THE PROFESSIONAL QUALITY OF LIFE OF MASTER'S LEVEL MENTAL HEALTH PROFESSIONALS AND THEIR GRADUATE TRAINING: A MIXED METHODS STUDY

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DEDICATION

This is dedicated to all of the mental health professionals out there who are working hard to provide support to those who need it. You are heroes, and the help you provide saves lives, changes lives, and heals lives. Continue to press on with the work that God has called you to do; he has prepared a way for you in advance for these good works you are doing.

ABSTRACT

Mental health professionals work hard to help those struggling with mental health issues. Understanding the emotional needs of others requires sustained mental and emotional effort on behalf of the professional. Factors inherent in this work put mental health professionals at risk for developing burnout, compassion fatigue, and secondary traumatic stress. These work demands drain one's psychological resources and can impact well-being, physical health, and mental health. An aim of the current study was to understand master's level mental health professionals' well-being from a career-stage perspective. This study also explored how master's level mental health professionals describe their career motivations and goals for the clients they are treating. Finally, this study determined if the sample reported sufficient graduate training in areas of burnout, compassion fatigue, secondary traumatic stress, and compassion satisfaction. Nonsignificant correlations existed between scores on professional quality of life scale and career stage of the professional. Although the results were not significant, scores of burnout and secondary traumatic stress were high for this sample. Compassion satisfaction scores significantly correlated with burnout and secondary traumatic stress scores; when compassion satisfaction scores were low, burnout and secondary traumatic stress scores were high. Results indicated that the participants rate their instruction in graduate training on compassion satisfaction as occurring rarely. Results from open-ended questions indicated that master's level mental health professionals reported they would benefit from increased instruction on concepts of professional quality of life in graduate training. Motivations, goals for client, and personal career goals were analyzed using qualitative data. The patterns and themes that emerged from the analysis fit in with what is theorized about master's level mental health professionals and their career development.

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Introduction

The well-being of helping professionals has been a topic of research interest for many years. With the onset of a global pandemic in 2020, scholars have recognized that the well-being of healthcare workers is now an urgent public health concern (Li et al., 2021; Sovold et al., 2021). Current studies exploring how healthcare professionals have been negatively impacted by the Covid-19 pandemic are being conducted. Some studies have revealed that globally, healthcare workers are experiencing an increase in stressors at work, which has led to a decrease in their mental, physical, and emotional well-being (Li et al., 2021; Sovold et al., 2021). In fact, the World Health Organization (WHO) estimates that by 2030, there will be a shortage of 18 million healthcare workers (Sovold et al., 2021). While this recent research on the impacts of Covid-19 has primarily studied physicians and nurses, mental health professionals are also at risk for decreased well-being due to the Covid-19 pandemic and after effects. Studies indicate that mental health issues such as anxiety, depression, and suicides have increased since the global pandemic, and mental health workers must respond by providing services to those in need (World Health Organization, 2022). Prior to the global pandemic, mental health professionals' well-being was a topic of concern, however recent events accelerated the need for scholars and practitioners to understand the problem, and provide practical solutions to help these professionals who continue to meet the daily demands of a challenging profession (World Health Organization, 2022).

Mental health professionals at the master's level who are licensed clinicians or pre-licensed clinicians (social workers, therapists, counselors)—provide a high level of support for individuals with mental health care needs (Ray et al., 2013). When working closely with others

and providing intense emotional support, these professionals can experience adverse impacts of their jobs. These adverse impacts lead to a decrease in well-being, an increase in mental health issues, and cause negative physical symptoms (Laverdière et al., 2018). The adverse effects include burnout, compassion fatigue, and secondary traumatic stress which decreases the quality of care provided to patients (Berjot et al., 2017; Dreison et al., 2018a; Laverdière et al., 2018; Sodeke-Gregson et al., 2013).

Statement of the Problem

When master's level mental health professionals are experiencing a decrease in well-being this ultimately results in negative outcomes for employees, organizations, and clients (Laverdière et al., 2018). Stamm (2010) developed the concept of professional quality of life, and it accounts for these negative conditions that can develop from working in the mental health field. Burnout is a condition that affects employees when they are under stress over long periods. Burnout is the result of depleted resources due to increased job demand and little effort in replenishing these resources (Hall et al., 2016). Master's level professionals working in mental health fields are more susceptible to burnout because of the duties of their jobs (Baugerud et al., 2018; Dreison et al., 2018b; El-Ghoroury et al., 2012; Laverdière et al., 2018; Rummell, 2015; Sodeke-Gregson et al., 2013). Other negative impacts of this job also manifest themselves in two other conditions. The first one is secondary traumatic stress which replicates the symptoms of posttraumatic stress disorder, but it results from hearing another's trauma stories (Rivera-Kloeppel & Mendenhall, 2021). The second one is compassion fatigue, occurring after prolonged exposure to compassion stress, and is a state of exhaustion as well as loss of functioning psychologically, biologically, and socially in the helper (Baker, 2012; Figley, 2002; Knight, 2013; Miller & Sprang, 2017; Rivera-Kloeppel & Mendenhall, 2021; Stamm, 2005).

As the result of these conditions in master's level mental health professionals, the organizations they work for are impacted by absenteeism and higher turnover rates (Morse et al., 2012). This also affects staff cohesion and places demands on organizations financially (Dreison et al., 2018b; Morse et al., 2012; Salyers et al., 2015, Scanlan & Still, 2019). When professional quality of life is low, it can lead to poor personal outcomes for mental health professionals; cardiovascular disease, depression, anxiety, sleep disturbance, and relationship issues (Dreison et al., 2018b; Hall et al., 2016). When mental health providers are experiencing low professional quality of life, the patients they are intended to help can experience low quality of care. Specifically, employee burnout has been linked to clinical errors, poor patient outcomes, lower perceived quality of care, and higher therapy dropout rates (Bakker & Costa, 2014; Dreison et al., 2018b; Hall et al., 2016; Salyers et al., 2015).

Studies on master's level mental health professionals have found students and professionals early in their careers are more at risk for burnout than are mid and late-career professionals (Ahola et al., 2017; Baugerud et al., 2018; Dreison et al., 2018b; Finklestein et al., 2015; Laverdière et al., 2018; Lawson & Myers, 2011). Studying professional quality of life from a career stage perspective, corresponds with what scholars have conceptualized theoretically about the development of the professional counselor/therapist. Ronnestad and Skovholt (2003) developed a model of counselor/therapist development. Students progress from lay helpers to advanced students, as they move through their learning in graduate training as well as experience in field internships. Their knowledge and experience further develops throughout their careers, and counselors/therapists often changed their approach to helping their clients. A significant relationship exists between experience level of the helper and the therapeutic

outcome; professionals later in their careers have therapeutic outcomes more favorable than those earlier in their careers (Ronnestad & Skovholt, 2003).

The demands on students and early-career professionals are often more intense than those demands on mid and late career professionals (Goncher et al., 2013). Continued work and school demand with few resources require "sustained physical or mental effort and are associated with certain physiological and psychological costs" (Demerouti et al., 2001, p.501). Burnout is a result of such stresses, which leads to a combination of exhaustion, disbelief in one's abilities at a job, and pulling away from others to protect one's resources (Barnett et al., 2007; Thompson et al., 2014). Pre-licensed and early-career master's level mental health professionals are experiencing higher rates of stress than the general population and lack resources to deal effectively with their stress (Dorociak et al., 2017; El-Ghoroury et al., 2012; Ray et al., 2013). Therefore, comparing how professionals in different stages of their careers approach their work, see their clients, and set professional goals adds to the knowledge on this topic of professional quality of life in various career stages of mental health professionals. (Dreison et al., 2018b; Ronnestad & Skovholt, 2003; Shoji et al., 2015). Training master's level mental health professionals on how to prepare for the demands of the mental health field has been suggested by several researchers in the field (Baugerud et al., 2018; Dreison et al., 2018b; Laverdière et al., 2018; Sexton & Adair, 2019). Graduate training programs for mental health providers lack clarity in training students on recognizing and seeking treatment for burnout, compassion fatigue, and secondary traumatic stress (Laverdière et al., 2018; Shen-Miller et al., 2015).

Background

Workplace strategies that educate and train mental health professionals to reduce the occurrence of burnout are called interventions (Ahola et al., 2017; Dreison et al., 2018b; Sexton

& Adair, 2019). Interventions vary in length and type, and are either focused on changing workplace stressors, building personal coping strategies, or a combination of both (Ahola et al., 2017; Dreison et al., 2018a; Sexton & Adair, 2019). Several studies have concluded that the occurrence of burnout is high in mental health workers surveyed; but not much is being done to provide relief to employees struggling with burnout as a result of working in the mental health field (Ahola et al., 2017; Dreison et al., 2018b; Sexton & Adair, 2019). A meta-analysis on burnout intervention research found that the occurrence of burnout in mental health professionals is concerning (Dreison et al., 2018a). After reviewing 35 years of research with a population of 1,894 mental health workers the authors found that the occurrence of burnout in these professionals was high; 21% to 67% of mental health workers were experiencing high levels of burnout. Several studies have linked demographic factors, organizational factors, and client factors to a higher likelihood of burnout in master's level mental health professionals (Baugerud et al., 2018; El-Ghoroury et al., 2012; Laverdière et al., 2018; Sodeke-Gregson et al., 2013).

Demographic factors linked to burnout include personal trauma history, less time in the field, more time spent in personal therapy, younger age, less training, and female gender (Baugerud et al., 2018; Dreison et al., 2018b; Kim et al., 2009; Laverdière et al., 2018; Sodeke-Gregson et al., 2013; Thompson et al., 2014). Organizational factors correlated with burnout include employment in community agencies or hospitals, less managerial support, and less control over caseloads (Laverdière et al., 2018; McKim & Smith-Adcock, 2014; Thompson et al., 2014). Studies have also found that little control over one's work environment, lack of personal resources, and lack of professional resources are variables that predict burnout (Dreison et al., 2018b; Morse et al., 2012; Salyers et al., 2015; Scanlan & Still, 2019). Client factors that place master's level mental health professionals at a higher risk for negative impacts of the job

such as burnout include more trauma clients, more clients diagnosed with a personality disorder, and more direct client hours a week (Ballenger-Browning et al., 2011; Dreison et al., 2018b; Laverdière et al., 2018; Lawson & Myers, 2011; McKim & Smith-Adcock, 2014).

Secondary traumatic stress, also known as vicarious traumatization, is another occupational risk for mental health professionals helping traumatized clients (Baker, 2012). Secondary traumatic stress is a condition that only impacts those mental health professionals who are working directly with clients who have experienced traumatic events. This happens when the provider becomes overwhelmed with hearing traumatic material and avoids this traumatic material to prevent further harm (Brown et al., 2017). This can be problematic because the helping professional will pull away from the clients they are expected to help (Figley, 2002). The first recognized symptom of secondary traumatic stress is re-experiencing the traumatic event that was described by the client (Laverdière et al., 2018). Due to this intrusive recollection of the traumatic material, the person affected will attempt to avoid the client's traumatic material (Stamm, 2010). This is done by avoiding the client completely, or avoiding becoming overinvolved emotionally when the client recalls the traumatic events, a process known as numbing (Lee et al., 2018). Hypervigilance, or feeling on alert all the time regarding one's own environment is another symptom of secondary traumatic stress (Figley, 2002; Ling et al., 2014; Thompson et al., 2014). Secondary traumatic stress has a profound impact on the helpers., it can transform the way one thinks, the way one perceives others, and the way one views spirituality (Knight, 2013; Miller & Sprang, 2017). The helper can go from believing the world is a safe place, to believing the world is not safe, and people cannot be trusted (Baker, 2012; Knight, 2013; Miller & Sprang, 2017).

The professional quality of life for a mental health professional can be measured by understanding levels of burnout, compassion fatigue, and secondary traumatic stress (Laverdière et al., 2018; Sodeke-Gregson et al., 2013; Thompson et al., 2014). Also included in this concept is the positive feelings that come with working in the mental health field; helpers can also experience compassion satisfaction. Compassion satisfaction is the pleasure that mental health professionals derive from working in the field. In the presence of high compassion satisfaction there is a lower rate of burnout (Baugerud et al., 2018; Ray et al., 2013; Sodeke-Gregson et al., 2013). The Professional Quality of Life Scale (ProQOL) has been used in studies to understand both the positive and negative aspects of providing mental health support to others (Laverdière et al., 2018; Sodeke-Gregson et al., 2013). The ProQOL has been used in studies of therapists, counselors, social workers, case managers, psychology graduate students, psychologists, psychiatrists, nurses, doctors, firefighters, and emergency service providers (Finklestein et al., 2015).

One criticism in the literature on this topic is the lack of theoretical understanding applied to the development of burnout in master's level mental health professionals (Bakker & Demerouti, 2017; Demerouti et al., 2001; Dreison et al., 2018a; Grover et al., 2017; Stensland & Landsman, 2017). The current study was designed with a theoretical model applied. The theoretical model is the job demands-resources model (JD-R) and it explains burnout as an imbalance between demands and job resources (Bakker & Demerouti, 2017; Demerouti et al., 2001). Variations between employee demands and job resources can lead to the condition of burnout if not addressed early on (Demerouti et al., 2001). Historically, burnout has been conceptualized as something that develops over long periods of time, however a few recent studies indicate that burnout can occur early on in the career of a mental health professional.

This is because early career professionals have less job resources than professionals who are later in their careers (Dorociak et al., 2017). Based on these recent findings, this study compares professional quality of life between early career and mid/late career professionals.

Research Questions

The following are the research questions this study addressed:

1. Are early career mental health professionals experiencing burnout, compassion fatigue, and secondary traumatic stress at higher rates than mental health professionals who are mid-career and late-career?
2. Do compassion satisfaction scores on ProQOL for master's level mental health professionals impact burnout, compassion fatigue, and secondary traumatic stress scores on the Professional Quality of Life Scale?
3. Are there differences between types of training and measures of professional quality of life?
4. How do master's level mental health professionals rate their graduate training in professional quality of life?
5. How do motivations, career goals, and goals for clients change as helping professionals are in different career stages?

Description of Terms

The following terms appear in this study. These terms have been carefully defined by a thorough examination of the literature on this topic**.**

Burnout. A syndrome that impacts one psychologically and is a result of ongoing interpersonal stress. Two major features of burnout include emotional exhaustion and feeling ineffective in one's ability to perform job duties. Another major feature of burnout is that it

causes professionals to seek personal distance from those they are expected to help—a process known as depersonalization (Barnett et al., 2007; Thompson et al., 2014).

Compassion fatigue. A form of caregiver burnout among mental health professionals, divided into two parts. The first part causes the helper, due to extended periods of time helping traumatized individuals, to experience emotional drain that results in dysfunction biologically, psychologically, and emotionally (Figley, 2002). The second part is secondary traumatic stress, which is a negative feeling driven by fear and work-related trauma. Some trauma at work can be primary trauma. In other cases, work-related trauma can be a combination of both primary and secondary trauma (Stamm, 2010). On the ProQOL; compassion fatigue is the combination of the subscales of burnout and secondary traumatic stress.

Compassion satisfaction. The pleasure derived from working in the mental health field and with trauma victims (Laverdière et al., 2018).

Depersonalization. The process a professional goes through to seek personal distance from those they are helping (Barnett et al., 2007; Thompson, et al., 2014).

Early-career master's level mental health professionals. Professionals within seven years of obtaining their professional license in social work, marriage and family therapy, or professional counseling. These professionals face unique stressors to being newly licensed in the field. These stressors include dealing with student debt, developing a professional identity, finding a job, and developing their personal lives in areas such as family and marriage (Dorociak et al., 2017).

Mid-career master's level mental health professionals. Professionals within 8-20 years of obtaining their professional license in social work, marriage and family therapy, or

professional counseling. These professionals have more experience and hold more leadership roles but continue to balance work and family responsibilities (Dorociak et al., 2017).

Late-career master's level mental health professionals. Professionals with over 20 years of experience in the field who are approaching the end of their roles. Some are terminating with clients and reducing their workload (Dorociak et al., 2017).

Hypervigilance. Being over-aware and feeling on alert all the time regarding one's own surroundings (Ling et al., 2014).

Job demands-resources model. A theory regarding employee engagement and burnout that emphasizes job demands and job resources. When the demands are high and resources low, this imbalance leads to burnout if not corrected (Dreison et al., 2018a; Grover et al., 2017; Stensland, & Landsman, 2017).

Master's level mental health professionals. Individuals from different disciplines, including professionals who are social workers, therapists, and counselors, who are licensed or pre-licensed and providing high-level support and therapy for persons needing complex mental health treatment (Ray et al., 2013).

Numbing. The professional avoids overinvolvement emotionally when clients are recalling their traumatic events (Barnett et al., 2007; Thompson et al., 2014).

Pre-licensed master's level mental health professionals. Individuals from different disciplines who are social workers, therapists, and counselors and are currently in school or recently graduated from school. They do not have their professional licenses and are working on obtaining their required training hours in the field to qualify them for licensure. Hour requirements vary depending on state and professional designation (Dreison et al., 2018a).

Professional quality of life. The quality of life one feels as a result of their work as a helper. Positive and negative aspects of doing one's work impacts the professional quality of life of the mental health professional. This includes both the positive and negative aspects of those who help people who have experienced trauma and suffering. Knowing one's own professional quality of life can improve the ability for self-help and keep balance in one's own life (Stamm, 2010).

Professional Quality of Life Scale (ProQOL). Professional quality of life is the quality one feels in relation to work as a helper (Stamm, 2010). Both the positive and negative aspects of doing one's job influence one's professional quality of life. The positive aspect is measured by the subscale of compassion satisfaction (Stamm, 2010). The negative aspects of doing one's job is measured by the subscale of compassion fatigue which is broken into two parts. The first part includes components such as exhaustion, anger, depression, and frustration: typical symptoms of burnout (Figley, 2002). The second part is secondary traumatic stress, characterized by trauma reactions similar to PTSD. These responses include re-experiencing the primary survivor's trauma, intrusive thoughts, and hypervigilance to one's surroundings (Ivicic & Motta, 2017). The ProQOL is an instrument developed to study and understand the conditions of compassion fatigue, burnout, secondary traumatic stress, and compassion satisfaction and how these conditions relate to one another. It measures these components to produce a measure of the professional quality of life in those who are in the helping professions (Stamm, 2010).

Secondary traumatic stress. Secondary traumatic stress (STS) manifests with a profound impact on helpers as it transforms the way one thinks, the way one perceives others, and the way one views spirituality. The helper can go from believing the world is a safe place to

believing that the world is not safe and that people cannot be trusted (Baker, 2012; Knight, 2013; Miller & Sprang, 2017).

Self-care. The process of connecting with one's self to heal what might be impaired due to the demands of the helping profession. This can include self-awareness, regulation of the self, or balancing the connections within the self to others and the community at large (Baker, 2009).

Surface Acting. Employees have an outward display of changing emotions, while inner true feelings are not altered (Morse et al., 2012).

Significance of the Study

This mixed-methods study investigates professional quality of life in master's level mental health professionals. This study also addresses how professionals rate their graduate training on professional quality of life. The content of this study may be helpful to master's level mental health professionals, graduate training programs for master's level mental health professionals, and employers of master's level mental health professionals. Pre-licensed master's level professionals and early-career master's level professionals possess several of the risk factors for developing adverse conditions of the job (Butler et al., 2017; Hall et al., 2016; Morse et al., 2012). Students in master's graduate training to become mental health professionals should be taught how to assess their current rates of burnout or their potential for burnout. One of the dangers of burning out early is that mental health professionals can start their careers with depleted resources (McKim & Smith-Adcock, 2014; Pakenham & Stafford-Brown, 2012). Burned out employees and those at risk for burnout pose a threat to organizations financially (Hall et al., 2016; Morse et al., 2012). Burned out employees also have a negative impact on the quality of care for persons receiving mental health treatment (Hall et al., 2016; Scanlan & Still, 2019). Finding ways to ameliorate burnout is a critical component in the prevention of

developing these conditions (Dreison et al., 2018a; Raab, 2014). Master's level mental health professionals all start their careers in graduate training programs, understanding how students and professionals assess their training on professional quality of life is a critical component of prevention (El-Ghoroury et al., 2012; Shen-Miller et al., 2015).

The current study applied a theoretical model, the JD-R theory, in understanding how master's level mental health professionals experience burnout. Ultimately, master's level mental health professionals in training can proactively measure their professional quality of life. If they are experiencing adverse effects of the job, elevated burnout scores, or elevated secondary traumatic stress scores, then they can proactively seek to create a balance between resources and demands (Berzoff & Kita, 2010; Figley, 2002).

Overview of Research Methods

The research questions guided the study, and a mixed-methods design was utilized to address the research questions. The methods included a quantitative survey on burnout, compassion fatigue, secondary traumatic stress, and compassion satisfaction (using the Professional Quality of Life Scale) for master's level professionals in the mental health field (Stamm, 2010). The study also included a quantitative section created by the researcher asking questions about participants' perception of graduate training in professional quality of life. The survey concluded with six qualitative questions created by the researcher on career goals, goals for client, and any additional information that would have been helpful in the participant's training in professional quality of life.

Chapter II

Review of the Literature

Introduction

Mental health professionals at the master's level who are licensed clinicians or pre-licensed clinicians (social workers, therapists, counselors)—work closely with individuals who have complex mental health care needs (Ray et al., 2013). These professionals can experience adverse impacts of their jobs. These adverse impacts include burnout, compassion fatigue, and secondary traumatic stress which decreases the quality of care provided to patients (Berjot et al., 2017; Dreison et al., 2018a; Laverdière et al., 2018; Sodeke-Gregson et al., 2013). Conversely, mental health professionals also experience satisfaction from helping others. This helps to mitigate some of the negative outcomes of the job. There are psychological benefits for mental health professionals who work with clients who have experienced trauma. Compassion satisfaction (CS) is the pleasure derived from helping others through therapeutic techniques. The helper experiences a sense of usefulness in their ability to make a lasting and positive impact in their community (Stamm, 2010).

Based on the unique aspects of their roles as helping professionals, master's level mental health professionals experience the workplace both positively and negatively (Baugerud et al., 2018; Cieslak et al., 2014; Laverdière et al., 2018). The benefits and consequences of working in the mental health field influence one's overall professional quality of life. The primary purpose of this mixed-methods study is to investigate professional quality of life in master's level mental health professionals. The secondary purpose of this study is to address how professionals rate their graduate training in professional quality of life. The literature review will offer comprehensive information as it relates to burnout, compassion fatigue, secondary traumatic

stress, and compassion satisfaction. Professional quality of life will be examined through and further explored by the following: 1) career stages and professional development, 2) workplace interventions and self-care, 3) graduate school interventions, and training for mental health professionals. This review will provide a background of current research and identified gaps in research, thus supporting the need for this study.

The Well-being and Quality of Life of Master's Level Mental Health Professionals

Well-being, or the professional quality of life for master's level mental health professionals includes both the negative aspects of working closely with others (burnout, compassion fatigue, and secondary traumatic stress) and the positive aspects of working closely with others (compassion satisfaction) in a therapeutic context (Stamm, 2010). Burnout is a syndrome impacting one psychologically and physically. It is a result of a combination of factors including ongoing interpersonal stress (Barnett et al., 2007; Thompson et al., 2014). Secondary traumatic stress manifests with a profound impact on the helper as it transforms the way the person processes events, the way one perceives others, and the way one views spirituality. The helper can go from believing the world is a safe place, to believing the world is unsafe, and believing people are untrustworthy. (Baker, 2012; Knight, 2013; Miller & Sprang, 2017). Compassion fatigue is a condition where the provider is experiencing a combination of high burnout scores and high secondary traumatic stress scores on the professional quality of life scale (ProQOL). STS occurs when the professional becomes overwhelmed with hearing traumatic material and avoids this traumatic material to prevent further harm (Brown et al., 2017). This can be problematic because the helping professional will pull away from the clients that they are expected to help. Burnout, compassion fatigue, and secondary traumatic stress has been prevalent in mental health professionals because of the number of traumatized individuals these

professionals treat (Cieslak et al., 2014). While the above negative impacts of counseling have been defined and researched, persons in helping professions can also experience compassion satisfaction. Compassion satisfaction is the positive outcome associated specifically with this profession (Figley, 2002).

The Professional Quality of Life Scale (ProQOL) measures the components of burnout, compassion fatigue, secondary traumatic stress, and compassion satisfaction in the professional quality of life in those who are in the helping professions. It is important to note the ProQOL has been widely used in studies of therapists, counselors, social workers, case managers, psychology graduate students, psychologists, psychiatrists, nurses, doctors, firefighters, and emergency service providers (Finklestein et al., 2015).

Burnout. Burnout occurs for some master's level mental health professionals as they begin and progress throughout their careers (Butler et al., 2017). Two major features of burnout include emotional exhaustion and feeling ineffective in one's ability to perform their job duties (Bakker & Costa, 2014). Physical health issues, mental health issues, and low quality of life for mental health care providers are just a few of the impacts of burnout on these employees (Butler et al., 2017). In addition, the effects of burnout reduce the quality of care for patients leading to treatment mistakes, negative attitudes towards clients, and decrease in satisfaction of care for clients (Dreison et al., 2018a). Employees experiencing burnout suffer decreased staff morale in their organizations. As a result of the burnout, employees are absent more at work. Additionally, employees have intent to leave and quit their jobs more often than employees that are not burned out (Dreison et al., 2018a; Hall et al., 2016; Scanlan & Still, 2019). When employees are contemplating turnover, clients can report fewer positive outcomes in therapy. Studies have

shown that turnover intention impacts client satisfaction level with treatment and increases the rate of client involuntary hospitalization (Dreison et al., 2018a; Dreison et al., 2018b).

A meta-analysis studied environmental factors in burnout symptoms in psychotherapists with both master's degrees and doctorate degrees (Lee at al., 2019). Results indicated that long work hours, role conflict, and role overload were strongly related to emotional exhaustion and burnout. The variables have been categorized as work setting factors, individual factors, and client factors (Laverdière et al., 2018; Sodeke-Gregson et al., 2014; Yang & Hayes, 2020).

