

Stress and Resilience Among Professional Counselors During the COVID-19 Pandemic

Stacey Diane Arañez Litam, Clark D. Ausloos, and John J. S. Harrichand

This study used a national sample of professional counselors ($N = 161$) providing services during the COVID-19 pandemic to examine the extent to which perceived stress, coping response, resilience, and posttraumatic stress predict burnout, secondary traumatic stress, and compassion satisfaction. The results of a multiple regression analysis indicated that resilience had a strong positive relationship with compassion fatigue and a strong negative relationship with burnout. Perceived stress was also strongly positively related to burnout. Implications and strategies for counselors to mitigate the effects of perceived stress during the COVID-19 pandemic by engaging in self-care practices and cultivating resilience are provided.




Keywords: COVID-19 pandemic, stress, resilience, burnout, empathic occupational hazards

Although the long-term impacts of COVID-19 on health care systems, policy, and economic infrastructure are forthcoming, the negative effects of the outbreak on mental health have been clearly established. When considering client populations, COVID-19-related mental health concerns disproportionately affect vulnerable groups, including communities of color and transgender folx who may lack access to resources (Litam & Hipolito-Delgado, 2021); international students (Anandavalli et al., 2020); and Asians, Asian Americans, and Pacific Islanders facing high rates of pandemic-related racial discrimination (Chan & Litam, 2021; Chea et al., 2020; Chen et al., 2020; Litam, 2020; Litam & Oh, 2020; Litam et al., 2021). Professional counselors must be prepared to support clients, especially those who face greater burdens and exacerbated mental health distress and are experiencing the compounding effects of social isolation; navigating the realities of living through a global health crisis; and addressing concerns related to mass unemployment, fear of illness, economic recession (Golberstein et al., 2020; Qiu et al., 2020; Torales et al., 2020), and suicide (Thakur & Jain, 2020). Although a growing body of research has begun to illuminate the deleterious effects of the COVID-19 pandemic on the psychological well-being of the general population (Brenan, 2020; Centers for Disease

Control and Prevention, 2020; Fiorillo & Gorwood, 2020; Holmes et al., 2020) and frontline health care workers (Litam & Balkin, 2021), an empirical investigation of how the pandemic has affected professional counselors has not yet been conducted.

Counselor Experiences of Stress

As helping professionals, counselors are tasked with listening to clients without absorbing the emotional pain of their stories. The extant body of research has reported the conditions associated with increased counselor stress, and consequently, vicarious trauma, compassion fatigue, and burnout. In a recent study, Moore et al. (2020) conducted consensual qualitative research among a sample of 13 counselors and identified client characteristics (i.e., unpredictability, manipulative, and impulsive), relationship dynamics (i.e., countertransference, intensity, and counselor-client match), counselor response (i.e., coping and questioning professional judgment and efficacy), and personal versus professional self as factors that contributed to interpersonal stress. Additional studies have linked increased counselor stress and burnout to countertransference management (Choi et al., 2014), ethical

Stacey Diane Arañez Litam  <https://orcid.org/0000-0001-5398-8305>, Counseling, Administration, Supervision, and Adult Learning, Cleveland State University; **Clark D. Ausloos**  <https://orcid.org/0000-0002-9348-8329>, Department of Counseling, Palo Alto University; **John J. S. Harrichand**  <https://orcid.org/0000-0002-3336-2062>, Department of Counselor Education, Brockport State University of New York. Correspondence concerning this article should be addressed to Stacey Diane Arañez Litam, Counseling, Educational Leadership, and Adult Learning, Cleveland State University, 2121 Euclid Avenue, Julka Hall 275, Cleveland, OH 44115 (email: s.litam@csuohio.edu).



dilemmas (Henderson, 2013; Mullen et al., 2017), negative counseling experiences, and professional self-doubt (Zeeck et al., 2012). Providing disaster mental health counseling may also increase counselor stress in ways that contribute to empathic occupational hazards. Findings reported by Lambert and Lawson (2013) indicated that counselors who provided disaster mental health counseling after hurricanes Katrina and Rita were twice as likely to experience compassion fatigue and vicarious trauma compared with a general sample of American Counseling Association (ACA) counselors.

Recognizing stressful counseling experiences and learning how to effectively respond are critical areas of foci because unmanaged emotional stress responses can increase the risk of empathic occupational hazards, identity confusion, and counselor impairment (ACA, 2014; Barlow & Phelan, 2007; Maslach, 2003; Stamm, 2010; Stebnicki, 2008). Counselors who continue to provide services when impaired are less effective in their therapeutic roles and are more likely to exact harm on clients (Figley, 2002; Lawson, 2007). Although professional counselors may be experts at holding space for clients to process their pain, they rarely extend this skill toward themselves (Thomas & Morris, 2017). Understanding how providing mental health services during a pandemic may affect the professional quality of life among professional counselors is critical because counselors may be experiencing many of the same existential stressors as their clients. Given the increased levels of client stress, professional counselors must be prepared to address their clients' pandemic-related concerns while mitigating the effects of their own stress in ways that protect their mental health and bolster wellness (Gleeson, 2020).

