

ELIGIBILITY

You must be 18 and older and a practicing social work or mental health counselor to participate in this survey.

POSSIBLE BENEFITS

There are no direct benefits for participating in this study; however, you will be contributing to the broader body of knowledge on how counselors are affected by their own personal trauma.

COMPENSATION

No compensation is offered for participation in this study.

POSSIBLE RISKS/DISCOMFORTS

There are no perceived risks for participating in this research study. Certain questions may cause some emotional discomfort. If at any time you experience discomfort you may exit the survey at no consequence to you. If you would like to talk to someone or are in crisis please call 1-800-273-TALK. Additionally, the researcher has contacts for counseling services upon request if needed.

ALTERNATIVE PROCEDURES

There are no alternative procedures offered for this study. However, you can elect not to participate in the study or quit at any time with no negative consequences.

WITHDRAWAL FROM THE STUDY

Participation in this study is voluntary. You may refuse to participate or quit at any time by closing the survey window.

NUMBER OF PARTICIPANTS:

We expect 500 participants to enroll in this study.

CONFIDENTIALITY:

This survey is intended to be anonymous. No identifying information will be collected from you and we will have no way of identifying you unless you contact us. If you contact us, we will have your identity (e.g. email address, phone number, name you provide) BUT we will not be able to link your survey responses to your identity. Every attempt will be made to see that your study results are kept confidential. The results of this survey will only be available to Joel Chaverri and his supervising professor, Dr. Regina Aguirre. A copy of the data from this study will be stored on the password protected computer of Dr. Aguirre and in a password protected online data backup program administered by the University of Texas at Arlington for at least three (3) years after the end of this research. The results of this study may be published and/or presented at meetings without naming you as a subject. Although your rights and privacy will be maintained, the Secretary of the Department of Health and Human Services, the UTA Institutional Review Board (IRB), and personnel particular to this research have access to the study records. If you contact the researcher with questions or discomfort, your identity will be kept separate from your answers on the survey. Your records will be kept completely confidential according to current legal requirements. They will not be revealed unless required by law, or as noted above.

If in the unlikely event it becomes necessary for the Institutional Review Board to review your research records, then The University of Texas at Arlington will protect the confidentiality of those records to the extent permitted by law. Your research records will not be released without your consent unless required by law or a court order. The data resulting from your participation may be made available to other researchers in the future for research purposes not detailed within this consent form. In these cases, the data will contain no identifying information that could associate you with it, or with your participation.

* **CONSENT:**

As a representative of this study, I, Joel Chaverri, have explained the purpose, the procedures, the benefits, and the risks that are involved in this research study.

By answering "Yes" below, you confirm that you have read or had this document read to you, that you are 18 or older, and that you are a practicing social work or mental health counselor.

You have been informed about this study's purpose, procedures, possible benefits and risks, and you have received a copy of this form. You have been given the opportunity to ask questions before you sign, and you have been told that you can ask other questions at any time.

You voluntarily agree to participate in this study. By answering "Yes" below, you are not waiving any of your legal rights. Refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled, and you may discontinue participation at any time without penalty or loss of benefits, to which you are otherwise entitled.

◯ Yes, I consent to complete this survey.

◯ No, I do not consent to completing this survey.

2. Thank You

We are sorry you have chosen not to participate in this study. Thank you for your time and interest. You can exit the survey by selecting the exit link or closing the browser window.

3. Demographics

* **Are you a practicing social work or mental health counselor?**

- ◯ Yes
- ◯ No

4. Thank You

Unfortunately, you must be a practicing social work or mental health counselor in order to participate in this survey.
Thank you for your time and interest. You can exit the survey by selecting the exit link or closing the browser window.