The work setting variables correlated with increase in burnout included working in institutional settings, less perceived managerial support, role overload, and less perceived positive work environment (Laverdière et al., 2018; Sodeke-Gregson et al., 2014; Thompson et al., 2014; Yang & Hayes, 2020). There are several individual risk factors associated with higher rates of burnout for master's level mental health professionals. These include less time working in the field, more hours spent in personal psychotherapy, a mental health history, and maladaptive coping skills (Baugerud et al., 2018; Laverdière et al., 2018; Yang & Hayes, 2020). Having a higher caseload volume, more traumatized clients, and more clients with personality disorders were also found to be associated with higher rates of burnout in master's level mental health professionals (Baugerud et al., 2018; Craig & Sprang, 2010; Laverdière et al., 2018; Sodeke-Gregson et al., 2014; Thompson et al., 2014; Yang & Hayes, 2020). Providing targeted training for graduate students on how to more effectively manage clients with personality disorders was suggested as one way to ameliorate the problem of burnout (Lee et al., 2019).

A study was conducted of Canadian psychotherapists on two factors (Laverdière et al., 2018). The first is how they experienced their work. The second was on the behaviors that have helped them endure difficult work circumstances. The researchers surveyed 240

psychotherapists, with both master's level and doctoral level schooling. The authors examined these psychotherapists' professional quality of life to explore their work conditions. The first part of the survey focused on demographic information. The second measure includes the ProQOL, measuring areas of compassion satisfaction, compassion fatigue, secondary traumatic stress, and burnout. The third measure was the Toronto Empathy Questionnaire, a scale containing 16 items that measures respondents' perception of their own empathic abilities. Analyses focused therapists' characteristics as they relate to their professional quality of life. The study found burnout was positively correlated with time spent in personal psychotherapy, caseload volume, and working only in institutional settings such as hospitals (Laverdière et al., 2018).

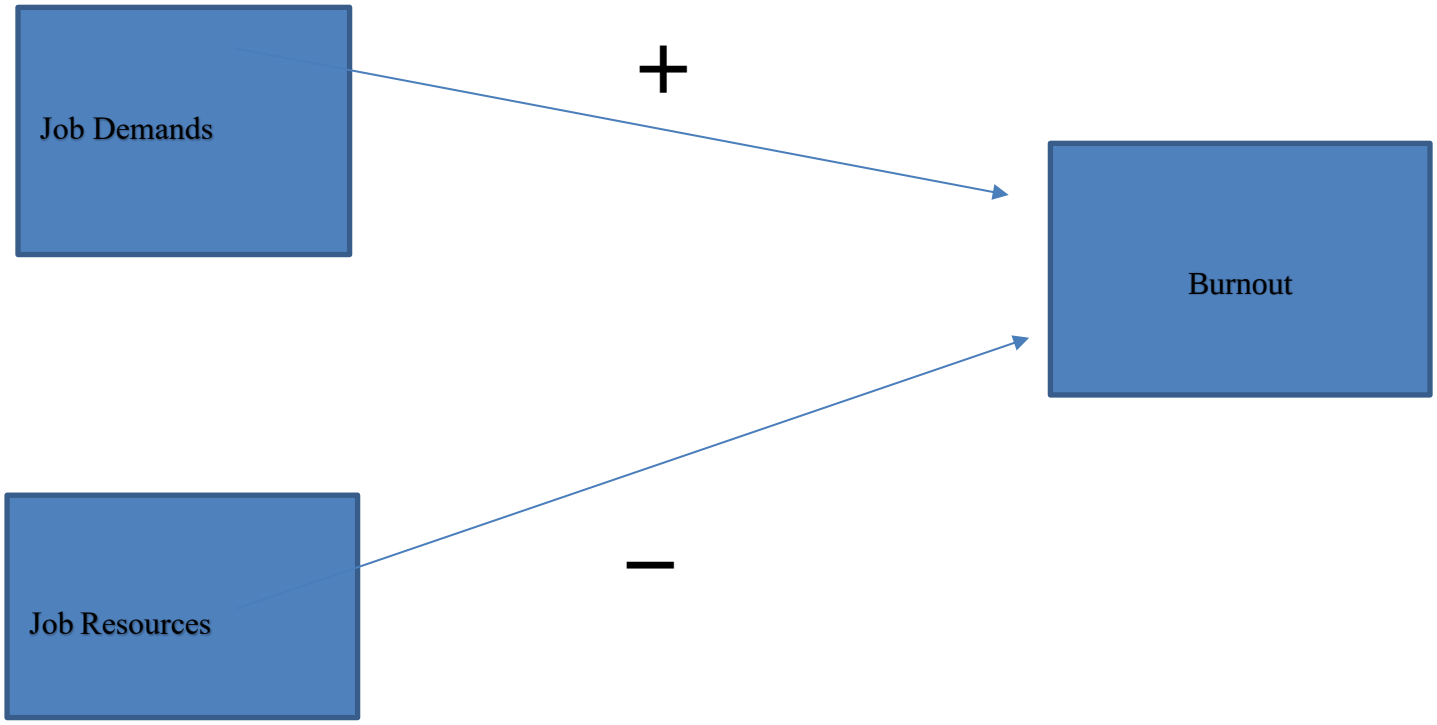
There are other variables associated with burnout scores that are not clinically significant (i.e. burnout scores that are not considered to be problematic). Variables found in several studies can create a buffer for mental health professionals from developing burnout. These include variables such as supervisor and peer support, type of work setting, perceived control over caseload, and more tenure in the field (Laverdière et al., 2018; Sodeke-Gregson et al., 2014; Thompson et al., 2014; Yang & Hayes, 2020). Another possible solution is to incorporate prevention training for burnout in graduate programs (Baugerud et al., 2018; Laverdière et al., 2018; Sodeke-Gregson et al., 2014; Thompson et al., 2014).

Theoretical model for burnout. One criticism in the literature on the variables associated with burnout is the lack of theoretical understanding to categorize these variables into a comprehensive framework that explains specifically how burnout develops (Bakker & Demerouti, 2017; Demerouti et al., 2001; Dreison et al., 2018a; Grover et al., 2017; Stensland & Landsman, 2017). The job demands-resources model (JD-R), first introduced to address burnout in employees, developed into a theory by 2011 (Bakker & Demerouti, 2017; Demerouti et al.,

2001). The JD-R model explains how variations between employee demands and resources can lead to the condition of burnout (Demerouti et al., 2001). For example, when job demands are high and resources low, this imbalance leads to burnout if not corrected (as seen in Figure 1) (Dreison et al., 2018a; Grover et al., 2017; Stensland & Landsman, 2017).

Figure 1

JD-R: The job-demands resources model



Note: Adapted from Bakker & Demerouti, 2001, p.275

Job demands in the JD-R model include any factor leading to a health impairment process. This requires a continued physical and mental effort from the employee (Bakker & Demerouti, 2017; Demerouti et al., 2001). These physical and mental strains can lead to chronic fatigue which impact the employee's ability to focus at work, connect with others, and stay healthy mentally and physically (Bakker & Costa, 2014; Demerouti et al., 2001). Job resources buffer the negative effects of job demands in the JD-R model. They are associated with higher

motivation and job satisfaction for the employee. In the presence of work resources, employees are more engaged and committed to their work. They are also less likely to experience burnout and intention to quit (Bakker & Costa, 2014; Bakker & Demerouti, 2017; Dreison et al., 2018a). Job demands are expected in any work environment. However, it is the imbalance between resources and demands (i.e., more demands and fewer resources) which lead to burnout according to the JD-R model (Bakker & Costa, 2014). In the work environment of the mental health professional, there is often an imbalance between demands and resources, especially for those earlier in their careers (Dreison et al., 2018b). Recent studies have focused on applying the JD-R model to mental health providers (Dreison et al., 2018b; Huynh et al.,2014; Scanlan & Still, 2019; Sexton & Adair, 2019; Stensland & Landsman, 2017; van Woerkom et al., 2016). Professionals working in healthcare services have been surveyed on the demands and resources available to them in their workplace setting (Scanlan & Still, 2019; Stensland & Landsman, 2017; van Woerkom et al., 2016). Researchers can predict absenteeism based on increased job demands (Stensland & Landsman, 2017; van Woerkom et al., 2016).

Compassion fatigue and secondary traumatic stress have been widely studied, but have yet to be conceptualized into the JD-R model (Demerouti et al., 2001; Dreison et al. 2018b; Grover et al., 2017; Scanlan & Still, 2019). Further application of theory can help scholars understand how the variables identified as leading to burnout or preventing burnout fit into the JD-R model as demands or resources for master's level mental health professionals (Baker, 2012; Knight, 2013; Miller & Sprang, 2017). Burnout does not distinctively impact those working in the counseling field. It is prevalent in this population because the resources are often less in number than the demands faced (Cieslak et al., 2014). Scholars assert that understanding

the ratio of demands to resources is an important next step in the research on this topic (Cieslak et al., 2014; Demerouti et al., 2001; Dreison et al., 2018b).

Compassion Fatigue and Secondary Traumatic Stress. Compassion fatigue and secondary traumatic stress are conditions impacting master's level mental health professionals working directly with traumatized clients (Figley, 2002; Stamm, 2010). This happens when the provider becomes overwhelmed with hearing traumatic material. The helper avoids this traumatic material to prevent further harm. Secondary traumatic stress or vicarious traumatization is another occupational risk for mental health professionals. STS manifests with a profound impact on the helper as it transforms the way the helper perceives the world, and the way they view their own spirituality (Baker, 2012). The first symptom of secondary traumatic stress is re-experiencing the traumatic event that was described by the client (Stamm, 2010). As a result of this intrusive recollection of the traumatic material, the person affected will attempt to protect themselves from the client's traumatic material by avoiding them. Another symptom the professional uses is numbing; which means that the professional restricts their emotional involvement in session, particularly when the client is recalling their traumatic events (Barnett et. al., 2007; Thompson et. al., 2014). Hypervigilance, or a heightened sense of one's surroundings is another symptom of STS (Figley, 2002; Ling et al., 2014; Thompson, et al., 2014).

Studies have identified risk factors that contribute to the development of compassion fatigue and secondary traumatic stress. Master's level mental health professionals who reported spending more time in individual supervision were at higher risk for developing compassion fatigue and STS (Laverdière et al., 2018). Professionals who spent more time in personal therapy were at a higher risk of developing compassion fatigue and secondary traumatic stress (Laverdière, et al., 2018; Sodeke-Gregson, et al., 2013). One explanation is those who are

negatively affected by their work seek out supervision and personal psychotherapy more frequently than those who are not (Laverdière, et al., 2018; Sodeke-Gregson, et al., 2013). In addition, if a professional has a personal trauma history, they are more likely to show symptoms of compassion fatigue and secondary traumatic stress (Laverdière, et al., 2018; Ray, et al., 2013; Sodeke-Gregson, et al., 2013). Risk factors found in the development of compassion fatigue and secondary traumatic stress include over involvement with clients, as well as a lack of clear boundaries with clients (Laverdière, et al., 2018; McKim & Smith-Adcock, 2014). Researchers surveyed trauma therapists nationally (half were master's level clinicians, the other half were doctoral level clinicians) using the ProQOL to measure professional quality of life for the sample (Craig & Sprang, 2010). Their results showed that compassion fatigue was correlated with age. In this sample, as age increased, compassion fatigue scores decreased. Compassion fatigue was also correlated with type of work setting. Employees working in institutions such as community mental health clinics and inpatient hospitals had higher scores of compassion fatigue than employees working in private practice. Clinicians who reported using evidence-based strategies such as Cognitive Behavior Therapy (CBT), Eye Movement Desensitization and Reprocessing (EMDR), and Behavioral Therapy had lower scores of compassion fatigue (Craig & Sprang, 2010). Laverdière and colleagues (2018) found that utilization of long-term psychotherapy approach with clients was associated with higher levels of secondary traumatic stress in psychotherapists. Researchers found a strong relationship between a perceived positive work environment and lower levels of compassion fatigue and secondary traumatic stress (Thompson et al., 2014). Based on the findings, future research should continue to explore factors that are associated both positively and negatively with compassion fatigue and secondary traumatic stress in diverse populations of healthcare professionals (McKim & Smith-Adcock, 2014). Work stress

and potential risks occur when individuals see their work environment as exceeding their personal coping resources.

Applying a theoretical understanding to professional quality of life is a consistent gap in the literature. Cieslak and colleagues (2014) conducted a meta-analysis exploring the relationship between secondary traumatic stress and job burnout among workers with exposure to trauma. After reviewing the literature, forty-one studies were included in the meta-analysis. The results of the analysis indicated that the relationship between secondary traumatic stress and burnout were moderated by the framework used. For example, if secondary traumatic stress and burnout were measured together in the same study, there was a consistently large shared variance. The authors suggested that the two constructs might be indistinguishable. For future studies, Cieslak and colleagues (2014) provided support for focusing on either secondary traumatic stress or burnout but not measuring them in the same study, specifically in studies conducted in the United States. Studies in the U.S. had significantly stronger correlations between secondary traumatic stress and burnout than studies done in other countries. The authors suggest future studies of secondary traumatic stress and burnout apply theoretical frameworks to their analyses. Researchers assert that this is a superior approach to understanding these concepts (Bae et al., 2019; Cieslak et al., 2014; Dreison et al., 2018b). One study explored the relationship between secondary traumatic stress and burnout exploring the direction of each relationship in a sample of psychologists and master's level mental health professionals in the United States and Poland (Shoji et al., 2015). The results indicated high scores of burnout predicted high scores of secondary traumatic stress six months after the initial measure was taken. Conversely, higher levels of secondary traumatic stress at time one did not predict higher levels of burnout six months later. The results indicate that burnout can lead to secondary traumatic stress, however,

the results do not infer that secondary traumatic stress leads to burnout. Additional research is needed on secondary traumatic stress and burnout to determine the causal relationship between these variables with a theoretical understanding to further explain the findings.

Compassion Satisfaction. Compassion satisfaction, the pleasure derived from working in the mental health field, is a component of professional quality of life, and a potential resource for mental health professionals (Laverdière et al., 2018; Sodeke-Gregson et al., 2014; Thompson et al., 2014). Compassion satisfaction is the level of satisfaction that one derives from their position as a mental health professional. It also includes the level of control the helper feels they have over the traumatic material to which they are exposed. When the helper feels they are doing well in their job, this can contribute to their overall level of compassion satisfaction (Stamm, 2010).

Compassion satisfaction was found to be inversely related to burnout in that those counselors who scored higher on levels of compassion satisfaction scored lower on levels of burnout (Laverdière et al., 2018; Sodeke-Gregson et al., 2014; Thompson et al., 2014). Compassion satisfaction levels were also higher when employees reported positive work conditions, worked in private practice settings, had tenure in the field, possessed higher levels of empathy, perceived positive challenges at work, and had a commitment to the organization (Laverdière et al., 2018; Sodeke-Gregson et al., 2014; Thompson et al., 2014). In one study, researchers surveyed a national sample of trauma treatment therapists (Craig & Sprang, 2010). Half of the sample were either licensed or pre-licensed psychologists and the other half were either licensed or pre-licensed social workers. The authors used the ProQOL to measure professional quality of life for the sample. Compassion satisfaction scores increased with age and clinical experience. Significant predictors of high compassion satisfaction scores in this sample

included age, time spent in research and development activities, and perceived supervisory support. When the therapists scored higher on scores of burnout and secondary traumatic stress, the potential for compassion satisfaction was lowered. This study focused on UK psychologists and cannot be generalized specifically to the United States population of master's level mental health professionals. This study provides validation, and direction for further exploring how compassion satisfaction serves as a job resource for clinicians. Teaching graduate students about the benefits of developing compassion satisfaction during their training can serve as a resource as they progress in their careers (Craig & Sprang, 2010; Laverdière et al., 2018; Sodeke-Gregson et al., 2014; Thompson et al., 2014).

Few studies in the literature have sought to apply theoretical understanding to compassion satisfaction. Historically, compassion satisfaction has been described theoretically as a separate phenomenon to compassion fatigue and secondary traumatic stress (Figley, 2002). Researchers conceptualize personal resources as a buffering effect for development of burnout (Tremblay & Messervy, 2011). Specifically, compassion satisfaction was conceptualized as a personal resource in the JD-R model for the purposes of their study of military chaplains. One hundred and twenty-two military chaplains were surveyed. The results indicated that compassion satisfaction did buffer the relationship between job demands and job strains. This study provides a basis for understanding how compassion satisfaction serves as a personal resource in the JD-R model. It also gives support to studying compassion satisfaction as a moderator for burnout in master's level mental health professionals. Other studies also utilized the JD-R model as a potential explanation for the importance of developing and cultivating compassion satisfaction to help mitigate the negative effects of burnout (Bae et al., 2019). External resources have been historically highlighted in studies of the factors associated with burnout in the workplace

(Laverdière et al., 2018; Sodeke-Gregson et al., 2014; Thompson et al., 2014; Yang & Hayes, 2020). However, the importance of internal resources as a way to prevent burnout from occurring has received some attention in the literature (Baugerud et al., 2018; Laverdière et al., 2018; Yang & Hayes, 2020). These authors used the JD-R Model as theoretical support for their study; proposing compassion satisfaction can be cultivated in employees by identifying the internal resources that are associated with it (Bae et al., 2019). Emotional intelligence, work-life balance, and work autonomy were all theorized to contribute to higher levels of compassion satisfaction in social work. The authors conclude that personal resources can contribute to an increase level of compassion satisfaction. Compassion satisfaction can increase by focusing on social worker strengths, rather than focusing on the negative aspects of the job (Bae et al., 2019). Other studies suggest the field of social work engage in a paradigm shift from a negativity focus to a positivity focus (Radley & Figley, 2007). Given that practitioners will inevitably face negative situations in helping others, the authors conclude that social workers must focus on increasing positive attitudes towards clients by understanding how to increase levels of compassion satisfaction. One way this can be done is through education in graduate training on self-care, cultivation of compassion satisfaction, and instruction on the importance of creating a supportive network (Bae et al., 2019; Radley & Figley, 2007). While this study lacks empirical evidence, it provides support for clinicians in the mental health field to focus on ways to improve personal resources. Specifically, compassion satisfaction as a way to lessen the negative impacts of working in the field (Radey & Figley, 2007). Research is still needed to understand how compassion satisfaction fits into the JD-R model, and if it has a significant relationship in reducing the occurrence of burnout, compassion fatigue, and secondary traumatic stress in master's level mental health professionals (Bae et al., 2019; Radey & Figley, 2007; Tremblay & Messervy, 2011).

Career Stages

Researchers have studied psychologists by looking at professional quality of life from a career-stage perspective (Dorociak et al., 2017; Warlick et al., 2020). Findings indicated that age was a significant predictor of burnout such that when age increases, burnout decreases. Researchers surveyed licensed psychologists in the state of Illinois in varied stages of their careers (Dorociak et al., 2017). This was one of the first studies to explore burnout as it relates to the developmental stage of practicing psychologists. The psychologists were divided into three developmental stages: early-career psychologists (within seven years of obtaining a doctoral degree), mid-career psychologists (professionals with 8-20 years of experience), and late-career psychologists (professionals with over 20 years of experience in the field). Early-career psychologists reported more emotional exhaustion, more depersonalization, and less personal accomplishment than mid and late-career psychologists. Early-career and mid-career psychologists also reported more intent to leave their jobs, higher work overload, greater perceived stress, and less career satisfaction than late-career psychologists (Dorociak et al., 2017). Studies of master's level mental health professionals have found more experience, increased amount of work resources, and older age were associated with lower scores of burnout, and compassion fatigue (Craig & Sprang, 2010; Laverdière, et al., 2018; Sodeke-Gregson, et al., 2013). These findings suggest professionals earlier in their career possess more risk factors for adverse impacts of the job than those who are later in their career.

Several studies of psychologists have begun to conceptualize professional quality of life from a career stage perspective. The population of psychologists is different from master's level mental health professionals because they are required more schooling and more clinical experience in the field, as well as a different licensing process. Reviewing burnout from a career

stage approach can be applied to different cohorts of behavioral health professionals. Studies of master's level mental health professionals have shown that age and types of evidence-based training are important factors in protecting clinicians from burnout and compassion fatigue (Baugerud et al., 2018; Laverdière et al., 2018; Sodeke-Gregson et al., 2014; Thompson et al., 2014; Yang & Hayes, 2020). Thus, interventions should be focused more on early-career mental health professionals (Dorociak et al., 2017).

Three different types of burnout were studied using the Copenhagen Burnout Inventory (CBI) and compared graduate-level clinicians to professional clinicians (Warlick et al., 2020). Although there were no significant differences on measures of burnout between pre-licensed and licensed clinicians, all clinicians studied were at risk of developing burnout, specifically personal burnout (Warlick et al., 2020). Burnout can happen in the beginning of one's career or over long periods of time working. It can also happen as frequently for new clinicians as it does for seasoned professionals. Therefore, if both early career and later career professionals are provided training on risks for burnout and how to manage stress to prevent burnout from occurring it can mitigate the harmful effects of working with traumatized individuals (Dorociak et al., 2017; Warlick et al., 2020). Specifically, Warlick and colleagues (2020) found that females had higher rates of overall burnout and personal burnout, due to the work-personal conflict and imbalance in caregiving duties (Warlick et al., 2020). Exploring how women experience the healthcare setting, 20 female hospital workers were interviewed by Stevenson and Duxbury (2019). The interviews illustrated that certain situations were more stressful for these women. These stressful conditions included time pressures, high volume of demands, a lack of clear guidelines, long lasting overload, and event uncertainty. These emerged as factors causing the women to appraise their

role as being stressful and overloaded. Younger women who had younger children also seemed to be more stressed than older women working in this environment.

Several studies conveyed the importance of addressing burnout at an early stage of a clinicians' career (Di Benedetto & Swadling, 2014; Lawson and Meyers, 2010; Warlick et al., 2020). Predictors of burnout associated with early career stages included type of workplace, clients having frequent relapses, less years of experience in the field, higher caseload volume, and more PTSD clients (Di Benedetto & Swadling, 2014; Lawson & Meyers, 2010; Yang & Hayes, 2020). Based on these findings, it appears that psychologists who remain in the field throughout their lifespan build resilience to burnout over time (Di Benedetto & Swadling, 2014; Lawson and Meyers, 2010; Warlick et al., 2020).

Longitudinal research is needed to understand the nature of the relationship between career span and burnout. Training can be adapted to educate students early in their careers on the risk factors that lead to burnout (Yang & Hayes, 2020). Training programs should take a more proactive approach in educating students on identifying and treating burnout before it affects the professionals' ability to provide quality care to their patients. There is still a lack of understanding of the lived experiences of master's level mental health professionals as they enter the field and encounter the demands and rewards of their profession. More analyses are needed to illuminate how new students entering their field placements feel about encountering clients who have experienced traumatizing life events (Bartoskova, 2017; Guerra, 2018; Yang & Hayes, 2020; Zoskly, 2013).

Theoretical Support for Understanding Professional Development. Therapeutic outcomes for patients have been studied in the context of counselor career stage. Several studies indicated that practitioners' later in their careers have more successful therapeutic outcomes than

practitioners' earlier in their careers (Lim et al., 2010; Chui et al., 2016; Salyers et al.,2016). One of the most measured indications of therapeutic success is lower therapy dropout rates (Lim et al., 2010; Schwartze-Mette et al., 2009). Studies show that clinicians earlier in their careers have higher dropout rates than those later in their careers (Lim et al., 2010; Schwartze-Mette et al., 2009). One way of understanding this phenomenon is to look at the theoretical literature regarding the professional development of the counselor/therapist. This research promotes an understanding of the progression of student to young professional, defining it as a complex process that is not yet fully understood (Koltz & Champe, 2010; Pratt & Lamson, 2011). The empirical study of counselor career course is a relatively new research pursuit (Ronnestad et al., 2018). Due to this, there are a lack of empirical studies supporting this topic, thus the articles referenced in this literature review tend to be older (Koltz & Champe, 2010; Pratt & Lamson, 2011; Ronnestad et al., 2018).

The theoretical model supporting counselor/therapist development was first introduced as a phase model (Ronnestad et al., 2018; Ronnestad & Skovholt, 2003). The theory can be described as the journey of student to young professional and later to advanced professional. It is important here to describe this theory in its entirety, describing each phase of counselor development. As the professional progresses in their career, there are significant changes in approaches to helping (Ronnestad et al., 2018; Ronnestad & Skovholt, 2003). When the helper enters graduate training, they are called the novice student. This phase is marked by anxiety and questioning abilities to help others (Ronnestad et al., 2018; Ronnestad & Skovholt, 2003). During the advanced student phase there is less anxiety, but the student still questions their ability to help others. Often the professional utilizes meetings with their supervisor to rely on external expertise to address their own clients (Ronnestad et al., 2018; Ronnestad & Skovholt,

2003). The first years after graduation represent a freedom and a testing of theoretical models learned in school. The professional enters the experienced professional phase, in which they now rely on their internal experiences as a counselor/therapist to help their clients. Finally, the "novice professional" becomes the "senior professional." They are now seen as experts in their field and expected to help the younger professionals on their journey. Many "senior professionals" find the work they do with those earlier in their careers to be rewarding (Ronnestad et al., 2018; Ronnestad & Skovholt, 2003).

Ronnestad and Skovholt (2003) indicated that throughout the counselor development model counselors are using their personal experiences and professional experiences as a self-reflecting tool in the work they accomplish with their clients. Several studies (Gant et al., 2019; Koltz & Champe, 2010; Meekums, 2008) have taken an autoethnographic approach to the counselors' journey during training. One study assessed the feelings of five social work students after spending time in their first field placement (Gant et al., 2019). An in-depth analysis led the authors to identify that students early in their careers must take time to self-reflect on their experiences (Gant et al., 2019; Koltz & Champe, 2010). In addition, early career students must be able to manage their own expectations about the work that they are accomplishing with their clients (Gant et al., 2019; Koltz & Champe, 2010). Instructors at training programs should have awareness of the students' concerns about field placements and work during their training to address as they begin their field work. The result of these studies acknowledged that this period in a professionals' life should be carefully monitored. Training programs should provide students additional support should they become overwhelmed with their own emotions (Gant et al., 2019; Koltz & Champe, 2010; Meekums, 2008).