Empathic Occupational Hazards

Professional counselors who provide mental health services must maintain healthy boundaries and engage in regular self-care practices to be effective (Stebnicki, 2017; Thomas & Morris, 2017). Unfortunately, the compounding effects of increasingly difficult client concerns, navigation of telehealth practices, difficulties related to online confidentiality, ethical obligations, and personal experiences related to COVID-19 may create significant challenges for counselors. These challenges may compromise the ability of professional counselors to sustain wellness during a pandemic (Cullen et al., 2020) and may have negative effects on their professional quality of life. Although a detailed literature review is beyond the purview of the current article, a brief description of compassion fatigue, burnout, and vicarious trauma as they relate to the wellness of professional counselors is provided.

Compassion Fatigue

Over the past few decades, researchers have turned their attention to understanding compassion fatigue (Adams et al., 2006;

Bowen & Moore, 2014; Smart et al., 2014) to promote the health and wellness of helping professionals. *Compassion fatigue* refers to the stress that occurs from helping or desiring to help traumatized people (Figley, 1995). Helping professionals with compassion fatigue experience a diminished capacity to care for others as a consequence of the direct exposure to their clients' suffering and knowledge of their traumatic experiences (Nimmo & Huggard, 2013). In many ways, the nature of the counseling profession places those who engage in this vocation at greater risk of experiencing compassion fatigue (Thompson et al., 2014). For example, professional counselors are called to demonstrate empathy and unconditional positive regard and enter into their clients' world in ways that promote a deep understanding of the clients' traumatic experiences. The empathic experiences that characterize the work of professional counselors therefore become imbued with the occupational hazard of internalizing clients' traumatic experiences in ways that compromise counselors' well-being. Although compassion fatigue is distinct from experiences of burnout and vicarious trauma, these professional challenges often overlap (Newell & MacNeil, 2010).

Burnout

Burnout refers to a state of physical, emotional, and mental exhaustion caused by ongoing involvement in emotionally demanding occupational situations (Pines & Aronsin, 1988). Whereas compassion fatigue is characterized by feelings of deep empathy and sorrow for those who suffer (Stamm, 2002), burnout refers to the overall diminished capacity to care (Rossi et al., 2012). Burnout encompasses an amalgam of experiences and is characterized by feelings of exhaustion, cynicism, anxiety, irritability, fatigue, withdrawal, and reduced professional efficacy (Maslach et al., 2001; Schaufeli & Enzmann, 1998). Influencing factors to burnout are related to dissatisfaction within the context of one's occupational role, such as number of hours worked and employment in an unsupportive or toxic workplace environment (Maslach et al., 2001; Rossi et al., 2012). Cherniss (1995) found that professionals with unrealistic expectations and high levels of perfectionism were the least likely to recover from burnout compared with professionals who were realistic about their strengths, weaknesses, and work preferences. Another study conducted with 190 South Australian clinical psychologists indicated that higher levels of emotional exhaustion were significantly associated with the participants having fewer personal resources and endorsing higher needs for control in therapy (Emery et al., 2009). The need for control in therapy was characterized by the therapists' belief that full understanding was required for a successful therapeutic outcome (Emery et al., 2009). Helping professionals who endorsed emotional and therapeutic control were more likely to experience high levels of distress (Emery et al., 2009; Hellman et al., 1987), which may lead to burnout.

The all-encompassing experience of burnout necessitates special consideration for professional counselors providing services during the pandemic. Counselors experiencing burnout may construct meaning in different ways that interfere with their ability to engage in self-care (Coaston, 2017; Rudick, 2012). Following the COVID-19 outbreak, professional counselors may be tempted to support more clients than before; spend additional hours engaging in documentation; and face barriers related to confidentiality, privacy, and security from providing at-home telehealth services (Bray, 2020). The presence of these ongoing pandemic-related stressors may gradually lead to burnout (Madani, 2020).

Vicarious Trauma

Vicarious trauma represents another occupational hazard faced by mental health professionals providing counseling during a pandemic. *Vicarious trauma* refers to traumatic experiences that abruptly arise from specific client-presented information (Trippany et al., 2004). Whereas burnout can occur in any profession (McCann & Pearlman, 1990), experiences of vicarious trauma solely occur in helping professionals who work with trauma survivors (Trippany et al., 2004). Individuals with vicarious trauma commonly experience intrusive imagery related to client content and face changes related to trust, control, intimacy, safety, and esteem (Rosenbloom et al., 1995). Because clients may present with COVID-19-related fears and experiences of death, dying, and becoming seriously ill, professional counselors and other mental health professionals working during the pandemic are inherently providing trauma counseling (Abrams, 2020; Litam & Hipolito-Delgado, 2021). When vicarious trauma is compounded with their own traumatic life experiences, professional counselors may become more susceptible to emotional arousal (Lawson & Myers, 2011), which may result in compassion fatigue and burnout (Lent & Schwartz, 2012; Sadler-Gerhardt & Stevenson, 2012).

