Journal of Counselor Preparation and Supervision

Volume 18 | Number 3 Article 2

2024

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Recommended Citation

Han, E., & Carrola, P. (2024). Adverse Childhood Experiences, Work-related Stress, and Trauma-informed Care among Novice Counselors. *Journal of Counselor Preparation and Supervision, 18*(3). 10.70013/508qkr18

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Keywords

counselors-in-training, trauma-informed care, adverse childhood experiences, secondary traumatic stress, indirect traumatization

Author's Notes

The authors have no relevant financial or non-financial interests to disclose. The study was approved by the University Institutional Review Board. All participants voluntarily participated in the survey and provided their informed consent. The authors appreciate the support from the Counseling Association (for blinded review purposes, removed the information): The current research project was awarded a research grant award.

JOURNAL OF COUNSELOR PREPARATION AND SUPERVISION
The official journal of the North Atlantic Region Association for Counselor Education and Supervision

Received: 08/10/23
Revised: 01/09/24
Accepted: 02/16/24

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Significance to the Public

The study demonstrated the impact of Adverse Childhood Experiences (ACEs) on work-related stress of novice counselors, particularly their risk of experiencing secondary traumatic stress. Counselors with higher ACEs might be more susceptible to secondary trauma, highlighting the need for targeted support for those with higher ACEs. The findings also showed that a higher level of familiarity with Trauma-informed Care (TIC) can reduce the risk of secondary traumatic stress among novice counselors. This insight is crucial for mental health organizations and educational institutions, underscoring the importance of incorporating TIC principles into counselor training programs. Ultimately, this approach can lead to better care for clients and improved mental health outcomes in the broader community.

Keywords: counselors-in-training, trauma-informed care, adverse childhood experiences, secondary traumatic stress, indirect traumatization

According to the American Counseling Association (ACA) Code of Ethics (2014), counselors have a responsibility to monitor themselves for signs of impairment from their own physical, mental, and emotional problems. In addition, the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2024) standards for counselor training delineate that practicing self-care strategies is under professional counseling orientation and ethical practice (section 3, A, 11).

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However, maintaining counselor wellness is challenging due to the emotional demands of counseling, given emotional contagion from clients can lead to negative effects on helping professionals' wellness (Howard et al., 2015). Figley (1995) termed this a 'cost to caring' and Pearlman and Mac Ian (1995) described vicarious traumatization from empathic engagement with clients' previous tragedy.

Researchers increasingly recognize that working with challenging clients, such as people with a trauma history, can result in burnout as well as indirect traumatization including vicarious trauma and secondary traumatic stress, in helping professionals (Howard et al., 2015; Knight, 2010). In this regard, the counseling profession has given increased attention to infusing a trauma-informed approach within the profession (Jones & Branco, 2020; Jordan, 2018; Moh et al., 2023; Shatto et al., 2023). *Trauma-informed Care* (TIC) is a term to indicate a philosophy that healthcare organizations and care teams should integrate an understanding of the pervasive impact of Adverse Childhood Experiences (ACEs) and trauma (Harris & Fallot, 2001a; SAMHSA, 2014). Trauma itself is an emerging topic in the counseling profession (Jones & Branco, 2020; Jordan, 2018;) and the recent establishment of the related division in the ACA (International Association for Resilience and Trauma Counseling) well-represents this increased interest and the rationale for more attention.

Despite the emerging interest in the prevalent traumatic experiences among the public (Gilbert et al., 2015; Harris, 2018) and the need for counselor training for trauma-informed counseling (SAMHSA, 2014), there is a chasm that the counseling profession needs to recognize: counselors' own trauma history. Previous literature suggested a potential association between past trauma victimization and the choice of a helping profession as a career (Pope & Feldman-Summers, 1992; Rompf & Royse, 1994). There is a growing body of research examining the prevalence of ACEs among helping professionals, including mental health counselors (Brown et al., 2022), child service providers (Esaki & Larkin, 2013), and direct support professionals (Keesler, 2018). However, the results have been mixed and outdated. Specifically, some studies found a link between personal history of trauma and secondary traumatic stress or burnout (Brown et al., 2022; Nelson-Gardell & Harris, 2003), while others showed contradictory results (Howard et al., 2015; Schauben & Frazier, 1995). A recent systematic review study (Leung et al., 2023) concluded that a personal history of trauma among helping professionals would predict indirect traumatization including secondary traumatic stress and vicarious traumatization.

Moreover, little research has explored how familiar novice counselors, including counselors-in-training and newly licensed counselors, are with this approach and its potential impact on work-related stress. Addressing these gaps is crucial in terms of counselor training to understand the relationship between ACEs and work-related stress among novice counselors and assess the level of familiarity with Trauma-informed Care. This knowledge will inform counselor preparation programs and guide efforts to promote wellness and prevent vicarious traumatization in the counseling profession's future generation.