5. Demographics

*** What is your sex?**

- ◯ Male
- ◯ Female
- ◯ Intersex

*** What is your race/ethnicity?**

- ◯ American Indian or Alaskan Native
- ◯ Asian or Pacific Islander
- ◯ Black, not of Hispanic origin
- ◯ Hispanic
- ◯ White, not of Hispanic origin

*** What is your age? (Please use whole numbers, for example: 50)**

6.

*** What is your profession?**

- ◯ Counselor
- ◯ Faith-based Counselor
- ◯ Psychiatric Nurse
- ◯ Psychiatrist
- ◯ Psychologist
- ◯ Social worker
- ◯ I am not a counselor
- ◯ Other (please specify)

*** Do you practice under a specific licensure? (Select all that apply)**

- ☐ LCDC
- ☐ LPC
- ☐ LMFT
- ☐ LMSW/LCSW or other social work licensure
- ☐ MD/DO
- ☐ PhD/PsyD/Ed
- ☐ RPN/APRN
- ☐ None
- ☐ Other (please specify)

*** What is the nature of your practice? (Select all that apply)**

- ☐ Private practice
- ☐ Hospital
- ☐ Clinic
- ☐ Faith-based organization
- ☐ Non faith-based, non-government organization
- ☐ Government agency
- ☐ Other (please specify)

7. Demographics

* **Approximately how many clients do you see per month?**

- ◯ Less than 20
- ◯ 20-40
- ◯ More than 40

* **On average, how many sessions do you have with a client before termination?**

- ◯ Less than 10
- ◯ 10-20
- ◯ More than 20

* **How often do you receive clinical supervision for your cases?**

- ◯ Weekly
- ◯ Monthly
- ◯ Every other month
- ◯ A few times a year
- ◯ Never

* **Do you primarily see clients for trauma-related issues (for example: combat, grief, violence and other situations where PTSD may be present)?**

- ◯ Yes
- ◯ No

8. Demographics

*** Which type of trauma is most common among your clients?**

- ◯ Combat trauma
- ◯ Environmental disaster
- ◯ Grief
- ◯ Physical or sexual violence
- ◯ Traumatic brain injury
- ◯ Other (please specify)

9. Demographics

*** What is the PRIMARY issue for the majority of the clients you work with?**

- ◯ Adjustment Disorders
- ◯ Anxiety Disorders
- ◯ Dissociative Disorders
- ◯ Eating Disorders
- ◯ Impulse-Control Disorders
- ◯ Mood Disorders
- ◯ Sexual Disorders
- ◯ Sleep Disorders
- ◯ Psychotic Disorders
- ◯ Sexual Dysfunctions
- ◯ Somatoform Disorders
- ◯ Substance Disorders
- ◯ Personality Disorders
- ◯ Other (please specify)

10. Demographics

*** What do you do for self care? (Select all that apply)**

- [ ] Group therapy
- [ ] Hobbies
- [ ] Physical Exercise
- [ ] Private therapy
- [ ] Social activities
- [ ] Stress-reduction techniques
- [ ] Nothing
- [ ] Other (please specify)

*** Have you personally experienced any type of trauma? (Select all that apply)**

- [ ] Combat trauma
- [ ] Environmental disaster
- [ ] Grief
- [ ] Physical or sexual violence
- [ ] None
- [ ] Other (please specify)

11. Demographics

* **Of the traumatic experiences previously identified, which would you say is the most prominent in your own life, i.e. generates the most invasive memories and stressful symptoms? (Select one)**

- ◯ Combat trauma
- ◯ Environmental disaster
- ◯ Grief
- ◯ Physical or sexual violence
- ◯ Other (please specify)

* **Approximately what percentage of your clients have experienced the same trauma you have?**

- ◯ Less than 25%
- ◯ 25% to 50%
- ◯ 50% to 75%
- ◯ More than 75%
- ◯ None

* **Have you ever received therapy for the trauma previously identified? (Select all that apply)**