Interventions

Studies on workplace strategies aimed at educating and training mental health professionals focused on ameliorating burnout through interventions (Ahola et al., 2017; Dreison et al., 2018b; Sexton & Adair, 2019). Interventions vary in length and type, and can include educational workshops, mindfulness practices, positive thinking, and organizational changes (Ahola et al., 2017; Dreison et al., 2018a; Sexton & Adair, 2019).

Studies on burnout intervention research found that the occurrence of burnout was high in mental health workers surveyed (Ahola et al., 2017; Dreison et al., 2018b; Sexton & Adair, 2019). Interventions included organizational changes, education, and job training. Despite the difference in interventions studied and the lack of intervention studies in the literature, all interventions were found to be somewhat effective. Scholars indicated that future studies and research endeavor to understand the most effective interventions for different types of professionals in graduate training and in the workplace (Ahola et al., 2017; Dreison et al., 2018b; Sexton & Adair, 2019).

Teaching various self-care strategies have also been found as an effective intervention at reducing burnout for mental health professionals (Mache et al., 2016; Sexton & Adair, 2019). Self-care can be described as the process of connecting with the self to heal what might be impaired due to the demands of the helping profession (Baker, 2009). This can include self-awareness, regulation of the self, or balancing the connections within the self to others and the community at large (Baker, 2009). Teaching positive thinking strategies, mindfulness, and coping skills were implemented as self-care strategies for mental health professionals working in community agencies. Positive thoughts were found to create a personal resource within the employee, and serve as a resilience factor for healthcare workers (Mache et al., 2016).

Mindfulness strategies have also been correlated with a reduction in burnout for mental health care professionals (Ahola et al., 2017). A combination of training in self-care and providing solution-focused counseling to psychiatrists was successful in reducing their perceived job stress and increasing their job satisfaction (Mache et al., 2016). Based on these studies, training for mental health professionals should include self-care skills, as they are effective at reducing perceived stress and are cost-effective (Ahola et al., 2017; Dreison et al., 2018b; Sexton & Adair, 2019).

Self-care. Self-care has become an important intervention for alleviating the negative impacts of working as a mental health professional. Self-care can be described as purposeful behavioral strategies, promoting the work and life balance of the self (Acker, 2018). Self-care can include self-awareness, regulation of the self, and balancing connections within the self to others (Baker, 2009). Evidence has indicated that self-care has a direct benefit to students in training and is considered an ethical imperative for professionals working in the field (Maranzan et al., 2018). Professionals have control over their engagement in self-care activities to mitigate the stress of their jobs. Therefore, teaching self-care and self-care strategies to students and professionals is an appealing and cost-effective intervention strategy (Acker, 2018; Callan, 2020; Maranzan et al., 2018; Warren & Park, 2018).

Not only are self-awareness and self-regulation components of self-care, but self-care also includes exercise, time spent with family, and short breaks between responsibilities (Di Benedetto & Swadling, 2014). Physical exercise, spiritual beliefs, and mindfulness as self-care behaviors contributed to overall well-being in several studies (Di Benedetto & Swadling, 2014; Goncher et al., 2013; Grover et al., 2017). Self-care activities correlated with an increase in burnout for counselors included engaging in dialogue outside of work about clients, and

counselors using substances such as alcohol and marijuana (Di Benedetto & Swadling, 2014; Goncher et al., 2013) Based on these findings, understanding the benefits of specific self-care behaviors in preventing burnout as well as a standardized measure of self-care behaviors is needed (Dreison et al., 2018b).

Psychologists early in their careers participated in less effective self-care activities than those later in their career (Dorociak et al., 2017). A Self-Care Behavior Inventory (SCBI) was developed in 2017 (Santana & Fouad, 2017). Prior to the development of this instrument, researchers used or modified the Professional Self-Care Scale (PSCS) for psychologists (Dorociak et al., 2017). This scale was developed specifically for practicing psychologists. A scale for other mental health professionals assessing self-care is still needed. The scale developed surveyed students in clinical or counseling doctoral programs (Santana & Fouad, 2017). The scale was divided into three subscales; the cognitive-emotional-relational aspect of self-care, the physical aspect of self-care, and the spiritual aspect of self-care. Their study developed and validated an instrument to assess professionals and students' self-care activities. The authors encourage other researchers to utilize this scale to help professionals and students understand self-care activities and how they relate to overall well-being.

Researchers explored self-care practices among social workers and found self-care strategies increased job satisfaction, and decreased intention to leave their jobs (Acker, 2018). The importance of studying self-care behaviors amongst psychology graduate students is critical as this is where training can have the most impact in the long-term professional life of mental health professionals (Santana & Fouad, 2017). Clarification of self-care behaviors is needed as they relate to well-being, competence, and burnout. It is also needed in studies using the SCBI on master's level mental health professionals and students in training. Reviews of the self-care

literature produced by several scholars (Callan et al., 2020; Rivera-Kloeppel & Mendenhall, 2021) yielded results that indicated a lack of robust methodology in the studies that exist on self-care and the mental health professional. The authors of both of these literature reviews indicated that the studies reviewed lacked reliability of instruments used, lack of representative samples, and lacked use of theoretical support to understand the findings (Benuto et al., 2018; Callan et al., 2020; Rivera-Kloeppel & Mendenhall, 2021). The authors suggested that future research on self-care in mental health professionals should include reflection of theory in analysis, utilize consistent and reliable measures, and specify with more clarity the types of mental health professionals studied. For example, the authors point out that not all mental health professionals have the same schooling and training. Therefore, scholars should work to understand the different types of professionals and how to study them separately. The mixing of types of professionals in the studies reviewed thus far lacks generalizability in applying these findings to all different types of mental health professionals (Benuto et al., 2018; Callan et al., 2020; Rivera-Kloeppel & Mendenhall, 2021).

Some more recent studies in the literature have attempted to summarize the literature findings to date on self-care and the mental health practitioner (Callan et al., 2020; Posluns & Gall, 2020; Schmidt & Hansson, 2018; Scott & Takarangi, 2019). These studies found that self-care was an effective intervention for students in psychology programs. Suggestions for future research included providing self-care instruction in psychology programs. While the review of the literature continues to support systematic instruction on self-care, the majority of the studies found in the literature were focused on doctoral students in psychology programs (Callan et al., 2020; Posluns & Gall, 2019; Schmidt & Hansson, 2018; Scott & Takarangi, 2019). The literature

needs to be expanded to include an understanding of self-care instruction for master's level mental health professionals.

Graduate School Interventions. Stressors unique to the student population have profound impacts on their well-being (El-Ghoroury et al., 2012; Rummell, 2015; Santana & Fouad, 2017). Limited resources, such as time and money, restrict the type of self-care practices students can utilize. There are very few studies that exist in the literature regarding specifically master's level mental health professionals and their experiences with graduate training (Myers et al., 2012; Zahniser et al., 2017). A meta-analysis was conducted to explore the relationship between self-care use and positive outcomes among professional psychology students (Colman et al., 2016). Overall, seventeen studies were found in the literature search, and of the studies found, four of them focused only on master's level mental health professionals in training (Colman et al., 2016). Eight studies focused on doctoral students, and five of the studies included a mix of both doctoral students and master's students. The results of the meta-analysis indicated there was a large effect size in favor of students engaging in self-care. Self-care was found to increase self-compassion, increase life satisfaction, and decrease psychological distress amongst the students in the studies. Graduate programs in professional psychology should create a culture of self-care in their graduate programs (Colman et al., 2016). In addition, professors in these programs should help students to develop a specific plan of self-care for their time in graduate school. Another study sought to understand wellness in students entering a master's level counseling program (Smith et al., 2007). They found those students who scored lower on wellness measures had higher scores on psychological distress measures than students who scored higher on wellness measures (Smith et al., 2007). The authors suggested using wellness scales as screening tools for students entering master's level graduate training. Providing

education on self-care to those students who might need to improve their overall wellness was also suggested as a potential intervention (Smith et al., 2007). Other studies of students in master's level mental health training provided self-care interventions (specifically mindfulness attitudes) and measured the effectiveness of these interventions on well-being and mental health (Shapiro et al., 2007; Stafford-Brown & Pakenham, 2012). Mindfulness-based self-care interventions were highly effective in improving students' mental health, and feelings of professional competency when treating clients. The authors suggested implementing mindfulness-based self-care strategies in graduate training programs for master's level mental health professionals (Shapiro et al., 2007; Stafford-Brown & Pakenham, 2012).

Overall, the studies of self-care as an intervention in graduate training are from psychologists in clinical or doctoral training. Top stressors for doctoral students enrolled in clinical training included coursework, lack of income, preoccupation with worrisome thoughts, and poor work/school-life balance (El-Ghoroury et al., 2012; Myers et al., 2012; Rummell, 2015). A majority of students reported experiencing serious physical symptoms that included headaches, back pain, irritable bowels, depression symptoms, and anxiety symptoms. This is more than double the rates that experience this in the general population (Rummell, 2015). Lower self-care efforts and lack of finances to engage in self-care efforts resulted in higher levels of burnout in the student population (El-Ghoroury et al., 2012; Rummell, 2015; Santana & Fouad, 2017). Eleven psychology students were interviewed and they were under extreme amounts of stress impacting them daily, specifically financial stress (Olson-Garriott et al., 2015). This situation had a negative impact on career choice, healthy coping skills, and relationships with others. Psychology training programs should provide additional support to their students

and to identify programs assisting students with coping with significant financial debt (El-Ghoroury et al., 2012; Olson-Garriott et al., 2015; Rummell, 2015; Santana & Fouad, 2017).

Coping strategies utilized most frequently by students included relying on friends and family support, physical exercise, and colleague support (El-Ghoroury et al., 2012; Myers et al., 2012; Santana & Fouad, 2015). Self-care practices associated with lower perceived stress for students included good sleep hygiene practices, strong social support, cognitive reappraisal, and formal mindfulness practices (El-Ghoroury et al., 2012; Goncher et al., 2013). Overall, students who participated in effective self-care were less likely to burnout. They also reported less perceived stress than those students who did not utilize self-care effectively (El-Ghoroury et al., 2012; Goncher et al., 2013; Myers, 2012; Santana & Fouad, 2015; Zahniser, 2017).

Evidence suggests self-care is associated with higher well-being and better training outcomes for psychology doctoral students. However, research on clinical training programs indicate a lack in clarity of teaching this concept in training programs (Bamonti et al. 2014; Myers et al., 2012; Rummel, 2015). A few studies explored formal practices in clinical psychology programs related to self-care instruction. There is little formal instruction on self-care in graduate training (Bamonti et al., 2014; Goncher et al., 2013; Zahniser et al., 2017). One course of action reported by students in graduate training for psychology endorsed by faculty is to seek utilization of psychotherapy services (Bamonti et al., 2014). Less than 20% of the students reported utilizing psychotherapy services due to financial constraints. Student perceptions of graduate training programs instruction on self-care lacked systematic instruction (Bamonti et al., 2014). Other perceptions of program self-care emphasis from students indicated that real efforts to encourage self-care were not made by faculty (Goncher et al., 2013). Self-care was not modeled for students by faculty and the culture did not value self-care because the

demands on students did not line up with the idea of taking care of one's self first (Bamonti et al., 2014; Goncher et al., 2013; Zahniser et al., 2017). Providing specialized training on professional quality of life and self-care is needed, given that students possess risk factors for adverse outcomes of the job. In addition, studies of graduate students and training, specifically for master's level mental health professionals enrolled in master's degree programs (in social work, counseling, or psychotherapy), are needed. The literature could help researchers clarify how this type of graduate training incorporates professional quality of life and self-care instruction into their curriculum and program culture (Rummell, 2015; Santana & Fouad, 2017).

Graduate Training for Mental Health Professionals

Improving graduate training for mental health professionals in areas of self-care, burnout, compassion fatigue, secondary traumatic stress, and compassion satisfaction has been suggested by the majority of research conducted on this topic (Callan et al., 2020; Rivera-Kloeppel & Mendenhall, 2021; Rummell, 2015; Santana & Fouad, 2017). However, the literature has very few studies that specifically explore graduate training for master's level mental health professionals. Internet-based training handbooks of general and clinical psychology doctoral graduate programs in the United States were reviewed by researchers (Bamonti et al., 2014). The authors determined that in the general psychology doctoral programs, the phrase "self-care" was referenced in about 8% of the programs. In the clinical psychology doctoral programs, about 24% contained references to self-care. The mention of the terms "work-life balance", "stress", and "burnout" was described as minimal (Bamonti et al., 2014). The study did not look at the masters' level clinical psychology training programs. Graduate programs for master's level mental health professionals and the training policies on burnout and self-care that they choose to adopt should be understood by researchers. A research-informed implementation of self-care

training in graduate programs for clinical psychology is still needed (Goncher et al., 2013). Another suggestion is to incorporate instruction on self-care and burnout into the curriculum for different types of training programs for master's level mental health professionals (Bamonti et al., 2014; Dorociak et al., 2017; Goncher et al., 2013).

One study reviewed training on professional quality of life in graduate programs; the researcher focused on the implementation of education on compassion fatigue and compassion fatigue prevention (Scroggins, 2016). The presence of compassion fatigue training and answers about barriers to implementing self-care training was studied. Chairs from clinical psychology doctoral programs were the majority of respondents (n=51), while the others were from counseling psychology doctoral programs (n=18). Results revealed that the overwhelming majority of responding chairs reported no compassion fatigue prevention training (75.4%). The most frequently responded reasons why there was not training was "other." "Lack of time", "lack of need", and "lack of funds" were the next most popular responses. The study also did not include any master's level clinical psychology programs. Despite the limitations, this study begins the exploration of how graduate training programs are addressing compassion fatigue in their training. Based on this study, there appears to be a lack of formal training in doctoral programs on compassion fatigue. The next step for the literature would be further research on training in professional quality of life for master's level programs for licensed professionals (Bamonti et al., 2014; Ray et al., 2013; Scroggins, 2016).

Incorporating prevention training for burnout into graduate programs has been suggested by several researchers (Baugerud et al., 2018; Ivicic & Motta, 2017; Laverdière et al., 2018; Sodeke-Gregson et al., 2014; Thompson et al., 2014). The integration of education on well-being

and awareness of emotional health may also be included in training programs for master's level mental health professionals (Laverdière et al., 2018).

Conclusion

It is apparent that mental health providers earlier in their careers possess several risk factors for developing adverse impacts of the job (Baugerud et al., 2018; Ivicic & Motta, 2017; Laverdière et al., 2018; Sodeke-Gregson et al., 2014; Thompson et al., 2014). Based on the findings from literature, it is important to understand how professionals experience conditions of burnout, compassion fatigue, and secondary traumatic stress over the span of their careers (Dorociak et al., 2017). Compassion satisfaction and self-care are important resources preventing professionals from developing adverse impacts of the job (Laverdière et al., 2018; Sodeke-Gregson et al., 2014; Thompson et al., 2014). The components of professional quality of life and how they serve as resources or demands in master's level mental health professionals needs to be understood using a theoretical model. One theoretical model that can be used to understand professional quality of life is the JD-R model (Dreison et al., 2018a; Shoji et al., 2015).

Mental health professionals receiving interventions in the literature findings often have positive outcomes including a decrease in likelihood to burnout (Ahola et al., 2017; Dreison et al., 2018b; Sexton & Adair, 2019). Based on these findings, more needs to be done to help these professionals through interventions and trainings (Dreison et al., 2018a). Interventions and trainings would be most practical for students in graduate school. The studies reviewed suggested not much is being done to address professional quality of life and self-care in the graduate training of master's level mental health professionals (El-Ghoury et al., 2012; Goncher, 2013; Myers, 2012; Santana & Fouad, 2015; Zahniser, 2017). Exploring theories of counselor development and applying them to graduate training is needed to help prepare these

professionals for well-being and overall competence in their professional pursuits (Koltz & Champe, 2010; Pratt & Lamson, 2011; Ronnestad & Skovholt, 2003). Finally, many of the studies in the literature are focused on psychologists, doctoral students, or a mix of master's level clinicians and psychologists. Master's level mental health professionals and their professional quality of life as well as their training in these concepts needs to be explored in the literature. Training for master's level mental health professionals is substantially different than the training for psychologists and those in doctoral training programs (Bamonti et al., 2014; Ray et al., 2013; Scroggins, 2015).

Chapter III

Design and Methodology

Introduction

The purpose of this mixed methods study was to examine master's level mental health professionals professional quality of life and training on professional quality of life. In addition, this study explored how master's level mental health professionals describe their motivations and goals for themselves in their professional lives as well as their goals for the clients that they are treating. In many institutional settings, hospital settings, and outpatient clinics in the United States, it is these clinicians or students enrolled in graduate training programs who are providing ongoing clinical support to persons diagnosed with mental health conditions (Goncher et al., 2013). Supporting and training these professionals to sustain a satisfactory professional quality of life benefits master's level mental health professionals and the patients that they are helping (Dorociak et al., 2017; Dreison et al., 2017; Zahniser et al., 2017).

Chapter III describes the methodology and research design utilized to collect and analyze data related to professional quality of life for master's level mental health professionals. This chapter describes the study's procedures such as instrumentation, population, and analysis. It also provides information on the role of the researcher, reliability of the study, and limitations of the study.

Research Questions

How master's level professionals experience professional quality of life and how their graduate training instructs on professional quality of life is an important area of research. (Dreison et al., 2018a; Dreison et al., 2018b; Hall et al., 2016; Laverdière et al., 2018). Based on these needs, the following are the research questions that this study addresses:

RQ1: Are pre-licensed master's level and early-career mental health professionals experiencing burnout, compassion fatigue, and secondary traumatic stress at higher rates than master's level mental health professionals who are mid-career and late-career?

RQ2: Do compassion satisfaction scores on ProQOL for master's level mental health professionals impact other scores on the Professional Quality of Life Scale?

RQ3: Are there differences between types of training and measures of professional quality of life?

RQ4: How do master's level mental health professionals rate their graduate training in professional quality of life?

RQ5: How do motivations, career goals, and goals for clients change as helping professionals are in different career stages?

Research Design

This study used a convergent mixed-method design to investigate the professional quality of life of master's level mental health professionals. This is a single-phase approach where both quantitative and qualitative data are collected at the same time and then compares both findings (Creswell & Creswell, 2018). Given the complexity of today's societal problems, multiple ways of answering difficult research questions should be considered (Greene & Caracelli, 1997). Greene and colleagues (1989), reviewed several mixed-methods designs, and provided five purposes for utilizing a mixed-methods approach. These five purposes are "a) triangulation, b) complementarity, c) initiation, d) development, e) expansion" (p.257). This study used a mixed methods approach to achieve triangulation and complementarity. Triangulation indicates that there is a convergence of results. Quantitative and qualitative findings overlap and better explain

the concepts of professional quality of life and training in burnout prevention for graduate students and professionals (Tashakkori & Teddlie, 1998). To achieve a complementarity design, findings from qualitative and quantitative methods clarified the respective findings from each method (Tashakkori & Teddlie, 2010). In this design, the qualitative methods helped provide additional information about master's level mental health professionals professional quality of life, and their training in professional quality of life. This approach occurs in one phase, and primarily assumes that both types of data provide different kinds of information that aid in answering the research questions (Creswell & Creswell, 2018). This design was chosen because quantitative methods are the most standard and most accepted in psychology research (Tashakkori & Teddlie, 2010). Results from qualitative methods often provide in depth understanding on a topic that has not been covered extensively in the literature (Tashakkori & Teddlie, 1998).

Participants

Quantitative. Participants for this study were drawn from a purposeful sample of master's level mental health professionals who are licensed clinicians or pre-licensed clinicians in the United States. Participants were recruited from announcing the study on social media (Instagram, Facebook, LinkedIn) and a subscribed listserv (Kent State University) of the researcher to complete an online survey through Qualtrics, an online survey management tool. Online surveys have become the predominant method of survey collection in academic research (Saleh & Bista, 2017). Online data collection has increased with popularity due to the ease of data collection and a higher response rate than paper surveys (Saleh & Bista, 2017). For this survey, the response rate was 26.5%. 446 persons clicked on the link to the survey and 118

persons completed the survey. Fifteen responses were discarded because they did not meet the criteria for participation. Participants were included if they met the following criteria:

- currently enrolled in a master's graduate training program for clinical psychology, counseling, social work, or marriage and family therapy
- graduated from a master's program in clinical psychology, counseling, social work, or marriage and family therapy
- currently employed or doing an internship at a site providing mental health care treatment.
- If they earned a doctorate degree beyond a master's degree, they were not included in the study.

The sample consisted of 14 males, 88 females and 1 gender queer from the United States. There were 47 early career master's level mental health professionals and 56 mid and late career master's level mental health professionals. There were different types of professionals including 56 pre-licensed or licensed therapists, 38 pre-licensed and licensed professional counselors and 9 pre-licensed or licensed social workers and 1 licensed mental health counselor (see Table 1).

Table 1

Clinician Demographics

Variable	N	%
Demographics		
Female	88	85.4%
Male	14	13.6%
Gender queer	1	1%
Professional characteristics		
Career Stage		
Early	47	45.6%
Mid	46	44.7%
Late	10	9.7%

Professional Status		
Pre-licensed Therapist or Licensed Therapist	56	54.4%
Pre-licensed Social Worker or Licensed Social Worker	9	8.7%
Pre-licensed Clinical Counselor or Licensed Clinical Counselor	38	36.9%
Education		
Masters in Counseling	35	33.9%
Masters in Clinical Psychology	33	32.0%
Masters in Marriage and Family Therapy	20	19.4%
Masters in Social Work	10	9.7%
Other	4	3.9%
Masters in Counseling Psychology	1	.97%

Qualitative. The qualitative sample in this convergent mixed methods design came from the one phase collection of data. The sample came from the same sample as the quantitative sample, however less participants completed the open-ended questions at the end of the survey. Creswell and Guetterman (2019) explain that this is common with qualitative questions, however the response rate should be at least above 50%, and in this study all open-ended questions had response rate above 50%. Qualitative methods help researchers to explain the processes that connect people and situations, while quantitative data explains variables as statistical relationships (Maxwell, 2013). In this study, qualitative data collected from the open-ended questions answered research question 4 and 5, and provided in depth information on the master's level mental health professionals' perspective on the meaning they give to their careers. Maxwell (2013) explains that one goal of qualitative research is to look at the "participants' perspective" (p.30); as these are a large part of the subjects' experiences that need understanding. The open-ended questions at the end of the survey provided the researcher the opportunity to find similarities and differences in how master's level mental health professionals viewed their professional goals, goals for clients, and motivations for working as a helping professional. In addition, Wallace and colleagues (2018) argue that open-ended questions in an online survey

elicit more candid responses and reduce the need for participant social desirability in their answers. Each open-ended question had a different response rate, but all were above 50% (see Table 2). According to Creswell and Guetterman (2019) an acceptable response rate for educational journals is 50% or higher.

Table 2

Open-ended Questions Response Rate

Question	Number of Responses	Early	Mid/Late	Overall Response Rate for each Question
If you received no training or minimal training on the above concepts, describe what would have been helpful to you during your training.	53	24	29	51%
Describe your motivations for your career choice as a helping professional.	87	41	46	84%
What do you view as your ultimate goals for the clients you help?	92	43	49	89%
How do you determine if you are reaching your professional goals?	82	37	45	80%
Do you feel that your own therapy is a critical component to helping your clients?	86	42	44	83%
If you could explain how you would like others to describe your work as a helper, what would it be?	89	41	48	85%

Data Collection

When collecting data from human subjects, researchers must be aware of any ethical issues that could arise. Specifically, a researcher needs to understand how to protect their subjects from harm, ensure confidentiality, and obtain a signed informed consent explaining the purpose of the study clearly to participants (Creswell & Creswell, 2018). As a first step in ensuring that this data was collected ethically, the researcher participated in training and

certification from the Association of Clinical Research Professionals on ethics and human subject protection (see Appendix G). As a next step to ensuring ethical research, an application was submitted to the Institutional Review Board (IRB) at Northwest Nazarene University (see Appendix F). The online survey was designed and distributed through Qualtrics. Qualtrics in an online tool for collection survey responses and ensures a valid process for data collection. Qualtrics provides information that is helpful to the researcher regarding number of visits to the survey, number of surveys started, and number of surveys completed.

The data collection process began in August 2020 and concluded in January 2021. A social media announcement for the study (see Appendix H) was made on the researcher's professional Instagram on September 8th, September 22nd, and December 14th. A social media announcement for the study was made on the researcher's personal Facebook page on September 8th, September 9th, September 24th, October 23rd, and December 14th. Also, the snowball method was used to recruit therapy colleagues to post the link to the survey on their Instagram and Facebook pages. Announcements on the researcher's LinkedIn account were made on September 9th, October 23rd, and December 14th. The survey was also posted to Kent State University listserv. The announcement was posted to this listserv on November 23rd, November 24th, and December 16th. An opportunity drawing was mentioned in the announcement for the survey, stating that three participants chosen at random had the chance to win a 50-dollar amazon gift card.

Once the potential participants clicked on the link to the survey, they were asked to read and sign an informed consent. An informed consent is important to ensure the data is collected ethically (Creswell & Creswell, 2013). The informed consent includes information provided to the participants before they agree to complete the study. This included the purpose of the study,

measures taken by the researcher to ensure confidentiality, potential risks to the participant, the ability of the participant to not answer any questions that made them uncomfortable, and the ability to drop out of the study at any time (see Appendix E). The informed consent also announced the opportunity drawing and that if participants wanted to be included in the drawing. If they did not want to participate in the drawing or did not want to provide their email address, they could refuse to participate (see Appendix E). If they selected to be included in the drawing, they were to provide an email address. Each participant in the drawing was assigned a number. Using numbergenerator.org, three numbers were chosen at random, and three participants won a $50 gift certificate to amazon.com. The gift cards were emailed to the winners. Participants had the choice to not participate in the opportunity drawing.