ACEs and Helping Professionals

Felitti et al. (1998) undertook the Adverse Childhood Experiences (ACEs) study two decades ago to explore the long-term relationship of early life experiences to important public health and medical problems. ACEs include psychological, physical and sexual abuse, physical and emotional neglect, poverty, parental psychopathology, and conflict between parents, which occur before the age of 18 (Chartier et al., 2010; Felitti et al., 1998). Since the pioneer study of ACEs (Felitti et al., 1998), researchers have steadily investigated the effect of ACEs on public health. Consequently, researchers found that ACEs are common in the general population (Gilbert et al., 2015), and early-life experiences of trauma are associated with neurobiological consequences (Teicher et al., 2003),

depressive disorder (Wingo et al., 2010), posttraumatic stress disorder (Copeland et al., 2007), wide impairments in behavior, emotion, interpersonal relationships, academic failure, and suicide (Giaconia et al., 1995), and even early death (Felitti et al., 1998; Brown et al., 2009). Moreover, there was a dose-response relationship between the ACEs and poor health, meaning that a higher ACEs score is likely to cause an increased risk to one's health (Felitti et al., 1998; Harris, 2018).

Recently, researchers have recognized a higher prevalence of Adverse Childhood Experiences in helping professionals such as child service providers (Esaki & Larkin, 2013) and direct support professionals (Keesler, 2018) and mental health counselors (Brown et al., 2022). Black et al. (1993) found that social work students demonstrated a high prevalence of family trauma in early life, which was significantly greater than that of non-helping professionals (i.e., business major students). Esaki and Larkin (2013) found that Adverse Childhood Experiences were more prevalent among their sample of child service providers than in the general population. Also, Keesler's (2018) research found that ACE scores were higher than average among direct support professionals who had ACE scores of four; the specific rate of ACEs was twice as prevalent as the number of ACEs that were found in the general population. As we know, however, there is only one empirical study (Brown et al., 2022) regarding the prevalence of ACEs among counseling professionals.

Before the ACEs study, there have been empirical studies indicating the high prevalence of trauma among counseling professionals. For instance, Pope and Feldman-Summers (1992) found that about 70% of the women and 33% of the male clinical and counseling psychologists reported previous experiences of physical or sexual abuse. Schauben and Frazier (1995) recruited counselors working with survivors of sexual violence for their study and they found that 70% of psychologists and 83% of counselors reported their own (i.e., not clients' but counselors') previous experience of sexual violence. However, it should be noted that the research studies on counseling professionals' own trauma are outdated. More investigation of the ACEs score will help the counseling profession better understand its members' wellness and service with empirical evidence.

Work-related Stress among Helping Professionals

There are various terms that describe the psychological phenomenon of experiencing negative consequences as a result of helping others. Secondary Traumatic Stress, Vicarious Trauma, Compassion Fatigue, and Burnout are all terms that have been used to describe the negative symptoms associated with the occupational work of helping other people. Rauvola et al. (2019) defined this experience of adverse psychological and/or physical reactions resulting from empathic engagement following trauma exposure as 'empathy-based stress' and summarized the definitions and symptoms of vicarious traumatization, secondary traumatic stress, and compassion fatigue. Some scholars have argued that there are commonalities shared between those concepts, while others emphasize the difference between secondary traumatic stress (Pearlman & Mac Ian, 1995), vicarious trauma (Baird & Kracen, 2006), and compassion fatigue (Figley, 2002).

To date, research findings on the link between helping professionals' personal trauma history and secondary traumatization have been mixed. Even before the ACEs measurement was established, scholars explored the connection between counselors' early trauma experiences and secondary traumatic stress. Some studies indicate that helping professionals with early life trauma are at significant risk of secondary traumatic stress (Ghahramanlou & Brodbeck, 2000; Nelson-Gardell & Harris, 2003). The prevailing view among researchers has been that a counselor's past trauma is a key predictor of secondary traumatic stress (Ghahramanlou & Brodbeck, 2000; Pearlman & Mac Ian, 1995). However, other studies have shown no significant difference in secondary trauma symptoms among counselors with a history of

victimization compared to those without such a history (e.g., Schauben & Frazier, 1995). Moreover, previous trauma history is often assessed using simple yes-or-no questions about experiencing traumatic events (e.g., Ghahramanlou & Brodbeck, 2000; Pearlman & Mac Ian, 1995) or limited to asking the history of sexual violence (e.g., Schauben & Frazier, 1995). Thus, previous researchers have suggested using a comprehensive measure to better understand the relationship between counselors' trauma history and secondary traumatic stress.