- ☐ Individual therapy
- ☐ Group therapy
- ☐ Never received therapy

* **Are you currently receiving therapy for the trauma previously identified?**

- ◯ Weekly
- ◯ Monthly
- ◯ Every other month
- ◯ A few times a year
- ◯ Not at this time

* **In the past, have you ever taken any medication for the trauma previously identified?**

- [ ] Antipsychotics
- [ ] Antidepressants
- [ ] Herbal Remedies
- [ ] Mood stabilizers
- [ ] Stimulants
- [ ] Never
- [ ] Other (please specify)

* **Currently, are taking any medication for the trauma previously identified?**

- [ ] Antipsychotics
- [ ] Antidepressants
- [ ] Herbal Remedies
- [ ] Mood stabilizers
- [ ] Stimulants
- [ ] Not at this time
- [ ] Other (please specify)

12. Demographics

* **Have you ever served in the U.S. Military?**

- ◯ Yes
- ◯ No

13. Demographics

*** How long since your last deployment to combat zone?**

- ◯ Never deployed to combat zone
- ◯ Less than one year
- ◯ One to two years
- ◯ More than three years

14. PTSD CheckList – Military Version (PCL-M) (Page 1 of 4)

Below is a list of problems and complaints that veterans sometimes have in reponse to stressful military experiences. Please read each one carefully, then chose your answer to indicate how much you have been bothered by that problem IN THE PAST MONTH.

*** Repeated, disturbing memories, thoughts, or images of a stressful military experience?**

	Not at all	A little bit	Moderately	Quite a bit	Extremely
.	○	○	○	○	○

*** Repeated, disturbing dreams of a stressful military experience?**

	Not at all	A little bit	Moderatly	Quite a bit	Extremely
.	○	○	○	○	○

*** Suddenly acting or feeling as if a stressful military experience were happening again (as if you were reliving it)?**

	Not at all	A little bit	Moderatly	Quite a bit	Extremely
.	○	○	○	○	○

*** Feeling very upset when something reminded you of a stressful military experience?**

	Not at all	A little bit	Moderatly	Quite a bit	Extremely
.	○	○	○	○	○

If at any time during this survey you feel distressed and would like to talk with someone at the National Suicide Prevention Hotline click here or call 1-800-273-8255 (Veterans press 1).

If at any time you feel like you need to query for a mental health provider in your local area click here.

15. PTSD CheckList – Military Version (PCL-M) (Page 2 of 4)

Below is a list of problems and complaints that veterans sometimes have in reponse to stressful military experiences. Please read each one carefully, then chose your answer to indicate how much you have been bothered by that problem IN THE PAST MONTH.

* **Having physical reactions (e.g. heart pounding, trouble breathing, sweating) when something reminded you of a stressful military experience?**

	Not at all	A little bit	Moderatetly	Quite a bit	Extremely
.	○	○	○	○	○

* **Avoiding thinking about or talking about a stressful military experience or avoiding having feelings related to it?**

	Not at all	A little bit	Moderately	Quite a bit	Extremely
.	○	○	○	○	○

* **Avoiding activities or situations becuase they reminded you of a stressul military experience?**

	Not at all	A little bit	Moderately	Quite a bit	Extremely
.	○	○	○	○	○

* **Trouble remembering important parts of a stressful military experience?**

	Not at all	A little bit	Moderately	Quite a bit	Extremely
.	○	○	○	○	○

If at any time during this survey you feel distressed and would like to talk with someone at the National Suicide Prevention Hotline click here or call 1-800-273-8255 (Veterans press 1).

If at any time you feel like you need to query for a mental health provider in your local area click here.

16. PTSD CheckList – Military Version (PCL-M) (Page 3 of 4)

Below is a list of problems and complaints that veterans sometimes have in reponse to stressful military experiences. Please read each one carefully, then chose your answer to indicate how much you have been bothered by that problem IN THE PAST MONTH.