Resilience

Cultivating resilience reflects active decisions that orient individuals toward wellness and health. According to Lawson and Myers (2011), counselors are called to be intentional about pursuing personal and professional behaviors that empower them to enjoy their work experiences more fully. Counselors providing disaster mental health services who practiced self-care activities were more likely to experience lower levels of burnout, compassion fatigue, and vicarious traumatization than those who did not practice self-care (Lambert & Lawson, 2013). Disaster mental health counselors who managed stress through self-care and stress management also experienced higher levels of posttraumatic growth (Lambert & Lawson, 2011), higher levels of job satisfaction, and lower levels of job stress (Bellamy et al., 2019) compared with their counterparts who did not

practice self-care. Indeed, Sadler-Gerhardt and Stevenson (2012) posited that professional counselors who work toward building their resilience may prevent compassion fatigue, vicarious trauma, and secondary stress and promote compassion satisfaction. Compassion satisfaction arises from activities that result in a sense of satisfaction from working with clients (Figley, 1995). Counselors are called to build resilience to mitigate the challenging aspects of their work and increase their sense of purpose (Lambert & Lawson, 2013; Sadler-Gerhardt & Stevenson, 2012), especially when providing services during a pandemic.

The Current Study

Mental health clinicians, including professional counselors, are often the primary point of contact and the first responders within larger health care systems for individuals with mental health concerns (Drus, 2020). Researchers are called to investigate the social and psychological effects of providing services during a pandemic on vulnerable groups, such as front-line workers (e.g., professional counselors) who are providing care for others and who are at risk of mental health issues (Li et al., 2020; Litam & Balkin, 2021; Thakur & Jain, 2020). Providing mental health care during a pandemic has placed unique burdens on mental health professionals in ways that may compromise their wellness and increase the likelihood of developing compassion fatigue, burnout, and vicarious trauma. Like their clients, professional counselors are not immune to the onslaught of unending news coverage, social media posts, and interpersonal dialogue related to the COVID-19 outbreak (Gleeson, 2020). The presence of these chronic stressors may prevent professional counselors from achieving self-care goals and maintaining their own psychological wellness.

The purpose of this study was to contribute to the research examining the experiences of professional counselors providing services during the COVID-19 pandemic. The following research question was identified: To what extent do perceived stress, coping responses, resilience, and posttraumatic stress predict professional quality of life as measured by the total score and subscale scores of the Professional Quality of Life Scale (ProQOL; Stamm, 2010)? We made the following hypotheses:

Hypothesis 1: Posttraumatic stress, coping responses, resilience, and perceived stress, as measured by the Posttraumatic Stress Disorder (PTSD) Checklist for *DSM-5* (PCL-5; Weathers et al., 2013), Coping Strategies Inventory–Short Form (CSI-SF; Addison et al., 2007), Resilience Scale (RS; Wagnild & Young, 1993), and Perceived Stress Scale (PSS; Cohen et al., 1983), respectively, will be strong, positive predictors of professional quality of life, as measured by the ProQOL total scores.

Hypothesis 2: Coping responses and resilience, as measured by the CSI-SF and RS, respectively, will be strong, positive predictors of compassion satisfaction, as measured by the ProQOL Compassion Satisfaction (CS) subscale, whereas posttraumatic stress and perceived stress, as measured by the PCL-5 and PSS, respectively, will be strong, negative predictors of compassion satisfaction, as measured by the ProQOL CS subscale.

Hypothesis 3: Posttraumatic stress and perceived stress, as measured by the PCL-5 and PSS, respectively, will be strong, positive predictors of burnout, as measured by the ProQOL Burnout (BO) subscale, whereas coping responses and resilience, as measured by the CSI-SF and RS, respectively, will be strong, negative predictors of burnout, as measured by the ProQOL BO subscale.

Hypothesis 4: Posttraumatic stress and perceived stress, as measured by the PCL-5 and PSS, respectively, will be strong, positive predictors of secondary traumatic stress, as measured by the ProQOL Secondary Traumatic Stress (STS) subscale, whereas coping responses and resilience, as measured by the CSI-SF and RS, respectively, will be strong, negative predictors of secondary traumatic stress, as measured by the ProQOL STS subscale.

Method

Participants

A total of 161 individuals participated in this study. Participants identified as female ($n = 135$, 83.9%); male ($n = 24$, 14.9%); and transgender, genderqueer, or nonbinary ($n = 2$, 1.2%). The mean age of participants was 39 years ($SD = 11$), with ages ranging from 21 to 66 years. Participants had obtained master's degrees ($n = 130$, 80.7%), doctorates ($n = 22$, 13.7%), and bachelor's degrees ($n = 9$, 5.6%). Regarding racial/ethnic identities, most participants were White ($n = 108$, 67.1%), followed by African American/Black Canadian/Barbadian ($n = 12$, 7.5%), Hispanic/Latinx ($n = 10$, 6.2%), Asian American/Asian/Asian Canadian ($n = 3$, 1.9%), Native Hawaiian/Pacific Islander ($n = 1$, 0.6%), and Arab American/Arab Canadian ($n = 1$, 0.6%); 26 participants (16.1%) identified as holding two or more identities (i.e., Hispanic/Latinx and African American/Black). With respect to other participant demographic characteristics, 38 (23.6%) were independently licensed professional counselors, 30 (18.6%) were independently licensed professional counselors, 30 (18.6%) were licensed professional counselors with a supervisory endorsement, 26 (16.1%) were counseling graduate students (any focus, master's or doctoral levels), 24 (14.9%) were licensed professional school counselors, nine (5.6%) identified as counselor educators, and four (2.5%) held multiple

roles (i.e., counselor educator and independently licensed professional counselor; percentages do not total 100 for this demographic category because of rounding). Many participants indicated working at a private practice setting ($n = 52$, 32.3%), as well as at community mental health organizations ($n = 38$, 23.6%) and K-12 educational settings ($n = 35$, 21.7%). A total of 17 participants (10.6%) indicated working at a college/university setting, seven (4.3%) worked in psychiatric/in-patient/hospital settings, three (1.9%) worked in private educational settings, three (1.9%) worked at hospice/nursing homes/home-based mental health, and six (3.7%) worked in "other" settings (i.e., corrections-based, autism clinic, Department of Veteran Affairs).