In the process of designing this research study, protection of human subjects was thoughtfully considered (Marshall & Rossman, 2016). While it was determined that taking the survey would have minimal impacts on participants, researcher contact information, and research supervisor's contact information was given in the event taking the survey brought up questions that they wanted to discuss further (see Appendix E). In addition, ethical consideration for human participants involves ensuring confidentiality. All identifying information was removed from the data prior to data analysis. The data was stored on a USB device, as well as a backup USB device requiring a password to open known only by the researcher. Data will be kept for three years and then destroyed, in compliance with the Federalwide Assurance Code.

Instrumentation

Quantitative. Quantitative surveys help researchers to answer questions about relationships between variables, descriptive information, and prediction about relationships over time (Creswell & Creswell, 2018). Once relationships are understood in the sample by measuring

and understanding correlations between variables, the results may generalize to a broader population. The instrument used to measure quality of life for master's level mental health professionals included the Professional Quality of Life Scale (ProQOL) (See Appendix B). The Professional Quality of Life Scale (ProQOL) was developed by Stamm (2010). According to the authors of the scale, there is good construct validity for this concept, with over 1000 published papers (n=1187) using the ProQOL as the scale (Stamm, 2010). Construct validity is an essential component of survey research, construct validity refers to the survey measuring accurately what it is supposed to measure (Creswell & Creswell, 2018). This instrument has been widely used in studies of burnout, compassion fatigue, secondary traumatic stress, and compassion satisfaction in therapists, counselors, social workers, and psychologists. There are three subscales; the burnout subscale, the secondary traumatic stress subscale, and the compassion satisfaction subscale. By looking at the scores on each subscale, the scale produces an overall measure of the professional quality of life for those in the helping professions. The ProQOL uses a 5-point Likert scale (1 – never to 5 – very often) with 30 items total. Respondents are asked to read each statement in relation to their current work situation and select the number that reflects how frequently they have experienced these occurrences in the last 30 days (Finklestein et al., 2015). In addition to validity, quantitative measures must demonstrate reliability. Reliability refers to the consistency of an instrument over time and over different studies (Creswell & Creswell, 2018). In quantitative research internal consistency is the most important form of reliability, and it refers to the items in the survey behaving the same way over time (Crano et al., 2015). Cronbach's alpha (α) is used in quantitative research to demonstrate a scale's internal consistency, and the value ranges from 0 to 10 (Creswell & Creswell, 2018). The degree of internal consistency is considered to be good if α is .75 or above (Crano et al., 2015). The

authors of the scale have provided the alpha scale reliability for each subscale of the ProQOL (see Table 3) (Stamm, 2010).

Table 3

Alpha Scale Reliability ProQOL

Subscale	Cronbach's Alpha (α)	n
Compassion Satisfaction	.88	1187
Burnout	.75	1187
Secondary Traumatic Stress	.81	1187

In addition to the ProQOL, a demographic questionnaire developed by the researcher was included in the study (see Appendix A). The demographic questionnaire was included at the beginning of the survey and included questions about age, race, and gender. The demographic questions also included education questions such as type of graduate training, specialized training, and length of time post-graduation. Career variable questions included professional license, type of vocational setting, hours per week seeing clients, length of time in vocational setting, professional license, and number of hours seeing trauma clients. These demographic questions were included to look for correlations between career characteristics and professional quality of life. The researcher developed a demographic questionnaire to address demographic questions based on the demographic variables of similar studies (Laverdière et al., 2018; Sodeke-Gregson et al., 2013).

The next area studied was participants' perceptions of their graduate training in professional quality of life (burnout, compassion fatigue, secondary traumatic stress, and compassion satisfaction). After the participants completed the professional quality of life scale, a new screen appeared with separate questions related to graduate training (see Appendix C). Crano and colleagues (2015) indicate that well designed questionnaires can systematically

measure people's experiences; and this continues to be a major benefit of research in the social sciences. Currently, there is no instrument developed in the literature to measure professional quality of life training in graduate training programs. The researcher developed a short questionnaire to assess this research question. When designing and developing new questionnaires, it is important to rely upon already established scales of measurement. For example, one of the most accepted scales of measurement is the Likert method of summated ratings. The Likert scale generally includes five options of responses in rank order from lowest to highest (Crano et al., 2015). The researcher was looking for participant attitudes about the frequency of teaching during graduate training on burnout, compassion fatigue, secondary traumatic stress, and compassion satisfaction (see Appendix C). The response choices were comprised of 5-point Likert scaled with responses including 1-Never, 2-Rarely, 3-Sometimes, 4-Often, 5-Very Often. In addition, because there are currently no validated instruments to measure graduate instruction in the professional quality of life, the questions to assess this research question were designed by the researcher. Without a test of validity and reliability or a pilot test, the questionnaire developed to understand the training in these areas might not have captured the reality of this area of interest.

Qualitative. The qualitative portion of the survey design included the final six questions of the survey and were open-ended questions seeking to understand more information about graduate training (see Appendix C) and the career stage of the professional (see Appendix D). While quantitative data often seeks to understand causal relationships between variables, qualitative data often seeks to understand the process that connects variables (Maxwell, 2013). For example, the strength of qualitative data is that it explains different processes leading to different outcomes in specific situations (Merriam, 1988). After the quantitative questions

regarding training on professional quality of life, there was one open-ended question for respondents to provide any additional information on their training in the areas previously questioned (see Appendix C). There are limited studies in the literature about graduate training in professional quality of life, (Baugerud et al., 2018; Dreison et al., 2018b; Laverdière et al., 2018; Sexton & Adair, 2019) and this additional question was designed to give the researcher more in-depth information about the participants' experiences in graduate training regarding research question four.

The qualitative questions in this study were developed to address research question five; regarding how do motivations, career goals, and goals for clients change as helping professionals are in different career stages. The open-ended questions are based on Ronnestad & Skovholt (2003) themes of counselor development, which seek to find answers to questions about how a mental health professional views their role as a helper; and if that process changes from the beginning stages of one's career to the later stages of one's career (See Appendix D). Open-ended questions have the advantage of not limiting answers to a set of already chosen responses (Allison et al., 2002; Crano et al., 2015). Freedom of response is a major advantage to open-ended questions. However, open-ended questions also have criticisms, such as they often make it harder to categorize and code responses (Maxwell, 2013). Despite the criticisms, the data gathered can often be rich in description and explain with more clarity a certain phenomenon of interest (Crano, 2015).

Analytical Methods

Quantitative Analysis. Creswell and Guetterman (2019) summarize the steps required for analyzing quantitative data. First, the researcher must prepare the data for analysis. This involves assigning numeric value to variables in the dataset. Second, the researcher can examine

their hypotheses by using inferential statistics. The quantitative analysis was completed using IBM SPSS Statistical Software Version 26 (IBM, SPSS, 2021). Survey data was collected using Qualtrics, a web-based platform. This platform provides transfer of data to the SPSS Statistical software. The data was carefully organized and data was removed when it did not meet the participant criteria. The researcher than reviewed demographic responses and scored the variables by providing numeric value to them. The variable of interest for analysis was career stage, so the category was coded in numerical value to reflect the career stage of the participant. Early career professionals were assigned the number 1, while mid and late career professionals were assigned the number 2. Another variable of interest was professional status, so this category was coded in numerical value as well. Each professional status was assigned a number, marriage and family therapists were assigned the number 1, counselors were assigned the number 2, and social workers were assigned the number 3. These variables were re-coded in SPSS to represent nominal variables, because in this case the numbers represent names and this is the default format for analysis in SPSS (Field, 2018). These groups represent natural occurring groups and are the independent variables in this research design.

Once the variables of interest were re-coded, each quantitative research question was analyzed using inferential statistics. Predicting early-career master's level mental health professionals would have higher levels of burnout, compassion fatigue, and secondary traumatic stress than mid-career and late-career mental health professionals was stated in the first hypothesis. Correlational research was used to determine the relationship between career stage and professional quality of life scores on the subscales of burnout, compassion fatigue, and compassion satisfaction. Cresewell and Guetterman (2019) describe that the purpose of

correlational research is to see if variables are associated. A correlation is a linear relationship that explains how two variables vary consistently.

High compassion satisfaction scores for both early career and mid/late career master's level mental health professionals were predicted to correlate with lower scores on the subscales of burnout and secondary traumatic stress in ProQOL for hypothesis 2. A multiple regression determined whether those who had higher scores on the compassion satisfaction subscale would have lower scores on the subscales of burnout and secondary traumatic stress. Multiple regression analysis allows the researcher to compare each predictor variable to other predictors to understand the significance of the relationship (Frey, 2016).

Pre-licensed and licensed therapists were predicted to have higher scores of burnout and secondary traumatic stress than pre-licensed and licensed social workers and counselors. Mean measures of the subscales of ProQOL were compared across groups of social workers, therapists, and counselors.

It was hypothesized that graduate programs for mental health professionals would not offer professional quality of life training as a part of their curriculum in hypothesis four. Each question about graduate instruction was analyzed to determine how frequently students recalled learning about professional quality of life terms. Frequencies were combined for sometimes/often/very often and combined for never/rarely. These results indicated if the sample reported sufficient graduate training in areas of burnout, compassion fatigue, secondary traumatic stress, and compassion satisfaction (See Table 4).

Table 4

Research Questions and Tests

Research Question	Quantitative or Qualitative Test	Independent Variable	Dependent Variable(s)
Are pre-licensed master's level and early-career mental health professionals experiencing burnout, compassion fatigue, and secondary traumatic stress at higher rates than master's level mental health professionals who are mid-career and late-career?	ANOVA	career stage	burnout secondary traumatic stress
Do compassion satisfaction level mental health professionals impact burnout and compassion fatigue, secondary traumatic stress scores on the Professional Quality of Life Scale?	Regression and Correlation	compassion satisfaction	burnout secondary traumatic stress
Are there differences between types of training and measures of professional quality of life?	Mann-Whitney	professional status	burnout secondary traumatic stress
How do master's level mental health professionals rate their graduate training in professional quality of life?	Frequencies	all professionals	graduate training in burnout secondary traumatic stress compassion satisfaction
How do motivations, career goals, and client goals change as helping professionals are in different career stages?	Coding and themes	career stage	motivations career goals

Qualitative Analysis. As with quantitative data, there is also a step by step process to analyzing qualitative data; this process contains six steps (Creswell & Guetterman, 2019). The first step in the process involves preparing the data for analysis by organizing the data. The data was organized by first dividing the answers by career stages (early and mid/late), numbering

each response, and adding each individual response into a data table with two columns. The first column included the response while the second column included a section for the thematic code of the response. The second step in the qualitative data analysis process is engaging in the beginning stage of inquiry through coding. The codes formed in this analysis can be described as in-vivo codes. Marshall and Rossman (2016) define in-vivo codes as codes that emerge in the data as it is collected (p.218). The advantage of using in-vivo codes is that the researcher is sensitized from the literature review to recognize themes that emerge from the literature that fit in with hypothesized relationships. At the same time, the researcher is also sensitized to recognizing when these themes do not appear in the data, and the different themes that have emerged during the data collection process. Each open-ended question in this analysis had several responses that were reviewed several times by the researcher before assigning a code. After reviewing the answers of each group to each question several times, initial broad categories were determined based on the frequency of similar responses and words. The third step in qualitative data analysis is using codes developed in the initial inquiry to develop themes. The researcher then took assigned codes and developed corresponding themes with a corresponding number, and the researcher coded each individual response by the respective theme number. Broad categories were identified with the help of grounded theories of counselor development such as importance of education, experience, and how goals change as one progresses in their career (Ronnestad & Skovholt, 2003). Once the themes were identified and assigned, frequency of responses were tallied and the number of responses was placed next to the theme. The fourth step in the qualitative data analysis process involves creating visual representations of the themes developed. The fifth step in the qualitative data analysis process involved explaining the meaning of the data based on the literature regarding the findings. Both of these steps will be

discussed further in Chapter IV. Finally, the sixth step of qualitative data analysis is having a strategy to validate the findings. Qualitative validity indicates that the researcher checks for accuracy of findings and qualitative reliability refers to the approach of the researcher as consistent across findings (Creswell & Creswell, 2018). To ensure both validity and reliability for the qualitative results, the researcher participated in peer debriefing with a person familiar with the study. Raw data, codes and themes were provided to the peer debriefer, and she conducted a thorough review of the qualitative data. The researcher and the peer debriefer reviewed themes together during several zoom meetings for accuracy and consistency ("Qualitative Data Meeting", S.J. Hohmann, personal communication, June 22, 2022, July 8, 2022, July 13, 2022).

Role of the Researcher

The researcher in this study had minimal interactions during the quantitative portion of the survey. The researcher's social media was used to announce the survey and recruit participants. Despite limited interaction with participants, the researcher is not without bias in designing this study. The author of this study is a licensed marriage and family therapist, trained in a clinical psychology program for pre-licensed marriage and family therapists. During training, the researcher worked at a community mental health clinic encountering clients who were severely traumatized. These encounters changed the researcher's worldview, caused the researcher to question her religious beliefs, and beliefs in others. The researcher experienced frequent exhaustion, sometimes dreaded going to work, and had difficulty meeting with clients with severe trauma histories. Hoping to receive graduate instruction or training on how to deal with these encounters with traumatized individuals, the researcher never learned of the concepts of burnout, compassion fatigue, secondary traumatic stress, and compassion satisfaction. Most professors responded to concerns with instructions to seek personal therapy. The researcher

could have ultimately benefitted from additional support and systematic instruction on professional quality of life and self-care. The design of this study is based on the researcher's distinctive point of view and experiences working in the field as a master's level mental health professional.

Limitations

Research studies are not without weaknesses or limitations (Creswell & Guetterman, 2019). There were several limitations to the results of this study. One limitation was survey fatigue. Due to the length of the survey, many participants became tired and did not complete the survey. The next limitation was the participant response rate. Due to the main approach of recruiting participants through social media, there were several results from unqualified candidates who completed the survey had to be removed from the data. The population studied was narrowed to master's level mental health professionals, therefore the findings from this study cannot be generalized to professionals not classified as master's level mental health professionals.

Chapter IV

Results

Master's level mental health professionals working in mental health care settings provide continuous support to patients seeking mental health treatment. These professionals often provide emotional support to persons who are suffering, and over time can take a toll on their emotional, physical, and mental well-being (Rivera-Kloeppel & Mendenhall, 2021). With the onset of the Covid-19 pandemic and the increase in reported mental health symptoms; several researchers have urged scholars and practitioners to prioritize the well-being of mental health professionals (Li et al., 2022; Sovold et al., 2021). Studies have indicated that some professionals experienced a decrease in well-being based on workplace setting factors, individual characteristics, and client variables (Berjot et al., 2017; Dreison et al., 2018a; Laverdière et al., 2018; Sodeke-Gregson et al., 2013). Workplace interventions targeted at the various factors contributing to a decrease well-being have been somewhat successful in alleviating the symptoms associated with stress in the workplace (Ahola et al., 2017; Dreison et al., 2018a; Sexton & Adair, 2019). In addition to workplace interventions as a potential solution to this problem, scholars have also suggested targeting interventions when professionals are still in their graduate school training (Callan et al., 2020; Rivera-Kloeppel & Mendenhall, 2021; Rummell, 2015; Santana & Fouad, 2017). There are many different types of training for mental health professionals, which can include master's level training in areas of clinical psychology, social work, professional counseling, and marriage and family therapy (Ray et al., 2013). Training can also include doctoral degrees in clinical psychology, social work, professional counseling, and marriage and family therapy. The literature to date on mental health professionals' well-being

often does not separate these professionals into distinct categories (Colman et al., 2016; Myers et al., 2012; Zahniser et al., 2017). In addition, there are a lack of studies specifically focusing on professional quality of life training for master's level mental health professionals in graduate training (Colman et al., 2016). The purpose of this mixed methods study was to examine quantitatively master's level mental health professionals' professional quality of life and training on professional quality of life. The qualitative portions of this study explored how master's level mental health professionals describe their training in professional quality of life as well as their motivations and goals for themselves in their professional lives as well as their goals for the clients that they are treating. The questions informing this dissertation were:

1. Are pre-licensed master's level and early-career mental health professionals experiencing burnout, compassion fatigue, and secondary traumatic stress at higher rates than master's level mental health professionals who are mid-career and late-career?
2. Do compassion satisfaction scores on ProQOL for master's level mental health professionals impact burnout, compassion fatigue, and secondary traumatic stress scores on the Professional Quality of Life Scale?
3. Are there differences between types of training and measures of professional quality of life?
4. How do master's level mental health professionals rate their graduate training in professional quality of life?
5. How do motivations, career goals, and goals for clients change as helping professionals are in different career stages?

Chapter IV offers data findings for each research question by using a convergent mixed-method design to investigate the professional quality of life of master's level mental health professionals. This single-phase approach using quantitative and qualitative data collection obtained both sets of data at the same time (Creswell & Creswell, 2018) and then compared both findings to answer the research questions. The data was collected from a purposeful sample of master's level mental health professionals who are licensed clinicians or pre-licensed clinicians in the United States.

Research Question #1

The professional quality of life for a mental health professional encompasses burnout, compassion fatigue, and secondary traumatic stress. In addition to the negative outcomes of working in the mental health field are the positive feelings that come with working in the mental health field: compassion satisfaction (Baugerud et al., 2018; Sodeke-Gregson et al., 2013). The Professional Quality of Life Scale (ProQOL) measures these concepts and has been used in studies of mental health professionals (Finklestein et al., 2015). Several studies on mental health professionals have found that students and professionals early in their careers possess several of the risk factors that can lead to increased levels of burnout, compassion fatigue, and secondary traumatic stress (Dreison et al., 2018b; Finklestein et al., 2015; Laverdière et al., 2018; Lawson & Myers, 2011). Based on these studies, the first research question sought to understand professional quality of life from a career stage perspective:

> Are pre-licensed master's level and early-career mental health professionals experiencing burnout, compassion fatigue, and secondary traumatic stress at higher rates than master's level mental health professionals who are mid-career and late-career?

The hypothesis for this question is: there will be a statistically significant difference between pre-licensed professionals and early career professionals compared to mid-career and late-career professionals on the ProQOL subscale of burnout and secondary traumatic stress such that those pre-licensed and early career professionals will have higher burnout and secondary traumatic stress scores than mid and late career professionals. This question was answered by using quantitative methods and comparing scores of burnout and secondary traumatic stress between early career master's level mental health professionals and mid/late career master's level mental health professionals. The latter category combined mid and late career professionals into one category based on the low response rate of late career master's level mental health professionals.

The parameters of these two distributions were normal, which was measured in early career professionals (M= 51.43, SD=10.11) and mid/late career professionals (M= 48.80, SD= 9.84). An Analysis of Variance (ANOVA) was utilized, as one nominal independent variable and one interval dependent variable were present (Frey, 2016). ANOVA is used when one wants to compare if the differences in means of the variables of interest are statistically significant (Creswell & Guetterman, 2019). In this case, the independent variable is career stage (early or mid/late) and the dependent variable is score on subscale of burnout and score on subscale of secondary traumatic stress. As a result of conducting the ANOVA, there was no significant difference between mean scores on the burnout subscale for early career and mid/late career professionals. Early career professionals' distribution for burnout had a mean of 51.43 with a standard deviation of 10.11. Mid/late career professionals' distribution for burnout had a mean of 48.80 with a standard deviation of 9.84. One effective statistical test to utilize when there is one nominal independent variable and there is one dependent variable that is an interval variable is the analysis of variance (ANOVA) (Frey, 2016).

Table 5

Descriptive Statistics for Burnout

Variable	*N*	*Mean*	*SD*	*F*	*p*
Early Career	47	51.43	10.11	1.785	.185
Mid/Late Career	56	48.80	9.84		

For this study, the null hypothesis states that there is no significant difference in mean scores of burnout based on career stage of the professional. Means were scored, compared, and calculated as two-tailed probabilities with significance at $p<.05$. Table 5 shows the results of comparing career stage (early or mid/late) and burnout scores on the ProQOL there was not a significant difference for mean scores of burnout between career stages on the ProQOL. Therefore, we fail to reject the null hypothesis (see Table 5) and conclude that there is not a significant difference between early career and mid/late career professionals on scores of burnout.

The next part of the research question was related to scores on the secondary traumatic stress subscale of the ProQOL. The parameters of the early career professionals' distribution were not normally distributed, and were skewed to the right. Therefore, a Mann-Whitney U test was conducted. Early career professionals' (M= 50.64, SD= 10.11) distribution for secondary traumatic stress was not normally distributed (see Table 6). Secondary traumatic stress scores for early career professionals (Mdn=47.91) were higher than those of mid/late career professionals (Mdn=49.80). A Mann-Whitney U test indicated that this difference was not significant, $U(N_{\text{early caereer}} = 47, N_{\text{mid/late career}} = 56 ,) = 130.75$, p=.955. The results indicated that there was difference between early and mid/late career professionals and secondary traumatic stress (U=1307.5, p= .955), but it was not significant.

Table 6

Descriptive Statistics for Secondary Traumatic Stress

Variable	*n*	*Mean*	*SD*	*U*	*p*
Early Career	47	50.64	10.95	130.75	.955
Mid/Late Career	56	49.46	9.19		

For this part of the study, the null hypothesis states that there is no relationship between career stage and secondary traumatic stress scores. Correlations were calculated as two-tailed probabilities with significance at $p<.05$. Table 6 shows the results of comparing career stage (early or mid/late) and secondary traumatic stress scores on the ProQOL. The was nonsignificant relationship between career stage on scores of secondary traumatic stress scores on the ProQOL. Therefore, we fail to reject the null hypothesis. The null hypothesis stated that there was no relationship between career stage and secondary traumatic stress scores. Also important to note here is that both early and mid/late career professionals had mean scores of 50.64 and 49.46, both above the high-risk score of 41 (Stamm, 2010). According to the author of the ProQOL, scores above 41 on the secondary traumatic stress subscale can be problematic, and speaking to a supervisor, colleague or health care professional about how hearing trauma stories is impacting work-life balance is recommended (Stamm, 2010).

Research Question #2

While there are negative outcomes to working in the mental health field, there are also positive outcomes that mental health professionals experience from helping others. One of the positive aspects of working as a mental health professional is known as compassion satisfaction. Compassion satisfaction is the pleasure that one derives from working with persons with complex emotional needs and trauma (Bae et al., 2020; Baugerud et al., 2018). One important area to study in master's level mental health professionals and their well-being includes how the

positive aspects of working in the field such as compassion satisfaction can serve as a resource to help mitigate the negative aspects of working in the field such as burnout and secondary traumatic stress (Butler et al., 2017; Craig & Sprang, 2010). This area of study can be answered by question two:

> Do compassion satisfaction scores on ProQOL for master's level mental health professionals impact burnout, compassion fatigue, and secondary traumatic stress scores on the Professional Quality of Life Scale?

For this question the hypothesis states: compassion satisfaction scores will correlate with scores on the subscales of burnout and secondary traumatic stress for all master's level mental health professionals, such that higher scores on subscales of compassion satisfaction will predict lower scores on subscales of burnout and secondary traumatic stress. In this case, the independent variable is compassion satisfaction and the dependent variables are scores on subscales of burnout and secondary traumatic stress. A simple linear regression was calculated to predict scores in burnout and secondary traumatic stress based on compassion satisfaction scores. The objective of correlational research is to look at the degree of relationship between two or more variables (Creswell & Guetterman, 2019). A significant regression equation was found $F(1,101)=107.25$, $p < .001$, with an r^2 of .52 . Table 7 presents the descriptive statistics for measures of compassion satisfaction with burnout and secondary traumatic stress.

Table 7

Significant Correlations with Compassion Satisfaction

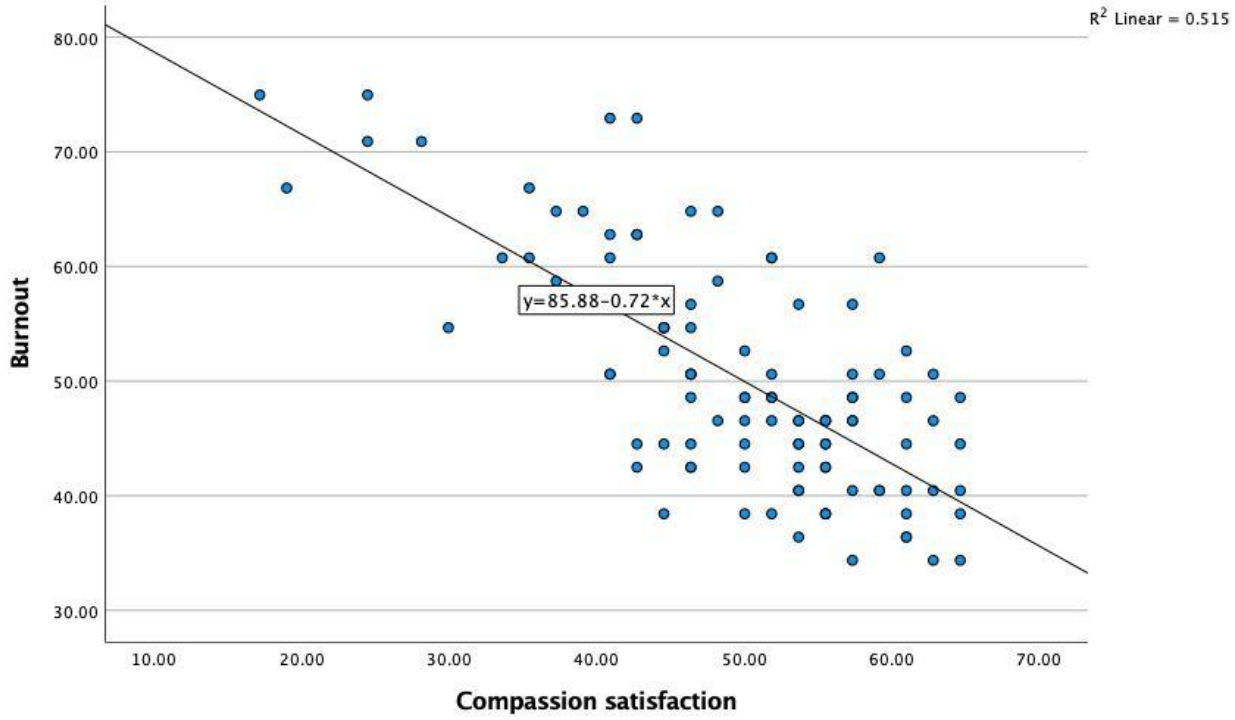
Variables (n=102)	correlation	r^2	p-value
Burnout	-.718	.52	.000
Secondary Traumatic Stress	-.270	.073	.006

Correlation is significant at p<.05 (2-tailed)

The regression coefficient for burnout (B=-.752 95% CI [-.907, -.597]) indicated that an increase in compassion satisfaction lead to a decrease in burnout. A negative correlation between burnout and compassion satisfaction was found to be significant (r=-.72, n=103, p=.000) (see Figure 2).