*** Loss of interest in activities that you use to enjoy?**

	Not at all	A little bit	Moderately	Quite a bit	Extremely
.	○	○	○	○	○

*** Feeling distant or cut off from other people?**

	Not at all	A little bit	Moderately	Quite a bit	Extremely
.	○	○	○	○	○

*** Feeling emotionally numb or being unable to have loving feelings for those close to you?**

	Not at all	A little bit	Moderately	Quite a bit	Extremely
.	○	○	○	○	○

*** Feeling as if somehow your future will be cut short?**

	Not at all	A little bit	Moderately	Quite a bit	Extremely
.	○	○	○	○	○

If at any time during this survey you feel distressed and would like to talk with someone at the National Suicide Prevention Hotline click here or call 1-800-273-8255 (Veterans press 1).

If at any time you feel like you need to query for a mental health provider in your local area click here.

17. PTSD CheckList – Military Version (PCL-M) (Page 4 of 4)

Below is a list of problems and complaints that veterans sometimes have in reponse to stressful military experiences. Please read each one carefully, then chose your answer to indicate how much you have been bothered by that problem IN THE PAST MONTH.

*** Trouble falling or staying asleep?**

	Not at all	A little bit	Moderately	Quite a bit	Extremely
.	○	○	○	○	○

*** Feeling irritable or having angry outbursts?**

	Not at all	A little bit	Moderately	Quite a bit	Extremely
.	○	○	○	○	○

*** Having difficulty concentrating?**

	Not at all	A little bit	Moderately	Quite a bit	Extremely
.	○	○	○	○	○

*** Being "super-alert" or watchful or on guard?**

	Not at all	A little bit	Moderately	Quite a bit	Extremely
.	○	○	○	○	○

*** Feeling jumpy or easily startled?**

	Not at all	A little bit	Moderately	Quite a bit	Extremely
.	○	○	○	○	○

If at any time during this survey you feel distressed and would like to talk with someone at the National Suicide Prevention Hotline click here or call 1-800-273-8255 (Veterans press 1).

If at any time you feel like you need to query for a mental health provider in your local area click here.

18. PTSD CheckList – Civilian Version (PCL-C) (Page 1 of 4)

Below is a list of problems and complaints that individuals sometimes have in response to stressful life experiences. Please read each one carefully, then chose your answer to indicate how much you have been bothered by that problem IN THE PAST MONTH.

* **Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?**

	Not at all	A little bit	Moderately	Quite a bit	Extremely
.	○	○	○	○	○

* **Repeated, disturbing dreams of a stressful experience from the past?**

	Not at all	A little bit	Moderatly	Quite a bit	Extremely
.	○	○	○	○	○

* **Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?**

	Not at all	A little bit	Moderatly	Quite a bit	Extremely
.	○	○	○	○	○

* **Feeling very upset when something reminded you of a stressful experience from the past?**

	Not at all	A little bit	Moderatly	Quite a bit	Extremely
.	○	○	○	○	○

If at any time during this survey you feel distressed and would like to talk with someone at the National Suicide Prevention Hotline click here or call 1-800-273-8255.

If at any time you feel like you need to query for a mental health provider in your local area click here.

19. PTSD CheckList – Civilian Version (PCL-C) (Page 2 of 4)

Below is a list of problems and complaints that individuals sometimes have in response to stressful life experiences. Please read each one carefully, then chose your answer to indicate how much you have been bothered by that problem IN THE PAST MONTH.

* **Having physical reactions (e.g. heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience from the past?**

	Not at all	A little bit	Moderatetly	Quite a bit	Extremely
.	○	○	○	○	○

* **Avoiding thinking about or talking about a stressful experience from the past or avoiding having feelings related to it?**

	Not at all	A little bit	Moderately	Quite a bit	Extremely
.	○	○	○	○	○

* **Avoiding activities or situations becuase they reminded you of a stressful experience from the past?**

	Not at all	A little bit	Moderately	Quite a bit	Extremely
.	○	○	○	○	○

* **Trouble remembering important parts of a stressful experience from the past?**

	Not at all	A little bit	Moderately	Quite a bit	Extremely
.	○	○	○	○	○

If at any time during this survey you feel distressed and would like to talk with someone at the National Suicide Prevention Hotline click here or call 1-800-273-8255.