Alongside the literature on the helping profession focusing on secondary traumatic stress, vicarious trauma, and compassion fatigue, researchers also have examined the issue of burnout (O'Halloran & Linton, 2000). There are multiple definitions of burnout (Stalker & Harvey, 2003), but one of the consistent aspects of burnout is its association with job-related stress (Maslach, 2017). Burnout includes negative changes in individuals' attitudes, decision-making, psychological states, mental and behavioral health, and occupational motivation (Freudenberger, 1990). Burnout can cause symptoms of fatigue, exhaustion, and insomnia (Armon et al., 2008). Lee et al. (2007) developed the Counselor Burnout Inventory, which is regarded as an overall robust instrument for measuring counselor burnout (Bardhoshi et al., 2019), and is specifically effective in measuring burnout for correctional counselors (Carrola et al., 2016), sexual offender and sexual abuse therapists (Lee et al., 2010), school counselors (Gnilka et al., 2015) and Korean counselors (Carrola et al., 2012).

The main difference between burnout and secondary traumatic trauma lies in the cause: secondary traumatic stress is the direct consequence of listening to traumatic events from clients, while burnout results from working with any clients (Canfield, 2005). In addition, previous researchers confirmed that secondary traumatic stress is a different construct than burnout (Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995), thus researchers who investigate burnout and secondary traumatic stress need to consider the similarities and differences among them. The literature on burnout has emphasized external factors causing burnout such as large caseload and isolation in a working environment (Canfield, 2005). Choi (2011) found helping professionals who received more support from their coworkers, supervisors, and work teams demonstrated lower levels of burnout as well as secondary traumatic stress.

Trauma-informed Care

Substance Abuse and Mental Health Service Administration (SAMHSA) has been leading the need to address trauma for public mental health since the 1990s (SAMHSA, 2014) and Trauma-informed Care (TIC) is a coined term by Harris and Fallot (2001b) to describe service providing that integrates an understanding of the pervasive impact of ACEs and trauma. Trauma-informed Care has the potential to help survivors affected by ACEs and other traumatic circumstances feel safe, recover from trauma, and regain their developmental stages (SAMHSA, 2014). Harris and Fallot (2001a) suggested that trauma theory has the power to explain stress, psychopathology, and coping to establish safety, trustworthiness, choice, collaboration, and empowerment. In the emerging era of Trauma-informed Care, exposure to this philosophy and intentionality to use this approach does matter. Previous researchers have emphasized more need for training in trauma for counselors and supervisors (Pearlman & Mac Ian, 1995). Moreover, future research examining the amount, content, and depth of trauma training has been warranted (Bride et al., 2009).

As there has been growing awareness of the impact of trauma on human development, the need to understand trauma and enhance a trauma-informed approach at the system level has increased. The SAMHSA (2014) published a document to guide a trauma-informed approach. The SAMHSA details 4Rs for a trauma-informed approach. These key assumptions are represented as 4Rs: *Realize, Recognize, Respond, and Resist*. First, people in a program, organization, or system that is trauma-informed will *realize* the broad impact of

trauma and understand potential ways to cultivate resilience. Second, trauma-informed systems will *recognize* the signs and symptoms of trauma in people involved with the system, and third, *respond* by fully integrating the knowledge about trauma into policies, practices, and procedures. Lastly, as a result of these processes, a trauma-informed system will *resist re-traumatization*. According to SAMHSA (2014), understanding trauma and trauma-specific interventions is not enough to optimize outcomes for trauma survivors. Therefore, Trauma-informed Care is essential to be implemented in a context such as an organization or system.

Six key principles of the trauma-informed approach (SAMHSA, 2014) were suggested to be applied to various settings: (1) Safety, (2) Trustworthiness and Transparency, (3) Peer Support, (4) Collaboration and Mutuality, (5) Empowerment, Voice, and Choice, and (6) Cultural, Historical, and Gender Issues. These six principles aim to facilitate resilience and recovery. Applying these principles and developing a trauma-informed approach requires multiple levels of change in organizations and systems. To provide a clear operational definition of Trauma-informed Care (TIC) and measurement to evaluate the TIC within the organization, Baker et al. (2016) developed the Attitudes Related to Trauma-informed Care (ARTIC) Scale and found the correlations between the level of familiarity with TIC and staff/system level indicators of TIC implementation.

Purpose of the Current Study

Given the high prevalence of Adverse Childhood Experiences (ACEs) among the public as well as even the higher index among helping professionals (Chartier et al., 2010; Esaki & Larkin, 2013; Keesler, 2018), it is important to understand the relationship between ACEs and work-related stress among novice counselors. Moreover, given the increased emphasis on Trauma-informed Care in the counseling profession, it is also critical to examine the level of familiarity with Trauma-informed Care among the new generation of counselors. This knowledge would provide the first step for the counselor education program to understand how to address Adverse Childhood Experiences and facilitate trauma-informed care. However, there is a dearth of empirical evidence regarding the prevalence of ACEs among novice counselors, their familiarity with trauma-informed approaches, and the relationship of ACEs with burnout/secondary traumatic stress.