Measures

PSS. The 10-item PSS (Cohen et al., 1983) measures the perception and degree of stress experienced over the past month on a 5-point Likert-type scale (0 = *never*; 1 = *almost never*; 2 = *sometimes*, 3 = *fairly often*, and 4 = *very often*). Higher scores indicate higher levels of self-perceived stress. The PSS scores demonstrated reliability (.78), and the scale demonstrated high criterion validity with other measures of stress, including the Job Responsibilities Scale (Ludlow, 1999). Sample items include "In the last month, how often have you been upset because of something that happened unexpectedly?" and "In the last month, how often have you felt nervous and 'stressed'?" (Cohen et al., 1983). In this study, scores derived from the PSS demonstrated strong evidence of reliability at .90.

ProQOL. The 30-item ProQOL (Stamm, 2010) measures the positive and negative effects of helping professionals working with people who have experienced traumatic events. The ProQOL uses a 5-point Likert-type scale (1 = *never*, 2 = *rarely*, 3 = *sometimes*, 4 = *often*, and 5 = *very often*). Respondents are asked to reflect on their experiences over the last 30 days. Sample items include "I get satisfaction from being able to help people" and "I find it difficult to separate my personal life from my life as a helper" (Stamm, 2010). The ProQOL has three subscales: CS (internal consistency = .88), BO (internal consistency = .75), and STS (internal consistency = .81; Stamm, 2010). In this study, scores derived from the CS, BO, and STS subscales demonstrated strong evidence of reliability, ranging from .82 to .91 for the present sample. Stamm (2010) discussed how the ProQOL subscales measure three separate constructs with very little shared variance. Stamm (2010) also shared how to interpret scores from individual subscales and how to interpret scale scores in combination. Therefore, we were interested in exploring factors on the total scores of the ProQOL as well as on the individual CS, BO, and STS subscales. In the present study, we examined each subscale to determine how they uniquely contributed to professional quality of life.

CSI-SF. The CSI-SF (Addison et al., 2007) is a four-factor, 15-item scale derived from the original 72-item Coping

Strategies Inventory (Tobin et al., 1989) that measures strategies for coping. The items are rated on a 5-point Likert-type scale (1 = *never*, 2 = *seldom*, 3 = *sometimes*, 4 = *often*, and 5 = *always*). Respondents are asked to reflect on questions such as “I try to let my emotions out” and “I try to put the problem out of my mind” (Addison et al., 2007). Scores from the CSI-SF subscales of Problem-Focused Engagement, Problem-Focused Disengagement, Emotion-Focused Engagement, and Emotion-Focused Disengagement demonstrated moderate evidence of reliability (ranging from .56 to .82) for the present sample.

RS. The RS (Wagnild & Young, 1993) is a 25-item instrument that asks participants to rate themselves on a 7-point Likert scale (ranging from 1 = *strongly disagree* to 7 = *strongly agree*), with higher scores associated with higher morale, better physical health, increased mental health, and more life satisfaction. The RS evidenced strong reliability (.91) and demonstrated a strong concurrent validity with “theoretically relevant constructs” (Wagnild & Young, 1993, p. 173). Respondents reflect on statements such as “When I make plans, I follow through with them” and “I feel that I can handle many things at a time” (Wagnild & Young, 1993). In this study, scores derived from the RS demonstrated strong evidence of reliability (.87) for the present sample.

PCL-5. The PCL-5 (Weathers et al., 2013) is a 20-item self-report measure assessing PTSD symptomatology identified in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013). The PCL-5 is used to screen individuals for PTSD, provide recommendations for a provisional diagnosis, and monitor changes in symptoms through treatment (U.S. Department of Veteran Affairs, 2019). Respondents are asked to reflect on how much they have been bothered by situations using a 5-point Likert-type scale (0 = *not at all*, 1 = *a little bit*, 2 = *moderately*, 3 = *quite a bit*, and 4 = *extremely*). Sample items include “In the past month, how much were you bothered by repeated, disturbing, and unwanted memories of the stressful experiences?” and “In the past month, how much were you bothered by trouble remembering important parts of the stressful experience?” (Weathers et al., 2013). Scores on the PCL-5 demonstrated strong internal consistency ($\alpha = .94$) and test-retest reliability ($r = .82$; Blevins et al., 2015). In this study, scores derived from the PCL-5 demonstrated very strong reliability (.95) for the present sample.