If at any time you feel like you need to query for a mental health provider in your local area click here.

20. PTSD CheckList – Civilian Version (PCL-C) (Page 3 of 4)

Below is a list of problems and complaints that individuals sometimes have in response to stressful life experiences. Please read each one carefully, then chose your answer to indicate how much you have been bothered by that problem IN THE PAST MONTH.

*** Loss of interest in activities that you use to enjoy?**

	Not at all	A little bit	Moderately	Quite a bit	Extremely
.	○	○	○	○	○

*** Feeling distant or cut off from other people?**

	Not at all	A little bit	Moderately	Quite a bit	Extremely
.	○	○	○	○	○

*** Feeling emotionally numb or being unable to have loving feelings for those close to you?**

	Not at all	A little bit	Moderately	Quite a bit	Extremely
.	○	○	○	○	○

*** Feeling as if somehow your future will be cut short?**

	Not at all	A little bit	Moderately	Quite a bit	Extremely
.	○	○	○	○	○

If at any time during this survey you feel distressed and would like to talk with someone at the National Suicide Prevention Hotline click here or call 1-800-273-8255.

If at any time you feel like you need to query for a mental health provider in your local area click here.

21. PTSD CheckList – Civilian Version (PCL-C) (Page 4 of 4)

Below is a list of problems and complaints that individuals sometimes have in response to stressful life experiences. Please read each one carefully, then chose your answer to indicate how much you have been bothered by that problem IN THE PAST MONTH.

*** Trouble falling or staying asleep?**

	Not at all	A little bit	Moderately	Quite a bit	Extremely
.	○	○	○	○	○

*** Feeling irritable or having angry outbursts?**

	Not at all	A little bit	Moderately	Quite a bit	Extremely
.	○	○	○	○	○

*** Having difficulty concentrating?**

	Not at all	A little bit	Moderately	Quite a bit	Extremely
.	○	○	○	○	○

*** Being "super-alert" or watchful or on guard?**

	Not at all	A little bit	Moderately	Quite a bit	Extremely
.	○	○	○	○	○

*** Feeling jumpy or easily startled?**

	Not at all	A little bit	Moderately	Quite a bit	Extremely
.	○	○	○	○	○

If at any time during this survey you feel distressed and would like to talk with someone at the National Suicide Prevention Hotline click here or call 1-800-273-8255.

If at any time you feel like you need to query for a mental health provider in your local area click here.

22. Oxford Happiness Questionnaire (Page 1 of 3)

Below are a number of statements about happiness. Would you please indicate how much you agree or disagree with each by entering a number alongside it according to the following code:

1=strongly disagree
2=moderately disagree
3=slightly disagree
4=slightly agree
5=moderately agree
6=strongly agree

	1 strongly disagree	2 moderately disagree	3 slightly disagree	4 slightly agree	5 moderately agree	6 strongly agree
1. I don't feel particularly pleased with the way I am.	○	○	○	○	○	○
2. I am intensely interested in other people.	○	○	○	○	○	○
3. I feel that life is very rewarding.	○	○	○	○	○	○
4. I have very warm feelings towards almost everyone.	○	○	○	○	○	○
5. I rarely wake up feeling rested.	○	○	○	○	○	○
6. I am not particularly optimistic about the future.	○	○	○	○	○	○
7. I find most things amusing.	○	○	○	○	○	○
8. I am always committed and involved.	○	○	○	○	○	○
9. Life is good.	○	○	○	○	○	○
10. I do not think that the world is a good place.	○	○	○	○	○	○