Based on the gaps in the existing literature, the purpose of this research consisted of three parts: (a) to examine the prevalence of Adverse Childhood Experiences (ACEs) among novice counselors, (b) to investigate if Adverse Childhood Experiences (ACEs) score predicts work-related stress including compassion satisfaction, burnout, and secondary traumatic stress among novice counselors, and (c) to explore if the level of familiarity with Trauma-informed Care predicts work-related stress among novice counselors.

Method

After the approval by the University Institutional Review Board, participants were recruited through the *Counselor Education and Supervision Network* listserv (CESNET-L) and the contact to counseling program directors. The counseling program directors' contact list was collected based on the CACREP-accredited programs and the CESNET-L included both accredited and non-accredited programs. In the mass email, participants were able to check the inclusion criteria, respond to the informed consent, and have access to the electronic survey. Participants also could invite other counseling professionals to participate in the survey. The mass email was distributed to counselor educators via *Facebook*, *Survey Circle*, and counselor educators who were willing to distribute the mass email to their students. Two inclusion criteria required participants to (a) be 18 years or older, and (b) be a graduate student in a counseling profession or currently certified/licensed counselor. After completing the survey, they were given access

to another separate link to provide personal contact information for a chance to receive an incentive by lottery ($20 each).

Participants

A priori power analysis using *G*Power (version 3.1.9.2)* demonstrated a minimum sample of 67 respondents was necessary for multiple regression analysis (alpha level = .05, predictor = 1, power = .95, effect size f^2= .20). 137 participants initially responded to the survey. After a careful review of the responses, the authors removed 14 participants for missing data and straight-lining answers with short response times—indicating participants were not paying attention—that does not meet the criterion (Zhang & Conrad, 2014). The criterion as acceptable data was based on a progress rate that indicates that each participant should respond to more than 80% of items across all measures. The amount of removed data is considered a typical amount for psychological research (Schlomer et al., 2010). In addition, 17 counselors who answered that they practiced as licensed/certified counselors for more than five years were removed from the analysis.

The mean age of participants was 26.4 years old (*SD* = 6.4) ranging from 20-year-old and 57-year-old. Most participants identify themselves as cisgender women (*n* = 90, 84.9%), followed by cisgender men (*n* = 6, 5.7%), others (*n* = 6, 5.7%), transgender women (*n* = 2, 1.9%), a transgender man (*n* = 1, 0.9%), and prefer not to say (*n* = 1, 0.9%). White (*n* = 79, 74.5%) were the majority of participants, followed by Black or African American (*n* = 8, 7.5%), Hispanic or Mexican American (*n* = 5, 4.7%), Asian or Pacific American (*n* = 5, 4.7%), Multiracial (*n* = 4, 3.8%), Do not want to respond (*n* = 3, 2.8%), American Indian or Alaska Native (*n* = 1, 0.9%), and Race not listed (*n* = 1, 0.9%).

Regarding the highest education they completed, most participants responded that they have 4 years degree (*n* = 65, 61.3%), followed by a master's degree (*n* = 39, 36.8%), and a Doctoral degree (*n* = 2, 1.9%). In other words, about 62% of participants may be in a counselor preparation program for the master's degree. The following question asked if participants were certified counselors or not, and if they are licensed, how many years they have been with that license/certification. The majority of participants said that they are not yet certified or licensed as a professional counselor (*n* = 93, 87.7%) and the rest of the participants in this analysis were either certified/licensed less than one year (*n* = 7, 6.6%), or one year to less than three years (*n* = 6, 5.7%).

Instruments

The survey collected demographic questions including age, gender, race/ethnicity, current location, highest education, and length of time as a certified/licensed counselor, followed by three measurements.

Revised Adverse Childhood Experiences (Revised ACEs)

The Revised ACEs scale (Finkelhor et al., 2015) consists of 14 items to measure Adverse Childhood Experiences which includes 10 original ACEs questions and four additional items to capture other dimensions of childhood adversity. Original items include physical and emotional abuse, sexual assault, emotional and physical neglect, mother treated violently, household substance abuse, household mental illness, parental separation or divorce, and incarcerated household members. Additional victimizations for a revised version contain low socioeconomic status, peer victimization, peer isolation and rejection, and exposure to community violence. For example, parental separation or divorce prompts a yes or no answer to the following question: *Was a biological parent ever lost to you through divorce, abandonment, or other reasons?* Item is a dummy variable with a score of 0 if the youth never experienced it and a code of 1 if the child experienced it. Cronbach alpha of the revised ACEs scale was .86 in the current sample.

Familiarity with Trauma-informed Care

The Familiarity with Trauma-informed Care consists of four items to measure participants' familiarity with Trauma-informed Care (Baker et al., 2016). Participants responded to this question with a 5 Likert scale from 0 (e.g., Never) to 5 (e.g., Always). These items were preliminary items to develop the Attitudes Related to Trauma-informed Care (ARTIC) scale. An example item was as follows: *How familiar are you with Trauma-informed Care?* In the current sample, Cronbach's alpha for the four items was = .82.