Figure 2

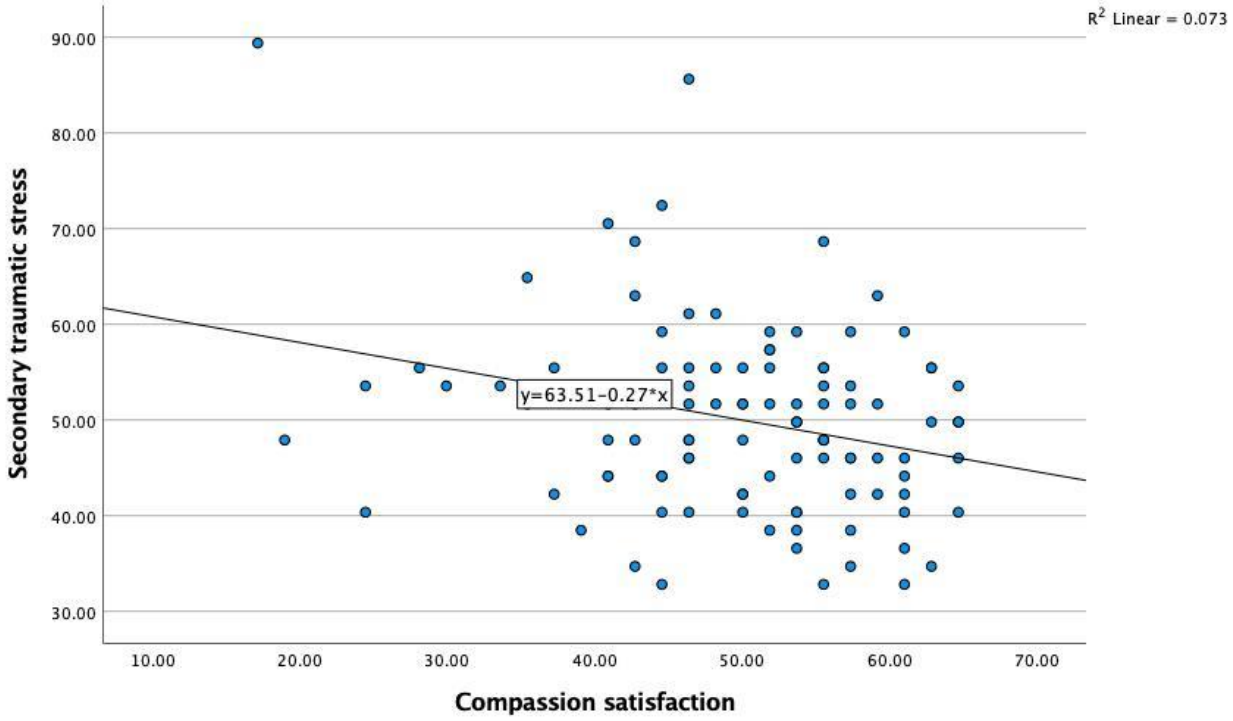
Scatterplot of compassion satisfaction and burnout



A negative correlation between secondary traumatic stress and compassion satisfaction was found to be significant (r=-.27, n=103, p =.006) with an r^2 of .073; as compassion satisfaction scores increase, secondary traumatic stress scores decrease (see Figure 3).

Figure 3

Scatterplot of compassion satisfaction and secondary traumatic stress



For all significant relationships, the correlation of determination, r^2 was calculated to control for the variance in the data. When a p-value is less than .05, it is considered significant. This mean difference of zero could be expected if the null hypothesis was true. However, in this case the results are significant, meaning that there is a notable difference between sample means, more than what we would expect by chance (Field, 2018). Due to the fact that there is a significant correlation between compassion satisfaction, burnout, and secondary traumatic stress, the null hypothesis is rejected. Scores on subscale of compassion satisfaction were compared with scores on subscales of burnout and secondary traumatic stress. A simple linear regression was

calculated to predict scores in burnout, and secondary traumatic stress based on compassion satisfaction scores. A negative correlation between compassion satisfaction, burnout, and secondary traumatic stress were found to be significant (p=.000, p=.006). As burnout scores and secondary traumatic stress scores increased, compassion satisfaction scores decreased.

Research Question #3

Despite many years of research on the topic of the well-being of mental health professionals, there are a lack of studies that focus specifically on master's level mental health professionals (Bamonti, et al., 2014; Ray et al., 2013; Scroggins, 2015). The majority of studies in the literature are focused on psychologists, doctoral students, or a mix of master's level clinicians and psychologists. Master's level mental health professionals and their professional quality of life as well as their training in these concepts needs to be explored in the literature. A meta-analysis explored the relationship between self-care use and positive outcomes amongst professional psychology students, and out of 17 studies found in the literature search only four of them focused specifically on master's level mental health professionals in training (Colman et al., 2016). It is important to isolate this part of the population of mental health professionals because training for master's level mental health professionals is substantially different than the training for psychologists and those in doctoral training programs (Bamonti, et al., 2014; Ray et al., 2013; Scroggins, 2015). The following research question looked specifically at the differences in professional quality of life of master's level mental health professionals:

> Are there differences between types of training and measures of professional quality of life?

For this research question the hypothesis states: burnout and secondary traumatic stress scores on the subscales of the ProQOL will be higher for marriage and family therapists than social workers and professional counselors. There will be a significant difference between social work, counseling, and therapy professionals, in ratings of professional quality of life. In this case, the independent variable is career status and the dependent variables are scores on subscales of burnout, secondary traumatic stress, and compassion satisfaction (see Table 8).

Table 8

Descriptive Statistics for Burnout for Career Status

Variable	*N*	*Mean*	*Standard Deviation*
MFT	56	50.21	10.10
Counselor	38	49.76	9.28

Table 9

Descriptive Statistics for STS for Career Status

Variable	*N*	*Mean*	*Standard Deviation*
MFT	56	52.22	11.17
Counselor	38	46.72	7.45

Table 10

Descriptive Statistics for CS for Career Status

Variable	*n*	*Mean*	*Standard Deviation*
MFT	56	49.86	9.49
Counselor	38	49.28	9.27

These distributions were not normal; therefore Mann-Whitney U tests were conducted to determine whether there is a difference between MFT and counselors. Social workers were not included in this analysis because the sample size was small (n=9). Scores of burnout between MFT's (Mdn= 46.55) and counselors (Mdn=48.58) were slightly higher for MFTs. Scores of secondary traumatic stress between MFT's (Mdn=51.68) and counselors (Mdn=46.97) were slightly higher for MFTs. Scores of compassion satisfaction for MFT's (Mdn=50.97) and counselors (Mdn=51.88) were similar for both MFTs and counselors. However, the results indicate non-significant differences between groups, specifically for secondary traumatic stress $U(N_{mft} = 56, N_{counselor}=38,)$ 753.50, z=-2.399, p = .016, burnout $U(N_{mft} = 56, N_{counselor}=38,) = 1051.00$, z=-.100, p = .920, and compassion satisfaction $U(N_{mft} = 56, N_{counselor}=38,) = 1015.00$, z=.379, p = .705. A Mann-Whitney test indicated that this difference was not statistically significant. In conclusion, the null hypothesis is not rejected and there is no significant difference in ProQOL scores between MFTs and counselors. MFT's did have slightly larger mean scores for burnout (M=50.21), compared to professional counselors (M=49.76). MFT's also had slightly higher scores for secondary traumatic stress (M=52.22), compared to professional counselors (M=46.72). However, these differences were not significant. In conclusion, there is no significant difference in ProQOL scores between MFT and professional counselors.

Research Question #4

Given that students possess risk factors for adverse outcomes of working in the mental health field, improving graduate training on professional quality of life is needed (Bamonti et al., 2014). Before implementing training procedures, researchers must clarify how master's level graduate training incorporates professional quality of life instruction into their curriculum and program culture (Rummell, 2015; Santana & Fouad, 2017). The literature lacks studies that

specifically quantify graduate training for master's level mental health professionals in professional quality of life, thus research question four addresses this area of interest:

> How do master's level mental health professionals rate their graduate training in professional quality of life?

They hypothesis for this question is: social workers, therapists and counselors will rate their graduate training in burnout, secondary traumatic stress, compassion fatigue, and compassion satisfaction as none or minimal. Participants were asked about the frequency of their training on professional quality of life concepts (burnout, compassion fatigue, secondary traumatic stress, and compassion satisfaction). The responses regarding how frequently they learned about these concepts included a Likert scale (never, rarely, sometimes, often, very often). Table 11 captures the frequency of responses to questions about graduate training.

Table 11

Survey Frequency Results: Research Question 4

Survey Question	Never	Rarely	Sometimes	Often	Very Often
In my graduate training program, I learned about secondary traumatic stress.	13.6%	22.3%	33.0%	21.4%	9.7%
In my graduate training program, I learned about burnout.	7.8%	15.5%	18.4%	33.0%	25.2%
In my graduate training program, I learned about compassion fatigue.	9.7%	16.5%	28.2%	26.2%	19.4%
In my graduate training program, I learned about compassion satisfaction.	35.0%	27.2%	16.5%	16.5%	4.9%

Each topic is expected to have been taught sometimes, often or very often; we would expect that graduate training in professional quality of life was taught often or very often. The frequencies were combined for to never/rarely and frequencies were combined for sometimes/ often/very often. Table 12 shows these combined frequencies.

Table 12

Combined Frequency Results: Research Question 4

Survey Question	Never/Rarely	Sometimes/Often/Very Often
In my graduate training program, I learned about secondary traumatic stress.	35.9%	64.1%
In my graduate training program, I learned about burnout.	23.3%	76.6%
In my graduate training program, I learned about compassion fatigue.	26.2%	73.8%
In my graduate training program, I learned about compassion satisfaction.	62.2%	37.9%

The combined frequencies indicate that concepts of STS, burnout, and CF were taught at least sometimes or more for this population. Compassion satisfaction was taught less frequently, with only 37.9% of respondents reporting that they learned about CS sometimes/often/very often. In fact, 62.2% of respondents reported that they learned about CS never/rarely. According to Field (2009) frequencies tell us the probability of something occurring in the general population. Based on these responses we can assume that this can apply to the general population of master's level mental health professionals; and that compassion satisfaction is taught less frequently. More information is needed to understand what is occurring in the general population in regards to graduate training in professional quality of life, but these responses begin the understanding and provide a foundation for future studies on this topic.

Research Question #5

Educating students and professionals to identify if they are at risk for developing burnout, secondary traumatic stress, and compassion fatigue before it affects their ability to provide care to their patients should be available during graduate training programs in mental health. There is still a lack of understanding of how students and professionals are educated about these adverse impacts of working in the mental health field. When policies or processes are looked at with the goal of improving existing practices, qualitative methods can provide the type of information needed to understand processes (Maxwell, 2013). In addition, it is important to understand how master's level mental health professionals encounter the demands and rewards of their profession (Bartoskova, 2017; Guerra, 2018; Yang & Hayes, 2020; Zoskly, 2013). The open-ended questions were the qualitative portion of this mixed methods design. There were six open-ended questions and participants were instructed to answer them in a few sentences. The participation rate for the qualitative questions were less than the participation for the quantitative portion of the survey (n=103). See Table 13 for the response rate for each open-ended question.

Table 13

Response rate for open-ended questions

Question	Number of Responses	Early	Mid/Late	Overall Response Rate for each Question
If you received no training or minimal training on the above concepts, describe what would have been helpful to you during your training.	54	25	29	52%
Describe your motivations for your career choice as a helping professional.	87	41	46	84%
What do you view as your ultimate goals for the clients you help?	92	43	49	89%
How do you determine if you are reaching your professional goals?	82	37	45	80%
Do you feel that your own therapy is a critical component to helping your clients?	86	42	44	83%
If you could explain how you would like others to describe your work as a helper, what would it be?	89	41	48	85%

According to educational research publications, a response rate of over 50% is acceptable for qualitative data studies (Creswell & Creswell, 2018). In qualitative data, one strategy described in the literature is to look for similarities in the raw data (Maxwell, 2013). Similarities can be represented in categorization and codes created by the researcher. The researcher reviewed the data collected for each question, and developed coding categories based on repeated ideas,

phrases, and words (Maxwell, 2013). Once the codes were identified, responses were given a code. The codes then developed into themes based on the researcher's knowledge of theoretical and conceptual frameworks in the literature (Creswell & Creswell, 2018). The following sections will describe the qualitative data codes and themes that emerged for each open-ended question.

Open-ended Question #1

The first open-ended question asked participants to describe how to improve graduate training on concepts of professional quality of life if there was minimal training in these concepts. The response rate for this question was 52%, meaning that about half of the participants answered this question (see Table 13). The responses were analyzed separately, by career stage (early and mid/late). The six steps for this process include starting with the initial coding, revisiting the coding, developing an initial list of categories, modifying this list, revisiting categories, and moving from categories to concepts (Creswell & Guetterman, 2019). Coding is the process of separating similarly occurring words and texts together based on frequency of responses to each question. Once these codes were developed, the researcher reviewed the categories for overlap. The codes were assigned to each answer and the researcher further analyzed the codes by reviewing the literature for information on graduate training in professional quality of life. Given that there are few articles on this topic (Bamonti et al., 2014; Scroggins, 2016), themes were developed based on research looking specifically at graduate training in professional quality of life (see Table 14). The charts provide more detail about each theme that emerged from the development of codes per career stage (see Figure 3,4). Following the charts will be a detailed description of each theme.

Table 14

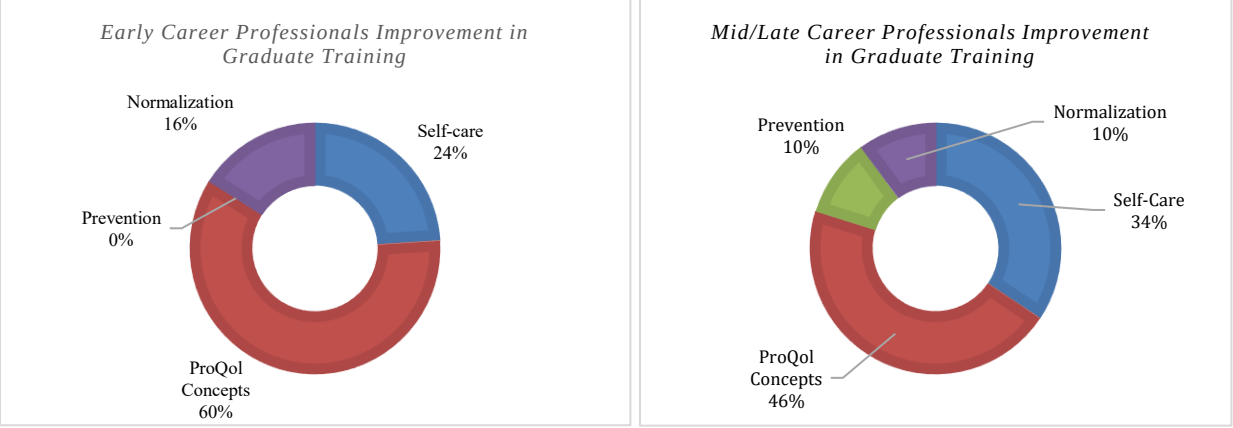
Qualitative Question 1 Themes for Improving Graduate Training

Themes	Early (n=25)	Mid/Late (n=29)
More instruction or discussion during classes on ProQOL Concepts	15	13
Improve training on balance, self-care, and/or professional boundaries	6	10
Creating a culture of normalization of these concepts	4	3
Prevention education on negative impacts of helping professions	0	3

Each group of open-ended responses to this question were analyzed separately based on career stage (see Figure 4).

Figure 4

Comparison of themes for open-ended question 1



Note: Percentages are based on frequency of coded occurrences.

A side by side comparison of qualitative results indicate that early career and mid/late career professionals had similar occurring themes for this question regarding graduate training. The

only theme that occurred for mid/late career professionals that did not occur for early career professionals was prevention. More detail on each theme is provided below.

ProQOL concepts. The first identified theme for question one centers on the idea that master's level mental health professionals reported that they wanted more instruction or discussion during classes on professional quality of life such as burnout, compassion fatigue, secondary traumatic stress, and compassion satisfaction in their graduate training. Similar statements such as, "more information given on these concepts…possibly a course (or part of a course) dedicated to these concepts" and "It would have been helpful to understand the effects my work with clients (specifically those with trauma) would have on me outside of the session." The response rates for early and mid/late career professionals were similar and represent the majority of responses (see Table 13).

Self-care. The second identified theme for question one centers on the idea that master's level mental health professionals reported that they wanted improved training on balance, self-care, and/or professional boundaries. Similar statement such as "How to balance my job with my personal relationships…how to have better boundaries as a helper" and "a course in managing personal life, work balance, and boundaries." There were slightly more responses for this category for mid/late career professionals than early career professionals (see Table 14).

Normalization. The third identified theme for question one centers on the idea that master's level mental health professionals reported that they wanted their graduate training to create a culture of normalization of professional quality of life concepts. Similar statements such as, "normalizing the process," and "just to hear these terms and normalization and validation of them." There were a similar number of responses for this category for early career professionals and mid/late career professionals (see Table 14).

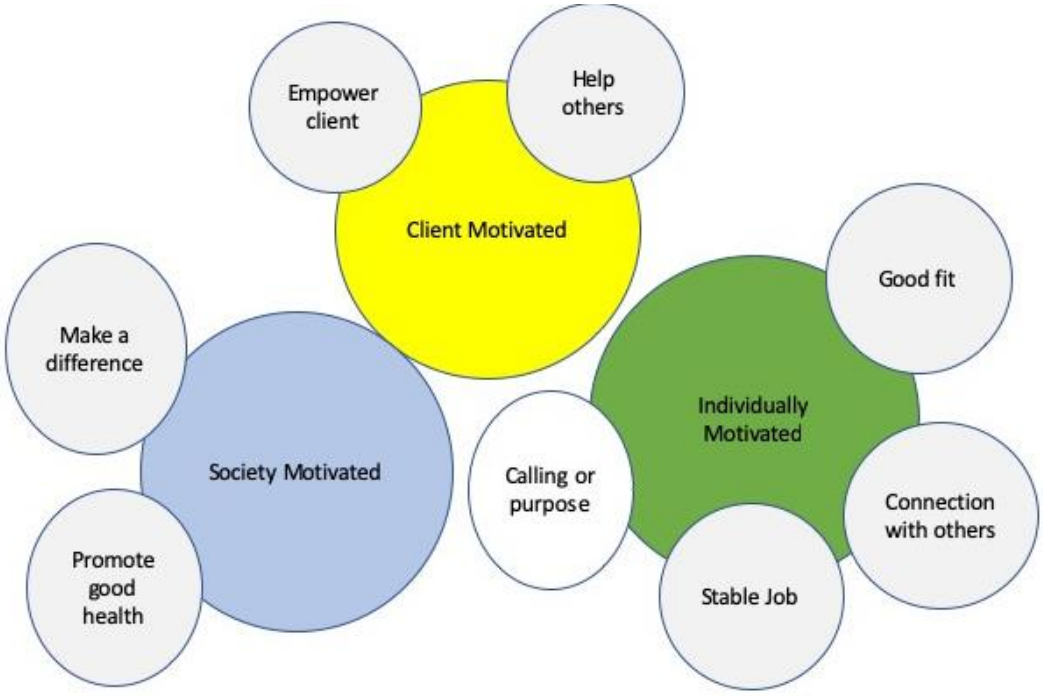
Prevention. The fourth identified theme for question one centers on the idea that master's level mental health professionals reported that they wanted their graduate training to provide prevention education on negative impacts of helping professions. Similar statements such as, "How to recognize burnout or secondary trauma," and "Exploring they symptoms of compassion fatigue/burnout, and how to manage/cope with those issues effectively." This theme only applied to mid/late career professionals as early career professionals did not identify this concept in their answers (see Table 14).

Open-ended Question #2

The second open-ended question asked participants to describe their motivations for their career choice as a helping professional. This question had an 84% response rate (see Table 13). The responses were analyzed separately, by career stage (early and mid/late). Codes were developed based on frequency of similar responses, and the researcher further analyzed the codes by reviewing the literature for information on graduate training in professional quality of life. The codes were than compiled into themes based on the literature relating to counselor development (Ronnestad et al., 2018). The themes were divided into categories of individually motivated, client motivated, and society motivated. Responses were grouped into how professionals are motivated by their career (see Figure 5).

Figure 5

Master's level mental health professionals career motivation



Individually motivated. Within the broader themes, subthemes emerged. For individually motivated therapists, there were three subthemes. The first one was good fit, meaning that the respondent stated that their skills or experiences were the right fit for their role as a helping professional. Responses such as "I am an excellent listener, able to identify latent meanings…," and "Plays to my strengths and life experiences," were similar. The next subtheme that emerged was that participants enjoyed the connection with others. Similar statements were found such as "Love the sense of connection," and "Experience of connection with clients." Some respondents were individually motivated because being a master's level mental health professional provided a stable job, the third subtheme in this category. Statements such as "Stability, support my family…," and "I wanted a job that made it possible for me to be my own boss." The final subtheme that emerged was that respondents saw the profession as their calling or purpose in

life. Statements such as “My faith, calling and purpose in life,” and “I was praying for a calling and sensed the prompting to become a counselor.”

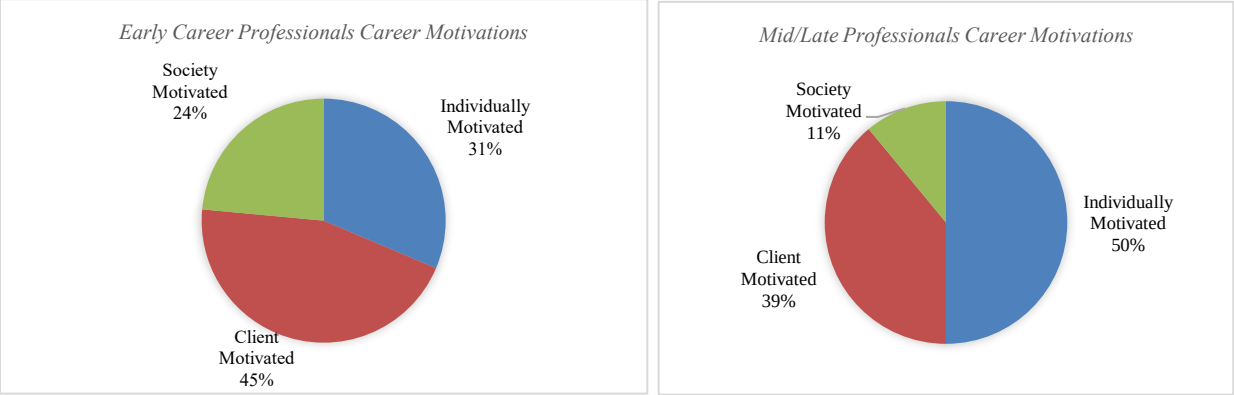
Client motivated. Master’s level mental health professionals reported they were frequently motivated in their careers by helping their clients. The first subtheme that emerged was helping clients in various ways. Similar statements such as “to help others,” and “helping others make life changing choices” emerged in the data. The second subtheme was slightly different, professionals were motivated to empower their clients. Statements such as “empower clients to make a positive change,” and “to give people tools they can use to have happy, healthy lives.”

Society motivated. Professionals were also motivated in their careers as a helper by improving society as a whole. The first subtheme that emerged was making a difference in society. Statements such as “I want to make the world a better place,” and “I felt like doing something that would make a difference” emerged in the data. The second subtheme that emerged was promoting good health in society. Statements such as “to normalize seeking mental health services,” and “I am an activist for well-being” indicated a desire to improve society.

The qualitative data for this question was also compared between early and mid/late career professionals. Early career professionals most frequently motivated by helping clients, while mid/late career professionals were most frequently motivated by individual needs (See Figure 6).

Figure 6

Comparison of themes for open-ended question 2



Note: Percentages are based on frequency of coded occurrences.

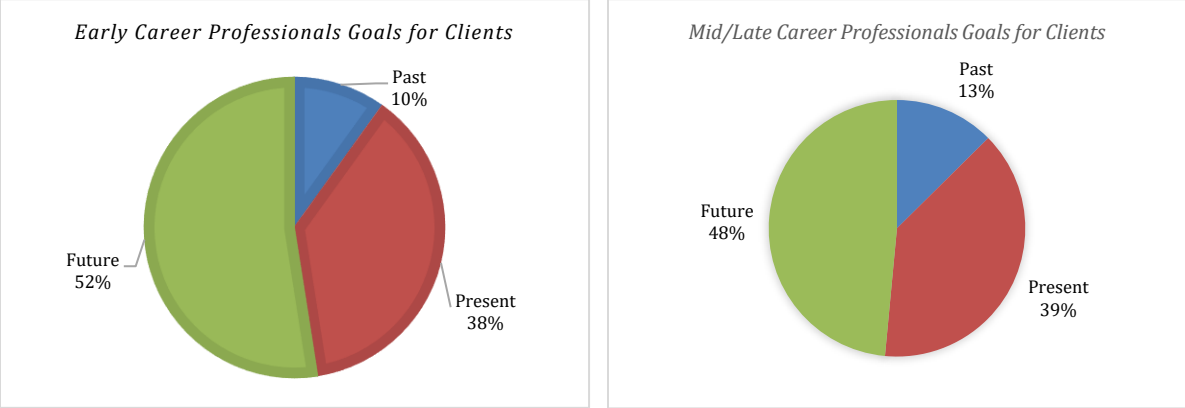
Mid/late career professionals were much less motivated by societal needs than early career professionals, who reported this as their career motivation 24% of the time. As consistent with the previous question, the same themes did emerge but the difference was in the frequency of occurrences of each theme.