Procedure

Upon approval by the institutional review board, recruitment emails were sent through professional counseling electronic mailing lists (i.e., ACA divisions and CESNET-L) and posted on the American School Counselor Association Scene forum (American School Counselor Association, 2020). Recruitment emails included a marketing flyer with a link to the study. A consent form was presented in the survey, followed by

demographic questions requesting participants’ age, gender, highest level of education, race/ethnicity, occupation, years of counseling experience, workplace setting, average number of hours worked per week (e.g., with clients, students), average number of clients/students seen per week, client/student demographic, and counseling specialization. Two COVID-19-specific items were included in the demographic form. One item assessed the frequency of client concerns related to COVID-19 on a 5-point Likert-type scale (1 = *never 0%* to 5 = *always 100%*), and one item assessed the frequency of concern felt by the counselor related to COVID-19 stress on a 5-point Likert-type scale (1 = *never 0%* to 5 = *always 100%*). Data were collected over a 6-week period from May to July 2020.

Data Analysis

We used a series of multiple regression analyses to determine “the existence of a relationship and the extent to which variables are related, including statistical significance” (Sheperis et al., 2017, p. 131). Multiple regression analyses can be predictive and can determine how much of the variation in a dependent variable is explained by the independent variables (Johnson, 2001; Laerd Statistics, n.d.-a). We found no multicollinearity between independent variables, so all variables were retained in the regression analyses using a forced entry method, with all predictors entered simultaneously (Field, 2013). Prior to the regression analyses, we examined Spearman rank-order correlations between demographic variables: age, gender identity, education, race/ethnicity, occupation, years of professional experience, work setting, hours in session, number of clients, ages of clients, specialization, COVID-19-related client concern, and COVID-19 counselor concerns (see Table 1). Additionally, prior to the regression analysis, we examined correlations between the variables as measured by the ProQOL, PSS, CSI-SF, RS, and PCL-5 (see Table 2). There were multiple significant correlations as determined by Pearson product-moment correlations. The ProQOL composite score was significantly correlated with PSS ($r = .45, p < .001$), RS ($r = -.21, p = .008$), and PCL-5 ($r = .48, p < .001$). PSS was significantly correlated with RS ($r = -.54, p < .001$) and PCL-5 ($r = .66, p < .001$). CSI-SF was significantly correlated with RS ($r = .25, p = .002$), and RS was significantly correlated with PCL-5 ($r = -.43, p < .001$).

Results

We used a standard multiple regression to examine the research question. First, data met assumptions for a multiple regression procedure based on a continuous dependent variable (scores on the ProQOL) with two or more independent variables (Osborne & Waters, 2002; Yoo et al., 2014). Independence of residuals was demonstrated, as assessed by a Durbin-Watson statistic of 1.945, which is near the value of



TABLE 1
Correlations of Demographic Variables

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13
1. Age	—	-.04	.12	.02	.29**	.64**	.08	-.06	.07	.01	.09	-.10	-.16*
2. Gender identity		—	.00	.09	-.05	-.10	.07	-.07	-.09	.27**	.16	-.01	.02
3. Education			—	.25**	.04	.11	-.17*	-.11	-.09	.10	-.00	-.07	-.10
4. Race/ethnicity				—	.09	.14	-.17*	-.05	-.08	.03	.08	.04	-.13
5. Occupation					—	.42**	.06	-.09	.27**	-.32**	.08	-.11	-.08
6. Years of professional experience						—	-.05	-.11	-.01	-.04	.11	.01	-.10
7. Work setting							—	-.09	.06	.02	.09	-.15	-.02
8. Hours in session								—	.46**	.04	-.03	.07	.00
9. Number of clients									—	-.19*	-.02	-.08	-.07
10. Ages of clients										—	.02	.14	.08
11. Specialization											—	.07	.09
12. COVID-19-related client concern												—	.40**
13. COVID-19 counselor concerns													—

Note. *N* = 160.
p* < .05. *p* < .01.

2, indicating independence of errors (Laerd Statistics, n.d.-b). Homoscedasticity was also evidenced, as assessed by visual inspection of a plot of studentized residuals versus unstandardized predicted values (Laerd Statistics, n.d.-b). Tolerance and variance inflation factor values were inspected to test the assumption of collinearity, and results indicated multicollinearity was not a concern. We located the studentized deleted residual values and identified a value of 3.46, which was filtered out in the proceeding steps. Leverage values were less than 0.2 and were all determined to be safe. No highly influential points were found when we examined Cook’s distance values (which were all less than 1). The distribution was approximately normally distributed as determined by a histogram and a P-P (probability-probability) plot.

Results from each regression, including regression coefficients and standard errors, are presented in Table 3. Hypothesis 1 was supported: Posttraumatic stress, coping responses, resilience, and perceived stress significantly predicted professional quality of life, $F(4, 156) = 13.60, p < .001$. Perceived stress ($p = .009$) and posttraumatic stress ($p < .001$) were statistically significant to the prediction. Posttraumatic

stress received the strongest weight in the model ($\beta = .33$), followed by perceived stress ($\beta = .27$). The unstandardized regression coefficients suggest that for each 1-point increase in posttraumatic stress scores, there was a .21-point increase in ProQOL total scores. Similarly, for each 1-point increase in perceived stress scores, there was a .19-point increase in ProQOL total scores. ProQOL total scores for participants in this study ranged from 46 to 84, with a mean of 61.76 and a standard deviation of 7.94; scores on the ProQOL CS subscale ranged from 10 to 40, with a mean of 30.17 and a standard deviation of 5.78; scores on the ProQOL BO subscale ranged from 11 to 37, with a mean of 21.13 and a standard deviation of 5.36; and, finally, scores on the ProQOL STS subscale ranged from 1 to 30, with a mean of 10.46 and a standard deviation of 5.55.