The Professional Quality of Life Scale (ProQOL)

The ProQOL contains 30 items to measure the positive and negative manifestations as a consequence of working as a helper (Stamm, 2010). The ProQOL was used to assess work-related stress in the current study. The positive aspect is named compassion satisfaction while the negative aspect is labeled compassion fatigue which consists of two parts: (a) burnout and (b) secondary traumatic stress. Secondary traumatic stress is a negative feeling driven by fear and work-related trauma while burnout is related to exhaustion, frustration, anger, and depression. Each sample item for three sub-domains are as follows: (1) compassion satisfaction: *I get satisfaction from being able to help people*, (2) burnout*: I feel trapped by my job as a helper*, and (3) secondary traumatic stress*: I feel as though I am experiencing the trauma of someone I have helped*. The ProQOL is based on a 5 Likert scale from 1 (Never) to 5 (Very often) and there are five reverse items: numbers 1, 4, 15, 17, and 29. In the current sample, Cronbach's alphas based on each sub-domain were as follows: Compassion Satisfaction = .84, Burnout = .72, and Secondary traumatic stress = .76.

Statistical Analysis

Data were analyzed by using *SPSS 27* and the *lavaan, readxl, car,* and *gvlma* packages in the RStudio program (2020). *Chi-square* and *t*-tests demonstrate that there is no significant relationship between missing data and participants' demographic information and the scores obtained from the measurements. The correlation coefficients were examined to determine covariates and associations among variables. Then, preliminary analysis using the *R gvlma* package demonstrated that the necessary assumptions of normality, linearity, and homoscedasticity for linear regression were acceptable. Lastly, we conducted a series of simple linear regressions to test if ACEs or Familiarity with TIC significantly predicted work-related stress.

Results

Descriptive Statistics: Prevalence of ACEs and Familiarity with TIC

The mean ACEs score was 4.1 (*SD* = 3.59) with a range of 0 to 13. In order to compare with the mean of ACEs from other helping professionals, the mean of the original ACEs score was examined as well (*M* = 2.89, *SD* = 2.62) with the range of 0 to 10. Among each category of the fourteen Adverse Childhood Experiences, peer isolation was the most frequent experience (*n* = 57), followed by emotional neglect (*n* = 47), emotional abuse (*n* = 46), and household member mental illness (*n* = 46). The least frequent experience was incarcerated household member (*n* = 6), followed by dangerous neighborhood (*n* = 9), low socioeconomic status (*n* = 13), and mother treated violently (*n* = 13).

To the first question asking how familiar they are with Trauma-informed Care, most participants responded that they are moderately familiar (*n* = 38, 35.8%), followed by "Slightly Familiar" (*n* = 21, 19.8%), "Very Familiar" (*n* = 20, 18.9%), "Not Familiar at all" (*n* = 15, 14.2%) and "Extremely Familiar" (*n* = 12, 11.3%). To the second question examining how much participants' research agenda is related to Trauma-informed Care, the biggest group of participants said that "Sometimes" (*n* = 31, 29.2%) their research was related to Trauma-

informed Care, followed by "Never" (*n* = 30, 28.3%), "About half the time" (*n* = 17, 16.0%), "Most of the time" (*n* = 17, 16.0%), and "Always" (*n* = 7, 6.6%). To the third question about former experiences of official training regarding Trauma-informed Care, the majority of participants said they "Never" had an official training regarding Trauma-informed Care (*n* = 43, 40.6%), followed by "Sometimes (*n* = 23, 21.7%), "Rarely" (*n* = 21, 19.8%), "Often" (*n* = 12, 11.3%), and "Very often" (*n* = 7, 6.6%). To the last question asking about the level of implements of Trauma-informed Care at the current program/institution, the majority of participants said that the institution "moderately well" implements the Trauma-informed Care (*n* = 48, 45.3%), followed by "Slightly well" (*n* = 26, 24.5%), "Very well" (*n* = 15, 14.2%), "Not at all" (*n* = 12, 11.3%), and "Extremely well" (*n* = 4, 3.8%).

The means of the ProQOL subdomains measured by 5 Likert-scale were calculated as follows: (a) Compassion satisfaction (*M* = 4.2, *SD* = 0.4), (b) Burnout (*M* = 2.0, *SD* = 0.4), and (c) Secondary traumatic stress (*M* = 2.1, *SD* = 0.5).

Correlations and Regressions

To determine the covariate which should be controlled in the main analysis, the relationships between demographic variables including age, gender, race, year after getting a certificate/license, and the Professional Quality of Life (ProQOL) scale were examined. Since there was no statistically significant relationship between the demographic variables and the ProQOL ($p \geq .05$), we decided to enter no control variable into the main analysis of regression (i.e., simple linear regression). Prior to the main analysis, the bivariate correlations between ACEs score, Familiarity with Trauma-informed Care, and the sub-domains of the Professional Quality of Life scale were examined to investigate the relationships.