Open-ended Question #3

The third open-ended question asked participants to describe what they considered the ultimate goal for the clients that they are helping. The response rate for this question was 89%, and was the most answered open-ended question (see Table 13). The responses were analyzed separately, by career stage (early and mid/late). Once the codes were developed and assigned, the researcher analyzed the codes by reviewing the literature for counselor development. The codes were further organized into themes. The themes included past-oriented goals, present-oriented goals, and future oriented goals. The answers for career stages were similar in frequency (see Figure 7).

Figure 7

Comparison of themes for open-ended question 3



Note: Percentages are based on frequency of coded occurrences.

Consistent with previous findings, the same themes emerged for early and mid/late career professionals. Answers were similar and there was not much difference in frequency of themes between the career stages. A small number of participants in each career stage viewed their goals as past oriented. Some examples of responses that fit into the category included "to help them move past trauma," and "resolve trauma." Several participants had goals that were oriented to the present. Statements such as "to be in control of their emotions, thoughts and behaviors," and "Give them a space to feel safe and connected." Finally, the majority of responses for both career stages were future-oriented. Statements that fit into this category included, "I wish for each of my clients to grow to where they do not need me," and "Empower them with skills so they do not need me anymore."

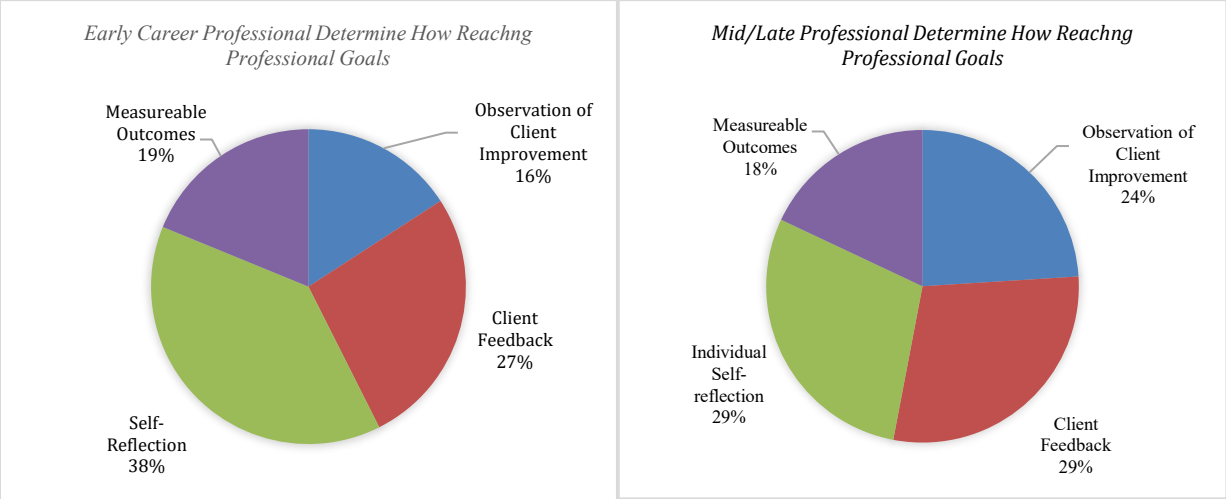
Open-ended Question #4

The next open-ended question asked respondents to describe how they determine if they are reaching their professional goals. The response rate for this question was 80% (see Table 13). The responses were analyzed separately, by career stage (early and mid/late). Once the codes

were developed and assigned, the researcher further analyzed the codes by reviewing the literature for counselor development. The codes were further organized into themes. The themes included observation of client improvement, direct client feedback of improvement, a personal self-reflection of meeting goals, or a measurable outcome or assessment. The answers for career stages were similar in frequency (see Figure 8).

Figure 8

Comparison of themes for open-ended question 4



Note: Percentages are based on frequency of coded occurrences.

The themes for this question that emerged were the same for both early and mid/late professionals. The themes also had similar frequencies peer career stage. Observation of client improvement was the first theme and early career professionals chose this theme 16% of the time while mid/late chose this theme 24% of the time. Some examples of responses that fit into the category included “When I have my clients leaving my office clearer and more confident with themselves…I feel more successful,” and “Seeing peoples’ satisfaction and positive actions. To watch them put into action what we discuss.” Several participants measured their success by hearing client feedback. This category had similar frequencies for both career stages. Statements

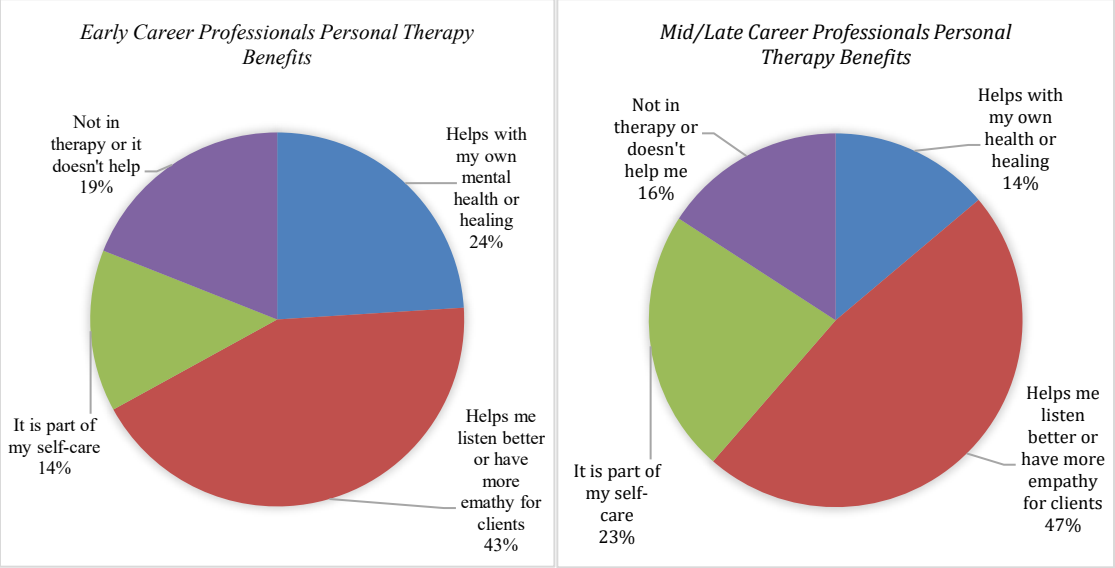
such as “My work with clients…their self-report that things are shifting for them individually and relationally,” and “Client feedback.” The next theme for this question was individual self-reflection and this theme had slightly more responses for early career professionals compared to mid/late career professionals. Statements that fit into this category included, “Very subjective, it is a feeling,” and “Satisfaction with what I am doing and knowing that I am making an impact even if I don’t see it.” The final theme mentioned by participants for them to be aware that they are reaching their professional goals was by looking at a measurable outcome or assessment. This was the smallest responded to theme, and frequencies were similar across career stages. Some examples of statements from respondents that fit into this category included “I write goals for myself that are measurable and see if I complete them,” and “Clients offer a feedback via survey my company provides.”

Open-ended Question #5

Respondents were asked in question five to describe how their own therapy impacted the work they did with their clients. The response rate for this question was 83%. Once the codes were developed and assigned, the researcher further analyzed the codes by reviewing the literature for counselor development. The codes were further organized into themes. The themes included helps with my own mental health or healing, helps me listen better or have more empathy for my clients, is a part of my self-care, and not in therapy or it does not help me. The answers for career stages were similar in frequency (see Figure 9)

Figure 9

Comparison of themes for open-ended question 5



Note: Percentages are based on frequency of coded occurrences.

The themes that emerged for this question were the same for both career stages. The responses also had similar frequencies peer career stage. Helps with my own healing or mental health was the first theme and early career professionals chose this theme 24% of the time while mid/late chose this theme 14% of the time. Some examples of responses that fit into the category included "If I do not maintain my own mental health, then my ability to serve and help others in that way becomes increasingly difficult," and "My healing affirms my belief that healing is possible." The next theme for this question was helps me listen better or have more empathy for my clients. This theme had similar number of responses for early career professionals compared to mid/late career professionals. Statements that fit into this category included, "Allows more empathy," and "More empathetic and a better listener." The next theme mentioned by participants for the benefit of personal therapy was that it is part of their self-care. Mid/late career professionals responded in this category more than early career professionals. Some examples of statements

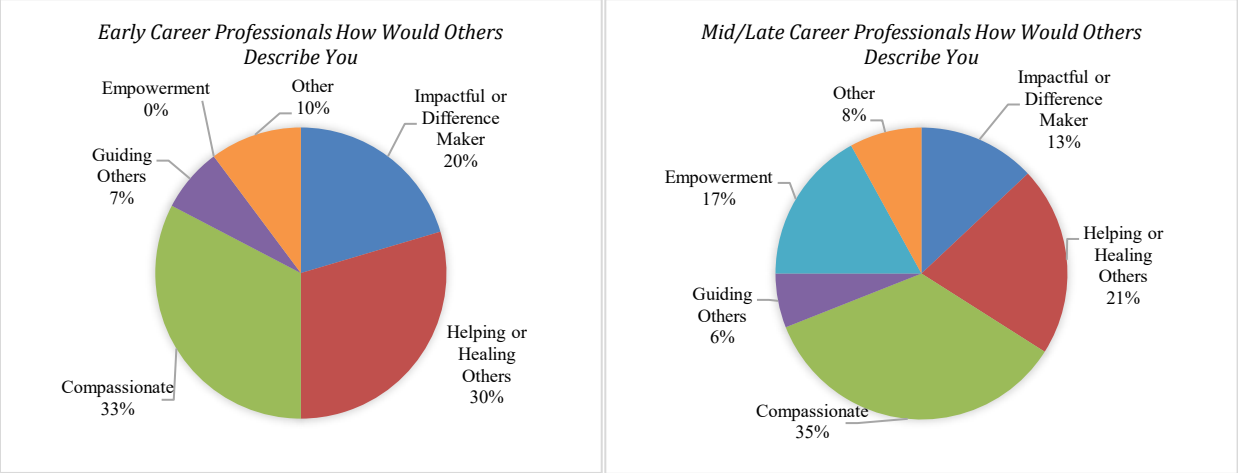
from respondents that fit into this category included “It helps me maintain my own self-preservation,” and “helps to stay balanced.” The final theme for this question was that therapy did not help or respondents were not currently in therapy. A similar number of responses for this theme were found in both early and mid/late career professionals. Examples of statements that fit into this theme included “I am not currently in my own therapy,” and “It’s been some time since I engaged in personal therapy.”

Open-ended Question #6

The next open-ended question asked respondents to describe how they would like others to view their work as a helper. The response rate for this question was 85%. Once the codes were developed and assigned, the researcher further analyzed the codes by reviewing the literature for counselor development. The codes were further organized into themes. The themes included words or phrases such as impactful, helping or healing others, compassionate, guide to others, empowerment, or other. The other responses were specific to the respondent and only included one response that was like it. The answers for this question were similar in frequency, however the empowerment theme was only present in mid/late career professionals’ responses (see Figure 10).

Figure 10

Comparison of themes for open-ended question 6



Note: Percentages are based on frequency of coded occurrences.

The themes for this question had similar frequencies peer career stage. The major difference was the theme of empowerment only occurred in mid/late career professionals. The first theme that emerged when professionals were asked how they would like others to describe their work as a helper, was impactful. Early career professionals chose this theme 20% of the time while mid/late chose this theme 13% of the time. Some examples of responses that fit into the category included “Impactful,” and “impactful, life changing.” The next theme for this question was helping or healing others. This theme had similar number of responses for early career professionals compared to mid/late career professionals. Statements that fit into this category included, “That I’m helping them,” and “I would like others to see my work as helpful.” The next theme mentioned by participants for how they would like others to describe their work was compassionate. Mid/late career professionals responded in this category similarly to early career professionals. Some examples of statements from respondents that fit into this category included “by being a compassionate listener,” and “compassionate, supportive.” The next theme for this

question was that professionals wanted others to describe them as guides or guiding others. A similar number of responses for this theme were found in both early and mid/late career professionals. Examples of statements that fit into this theme included “I am a guide,” and “I guide people in the process of caring about themselves.” The next theme was empowerment, and it only occurred frequently for mid/late career professionals. Examples of the statements for this theme included “Empowering victims to take control of their lives,” and “I empower folks to meet their goals.” The final theme was other, because the responses were so specific and only occurred once. This was similar for both early and mid/late career professionals. Some examples of these specific responses included “I am a researcher too,” and “Play therapy heals!”

Conclusion

Chapter IV presented the findings of both the quantitative and qualitative data collection for professional quality of life of master’s level mental health professionals. Descriptive statistics, analysis of variance, and regression tests were run on statistical data. Some tests found statistically significant relationships between variables. Other tests found non-significant relationships between variables. Due to the fact that most relationships between variables were weak, qualitative methods gave the researcher further information about the lived experiences of master’s level mental health professionals. Open-ended questions at the end of the survey were analyzed, coded, and themes were developed based on frequency of responses. These questions provided further information about graduate training in professional quality of life. These questions also provided information on mental health professionals’ career development issues such as career motivations, goals for work with clients, and benefits of engaging in personal therapy. The data in this chapter will be further discussed in the following chapter.

Chapter V

Discussion

Introduction

An increase in reported mental health symptoms since the Covid-19 pandemic has placed additional pressure on master's level mental health professionals who provide ongoing support to persons with mental health issues (Li et al., 2021; Sovold et al., 2021). Those working in the mental health field are exposed daily to stressors on the job that are unique to their profession and put them at risk for adverse outcomes. These adverse outcomes can include burnout, compassion fatigue, and secondary traumatic stress. In addition, master's level mental health professionals can experience an increase in mental health symptoms and a decrease in physical well-being due to the demands of their jobs (Berjot et al., 2017; Dreison et al., 2018a; Sodeke-Gregson et al., 2013). Several studies in the literature identify the conditions that can increase the likelihood of these adverse outcomes occurring, but few studies have identified how to treat these conditions or even prevent them (Dreison et al., 2018a; Raab, 2014). Furthermore, the few studies that address prevention efforts do not specifically look at master's level mental health professionals (Bamonti et al., 2014; Goncher et al., 2013; Scroggins, 2016).

Workplace interventions have been suggested as a way to help professionals who are experiencing decreased well-being and are at risk for burnout, compassion fatigue, and secondary traumatic stress (Ahola et al., 2017; Dreison et al., 2018a). Studies to date on workplace interventions have provided mixed results. Perhaps one explanation of these results is that interventions in the workplace can vary greatly (Ahola et al., 2017). Currently, there is no agreed upon approach to addressing this issue in the workplace. However, several scholars have suggested prevention efforts in graduate training be implemented (Baugerud et al., 2018; Ivicic

& Motta, 2017; Laverdière et al., 2018; Sodeke-Gregson et al., 2014; Thompson et al., 2014). Given that all professionals begin their careers in a graduate training program, prevention efforts can be targeted and implemented in a systematic way (Goncher et al., 2013; Scroggins, 2016). In addition, students often possess several risk factors for developing these adverse conditions, so teaching them early in graduate training can potentially have the most impact (Thompson et al., 2014).

The questions examined in this study were:

1. Are pre-licensed master's level and early-career mental health professionals (social workers, therapists, counselors) experiencing burnout, compassion fatigue, and secondary traumatic stress at higher rates than master's level mental health professionals who are mid-career and late-career?
2. Do compassion satisfaction scores on ProQOL for master's level mental health professionals (social workers, therapists, counselors) impact other scores on the Professional Quality of Life Scale?
3. Are there differences between types of training (social workers, therapists, counselors) and measures of professional quality of life?
4. How do master's level mental health professionals (social workers, therapists, counselors) rate their graduate training in professional quality of life?
5. How do motivations, career goals, and goals for clients change as helping professionals are in different career stages?

Chapter V provides an interpretation of the study's results, relationship to current research, and connection to the theoretical framework. Finally, there will be a discussion on recommendations

for future research and how the study's results inform prevention efforts in graduate training for master's level mental health professionals.

Summary of Results

This mixed methods study examined master's level mental health professionals' professional quality of life and training on professional quality of life. In addition, this study examined how master's level mental health professionals describe their career goals, goals for clients, and motivations for working as a helping professional. A mixed methods approach to research design is used when the researcher uses both quantitative and qualitative data to further understand the research questions (Creswell & Guetterman, 2019). This approach is important in this study because the quantitative methods alone did not provide all of the information on graduate training in professional quality of life. The qualitative methods provide additional information important to the research questions. A convergent mixed-method design was used to investigate the research questions. This is a single-phase approach where the quantitative and qualitative data were collected at the same time and findings from both methods were compared (Creswell & Creswell, 2018). The data was collected by using an online survey developed through Qualtrics. A purposeful sample of master's level mental health professionals was obtained through the social media accounts of their researcher. A total of 118 responses were collected, however 15 of the responses were not used because the respondents did not meet the participation criteria (n=103). For the quantitative portion of the survey, respondents completed the professional quality of life scale (Stamm, 2010) and a scale created by the researcher to assess graduate training in professional quality of life. Following the quantitative portion of the survey, respondents were asked to complete six open-ended questions assessing professional quality of life, career motivations, goals for professional lives, and goals for their clients' lives.

Quantitative analysis of the survey portion of the data was conducted using IBM SPSS, Version 26. Descriptive statistics, correlational analysis, and regression analysis were used to answer research questions one through four. The use of frequencies provided information to the researcher regarding the sample obtained through the purposeful sampling of master's level mental health professionals. The independent variables used in the quantitative component of the research design included career stage (early and mid/late) and professional status (therapist, counselor, or social worker). Correlational analysis was conducted to determine if there was significant difference by career stage and professional status in scores on burnout and secondary traumatic stress subscales. The results of this analysis indicated that there were no significant differences between career stage and professional status in measures of professional quality of life. A regression analysis was performed to determine if there was a significant relationship between compassion satisfaction, burnout, and secondary traumatic stress. The results indicated that there was a significant relationship between compassion satisfaction and burnout. There was also a significant relationship between compassion satisfaction and secondary traumatic stress. The relationship for both indicated that as burnout and secondary traumatic stress scores increased, compassion satisfaction scores decreased. Frequencies for questions regarding graduate training in professional quality of life concepts including burnout, compassion fatigue, secondary traumatic stress, and compassion satisfaction were analyzed. These questions were included in the survey after the ProQOL, to assess participants' recollection of frequency of training in these concepts. There is currently no instrument to assess graduate training in professional quality of life, so the researcher created the instrument. Results for each quantitative question will be explored further in this chapter.

Qualitative data was collected at the same time as quantitative data and provided additional information to clarify the results of this study. Using data supplied from open-ended questions, the researcher analyzed the qualitative data using the three C's of data analysis (Lichtman, 2013). The three C's of data analysis include codes, categories, and concepts. The six steps for this process include starting with the initial coding, revisiting the coding, developing an initial list of categories, modifying this list, revisiting categories, and moving from categories to concepts. Results for each open-ended question will be explored further in this chapter.

Research Question #1: Summary of Results and Discussion

The first research question in this study was, "Are early-career master's level mental health professionals experiencing burnout, compassion fatigue, and secondary traumatic stress at higher rates than mid-career and late-career master's level mental health professionals?" The results indicated that there was not a significant difference between early career professionals and mid/late career professionals on scores of burnout. Both groups scored similarly on burnout scales. The parameters of these two distributions for this question were normally distributed. Early career professionals' distribution for burnout had a mean of 51.43 with a standard deviation of 10.11. Mid/late career professionals' distribution for burnout had a mean of 48.80 with a standard deviation of 9.84. One effective statistical test to utilize when there is one nominal independent variable and there is one dependent variable that is an interval variable is the analysis of variance (ANOVA) (Frey, 2016). In this case, the independent variable is career stage (early or mid/late) and the dependent variable is score on subscale of burnout and score on subscale of secondary traumatic stress. As a result of running the ANOVA, there was no significant difference between scores on the burnout subscale for early career and mid/late career professionals. The hypothesis for this question states that there will be a statistically significant

difference between early career professionals compared to mid-career and late-career professionals on the Professional Quality of Life Scale (ProQOL) sub-scales of burnout and secondary traumatic stress. For the present study, the null hypothesis states that there is no relationship between career stage and burnout. Correlations were calculated as two-tailed probabilities with significance at $p<.05$. There was not a significant relationship between career stage on scores of burnout on the ProQOL. While this study did not yield significant difference between groups, the result indicates that burnout is not a condition that develops over time, but rather can affect early career professionals just as much as mid and late career professionals. Studying mental health professionals' professional quality of life from a career stage perspective is a newer concept in the literature (Dorociak et al., 2017; Warlick et al., 2020). While early career professionals possess several of the risk factors for developing adverse outcomes for working in the mental health field, few studies have specifically compared master's level mental health professionals scores on the ProQOL scale.

Results from the literature are mixed, while some studies found no significance between career stages and burnout (Warlick et al., 2020), other studies did find significance between career stage and burnout (Dorociak et al., 2017) for psychologists. It is important to note that psychologists are different than master's level mental health professionals in their training and education as well as in their workplace stressors. In the present study, there was a non-significant relationship between the independent variable (career stage) and dependent variable (burnout scores). However, the average burnout score for all professionals in this study is important to recognize. Early career professionals had an average score of 51.43 on the burnout subscale, and mid/late career professionals had an average score of 48.80 on the burnout subscale. This study focused on the population of master's level mental health professionals and included professional

designations of social workers, marriage and family therapists, and professional counselors in the analysis. The results of this question related to how these professionals are experiencing burnout. While not statistically significant, the results indicate that these professionals are in the average range for scores of burnout. The author of the ProQOL suggests that scores of 57 and above indicate that an individual may be experiencing burnout. If an individual scores above 41 on the subscale of burnout the individual should consider how work might be contributing to feelings of inadequacy (Stamm, 2010). The scores of this sample indicate that this is the best time for intervention and prevention efforts. These professionals are experiencing enough of the symptoms of burnout to be receptive to learning how to monitor as well as how to prevent the score from increasing. The occurrence of burnout in mental health workers was high in one study; 21% to 67% of those surveyed were experiencing burnout (Dreison et al., 2018a)

From a theoretical perspective, the JD-R model explains how burnout can occur when there are variations between employee demands and resources (Demerouti et al., 2001). This result might indicate that for both early and mid/late career professionals in this sample, problematic burnout scores could be a result of imbalance of resources and demands (Dreison et al., 2018a; Grover et al., 2017; Stensland & Landsman, 2017). These results may also suggest that the increased occurrence of patients needing mental healthcare since the onset of the Covid-19 pandemic may be contributing to an imbalance between demand and resources. In fact, early studies indicate that stressors at work have increased for healthcare workers which has led to a decrease in their mental, physical, and emotional well-being (Li et al., 2021; Sovold et al., 2021).

In addition to burnout, secondary traumatic stress scores were compared between early career and mid/late career master's level mental health professionals in this study. The early career professionals' distribution was not normally distributed, but were skewed to the right. A

Mann-Whitney U test was conducted for the early career professionals' distribution. Secondary traumatic stress scores for this group had a mean of 50.64 with a standard deviation of 10.11. There was a non-significant difference between early and mid/late career professionals and secondary traumatic stress ($U=1307.5$, $p= .955$). Mid/late career professionals' distribution for secondary traumatic stress was normally distributed and had a mean of 49.46 with a standard deviation of 9.19. The null hypothesis stated that there was no relationship between career stage and secondary traumatic stress scores. Correlations were calculated as two-tailed probabilities with significance at $p<.05$ and there was a non-significant relationship between career stages on scores of STS. While results are not significant, it is important to note that both early and mid/late career professionals had mean scores of 50.64 and 49.46, both in the average range for developing secondary traumatic stress. A score above 57 on the STS subscale can be problematic, those who score above 41 on the STS scale are advised to take some time to consider what about work is causing feelings of fear and to consider speaking to a colleague, supervisor, or therapist about the fear associated with helping others with their trauma (Stamm, 2010). Based on the average levels of STS found in the current study, it is important to target interventions on secondary traumatic stress in master's level mental health professionals to when they are not yet experiencing STS but have symptoms and can be the most receptive to intervention efforts (McKim & Smith-Adcock, 2014). Applying a theoretical understanding to the development of STS is a consistent gap in the literature. Studies have shown that there is a relationship between secondary traumatic stress and burnout, such that when STS and burnout were measured together in the same study, there was a consistently large shared variance and results can be confounded if both are measured in the same study (Cieslak et al., 2014; Stamm, 2010). While there was a non-significant difference between early and mid/late career

professionals on scores of burnout and STS in this study, the results do indicate that early career professionals can experience adverse impacts of the job in the beginning of their career. This dispels any misconception that burnout occurs over long periods of time. The results from this question provide evidence that early intervention and education would be very helpful to professionals as they prepare for careers in the mental health field. This is consistent with literature findings; early career psychologists had fewer resources which lead to a decrease in well-being; and early career professionals faced greater work demands than those later in their career (Dorociak et al., 2017). Conversely, late career psychologists engaged in more self-care and had better overall scores of well-being (Warlick et al., 2020).