23. Oxford Happiness Questionnaire (Page 2 of 3)

Below are a number of statements about happiness. Would you please indicate how much you agree or disagree with each by entering a number alongside it according to the following code:

1=strongly disagree
2=moderately disagree
3=slightly disagree
4=slightly agree
5=moderately agree
6=strongly agree

	1 strongly disagree	2 moderately disagree	3 slightly disagree	4 slightly agree	5 moderately agree	6 strongly agree
11. I laugh a lot.	○	○	○	○	○	○
12. I am well satisfied about everything in my life.	○	○	○	○	○	○
13. I don't think I look attractive.	○	○	○	○	○	○
14. There is a gap between what I would like to do and what I have done.	○	○	○	○	○	○
15. I am very happy.	○	○	○	○	○	○
16. I find beauty in some things.	○	○	○	○	○	○
17. I always have a cheerful effect on others.	○	○	○	○	○	○
18. I can fit in everything I want to.	○	○	○	○	○	○
19. I feel that I am not especially in control of my life.	○	○	○	○	○	○
20. I feel able to take anything on.	○	○	○	○	○	○

24. Oxford Happiness Questionnaire (Page 3 of 3)

Below are a number of statements about happiness. Would you please indicate how much you agree or disagree with each by entering a number alongside it according to the following code:

1=strongly disagree
2=moderately disagree
3=slightly disagree
4=slightly agree
5=moderately agree
6=strongly agree

	1 strongly disagree	2 moderately disagree	3 slightly disagree	4 slightly agree	5 moderately agree	6 strongly agree
21. I feel fully mentally alert.	○	○	○	○	○	○
22. I often experience joy and elation.	○	○	○	○	○	○
23. I do not find it easy to make decisions.	○	○	○	○	○	○
24. I do not have a particular sense of meaning and purpose in my life.	○	○	○	○	○	○
25. I feel I have a great deal of energy.	○	○	○	○	○	○
26. I usually have a good influence on others.	○	○	○	○	○	○
27. I do not have fun with other people.	○	○	○	○	○	○
28. I don't feel particularly healthy.	○	○	○	○	○	○
29. I do not have particularly happy memories of the past.	○	○	○	○	○	○

25. The End

Thank you for your time and interest.

If you know others counselors who who may be interested in participating, please feel free to direct them to this anonymous survey. It should be noted that in no way will your responses be connected to their responses. You can exit the survey by selecting the exit link or closing the browser window.

If you at all feel distressed and would like to talk with someone click here or call 1-800-273-8255.

If you would like to query for a mental health provider in your local area click here.

APPENDIX J

“OTHER” RESPONSES

A category was only assigned to a response if the respondent did not select a category themselves. Since some question allowed the respondent to select all that apply, if they both made a selection and inserted a comment, then the response was not categorized and “n/a” is listed in the category section.

Q6: What is you profession?

“Other” Response	Assigned Category
Graduate Student in Family Counseling and Pyschology	Counselor
Marriage and Family Therapist (x8)	Counselor
Psychologist-in-training	Psychologist
Psychologist Intern; master's degree	Psychologist
Clinical Psychology Doctoral Student	Psychologist
Clinical Psychology Intern	Psychologist
Psychology Graduate Student	Psychologist
MSW Intern	Social Worker
Graduate Student - therapist in training	Other
Doctoral Student/ Intern	Other
I teach undergraduate psychology classes	Other

Q7: Do you practice under a specific licensure? (Select all that apply)