To test Hypothesis 2, we used a standard multiple regression analysis. The following assumptions were tested and were met prior to statistical analysis: (a) two or more continuous or categorical independent variables, (b) a continuous dependent variable, (c) independence of residuals, (d) linearity, (e) homoscedasticity, (f) absence of multicollinearity, and (g) no significant outliers (Osborne & Waters, 2002; Yoo et al., 2014). We located a studentized deleted residual value over ± 3 , which was filtered out, and the regression analysis was run again. No violations were found. The multiple regression results partially supported Hypothesis 2, as posttraumatic stress, coping responses, resilience, and perceived stress significantly predicted compassion satisfaction, $F(4, 154) = 35.56, p < .001$. Resilience ($p < .001$) and perceived stress ($p = .056$) added statistical significance to the prediction, with resilience receiving the strongest weight ($\beta = .60$), followed by perceived stress ($\beta = -.17$). Most significantly, for each 1-point increase in resilience, there was 1.12 increase in compassion satisfaction.

A standard multiple regression analysis was conducted to test Hypothesis 3. The following assumptions were tested and

TABLE 2
Correlations of Variables of Interest

Scale	1	2	3	4	5
1. ProQOL	—	.45***	.05	-.21**	.48***
2. PSS		—	.05	-.54***	.66***
3. CSI-SF			—	.25**	.05
4. RS				—	-.43***
5. PCL-5					—

Note. *N* = 160. ProQOL = Professional Quality of Life Scale; PSS = Perceived Stress Scale; CSI-SF = Coping Strategies Inventory– Short Form; RS = Resilience Scale; PCL-5 = Posttraumatic Stress Disorder Checklist for DSM-5.
p* < .01. *p* < .001.

TABLE 3
Multiple Linear Regression Analyses Predicting Professional Quality of Life

Model and Steps	<i>B</i>	<i>SE</i>	β	<i>p</i>
Model 1 (<i>N</i> = 160)				
Constant	-0.86	.45		.055
Perceived Stress Scale	0.19**	.07	.27	.009
Coping Strategies Inventory–Short Form	-0.00	.13	.00	.975
Resilience Scale	0.07	.08	.08	.387
Posttraumatic Stress Disorder Checklist for <i>DSM-5</i>	0.21***	.06	.33	.000
Model 2 (<i>N</i> = 159)				
Constant	-5.55	.78		.906
Perceived Stress Scale	-0.26	.13	-.17	.056
Coping Strategies Inventory–Short Form	0.28	.24	.08	.215
Resilience Scale	1.12***	.14	.60	.000
Posttraumatic Stress Disorder Checklist for <i>DSM-5</i>	0.09	.11	.07	.400
Model 3 (<i>N</i> = 155)				
Constant	3.26***	.68		.000
Perceived Stress Scale	0.68***	.11	.46	.000
Coping Strategies Inventory–Short Form	-0.45	.21	-.12	.362
Resilience Scale	-0.73***	.12	-.40	.000
Posttraumatic Stress Disorder Checklist for <i>DSM-5</i>	-0.04	.09	-.03	.755
Model 4 (<i>N</i> = 158)				
Constant	-0.09	.84		.860
Perceived Stress Scale	0.19	.14	.13	.098
Coping Strategies Inventory–Short Form	-0.09	.25	-.03	.685
Resilience Scale	-0.13	.15	-.07	.422
Posttraumatic Stress Disorder Checklist for <i>DSM-5</i>	0.61***	.11	.47	.000

** $p < .01$. *** $p < .001$.

were met prior to statistical analysis: (a) two or more continuous or categorical independent variables, (b) a continuous dependent variable, (c) independence of residuals, (d) linearity, (e) homoscedasticity, (f) absence of multicollinearity, and (g) no significant outliers (Osborne & Waters, 2002; Yoo et al., 2014). We located four studentized deleted residual values over ± 3 , which were filtered out, and the regression analysis was run again. Perceived stress ($p < .001$) and resilience ($p < .001$) were significant predictors of burnout, $F(4, 150) = 51.77, p < .001$. Perceived stress received the strongest weight in the model ($\beta = .46$), followed by resilience ($\beta = -.40$). From this model, we used unstandardized regression coefficients and determined that for each 1-point increase in perceived stress, there was a .68-point increase in burnout. Conversely, for each 1-point increase in resilience, there was a .73-point decrease in burnout.