Research Question #2: Summary of Results and Discussion

The second research question in this study is, "Do compassion satisfaction scores on ProQOL for master's level mental health professionals (social workers, therapists, counselors) impact other scores on the Professional Quality of Life Scale?" For this research question, the hypothesis predicted that high compassion satisfaction scores for all master's level mental health professionals will predict lower scores on the subscales of burnout and secondary traumatic stress in the ProQOL. For this sample, scores on subscale of compassion satisfaction were compared with scores on subscales of burnout and secondary traumatic stress. A simple linear regression was calculated to predict scores in burnout and secondary traumatic stress based on compassion satisfaction scores. A negative correlation between compassion satisfaction, burnout, and secondary traumatic stress were found to be significant ($p=.000$, $p=.006$). As burnout scores and secondary traumatic stress scores increased, compassion satisfaction scores decreased. This is consistent with studies found in the literature of psychologists, therapists, and counselors that have found those who scored higher on scores of burnout and secondary traumatic stress, had

lower scores of compassion satisfaction (Craig & Sprang, 2010; Laverdière et al., 2018; Sodeke-Gregson et al., 2014; Thompson et al., 2014). Compassion satisfaction traditionally has been described as a separate phenomenon to burnout and secondary traumatic stress (Figley, 2002). Lacking in the literature is application of a theoretical understanding of compassion satisfaction. Only a handful of studies have conceptualized compassion satisfaction as a component of the JD-R model (Bae et al., 2019; Radley & Figley, 2007). The ultimate goal of studying professional quality of life amongst master's level mental health professionals is to be able to provide targeted and effective interventions. The results of this question indicate that compassion satisfaction is an important area to develop in students and professionals to prevent negative outcomes of the job from occurring. The significant correlation found in this analysis indicates that low compassion satisfaction scores are associated with higher scores of burnout and secondary traumatic stress. This finding can guide prevention and intervention efforts going forward. Looking ahead in this study to the qualitative section, it was found from many of the participants that compassion satisfaction was not taught in graduate training (see Research question #4, summary of results and discussion). The connection between low levels of compassion satisfaction and high levels of burnout and secondary traumatic stress scores is a major finding of the current research study and can be applied to all master's level mental health professionals, regardless of career stage.

Research Question #3: Summary of Results and Discussion

The third research question in this study, "Are there differences between types of training (social workers, therapists, counselors) and measures of professional quality of life?" The hypothesis for this question was that burnout and secondary traumatic stress scores on the subscales of the ProQOL will be higher for marriage and family therapists than social workers

and professional counselors. The researcher compared mean scores on subscales of the ProQOL between marriage and family therapists and counselors. Social workers were not included in this analysis because their sample size was too small for disaggregration (n=9). Due to the distribution being not normal, Mann-Whitney U tests determined whether there was a difference between MFT and counselors. The results indicate non-significant differences between groups for secondary traumatic stress ($U = 821.0$, $p = .053$), burnout ($U = 968.0$, $p = .444$), and compassion satisfaction ($U = 863.5$, $p = .109$). MFT's did have slightly larger mean scores for burnout ($M=50.21$), compared to professional counselors ($M=49.76$), although this result was not significant. Additionally, the scores of psychotherapists for secondary traumatic stress ($M=52.22$) was slightly higher, than those scores for professional counselors ($M=46.72$), although not statistically significant. One possible explanation for the slightly higher scores of STS for MFTs is found in the literature. Psychotherapists often encounter more clients with posttraumatic stress disorder, more clients who relapse, and more clients with personality disorders (Yang & Hayes, 2020). These client factors can lead to an increase in burnout and secondary traumatic stress for psychotherapists. Currently, there are a lack of studies specifically comparing the professional quality of life of master's level mental health professionals' professional designations (Colman et al., 2016; Myers et al., 2012; Zahniser et al., 2017). A major weakness of the literature to date has been how scholars have "haphazardly mixed mental health disciplines together" (Rivera-Kloeppel & Mendenhall, 2021, p.9). This is problematic because different mental health professionals have different resources, training, and clients they treat.

Providing information to different professional designations about which workplace stressors, client stressors, and individual stressors are risk factors for them can be helpful for

training and in the workplace. Master's level mental health professionals share many similar struggles in the workplace, however different professional designations also maintain many differences in their work with clients. While the results of the current study were not significant, the slight differences observed in scores between MFTs and counselors provides insight into a population that has historically not been studied in the literature (Colman et al., 2016; Rivera-Kloeppel & Mendenhall, 2021). The more knowledge and insight researchers can gain into understanding these similarities and differences, the more effective intervention and prevention efforts can be.

Research Question #4: Summary of Results and Discussion

The fourth research question in this study, "How do master's level mental health professionals (social workers, therapists, counselors) rate their graduate training in professional quality of life?" The current research question attempted to understand how master's level mental health professionals recall the frequency of training in their graduate programs on burnout, secondary traumatic stress, compassion fatigue, and compassion satisfaction. The present study is one of the only studies in the literature to ask master's level mental health professionals to describe their training on professional quality of life. Four questions were asked of participants. The first question stated "In my graduate training program, I learned about secondary traumatic stress." Respondents were asked to choose between five responses (never, rarely, sometimes, often, and very often). Frequencies are appropriate in this analysis because they tell us about the probability of a score occurring (Field, 2018). In this case the frequencies of sometimes/often/very often categories were combined into one category, while never/rarely were combined into one category. It was more likely that respondents learned about STS

(64.1%), burnout (76.6%), and CF (73.8%) in graduate training. It was less likely for the respondents to have learned about CS (37.9%) in graduate training (see Table 15).

Table 15

Frequency Results: Professional Quality of Life Concepts

Concept	Never/Rarely	Sometimes/Often/Very Often
Secondary Traumatic Stress (STS)	35.9%	64.1%
Burnout	23.3%	76.6%
Compassion Fatigue (CF)	26.2%	73.8%
Compassion Satisfaction (CS)	62.2%	37.9%

The null hypothesis states that there is no difference in the frequencies of these four questions. In fact, the scores for frequency of training in compassion satisfaction are low. This is particularly concerning given the significant results in research question two regarding the association of low compassion satisfaction scores with higher scores of burnout and secondary traumatic stress. The importance of prevention and intervention efforts for improving the professional quality of life for master's level mental health professionals has been repeatedly emphasized in the literature on this topic (Colman et al., 2016; Goncher et al., 2013; Lim et al., 2010; Rivera-Kloeppel & Mendenhall, 2021; Scroggins, 2016; Warlick et al., 2020). However, the results of the current study clearly indicate the lack of instruction on compassion satisfaction. These are consistent with the findings that revealed that compassion fatigue and burnout were rarely taught in clinical doctoral programs for psychology (Bamonti et al., 2014; Scroggins, 2016). The result of this inquiry is concerning because not only are master's level mental health professionals experiencing a decrease in well-being due to the demands of the job, but students in graduate training are also reporting a decrease in well-being. In fact, several studies have shown that

doctoral students are experiencing poorer mental health and physical health than the general population (El-Ghoroury et al., 2012; Myers et al., 2012; Rummell, 2015). Several scholars have suggested an improvement in graduate training on well-being, self-care, and prevention efforts for negative impacts of the job such as burnout (Colman et al., 2016; Goncher et al., 2013; Lim et al., 2010; Rivera-Kloeppel & Mendenhall, 2021; Scroggins, 2016; Warlick et al., 2020). However, there are few studies that quantify the training currently offered in master's graduate programs for mental health. The results of the current study indicate that concept of compassion satisfaction was rarely taught in graduate training for these participants. This theme is consistent with findings in the literature suggesting that graduate training shift from a culture of reactivity to issues of wellness, to a culture of prevention and a stance of being proactive on issues of wellness (Bamonti et al., 2014; Scroggins, 2016). Additionally, if universities shifted to a preventative model during graduate training, this could provide a foundation for students to pursue professional well-being for their entire career even as roles may change throughout (Myers et al., 2012).

The current study explored further from a professionals' perspective to describe reflectively what might have been helpful in the absence of training on professional quality of life. To date this is the only study in the literature specifically asking professionals to provide insight into how to improve this aspect of their graduate training. Research question four was also answered by open-ended question one (see Appendix C). Open-ended question one asked respondents, "If you received no training or minimal training on the above concepts, describe what would have been helpful to you during your training." There was minimal difference in responses between early career and mid/late career professionals. The themes that emerged for both groups included instruction on ProQOL concepts, instruction or emphasis on self-care, and

normalization of ProQOL concepts. Instruction on prevention of ProQOL concepts emerged in the data for mid/late career professionals, but did not emerge in the early career professionals' responses.

Theme one: More instruction on professional quality of life concepts. The first theme that emerged from this question was that respondents wanted more instruction on concepts such as burnout, compassion fatigue, secondary traumatic stress, and/or compassion satisfaction. This finding is consistent with reports in the literature that there is a minimal amount taught on burnout, compassion fatigue, secondary traumatic stress, and compassion satisfaction in graduate training programs. Currently a lack of formal training in doctoral programs on compassion fatigue, a lack of focus on wellness, and a lack of instruction on cultivation of compassion satisfaction has been reported (Bamonti, et al., 2014; Ray et al., 2013; Scroggins, 2016). Table 16 shows specifically what was mentioned by participants.

Table 16

Theme 1: More on ProQOL Concepts

	Early	Mid/Late
In general, more on any of these concepts (did not specify)	3	6
More on burnout	0	2
More on secondary traumatic stress	4	1
More on compassion satisfaction	5	2
More on compassion fatigue	2	1

The responses for both professional stages were similar, and are shown in several statements from early career professionals and mid/late career professionals who indicated that they would have liked more instruction in graduate training on professional quality of life concepts. For example, early career professionals wanted more emphasis, training, or even a course on burnout, secondary trauma, and compassion satisfaction. One respondent even did not recall learning about compassion satisfaction "I don't recall learning about compassion satisfaction… It would have been helpful to hear about compassion satisfaction more." Mid/late career professionals also indicated that they wanted more instruction on professional quality of life concepts such as burnout, compassion fatigue, and compassion satisfaction. Specifically, several respondents indicated that they would have liked to learn how to recognize the symptoms of compassion fatigue and burnout. One respondent was also unfamiliar with compassion satisfaction "Compassion satisfaction is a new concept to me… Getting more information on this concept would be helpful…" Studies on burnout prevention found that education in the second year of graduate training about work-related stress and secondary traumatic stress is considered a preventative measure that can help professionals from developing problems later in their career (Ahola et al., 2017; Laverdière et al., 2018). While the studies mentioned above suggest that graduate training incorporate professional quality of life concepts, none of these studies directly asked students or professionals how to improve training on professional quality of life. The current study is the only study in the literature to ask professionals directly how they rate their training on professional quality of life concepts, and how they would suggest improving it. The answers for these open-ended questions provide in-depth information from the student and professional perspective on how graduate training could be improved. Scholars and instructors in graduate training should take these suggestions and learn to incorporate them in their instruction.

It could be as simple as talking about wellness and professional quality of life concepts in already established courses, bringing in a guest speaker to talk about their experiences with burnout, or creating a new course specifically designed for teaching concepts of professional quality of life.

Theme two: Emphasis on self-care. The second theme that emerged was emphasis on self-care. This theme was mentioned for early career professionals 25% of the time, and for mid/late career professionals 34% of the time. There was a slightly higher number of responses in this theme for mid/late career professionals (n=10), compared to early career professionals (n=6). As mentioned earlier, there are minimal studies that have explored what is currently being offered in graduate training to address professional quality of life. The results from this study for question one indicated that early career and mid/late career professionals were experiencing symptoms of STS and burnout, and it is also clear from the literature that students in graduate training possess several risk factors for developing adverse impacts of working in the mental health field (Bamonti et al., 2014; El-Ghoroury et al., 2012; Goncher et al., 2013). In fact, studies of students in clinical and counseling graduate training found that these students were experiencing higher rates of depression and anxiety than the general population (Myers et al., 2012; Rummell, 2015). A few studies of satisfaction with programs revealed dissatisfaction in areas of self-care emphasis, mentor relationships with faculty, and time for non-work related activities (Myers et al., 2012; Rummell, 2015). The responses of these students were also reflected in the theme of more emphasis on self-care that occurred for the participants in the current research study when asked about how to improve their graduate training. Responses for the professional stages were similar. Early career professionals agreed that there should have been more emphasis on self-care in graduate training, specifically on learning what effective self-care is and how to practice it.

One respondent indicated that "I think it would have been great to learn and practice in class some techniques to combat the stress…" Mid/late career professionals also indicated a desire for their programs to have more emphasis on self-care. A discussion of healthy self-care activities in graduate training would have been helpful to one participant in learning how to take care of their own needs prior to taking care of the needs of others; "Learning how to take care of yourself first prior to taking care of others…" Training in self-care has been found successful in reducing mental health professionals' perceived job stress and increasing their job satisfaction (Mache et al., 2016). This theme is consistent with findings in the literature that indicate training for mental health professionals include self-care skills, as they are effective at reducing perceived stress and are cost-effective (Mache et al., 2016; Rummell, 2015; Sodeke-Gregson, 2013).

Theme three: Creating a culture of normalization of these concepts. The third theme that emerged from this data was that respondents reported that it would have been helpful to have a culture of normalization about the potential for developing burnout, compassion fatigue, and secondary traumatic stress. Responses in this theme for early career professionals and mid/late career professionals were similar. 16% of early career professionals provided a response in this category, while 10% of mid/late career professionals provided a response. This theme is consistent with findings in the literature on graduate training programs. A few studies found that graduate students in their programs desired greater connection with faculty, a culture change to value well-being, and a recognition of student perspective by faculty (Rummell, 2015; Zahniser et al., 2017). For the participants in the current study, responses for each career stage were similar, early career professionals desired a culture of normalization of professional quality of life concepts. Several suggested that having a guest speaker come to class and talk about their experiences with burnout, secondary traumatic stress, and compassion fatigue would have been

helpful. One respondent stated “I feel it would have been beneficial to learn more about these topics above and to possibly hear from those in the field about how this is normal and how it has affected them…” Mid/late career professionals also desired that a culture of normalization of professional quality of life concepts. One respondent indicated that just hearing the terms in graduate training would have been beneficial, “Just to hear these terms and normalization and validation of them…” Creating a culture change in graduate training programs for psychology helping professionals has been a consistent finding in the few studies that have assessed what is currently being offered for graduate students on professional quality of life and well-being (Myers et al., 2012; Rummell, 2015; Zahniser et al., 2017). While this can be done with raising faculty awareness for the importance of well-being amongst both faculty and students, a first place for programs to start is with a thorough evaluation of systematic efforts in training on well-being (Goncher et al., 2013). Given the findings of the current study and the lack of emphasis on professional quality of life reported by students and participants, graduate programs need to evaluate how effectively they are preparing their students to face the demands of working in the mental health field.

Theme four: Prevention education on negative impacts of helping professions. The fourth theme that emerged was that participants wanted to hear specific information on how to prevent the negative impacts that might occur from working in the helping professions. Mid/late career professionals responded 10% of the time to this theme. Early career professionals did not have this theme in their responses. This theme is consistent with literature suggesting that graduate training shift from a culture of reactivity to issues of wellness, to a culture of prevention, and proactive on issues of wellness (Bamonti et al., 2014; Myers et al., 2012). In the current study, one respondent made statements regarding how beneficial a preventative approach would have

been during training, “A class on who/what circumstances are most vulnerable to the above concepts, how we know if we’re experiencing them and what to do EARLY on to prevent getting to a point of no return…” Still another participant specifically would have liked to have known the symptoms of compassion fatigue/burnout and how to best cope with these issues. Based on the qualitative findings for open-ended question one, there is still improvement that needs to occur in graduate training for mental health professionals in professional quality of life and well-being. Findings from this study indicate master’s level mental health professionals reported that training programs were severely lacking in instruction on well-being, professional quality of life concepts, and self-care. In addition to improving instruction, respondents suggested that programs should create a culture of normalization, and take preventative measures to ensure better outcomes for these professionals.

Research Question #5: Summary of Results and Discussion

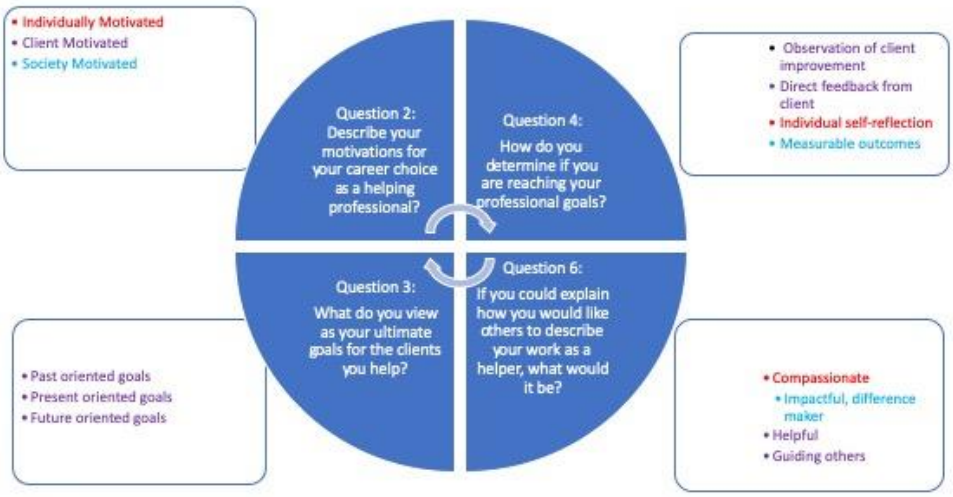
The fifth research question in this study asked, “How do motivations, career goals, and goals for clients change as helping professionals are in different career stages?” This research question was answered by respondents completing five open-ended questions. Therapeutic outcomes for patients are often dependent on the career stage of the mental health professional. Practitioners’ later in their careers are more successful in their therapeutic outcomes than practitioners’ earlier in their careers (Chui et al., 2016; Lim et al., 2010; Salyers et al., 2016). Additionally, lower therapy dropout rates have been reported for late career professionals than early career professionals (Lim et al., 2010; Schwartze-Mette et al., 2009). Research promoting an understanding of the progression of student to young professional can help researchers understand what resilience factors are present in later career professionals when compared to early career professionals (Koltz & Champe, 2010; Pratt & Lamson, 2011). In addition, graduate

training can incorporate these resilience factors into training for early career professionals to serve as preventative measures to developing poor professional quality of life and well-being. Minimal studies exist on a theoretical model for counselor development, the results from this study help to provide more information on this topic.

Open-ended questions 2, 3, 4, 6. Several of the open-ended questions followed similar themes. There was not a significant difference between early career and mid/late career professionals for these answers, and the majority of themes were represented in both career stages with only a few being unique to the career stage. It is important to note that there are not many studies that ask a large group of master's level mental health professionals to describe their motivations, career goals, and measuring of achievement of career goals through open-ended question format. There are a few studies that interview a small number of participants, but none with qualitative data from a larger sample (Ayala et al., 2018; Bartoskova, 2017; Gant, 2019). Overall, the responses to these questions were supported by literature, while some of the responses represented novel findings. Below is an overall summary of themes for questions 2, 3, 4, 6 (see Figure 11).

Figure 11

Summary of Questions 2, 3, 4, 6



The above table indicates that the responses to these questions felt similar in theme. By putting the themes together in one figure, we can see that the themes are distinct, however closer analysis reveals that there is some overlap. The similar themes for each question are color coded. The themes that emerged from the data for open-ended question 2 indicated that these professionals were motivated in their careers by three things: individually motivated (red), client motivated (purple), or society motivated (blue). These three themes followed similarly in questions 3, 4, and 6. Below is a summary of these themes and how they occurred in several of the responses for different questions.

Individually motivated. For open-ended question two, participants were asked, "describe your motivations for your career choice as a helping professional?" The differences that existed between career stages in these themes indicated that early (31%) and mid/late (50%) career

professionals were motivated by their own individual needs. Many of the responses indicated that these professionals saw their careers as fitting in with their already existing strengths and skills. This fits in with the current research that places an emphasis on personal accomplishment, feelings of satisfaction, and competence in one's performance at their job (Dreison et al., 2018b; Lim et al., 2010). Self-efficacy has been associated with lower rates of burnout in mental health professionals and serves as a job resource in the JD-R model (Dreison et al., 2018b). Self-efficacy refers to the need to feel capable of achieving desired outcomes. Those professionals' who are individually motivated have an existing level of competency and are thus motivated by this. Studies of mental health professionals have found that feelings of personal accomplishment and feelings of more control over desired goals can mitigate burnout (Lim et al., 2010; Dreison et al., 2018b). Those early in their career motivated by individual desires made statements indicating that they innately had a talent for helping others with their problems, and that is why they chose their career path. One respondent stated that it had been their desire for a long time, "It is something I have always wanted to do but did not have a chance until later in life…I feel it is my time to shine and do what makes me happy…" Several mid/late career professionals identified individual strengths and how these strengths motivate them in their careers, "My heart and empathy are insights and strengths…" Consistent with literature findings that indicated early career psychologists reported less professional well-being than late career psychologists because they lack the resources that contribute to a sense of accomplishing goals on their career path (Dorociak et al., 2017). Late career psychologists possess many more of those personal career accomplishments including increase in salary, a better work placement, and more opportunities for professional development (Dorociak et al., 2017). These individual accomplishments serve as a resource for these professionals and are hypothesized to mitigate levels of burnout (Demerouti

et al., 2001; Stensland & Landsman, 2017). The relationship between motivation and career stage is an area that requires further understanding, however the results from this open-ended question begin to provide insights into a specific sample, and how they define their motivations for their careers as helping professionals. A similar theme emerged in question four when participants were asked, "how do you determine if you are reaching your professional goals?" Both early career (38%) and mid/late career (29%) professionals often evaluated their success based on a feeling, intuition, and individual self-reflection, "If I feel fulfilled and like I am putting my best foot forward with each client," and "Knowing that I am making an impact even if I don't get to see it." Professionals determining individual success or patient success through personal self-reflection has been advised against in the literature (Babione, 2010). It should be the responsibility of graduate programs to teach students how to effectively evaluate their success, and currently there is a lack of this in training programs which might explain why clinicians are experience a lack in feelings of personal accomplishment. Going beyond a simple feeling of success or intuition should be emphasized for those in training to help them prepare professionally for the longevity of their career (Koltz & Champe, 2010). This question begins to provide insights into how clinicians view their success, and if they should be evaluating their success based on their own feeling or an outside assessment. Master's level mental health professionals are called to ethical standards based on their professional licensing boards. Ethical standards include providing the most effective possible treatment when working with their clients. In order to operate effectively, with clinical expertise and for the most benefit of the client, professionals must carefully consider the interventions utilized based on client factors, patient characteristics, culture, and patient preferences (Babione, 2010). Question six asked respondents "if you could explain how you would like others to describe your work as a helper,

what would it be?" The most frequently occurring theme for both early (33%) and mid/late career (35%) was "compassionate." Some examples of this response included, "compassionate, non-judgmental listener," and "compassionate and authentic." Given that this theme of being motivated by individual needs carries throughout the open-ended questions, it follows that respondents to this question would be highly motivated by others seeing them in a positive light. The high number of respondents that were concerned with their individual perception rather than the outcomes from their work is an important aspect of these findings and should be considered when evaluating therapeutic outcomes. Studies on counselor development found that healthy professional identity develops through autonomy rather than looking for approval from others with regard to skills and responsibilities (Babione, 2010; Koltz & Champe, 2010; Pratt & Lamson, 2011; Ronnestad et al., 2018).

Client motivated. The next theme that emerged for question two and appeared throughout the open-ended questions was that these professionals were motivated in their careers by their clients, specifically by helping their clients. Early career professionals reported this as their motivation in question 2 45% of the time, while mid/late career professionals reported this as their motivation 39% of the time. This corresponds with literature on professional development, specifically that early career professionals were often influenced by experiences with clients. Several early career professionals described their motivation to work was to help or empower their clients. One respondent was specific about helping their clients by empowering them, "Be a positive influence in someone's life and empower them to make positive change…" Mid/late career professionals were also client motivated and enjoyed helping others on their journey, helping people manage their mental health, and helping people find support. One respondent stated simply, "I wanted to help others…" Open-ended question three asked participants**, "**What

do you view as your ultimate goals for the clients you help?" The responses to this question were all client-centered whether they were focused on goals oriented to the past, present, or future. Some early career professionals reported that they their ultimate goal for helping their clients was oriented towards the past, whether it was healing a trauma or resolving relationship issues. This response encompassed 10% of the participants responses and was the lowest mentioned category. Mid/late career professionals reported this as their ultimate goal for clients 13% of the time. Early career professionals and mid/late career professional reported past oriented goals such as healing trauma, moving on from past trauma, and processing past experiences. While there is not much research about how a past oriented approach with clients can impact professional quality of life, a couple of studies did find that a psychodynamic approach was correlated with higher rates of burnout for mental health professionals (Craig & Sprang, 2010; Laverdière, et al., 2018). A psychodynamic approach is concerned with understanding the clients' childhood experiences, development, and how this development influences unconscious processes. One of the criticisms of a psychodynamic approach is that it places too much of an emphasis on the past (King, 2011). Primarily focusing on past traumas in therapy has been correlated with an increase in secondary traumatic stress (Laverdière, et al., 2018; McKim & Smith-Adcock, 2014). When a professional is experiencing STS, they can use a technique known as numbing; which means that the professional restricts their emotional involvement in session, particularly when the client is recalling their traumatic events (Barnett et al., 2007; Thompson et al., 2014). Given that only a few studies have considered therapeutic approach with clients, the responses to this question indicates that there are several professionals motivated by resolving the past. This should be taken into consideration when analyzing rates of STS in helping professionals. Professionals were also motivated by helping their clients to achieve goals in the

present, whether it was in session, or goals that they could use to improve their daily lives. Early career professionals reported this orientation towards client goals 38% of the time, while mid/late career professionals reported this orientation towards goals 39% of the time. Responses for both career stages included helping clients to feel listened to, cared for, teaching them how to regulate emotions, and understanding reality. One respondent stated, "To be aware of their emotions and learn to regulate…" While few studies have looked at the therapeutic approach taken with clients and impacts on professional quality of life, one study found that clinicians who reported using evidence-based strategies such as Cognitive Behavior Therapy (CBT) or Behavioral Therapy had lower scores of compassion fatigue (Craig & Sprang, 2010). These approaches focus on present oriented goals such as understanding how thoughts and behaviors lead to actions (Greenberger & Padesky, 2016). Some participants also responded when asked about their goals for their clients was an orientation towards achieving future goals. Early career professionals reported this as their goal with clients 52% of the time, and mid/late career professionals reported this as their goal with clients 48% of the time. Early career professionals and mid/late career professionals described their future oriented goals as helping clients to live their best lives, meet their goals, experience personal growth, work towards self-actualization, and learn to seek help in the future. One respondent indicated that providing clients with resources for the future was key, "To provide them with enough power and resources that they can imagine how to help themselves and others in the future…" While little exists in the research about having client goals oriented towards the future, one study found that counselors, specifically early career counselors must learn to manage their expectations of clients' success in therapy (Koltz & Champe, 2010). Those professionals who are motivated by future oriented goals must develop a way to measure their success as often these types of goals are not witnessed. Question four asked participants "how do

you determine if you are reaching your professionals goals?" Client centered responses to this question included observation of client improvement and direct feedback from client. Early career professionals determined they were reaching their professional goals by this method 16% of the time, while mid/late career professionals determined they were reaching their professional goals 24% of the time. Early career professionals reported that observations of client improvement were very valuable in measuring their success. One respondent indicated, "When they start to follow the boundaries I try and set and when they start to try things on their own and succeed and feel like they don't need to talk to me as much…" Mid/late career professionals' observation of client improvement was often based on a general observation of improvement and progress. In addition to client observation, direct feedback from clients emerged for professionals in their determination of achieving career goals was direct feedback from the client. While this could appear to be a less biased approach to assessing professional goals than from general observations of the professional, client feedback can also contain bias that prevents the professional from accurately assessing client improvement. Due to the power differential that exists in a therapeutic relationship, clients might not feel comfortable to express directly to the therapist their feeling about treatment (Ronnestad & Skovholt, 2013). Question six which asked respondents about how they would like others to describe their work as a helper, and a few themes emerged that were client-centered. Professionals wanted others to view their work as helpful. Early career professionals reported this as important to them 30% of the time while mid/late career professionals reported this as important to them 23% of the time. Examples of these responses included, "helping others to live their best life," and "help others meet personal goals." The other theme that emerged that was client-centered was that guiding others was important for these professionals' in how others viewed their work. This theme had a low

response rate for both early (7%) and mid/late career professionals (6%). Examples of these responses included, “I am a guide…” and “Journeying with people while guiding them.” In this sample, participants were motivated by helping clients in the themes that commonly emerged in several of the questions. Studies have indicated that several client factors can lead to burnout, compassion fatigue, and secondary traumatic stress. Secondary traumatic stress and compassion fatigue were correlated with over involvement with clients, lack of clear boundaries with clients, and having more clients who had experienced trauma (Laverdière, et al., 2018; McKim & Smith-Adcock, 2014). While many mental health professionals are motivated by the work that is done with clients, becoming overinvolved with clients can be a risk factor for developing burnout and secondary traumatic stress (Laverdière, et al., 2018). Given that early career students are often motivated by their work with clients, it is important for them to learn how to manage their own expectations about the work that they are accomplishing with their clients and have realistic goals for their clients (Gant et al., 2019; Koltz & Champe, 2010). The qualitative data provided for these questions further support the literature that indicates training programs should carefully monitor students as they enter their field placements and be available to discuss any issues or concerns. The thematic results in this study indicate a high prevalence of professionals motivated by helping clients and it warrants understanding into how those who are motivated by helping clients are experiencing professional quality of life and well-being. In this study, the scores for STS and burnout were high perhaps indicating that the sample would benefit from education on the importance of boundaries with clients.