“Other” Response	Assigned Category
LAMFT	LMFT
LCSW	LMSW/LCSW or other social work licensure
LAPSW state of TN	LMSW/LCSW or other social work licensure
Social Work Clinical Intern	LMSW/LCSW or other social work licensure
APSW	LMSW/LCSW or other social work licensure
Pre-Licensed LCSW, Licensed Psychiatric Technician [Calfornia]	LMSW/LCSW or other social work licensure
LPCA	LPC
LPC-A	LPC
PhD candidate	PhD/PsyD/Ed
Under my supervisors' PhD	PhD/PsyD/Ed
pre-internship practicum (Psychologist)	PhD/PsyD/Ed
Under a licensed Ph.D. supervisor	PhD/PsyD/Ed
Not yet	None
Graduate Student	None
MFT Grad Student	None
intern	None
LEAP/CEAP, LCAS, CCS, SAP	Other
LMHC	Other
Certified Pastoral Counselor (AAPC), LCAS	Other
ADCII/CAC	Other
CAS - American Academy certification	Other
Certified Alcohol and Drug Counselor	Other
LAT	n/a
ATR (Registered Art Therapist)	n/a
in training	n/a
I am certified as a school social worker as well	n/a
Both are provisional licenses	n/a

in my state a certificate is only necessary to be school social worker	n/a
JD (law)	n/a
School counselor certificate	n/a

Q8: What is the nature of your practice? (Select all that apply)

"Other" Response	Assigned Category
Specialty academic medical clinic	Clinic
University based training clinic	Clinic
military hospital (not sure if that's hospital or govt agency?)	Hospital
school social work	Other
Sexaul Assualt Community Agency	Other
non-profit group home for adolescent boys	Other
Juvenile Detention Facility	Other
Graduate Internship	Other
Case Manager for major Health Insurance Company	Other
school	Other
University/Educational	Other
Closed private practice and can't find work as employee	Other
College	Other
Dod navy	Other
schools	Other
School	Other
schiol social worker	n/a
School Social Worker	n/a
state worker for DCS	n/a
Dept. of Veterans Affairs: Vet Center	n/a
Community agency	n/a
public school	n/a
school district	n/a
Counseling Center	n/a
Privately owned chemical dependency treatment center	n/a

Q13: Which type of trauma is most common among your clients?

"Other" Response	Assigned Category
All of the above	Combination
Grief, Sexual Violence	Combination
Cancer diagnosis	Other
Marriage & family	Other

Q14: What is the primary issue for the majority of the clients you work with?

"Other" Response	Assigned Category
Adolescent adjustment	Adjustment Disorders
All issues, but tend very slightly toward adjusent	Adjustment Disorders
No one primary	Other
Marriage Issues	Other

Disorders of Childhoood/Adolescence	Other
HIV/AIDS	Other
Parenting	Other
medcial conditions. primarily oncology	Other
Crisis Intervention	Other
Mechanical ventilation	Other
Elderly	Other
There is no primary reason it could be any or all of the above issues/concerns	Other
eligible for nursing home placement, variety of reasons	Other
Educational Issues	Other
Special Needs, ADHD, Asbergers, Autism, Bi-Polar, GAD, OCD	Other
Marital and family problems.	Other
Relational Disorders (V Codes)	Other
Pain and Depression	Other
Psychiatric disorders secondary to a general medical condition. This includes, primarily, depression, anxiety, and impulse-control disorders	Other
Schizophrenia or major mental health Dx	Psychotic Disorders

Q15: What do you do for self care? (Select all that apply)

“Other” Response	Assigned Category
Spiritual growth and development	Other
Sailing, Being alone	Other
Science of Mind positivity training	Other
Not nothing, but not enough.	Other
develop/launch new academic programs in psychology	Other
Church / faith	n/a
Deep Tissue massage	n/a
extra sleep	n/a
Faith practice/Prayer	n/a
Faith, prayer, talk with friends	n/a
family centered activities	n/a
Get together with other military psychologists.	n/a
good sleep and healthy eating habits; watch TV	n/a
Meditation	n/a
meds	n/a
Music - I play my guitar everyday after work and that reduces stress considerably	n/a
music and rides in my convertible with top down	n/a
pray & sing	n/a
prayer	n/a
read and listen to audiobooks after work on way home	n/a
read, watch movies, laugh with family and	n/a

friends, cohort groups with other school social workers	
reading	n/a
sleep	n/a
spend time with family	n/a
Spending time with my children	n/a
Talk to family, friends and colleagues	n/a