Table 1

Bivariate Correlations Between Main Variables

		ACEs	Familiarity with TIC	ProQOLS _CS	ProQOLS _BO	ProQOLS _STS
ACEs	Pearson Correlation	1				
	Sig. (2-tailed)					
Familiarity with TIC	Pearson Correlation	−.16	1			
	Sig. (2-tailed)	.11				
ProQOLS_CS	Pearson Correlation	.02	−.04	1		
	Sig. (2-tailed)	.86	.65			
ProQOLS _BO	Pearson Correlation	.19	−.23*	−.53**	1	
	Sig. (2-tailed)	.05	.02	.00		
ProQOLS _STS	Pearson Correlation	.33**	−.22*	−.08	.46**	1
	Sig. (2-tailed)	.00	.02	.39	.00	

Note. ACEs indicate the Adverse Childhood Experiences scores measured by the revised ACEs scale. ProQOLS_CS indicates compassion satisfaction, a positive aspect of being a helper, measured by the first sub-domain of the professional quality of life scale. ProQOL_BO indicates burnout, a negative consequence of being a helper, measured by the second domain of the professional quality of life scale. ProQOLS_STS indicates secondary traumatic stress, the other negative consequence of being a helper, measured by the third domain of the professional quality of life scale. **$p < .01$, *$p < .05$

Relationships between ACEs and Work-related Stress

While there was no statistically significant relationship of ACEs scores with burnout and compassion satisfaction ($p \geq .05$), there was a statistically significant relationship between ACEs score and secondary traumatic stress ($r = .33$, $p < .05$; see Table 1). Thus, we decided to proceed with the analysis to test our hypothesis that ACEs would explain a significant amount of variance in secondary traumatic stress.

Simple linear regression was used to test if the ACEs score significantly predicted secondary traumatic stress. The overall regression was statistically significant ($R^2 = .11$, F (1, 104) = 12.77, $p < .01$), indicating that 11% variance in secondary traumatic stress was accounted for by the ACEs score. In other words, the ACEs score significantly predicted secondary traumatic stress. Specifically, we expected that .33 standard deviation increase in secondary traumatic stress per one standard deviation increase in ACEs score ($\beta = .33$, $p < .01$).

Relationships between Familiarity with TIC and Work-related Stress

While there was no statistically significant relationship between familiarity with Trauma-informed Care with compassion satisfaction ($p \geq .05$), there was a statistically significant relationship between familiarity with Trauma-informed Care and Burnout ($r = -.23$, $p < .05$; see Table 1); and familiarity with Trauma-informed Care and secondary traumatic stress ($r = -.22$, $p < .05$; see Table 1). Thus, we decided to proceed with the analysis to test our hypothesis that familiarity with Trauma-informed Care would explain a significant amount of variance in burnout and secondary traumatic stress.

Simple linear regression was used to test if familiarity with Trauma-informed Care significantly predicted secondary traumatic stress. The overall regression was statistically significant ($R^2 = 0.05$, F (1, 104) = 5.31, $p < .05$), indicating that 5% variance in secondary traumatic stress was accounted for by familiarity with Trauma-informed Care. In other words, familiarity with Trauma-informed Care significantly predicted secondary traumatic stress. Specifically, we expected that .22 standard deviation decrease in secondary traumatic stress per one standard deviation increase in familiarity with Trauma-informed Care ($\beta = -.22$, $p < .05$).

Simple linear regression was used to test if familiarity with Trauma-informed Care significantly predicted burnout. The overall regression was statistically significant ($R^2 = 0.05$, F (1, 104) = 5.55, $p < .05$), indicating that 5% variance in burnout was accounted for by the familiarity with Trauma-informed Care. In other words, familiarity with Trauma-informed Care significantly predicted burnout. Specifically, we expected that .23 standard deviation decrease in burnout per one standard deviation increase in familiarity with Trauma-informed Care ($\beta = -.23$, $p < .05$).

Discussion

The current study aimed to examine the Adverse Childhood Experiences (ACEs) among novice counselors, including both counselors-in-training and new clinicians. The study also explored the relationship between these early traumas and secondary traumatic stress/burnout. Given the emerging interest in the Trauma-informed Care, the level of familiarity with Trauma-informed Care was examined, and its link to burnout and secondary traumatic stress was investigated as well. The original ACEs study found high trauma prevalence among clients (Felitti et al., 1998), and our study showed a higher ACEs score among novice counselors. This underscores the importance of recognizing the widespread impact of trauma (SAMHSA, 2014) among helping professionals.