A standard multiple regression analysis was conducted to test Hypothesis 4. The following assumptions were tested and were met prior to statistical analysis: (a) two or more continuous or categorical independent variables, (b) a continuous dependent variable, (c) independence of residuals, (d) linearity, (e) homoscedasticity, (f) absence of multicollinearity, and (g) no significant outliers (Osborne & Waters, 2002; Yoo et al., 2014). All assumptions were met, with the exception of one studentized deleted residual value over ± 3 , which was filtered out, and the regression analysis was run again. Posttraumatic stress, coping responses, perceived stress, and resilience were all significant predictors of secondary traumatic stress,

$F(4, 154) = 21.87, p < .001$. Only posttraumatic stress ($p < .001$) added statistical significance to the prediction ($\beta = .47$). For each 1-point increase in posttraumatic stress, there was a .61 increase in secondary traumatic stress.

Discussion

The present study identified a strong association between posttraumatic stress and perceived stress on the overall professional quality of life among counselors. The finding from our first multiple regression analysis (Hypothesis 1) indicates that levels of perceived stress and posttraumatic stress are strong predictors of professional quality of life among counselors providing services during the pandemic. Our finding supplements the existing body of research on disaster and crisis counseling (Bellamy et al., 2019; Lambert & Lawson, 2013; Pow & Cashwell, 2017) while contributing novel findings specific to counselors working during the COVID-19 pandemic. Professional counselors who are providing counseling services during the global COVID-19 pandemic may be facing higher levels of stress and posttraumatic symptoms in ways that affect their professional quality of life.

The results from our second multiple regression analysis (Hypothesis 2) indicate that resilience is a strong predictor of compassion satisfaction. Professional counselors in this study who reported higher levels of resilience were more likely to experience compassion satisfaction than those with lower levels of resilience. This finding supports assertions posited



by Sadler-Gerhart and Stevenson (2012), who reported that professional counselors who cultivated resilience may be more likely to experience compassion satisfaction. Indeed, counselors who build resilience were able to successfully mitigate work stress and increase their sense of purpose (Lambert & Lawson, 2013; Sadler-Gerhart & Stevenson, 2012). One possible explanation for this finding may be that professional counselors providing services during the COVID-19 pandemic may be exhibiting resilience by conceptualizing their work as an opportunity to empower clients who are in need of support, thus fostering a greater sense of purpose. Our assertion is supported by earlier studies that postulated counselors who reframed clinical difficulties as a natural part of the therapeutic process also demonstrated higher levels of resilience (Macdonald & Mellor-Clark, 2015; Nissen-Lie et al., 2017).

The results from our third multiple regression analysis (Hypothesis 3) indicate that perceived stress and resilience are both strong predictors of burnout. Thus, professional counselors in this study who reported higher levels of stress were more likely to experience burnout, whereas those with higher levels of resilience were less likely to experience burnout. One possible explanation for this finding may be that professional counselors in this study cultivated robust self-care, coping strategies, and resilience through their graduate training and/or work experiences and were able to successfully implement those skills in ways that served as protective factors to burnout. Another explanation may be that professional counselors in this study represent a unique subset of individuals who already embodied other resilient characteristics not explicitly measured in this study (e.g., temperament, locus of control, attitude, ability to manage stress), which resulted in higher levels of resilience. Our findings supplement earlier studies that have established the relationship between counselor stress and burnout (Choi et al., 2014; Henderson, 2013; Mullen et al., 2017; Stamm, 2010; Stebnicki, 2008), as well as literature that has outlined how resilience may have a buffering effect on burnout among counselors (Lee et al., 2019; Skovholt et al., 2001; Zeeck et al., 2012).

The results from our fourth multiple regression analysis (Hypothesis 4) indicate that posttraumatic stress is a strong predictor of secondary traumatic stress. Based on this finding, it is possible that professional counselors in this study who were unable to mitigate the effects of posttraumatic stress through self-care, resilience, and/or coping strategies were more likely to experience posttraumatic stress symptoms. Our finding is consistent with extant research that indicated work-related stressors were significant predictors of burnout (Henderson, 2013; Maslach et al., 2001; Moore et al., 2020; Mullen et al., 2017; Rossi et al., 2012) and counselor impairment (Barlow & Phelan, 2007; Maslach, 2003; Stamm, 2010; Stebnicki, 2008) while contributing novel findings about how perceived stress during a pandemic affects professional counselors.

Implications for Counselors

The findings from our study supplement the extant body of research that establishes the importance of cultivating resilience and fostering coping strategies to decrease burnout, increase professional work experiences (Lawson & Myers, 2011), and mitigate the effects of compassion fatigue (Sadler-Gerhart & Stevenson, 2012) and vicarious trauma (Trippany et al., 2004) among professional counselors. Our findings are somewhat representative of the national U.S. professional counselor population. In 2017, approximately 73.3% of counselors in the United States were women (Data USA, n.d.), a percentage that was fairly similar to our sample of 83.9%. Whereas the median age of U.S. counselors in 2017 was 41.7, ours was 39. The majority of our participants identified their racial and/or ethnic identities as White, followed by Black or African American, which is similar to the national demographics of U.S. professional counselors in 2017 (Data USA, n.d.).

On the basis of our findings, professional counselors are encouraged to cultivate resilience and coping strategies in ways that increase compassion satisfaction and decrease the likelihood of burnout during the COVID-19 pandemic and beyond. Indeed, counselors working in disaster mental health have been called to incorporate emotion regulation and mindfulness practices (Pow & Cashwell, 2017), in addition to holistic self-care practices that attend to the mind-body-spirit triad (Lambert & Lawson, 2013). Specifically, counselors may benefit from participating in spiritual and/or religious activities consistent with their goals and values as a means of self-care (Coaston, 2017).