Q16: Have you personally experienced any type of trauma? (Select all that apply)

"Other" Response	Assigned Category
bullying	Other
Car accident	Other
Car wrecks and other accidents	Other
growing up in a DV home an repeated suicide attempts by mother	Other
Harassment	Other
I have been in a fire.	Other
military experience	Other
Motor vehicle accident	Other
NoComment	Other
physical disabilites during wartime service	Other
TBI (1987), previous career was a professional pilot	Other
Vicarious traumatization secondary to my work.	Other
2nd hand trauma	n/a
Childhood, Domestic - Verbal/Emotional, Infidelity/Divorce	n/a
emotional	n/a
Graduate school	n/a
health issues	n/a
Medical	n/a
military work related trauma	n/a
MVAs Boat Accident	n/a
robbery	n/a
Suicide of Father	n/a
Traumatic ICU Hospitalization (Self)	n/a
workplace violence	n/a

Q17: Of the traumatic experiences previously identified, which would you say is the most prominent in your life, i.e. generates the most invasive memories and stressful symptoms? (Select one)

"Other" Response	Assigned Category
Hurricane Katrina	Environmental Disaster
Graduate school	n/a
Harassment	n/a
bullying	n/a
I am not experiencing invasive symptoms.	n/a
i don't have any invasive memories anymore	n/a
ICU Hospitalization	n/a
Medical	n/a

military work related	n/a
Motor vehicle accident	n/a
NoComment	n/a
none	n/a
none	n/a
None at present	n/a
physical pain and disabilities	n/a
Safety issues	n/a
Suicide of Father	n/a
the rage	n/a
Verbal/Emotional Abuse	n/a
Vicarious tramatization secondary to counseling veterans.	n/a
workplace trauma	n/a
wrecks	n/a

Q21: In the past, have you ever taken any medication for the trauma previously identified?

"Other" Response	Assigned Category
Antianxiety	Other
Pain Rx	Other
Phenobarbitol and Dilantin (profilactic only)	Other
anti-anxiety/sleep	n/a
Benzidiazepines	n/a
pain meds	n/a

Q22: Currently, are you taking any medication for the trauma previously identified?

Anti-anxiety meds	Other
anti-anxiety/sleep	Other
Pain Rx	Other
lithium	n/a
Nightmeres	n/a
pain	n/a
Vitamins, Visitril	n/a

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BIOGRAPHICAL INFORMATION

Joel Chaverri was raised in Dallas, Texas and graduated from Victory Christian Academy in 2001. He attended Christ for the Nations Institute, Cedar Valley College, and the University of Texas at Arlington where he graduated with his Bachelors in Social Work (BSW) in 2009, and Masters of Science in Social Work (MSSW) in 2011.

In June 2002, Joel joined the U.S. Marine Corps where he studied photojournalism and public affairs at the Defense Information School in Fort Mead, Maryland. There, he earned his certificate in military journalism and later reported to the Naval Air Station-Joint Reserve Base in Fort Worth, Texas. In 2004, he was activated in support of Operation Iraqi Freedom to serve overseas as a public affairs specialist.

While in Iraq, Joel reported on some of the war's most compelling events including the battle for Fallujah in November 2004 and was subsequently awarded Department of Defense photojournalist of the year. He occasionally displays his award winning photographs at veteran appreciation events around the country.

Since December 2005, Joel has worked at the Department of Veterans Affairs as the Veterans Outreach Specialist for the Vet Centers in North Texas. His duties include outreach to local military installations, providing training and information to community agencies, and advocating for clients to expedite services. A Staff Sergeant in the Marine Corps Reserve, Joel currently serves as reserve Public Affairs Chief at Marine Aircraft Group-41 in Fort Worth, Texas.