The findings indicated that novice counselors had a notably higher prevalence of Adverse Childhood Experiences compared to other helping professionals or the general public (Esaki & Larkin,

2013; Keesler, 2018). Esaki and Larkin (2013) highlighted that about 70% of Child Service Providers experienced at least one Adverse Childhood Experience, with around 16% experiencing four or more. Keesler (2018) reported that 75% of direct support professionals had at least one ACE, and 30% had four or more. In our study, using a part of the ACEs scale (original scale) for assessing past traumatic experiences in novice counselors, 77.4% reported at least one ACE, and roughly 41% reported four or more. When including additional victimization such as low socioeconomic status and peer isolation (the revised ACEs scale), the prevalence of ACEs increased; over 80% of novice counselors experienced at least one ACE, and 52.8% reported four or more before adulthood.

The study found that the prevalent trauma categories among novice counselors were similar to those of other helping professionals. The four common Adverse Childhood Experiences reported by Child Service Providers and direct support professionals were similar: household mental illness, physical/emotional abuse, substance abuse, and divorce (Esaki & Larkin, 2013; Keesler, 2018). In our sample of counseling professionals, peer isolation, emotional abuse, emotional neglect, and divorce were frequently reported as early traumatic experiences. Notably, peer isolation was a new addition to the revised ACEs scale, and the other frequent categories are similar to those from other helping professionals. Given that peer isolation measured by the revised version of the ACEs scale was the most frequent Adverse Childhood Experience among counseling professionals, one of the six principles of Trauma-informed Care (i.e., peer support) becomes more meaningful. In order to facilitate a safe and collaborative learning environment, corrective emotional experiences among counseling colleagues would be critical.

Given the prevalent Adverse Childhood Experiences (ACEs) among novice counselors, it becomes more significant to gain a deeper understanding of the association between the previous trauma and the current manifestation of trauma reactions among this population based on empirical evidence. Moreover, the current findings revealed that the participants with high ACEs scores may experience more secondary traumatic stress, which was consistent with the previous literature that early life traumatic experiences would be a significant predictor of secondary traumatic stress (Ghahramanlou & Brodbeck, 2000; Nelson-Gardell & Harris, 2003). Secondary traumatic stress measured in the current study was characterized by including but not limited to the inability to sleep, lack of boundaries between professional and personal life, experiencing traumatic symptoms, and avoiding activities (Stamm, 2010). This highlights the importance of addressing the impact of prevalent trauma and the practices of self-care among novice counselors. For instance, we can use Hayden et al. (2015)'s framework to address secondary traumatization using wellness-based clinical supervision or Jordan's (2018) trauma-informed counseling supervision as examples of self-care practices for novice counselors.

In contrast, there was no significant relationship between ACEs score and burnout in the current study, which may support the previous literature that burnout and secondary traumatic stress should be understood as different constructs (Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995). In the current study, burnout was related to feelings of hopelessness and difficulties in effectively dealing with their jobs (Stamm, 2010) and counselors' previous history of trauma did not predict the current burnout. This finding may support the interpretation that burnout is attributed to external factors of the working environment such as caseload or social isolation (Canfield, 2005), not individual factors. Nevertheless, it should be noted that novice counselors (i.e., counselors-in-training and newly graduated counselors) in the current study may experience burnout due to their coursework and other external factors including working and going to school at the same time or transitioning their counselor identity from students to clinicians. Thus, future research should consider these differences in their research studies.

Interestingly, the results between the current study and the most recent study in this area by Brown et al. (2022) hold both similarities and

differences. Brown et al. (2022) conducted a similar design study investigating the relationship between Adverse and Positive Childhood Experiences and compassion satisfaction, burnout, and secondary traumatic stress. The current study only found a significant prediction of secondary traumatic stress while Brown et al. (2022) demonstrated significant relationships between ACEs score and compassion satisfaction/burnout. The big differences between the two study designs are as follows: (a) ACEs scale version, and (b) participants. Given that the current study used the ACEs scale revised version, and the most frequent adverse experience was peer isolation which does not exist in the original ACEs scale, using the revised version of the ACEs scale may explain more variance in indirect traumatization. In terms of the results and specific categories of Adverse Childhood Experiences, the categories with high frequencies were different. While the current participants reported peer isolation, emotional abuse, and household mental illness as the top Adverse Childhood Experiences, Brown et al. (2022) showed that emotional abuse, physical abuse, sexual abuse, and lack of support as the top four Adverse Childhood Experiences. Moreover, we attribute these differences to the new version of the scale as well as the participants' demographic information. The current study included novice counseling professionals who are in graduate schools. As such, the participation in the current study was young (M = 26.4, SD = 6.4) compared to the other study (M = 38, SD = 11.0).