Professional counselors must give themselves the same empathy and care that they extend to their clients to role model boundaries, wellness, and self-care and to minimize burnout. Wellness strategies to minimize burnout include mindfulness practices such as expressing emotions, non-judgmental awareness, healthy physiological practices (e.g., maintaining healthy eating, sleeping, and exercising routines), and journaling. Additionally, self-reflection has been established as an important strategy to cultivate self-awareness and prevent compassion fatigue and burnout in counselors (Merriman, 2015; Young, 2013). During times of national crises, professional counselors are encouraged to attend to their interpersonal relationships, including those with partners, friends, and family. Counselors are further encouraged to promote self-awareness by seeking their own personal counseling, consultation, and supervision and/or to seek support from colleagues, supervisors, and peers to validate their experiences and process the challenges of providing services during a pandemic. When clinically challenging situations arise, taking time to acknowledge client difficulties as a natural part of the therapeutic process may be an effective strategy to mitigate stress (Macdonald & Mellor-Clark, 2015; Nissen-Lie et al., 2017).

The importance of seeking additional resources cannot be understated. For example, to minimize stress, counselors working in crisis environments are encouraged to receive training in psychological first aid and intervention skills for psychological recovery, healing after trauma, and families who experience loss (Bellamy et al., 2019). Professional counselors may also benefit from reviewing relevant publications outlining culturally sensitive strategies for counseling marginalized populations that are affected by the COVID-19 pandemic (see Chan & Litam, 2021; Litam, 2020; Litam & Hipolito-Delgado, 2021; Litam & Oh, 2020; Litam et al., 2021). Ultimately, professional counselors must remember that “self-care is not selfishness” (Ruddick, 2012, p. 564). Professional counselors must be reminded that regardless of the environmental circumstances that may directly or indirectly affect their work, it is fundamental to engage in regular self-care practices and pursue personally fulfilling activities that promote posttraumatic growth, resilience, and wellness and prevent burnout. Indeed, building resilience is an important way to mitigate challenging work experiences and increase one’s sense of purpose during times of crisis and disaster (Lambert & Lawson, 2013; Sadler-Gerhardt & Stevenson, 2012).

To prevent burnout, professional counselors must identify and honor personal and professional boundaries (Coaston, 2017). For example, continuous exposure to COVID-19-related media may further exacerbate related stress and contribute to secondary trauma (Torales et al., 2020). Therefore, professional counselors are encouraged to avoid exposure to COVID-19-related news outside of working hours to allow for time to decompress and maintain work-life balance. Counselors may also consider the value of a “media diet” and selectively choose trusted, neutral media sources and allot a specific duration of time in which they expose themselves to COVID-19-related news. According to Sadler-Gerhardt and Stevenson (2012) and Stebnicki (2017), professional counselors can cultivate resilience by making choices that attend to their self-care and wellness and by engaging in positive thinking. For example, counselors can participate in community-enriching practices such as sharing client success with colleagues in person and/or through online and virtual HIPAA (Health Insurance Portability and Accountability Act)-compliant platforms. Counselors can also practice positive thinking by recognizing that despite existing challenges, they are participating in meaningful work. Finally, professional counselors may build resilience by acknowledging that they cannot control their clients’ decisions. For instance, counselors may practice relinquishing control over clients’ decisions and recognize how risk-taking behaviors can result in consequences that become teachable moments in counseling.

Limitations and Future Directions

The findings from this study must be interpreted in light of the limitations. One limitation concerns the use of participant recruitment through electronic mailing lists. Although we

sought to obtain a national sample, readers must interpret the findings with caution because participants may not be representative of the counselor population in the United States. Future areas of study may consider using a stratified sampling process. Professional counselors who were not members of the organizations we chose did not participate in the study. Specifically, counselors in rural settings or those who are not involved with professional counseling organizations were not well represented in this study. Another limitation is related to the use of an adapted instrument with COVID-19-specific prompts. At the time of the study, a measure of COVID-19 impact had not yet been psychometrically validated. Future researchers might consider the development of measures that assess COVID-19 impact through confirmatory and exploratory factor analyses. Although statistical significance was identified in several hypotheses, readers must be cautioned when interpreting these findings, because they could be explained by the effect of common method variance. Only robust findings from our study were presented to avoid restating findings with small effects. Future areas of study should explore whether additional variables such as workplace setting, client demographic, presenting concern, and hours worked per week contribute to burnout, compassion fatigue, and secondary traumatic stress. Future studies may also investigate whether specific self-care practices, coping responses, or mindfulness practices individually mitigate the effects of perceived stress in a postpandemic reality and whether differences exist across diverse demographics (e.g., age, race/ethnicity, gender). Last, future studies should explore the relationship between telehealth service delivery and in-person delivery.

Conclusion

This study’s findings emphasize the importance for professional counselors to cultivate resilience and self-care practices during the pandemic, and perhaps during crisis and disaster mental health counseling more generally. The results of this study contribute to the emerging body of research on the protective effects of resilience and coping among disaster mental health and crisis counselors. Clinical implications for practice, self-care, and cultivating resilience were additionally provided.

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