Implications for Counselor Education

The current study indicates the need for counselor preparation programs to integrate Trauma-informed Care into their training curriculum and organizational structure, extending beyond counseling practice. Since SAMHSA (2014) suggested helping professionals adopt Trauma-informed Care and integrate its practice into entire organizations, helping professionals have strived to incorporate Trauma-informed Care into their practice. The current empirical findings regarding the high prevalence of Adverse Childhood Experiences (ACEs) among counseling students and novice counselors are further highlighting the need for Trauma-informed Care (TIC) in counselor preparation programs. Specifically, SAMHSA's six principles serve as useful guidelines for individual counseling courses, programs, and curricula, as well as for fostering organizational change. For instance, safety, the first principle outlined by SAMSHA, holds different meanings for different students. Counselor educators can initiate discussions on safety during the first day of the class, encouraging students to reflect on its meaning and collaboratively establish rules for creating a safe and brave space. Given that counseling classes often promote self-awareness, preparing students to contemplate the concept of safety and discomfort associated with learning beforehand can facilitate navigating challenging discussions later. Another strategy involves educating students early on about ACEs and their effect on health. Equipping students with the ability to identify their triggers and develop coping skills for them is crucial for their development as both counseling students and future counselors.

The current findings indicate that almost forty percent of participants reported never receiving official training on Trauma-informed Care, yet most participants stated they are moderately familiar with the concept and that their program/institution moderately well implements Trauma-informed Care. This suggests a lack of organized training and formal attention from counselor education programs, despite the growing trend of the TIC in the counseling profession. Once again, the current results underscore the need for greater adoption of the TIC for counselor education programs, as well as further investigation into specific strategies, resources, and barriers to its implementation in counselor preparation programs. Particularly noteworthy is the negative relationship between familiarity with TIC and secondary traumatic stress and burnout. Trauma-informed Care is a philosophical framework that inherently focuses on transforming entire organizations and systems. Considering TIC would foster a safe learning environment, it is logical to guess the relationship between familiarity with TIC and reduced secondary traumatic stress symptoms.

Nevertheless, we need a more in-depth understanding of the effect of the TIC framework and specific strategies to facilitate TICs among counselor preparation programs. Furthermore, counselor educators fulfill multiple roles, including educator, supervisor, gatekeeper, and researcher. When the TIC framework is not only applied to support clients but also to train helpers, there is another layer of considerations. For instance, how to perform gatekeeping with TIC philosophy would be an important area for further discussion and investigation.

Limitations and Future Directions

First, the participants in the current study are novice counselors and results can not be used to make implications about experienced counselors. The number of years/experience of counselors in the counseling practice should be considered in interpreting the results and designing/analyzing future research. Another limitation of the current study is its usage of cross-sectional data. Although the ACEs scale asks about the early experiences of childhood (i.e., before 18 years), the result should carefully be interpreted on causality and the retrospective nature should be considered when understanding the current results. Also, we found a significant coefficient in the relationship between the familiarity with the TIC and work-related stress, but the size of the variance explained was very small. Further investigation to understand the teaching and learning based on TIC is necessary to understand the relationship between two variables. Lastly, the nature of the self-report of various scales needs to be considered. Because the current study was designed to be anonymous, we believe that participants answered the question with their transparency. Nevertheless, social desirability or the nature of self-perception needs to be considered. For future studies, additional measurement tools, besides self-report scales, to assess work-related stress are encouraged to be adopted.

Conclusion

The current study investigated the prevalence of Adverse Childhood Experiences, work-related stress, and the level of familiarity with Trauma-informed Care among novice counselors including counselors with less than three years of experience and counselors-in-training. The main analysis was based on two purposes: to see if (a) the high prevalence of past trauma (i.e., ACEs score) may have a relationship with the current working stress of indirect traumatization among novice counselors, and (b) the familiarity with Trauma-informed Care from counseling preparation program may have an association with the current working stress of indirect traumatization among novice counselors.

Based on data from 106 novice counselors, the results showed that the Adverse Childhood Experiences (ACEs) significantly predicted secondary traumatic stress, but not burnout or compassion satisfaction. The study also examined the familiarity of novice counselors with Trauma-informed Care, finding a negative association with secondary traumatic stress and burnout. While the study does not establish causation in these relationships, it highlights the need for future research into how past trauma affects novice counselors' training and the mechanism behind the negative link between Trauma-informed Care familiarity and indirect traumatization. The findings, including the high trauma prevalence, ACEs' connection with secondary traumatic stress, and the importance of Trauma-informed Care, emphasize the need for counselor programs to prioritize Trauma-informed Care and provide systematic support to enhance novice counselors' wellness.

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Author Information

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

The author(s) appreciate the support from the Korean Counseling Association-International Chapter. The current research project was awarded a research grant award.

How to Cite this Article:

Han, E. & Carrola, P. (2024). Adverse Childhood Experiences, Work-related Stress, and Trauma-informed Care among Novice Counselors. *Journal of Counselor Preparation and Supervision, 18*(3), 1-14.