Society motivated. The next theme that emerged from question two that continued only in one other open-ended question was that some professionals were motivated by making a difference in society. For question two, early career professionals were motivated by making a

difference in society 24% of the time, while mid/late career professionals were motivated by making a difference in society 11% of the time. One early career professional viewed their motivation to work as a helping professional, “I am an activist for well-being…” Another simply stated, “I want to help society as a whole…” Mid/late career professionals were less motivated by improving society than early career professionals, however several respondents had more altruistic goals for their work, “I want to make the world a better place...” and “I wanted to create greater access to mental health...” Question six asked participants how they would want others to describe their work. There were slightly more responses in this category for early career professionals (20%) than mid/late career professionals (13%). Some examples of this response are, “I want to be seen as impactful,” and “impactful, important.” This theme has rarely shown up in the literature to date, however a few studies of counselor development indicate the importance of professional development, healing involvement, and continuous reflection (Ronnestad et al., 2018; Schwartz-Mette et al., 2019). By having a motivation that is outside the client and the individual, professionals can engage in these activities more frequently. This new finding is important and should be considered when studying professional quality of life. When participants were asked about determining their own success in reaching professional goals in question four, some respondents determined their success through measurable outcomes and assessments. While this is not specifically indicating that they are motivated by society, these respondents are motivated by something beyond individual assessment and client feedback. Early career professionals reported this method of determining their professional goals 19% of the time while mid/late career professionals reported this method for determining professional outcomes 18% of the time. Early career professionals and mid/late career professionals indicated that measurable outcomes were important for measuring their success. Measuring treatment

goals, feedback from supervisors, reviewing taped sessions, and assessment of treatment planning were all examples given. The importance of career development for the counselor over the span of their career was found to be achieved by new learning which included positive skill change, overcoming limitations, and therapeutic mastery (Gant et al., 2019; Koltz & Champe, 2010; Pratt & Lamson, 2011; Ronnestad et al., 2018; Ronnestad & Skovholt, 2003). Perhaps implementing training on measurable outcomes and continually assessing these achievements can help professionals at all stages of their careers thrive.

Importance of personal psychotherapy. Open-ended question five in the study asked participants, "Do you feel that your own therapy is a critical component to helping your clients?" It is still unclear in the literature if attending individual psychotherapy is beneficial to the mental health professional. Some studies found that personal psychotherapy was associated with higher rates of burnout for mental health professionals (Di Benedetto & Swadling, 2014; Laverdière et al., 2018). Other studies found that psychotherapists who had trauma histories were also more likely to experience secondary traumatic stress and attend psychotherapy than those who did not have trauma histories (Sodeke-Gregson et al., 2014; Yang & Hayes, 2020). Additionally, trainees with significant trauma histories reacted negatively when faced with hearing client trauma stories (Butler et al., 2017).

The themes that emerged from this study when participants were asked about their personal psychotherapy included helps with my own mental health or healing, helps me listen better or have more empathy for my clients, it is part of my self-care, and not in therapy or does not help. Both early and mid/late career professionals had the same themes, however some themes were more prominent for mid/late career professionals than early career professionals. More detailed information about themes are described below.

Theme one: Helps with my own mental health or healing. The first theme mentioned by participants was that attending therapy helped them with their own mental health or healing. Early career professionals had more frequency of responses in this category (24%) than mid/late career professionals (14%). This is consistent with literature findings as often early career professionals are still learning about their own mental health issues and advised to attend psychotherapy for these impairments in graduate training programs frequently (Bamonti et al., 2014). Several participants reported that therapy made them healthier, helped with healing, or helped with triggering issues. One respondent stated, "I need my own therapy because of my own mental health struggles…" Encouraging students to seek personal psychotherapy as a form of self-care as well as to manage their own mental health is common practice in graduate training for mental health professionals (Bamonti et al., 2014). However, studies are mixed in their findings on whether personal psychotherapy is helpful for clinicians. One finding that can be applied to this study is that evidence-based practice was significantly negatively correlated with compassion fatigue, and indicated that an increase in use of evidence-based practice resulted in a significant decrease in compassion fatigue (Craig & Sprang, 2010).

Theme two: Helps me listen better or have more empathy for my clients. The second theme that emerged from the data was that personal psychotherapy helped participants to listen better or have more empathy for clients. Early career professionals described this as their response 43% of the time while mid/late career professionals described this as their response 47% of the time, having a similar rate of responses. Respondents indicated that their own therapy helped them to have more empathy for their clients, helps them to understand relational patterns, and helped them to be a better listener. For example, one respondent said "It has helped a lot. I get to use that empathically and relationally…" While another respondent was focused on the

empathy aspect, “It gives me renewed empathy…” Attending psychotherapy for these professionals was perceived as helpful to them to be better therapists. Some studies have found that self-compassion, having sympathy for the self, acceptance of one’s own struggles, and maintaining self-awareness are all effective forms of self-care for the mental health professional in reducing burnout (Ayala & Almond, 2018; Beaumont et al., 2017; Beaumont & Sisson-Curbishley, 2020).

Theme three: It is part of my self-care. Participants in this study described the benefit of attending psychotherapy as a form of their self-care. One study of self-care in graduate training found that attending psychotherapy was one of the most frequently mentioned forms of self-care for mental health issues by graduate handbooks (Bamonti et al., 2014). Perhaps these respondents learned in graduate training about psychotherapy as a form of self-care. Early career professionals had this response 14% of the time while mid/late career professionals had this response 23% of the time. Early and mid/late career professionals reported that therapy is a form of self-care, helps them to keep perspective, helps them to stay balanced, and reminds them to practice self-care. One respondent reported that personal psychotherapy, “Sustains me...” In fact, some studies of self-care, specifically in graduate training found that some forms of self-care were beneficial to mental health professionals while others were not. Reviews of the self-care literature resulted in a lack of robust methodology for evaluating self-care strategies for the mental health professional (Callan et al., 2020; Rivera-Kloeppel & Mendenhall, 2021). In addition, studies of self-care in the literature lack reliability of instruments and a lack of theory application to understand the findings (Benuto et al., 2018; Callan et al., 2020; Rivera-Kloeppel & Mendenhall, 2021).

Theme four: I am not currently in therapy or it doesn't help me. The fourth theme from this question was that respondents reported that they were not currently in therapy or that it didn't help them. This is consistent with findings in the literature about personal psychotherapy. Results are mixed as to whether personal psychotherapy benefits the helping professional (Di Benedetto & Swadling, 2014; Laverdière et al., 2018). One conclusion that can be drawn from the literature is that personal psychotherapy is beneficial when one is developing certain skills such as mindfulness, reevaluation, and self-compassion (Andela & Truchot, 2017; Ayala & Almond, 2018; Beaumont et al., 2017; Beaumont & Sisson-Curbishley, 2020). Another surprising finding in this theme is that early career professionals responded this way 19% of the time. This is surprising because most students are encouraged or required to attend psychotherapy during their training (Bamonti et al., 2014). While not specified in their answers, one explanation for this response is the financial obligations that early career professionals experience prevents them from seeking psychotherapy services (Rummell, 2015; Santana & Fouad, 2017). A few respondents indicated that personal therapy does not help them in their own careers, "It doesn't help me…" Several other respondents indicated that they are not currently attending therapy, "Not currently in my own therapy…" More information is needed in this sample to understand if participants are not attending therapy because of financial constraints, or if it is because they do not find it helpful. Engaging in self-care efforts for students was difficult due to financial constraints and resulted in higher levels of burnout in the student population (El-Ghoroury et al., 2012; Rummell, 2015; Santana & Fouad, 2017). In one study, less than 20% of the students reported seeking psychotherapy services due to lack of affordability of services (Bamonti et al., 2014). One suggestion to address this problem is for psychology training programs to provide additional financial support to students struggling with significant financial debt (El-Ghoroury et

al., 2012; Olson-Garriott et al., 2015; Rummell, 2015; Santana & Fouad, 2017). Qualitative data collected from this question begin to provide insights into the perceived benefits or lack of helpfulness in participating in personal psychotherapy.

Conclusion

Mental health professionals spend many hours a day attending to the needs of others. The emotional toll that this work takes on those providing it should not be overlooked. Addressing the problem now with purpose, targeted interventions, and early preventative education can prevent further negative outcomes from occurring. Poor professional quality of life in these professionals leads to physical health problems, mental health symptoms, and poor treatment outcomes for clients (Laverdière et al., 2018; Sodeke-Gregson et al., 2013). Burnout and secondary traumatic stress scores for these participants were above average, indicating that poor professional quality of life for master's level mental health professionals should be further understood. Prevention efforts can be specifically targeted in graduate training programs as well as workplaces. Slightly higher scores on both burnout and secondary traumatic stress scales for early career professionals show these conditions can occur for those earlier in their careers. Literature contends that early career professionals possess many of the risk factors that can lead to adverse outcomes (Berjot et al., 2017; Dreison et al., 2018a; Laverdière et al., 2018; Sodeke-Gregson et al., 2013). Not all aspects of working in the mental health field are negative, and many professionals feel a unique sense of satisfaction from helping others. Findings from this study indicate that compassion satisfaction is a critical element in understanding the overall wellness for these professionals. CS was significantly correlated with burnout and STS such that as scores of CS decreased, scores of burnout and STS increased. Literature to date has not clearly articulated the relationship between burnout, STS, and compassion satisfaction (Laverdière et al.,

2018; Sodeke-Gregson et al., 2014). The present study found significance in understanding the correlation between these aspects of professional quality of life. While there is a breadth of literature to date on the negative outcomes of working in the mental health field, very few studies have focused on how the positive outcomes of working in the mental health field can mitigate the negative outcomes (Laverdière et al., 2018; Sodeke-Gregson et al., 2014; Thompson et al., 2014). Another finding from this study that was concerning is how little students and professionals recall learning about compassion satisfaction. Creating a culture of normalization of these topics and teaching about these concepts in courses was suggested by both early career and mid/late career professionals as a helpful action for graduate training programs. This has been suggested by practitioners and scholars repeatedly in the literature (Ahola et al., 2017; Baugerud et al., 2018; Dreison et al., 2018b; Finklestein et al., 2015; Laverdière et al., 2018; Lawson & Myers, 2011). However, few studies to date have done a thorough assessment of master's level graduate training programs and education on concepts of professional quality of life. A novel approach taken in this study was to ask a large sample of master's level mental health professionals open-ended questions about their motivations for working as helping professionals. A qualitative analysis of these responses indicated that a majority of respondents both early and mid/late in their career were motivated by helping their clients. The theoretical approach in this paper utilized the JD-R model, and this model is based on employee motivation. Therefore, understanding the motivation of helping professionals and how it relates to professional quality of life remains of continued importance.

Recommendations for Future Research

The factors that contribute to professional quality of life and well-being of master's level mental health professionals is an important area for future research. This study focused on

differences between career stages and professional status on scores of burnout, secondary traumatic stress, and compassion satisfaction. This study also focused on how the positive aspect of working in the field; compassion satisfaction impacts scores of burnout, and secondary traumatic stress. Qualitative data further informed the research questions and provided insights on how master's level mental health professionals experience the different unique aspects of their careers. These quantitative findings were considered in light of the JD-R theoretical model (Bakker & Demerouti, 2017; Demerouti et al., 2001).

Compassion satisfaction was significantly correlated with burnout and secondary traumatic stress in this study, such that lower scores on compassion satisfaction lead to higher scores on STS and burnout. In addition, using a theoretical framework such as the JD-R model can help researchers account for the shared variance of STS and burnout (Bae et al., 2019; Cieslak et al., 2014; Dreison et al., 2018b). The JD-R model should be applied to future studies on this topic, specifically if STS could be considered a demand in the JD-R model that leads to burnout and if compassion satisfaction could be considered a resource in the JD-R model that prevents burnout. This research can directly lead to an improvement in quality of care; when burnout is low, clients receive a better quality of care from clinicians as they are less focused on self-preservation (Andela & Truchot, 2017; Laverdière et al., 2018).

Students and professionals in the current study reported a significant lack of instruction on compassion satisfaction during graduate training. Further research should explore how master's level mental health professionals are trained in professional quality of life concepts, specifically compassion satisfaction. Research exploring what is currently being offered for master's level mental health professionals in self-care and professional quality of life training is still needed. A re-evaluation of systematic instruction efforts in training continues to be an

important aspect to study. The lack of current studies in the literature in this area is concerning (Bamonti et al., 2014; Goncher et al., 2013; Myers et al., 2012; Rummell, 2015; Zahniser et al., 2017).

Qualitative data in this study found that master's level mental health professionals are motivated in many aspects of their careers by helping their clients. Further studies should explore if a professional motivated by individual outcomes, client outcomes, or societal outcomes has any influence on professional quality of life. In addition, research should explore how systematically measuring client outcomes can contribute to a reduction in burnout for mental health professionals. Psychology training can move towards evidence-based practices, as often students come with misconceptions about how to be an effective clinician (Babione, 2010). Graduate training programs should educate students about how to accurately assess effectiveness in clinical interventions that go beyond observations or conversations with clients. On the development of poor professional quality of life, exploring further how professionals' view their work with clients is an important area to study. The lack of occurrences in this study of specific, evidence-based objectives to helping clients was a concerning finding to the researcher. Obtaining competence is an important component in the developmental process of the professional (Ronnestad et al., 2018). More research on competence, how it develops over the course of the mental health professionals' career, and how it is measured is needed (Ronnestad et al., 2018). Furthermore, studies have indicated that several client factors can lead to burnout and secondary traumatic stress. Secondary traumatic stress and compassion fatigue were correlated with over involvement with clients, lack of clear boundaries with clients, and having more clients who had experienced trauma (Laverdière, et al., 2018; McKim & Smith-Adcock, 2014). Given that early career students are often motivated by their work with clients, it is important for them

to learn how to manage their own expectations and have realistic goals for their clients (Gant et al., 2019; Koltz & Champe, 2010). Training programs should carefully monitor students as they enter their field placements, and instructors should be available to discuss any issues or concerns. Given the thematic results in the study and the high prevalence of professionals motivated by helping clients, further research should explore how those who are motivated by helping clients experience professional quality of life and well-being.

Professionals in this study were asked to evaluate how personal psychotherapy helps them in their roles as helping professionals. Although only a small number of respondents did not find personal psychotherapy beneficial, this finding warrants future research on this topic. Studies to date have found that attending psychotherapy correlates with higher scores of burnout and secondary traumatic stress for some mental health professionals (Di Benedetto & Swadling, 2014; Laverdière et al., 2018; Sodeke-Gregson et al., 2014; Yang & Hayes, 2020). Despite some negative findings, attending psychotherapy has been prescribed as the most frequently mentioned form of self-care in studies of graduate training (Bamonti et al., 2014). More research on types of psychotherapy received by mental health professionals and their impact on well-being and professional quality of life needs to be conducted. The benefits of psychotherapy for professionals should be more systematically understood, given that graduate training programs often prescribe this as a necessary form of self-care. Additional research is needed to understand if greater self-reflection and empathy skills is one of the specific benefits of attending personal psychotherapy. Perhaps if these are explored as effective coping strategies in therapy, mental health professionals can use them when working with clients. Additionally, future research should seek to clarify if students in graduate training are not seeking psychotherapy services because of financial constraints, or if it is due to their belief that it does not help them.

Implications for Professional Practice

Research on interventions for master's level mental health professionals have found that interventions are somewhat successful in alleviating burnout (Ahola et al., 2017). Outcomes for interventions would be most favorable if they were implemented early in the lifespan of the mental health professional. The earliest and most effective time for intervention is during graduate training (Myers et al., 2012; Rummell, 2015; Zahniser et al., 2017). In addition to training, self-care emerged as an important strategy for mental health professionals in alleviating symptoms of burnout. Currently, self-care encouraged in graduate school lacks systematic instruction (Schmidt & Hansson, 2018; Scott & Takarangi, 2019). Graduate instruction should include an understanding of effective self-care strategies for master's level mental health professionals and provide systematic instruction on self-care in master's graduate training programs (Schmidt & Hansson, 2018; Scott & Takarangi, 2019). Graduate training should clearly identify healthy self-care and unhealthy self-care in order to help this population engage in the most beneficial activities for their professional well-being. Students and professionals already lack time and resources, providing them with instruction on the most effective forms of self-care will help to preserve their resources. Specifically, master's level training programs can take a preventative approach in educating students on identifying and treating burnout before it affects their ability to provide adequate care to their clients. Master's level mental health professionals often derive many tangible benefits from working in the mental health field (Craig & Sprang, 2010; Laverdière et al., 2018; Sodeke-Gregson et al., 2014; Thompson et al., 2014). Encouraging these professionals to cultivate an awareness of these benefits could go a long way in preventing negative outcomes from occurring.

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Appendix A

Adapted Survey

1. With what gender do you identify?
    a. Male
    b. Female
    c. Other _____

2. How old are you? Fill in number.

3. What is your current counseling/clinical employment or internship setting?
    a. Adult Clinic
    b. Hospital
    c. University
    d. Partial Hospitalization Program
    e. Shelter
    f. Foster Home
    g. Youth Clinic
    h. Elementary School
    i. Middle School
    j. High School
    k. Community Counseling Center
    l. Drug Rehab
    m. Sober Living Home
    n. Eating Disorder Treatment Center
    o. Private Practice
    p. Other _____

4. How long have you been working in your current counseling/clinical position?
    a. Less than 6 months
    b. 7 months- 1 year
    c. 1 - 2 years
    d. 3-4 years
    e. 5-6 years
    f. 7-8 years
    g. 9-10 years
    h. 11-15 years
    i. 15-19 years
    j. 20 plus years

5. When did you graduate from your graduate training program?
    a. Currently enrolled in school
    b. 1-2 years ago
    c. 3-4 years ago
    d. 5-6 years ago
    e. 7-8 years ago
    f. 9-10 years ago
    g. 10-19 years ago
    h. over 20 years ago

6. What type of program are you enrolled in or were enrolled in during graduate school?
    a. Master's in Clinical Psychology
    b. Master's in Social Work
    c. Master's in Counseling Psychology
    d. Doctoral in Clinical Psychology
    e. Other _____

7. How many hours a week do you interact with clients who have experienced traumatic events?
    a. 0-4
    b. 5-10
    c. 11-15
    d. 16-20
    e. 21-25
    f. 26-30
    g. 31-35
    h. 36-40
    i. more than 40

8. What is your current professional status?
    a. MFT trainee
    b. MFT Associate
    c. Licensed MFT
    d. Associate Social Worker
    e. Licensed Social Worker
    f. Associate Professional Counselor
    g. Licensed Professional Counselor
    h. Doctoral Student
    i. Licensed Educational Psychologist
    j. Licensed Professional Psychologist
    k. Doctorate in Clinical Psychology (PsyD)
    l. Other _____

9. I have specialized training in _____

Appendix B

Professional Quality of Life Scale (ProQOL)

1. I am happy.
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. Very Often

2. I am preoccupied with more than one person.
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. Very Often

3. I get satisfaction from being able to help people.
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. Very Often

4. I feel connected with others.
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. Very Often

5. I jump or am startled by unexpected sounds.
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. Very Often

6. I feel invigorated after working with those that I help.
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. Very Often

7. I find it difficult to separate my personal life from my life as a helper.
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. Very Often

8. I am not as productive at work because I am losing sleep over traumatic experiences of a person.
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. Very Often

9. I think that I might have been affected by the traumatic stress of those I help.
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. Very Often

10. I feel trapped by my job as a helper.
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. Very Often

11. Because of my helping, I have felt “on edge” about various things.
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. Very Often

12. I like my work as a helper.
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. Very Often

13. I feel depressed because of the traumatic experiences of the people I help.
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. Very Often

14. I feel as though I am experiencing the trauma of someone I have helped.
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. Very Often

15. I have beliefs that sustain me.
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. Very Often

16. I am pleased with how I am able to keep up with helping techniques and protocols.
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. Very Often

17. My work makes me feel satisfied.
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. Very Often

18. I feel worn out because of my work as a helper.
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. Very Often

19. I have happy thoughts and feelings about those I help and how I could help them.
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. Very Often

20. I feel overwhelmed because my case workload seems endless.
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. Very Often

21. I believe I can make a difference through my work.
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. Very Often

22. I avoid certain activities or situations because they remind me of frightening experiences of the people I help.
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. Very Often

23. I am proud of what I do.
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. Very Often

24. As a result of my helping, I have intrusive, frightening thoughts.
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. Very Often

25. I feel "bogged down" by the system.
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. Very Often

26. I have thoughts that "I am a success" as a helper.
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. Very Often

27. I can't recall important parts of my work with trauma victims.
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. Very Often

28. I am a very caring person.
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. Very Often

29. I am happy that I chose to do this work.
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. Very Often

Appendix C

Graduate training

Please answer the following questions about your training.

1. In my graduate training program, I learned about secondary traumatic stress.
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. Very Often

2. In my graduate training program, I learned about burnout.
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. Very Often

3. In my graduate training program, I learned about compassion fatigue.
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. Very Often

4. In my graduate training program, I learned about compassion satisfaction.
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. Very Often

5. If you received no training or minimal training on the above concepts, describe what would have been helpful to you during your training.

Appendix D

Career Stage Questions

Please answer the following questions in 1-3 sentences.

1. Describe your motivations for your career choice as a helping professional

2. What do you view as your ultimate goals for the clients you help?

3. How do you determine if you are reaching your professional goals?

4. Do you feel that your own therapy is a critical component to helping your clients?

5. If you could explain how you would like others to describe your work as a helper, what would it be?

Appendix E

Informed Consent

INFORMED CONSENT FORM – to be read and signed electronically

A. PURPOSE AND BACKGROUND
Amy Quinn, MA, MS, LMFT, a doctoral student in Educational Leadership at Northwest Nazarene University, is conducting a research study related to graduate education training on mental health workers' professional quality of life and self-care. You are being asked to participate in this study because you are currently working in the field as a mental health worker.

B. PROCEDURES
If you agree to be in the study, the following will occur:

1. You will be asked to sign an Informed Consent Form, volunteering to participate in the study.

2. You will answer a set of multiple choice, Likert scale and open-ended questions. This survey will take approximately 30-45 minutes to complete. Your response(s) will help to provide insight into mental health workers professional quality of life and self-care activities.

3. You may choose to end the interview at any time.

C. RISKS/DISCOMFORTS
1. Some of the discussion questions may make you uncomfortable or upset, but you are free to decline to answer any questions you do not wish to answer or to stop participation at any time.

2. For this research project, the researcher is requesting demographic information. The researcher will make every effort to protect your confidentiality. However, if you are uncomfortable answering any of these questions, you may leave them blank.

3. Confidentiality: Participation in research may involve a loss of privacy; however, your records will be handled as confidentially as possible. No individual identities will be used in any reports or publications that may result from this study. All data will be kept in a locked file in the researcher's password protected computer. In compliance with the Federalwide Assurance Code, data from this study will be kept for three years, after which all data from the study will be destroyed (45 CFR 46.117).

4. Only the primary researcher and the research supervisor will be privy to data from this study. As researchers, both parties are bound to keep data as secure and confidential as possible.

D. BENEFITS
There will be no direct benefit to you from participating in this study. However, the information you provide may help educators understand graduate training for mental health workers.

E. PAYMENTS
There are no payments for participating in this study.

F. QUESTIONS
If you have questions or concerns about participating in this study, you should first talk with the researcher. Amy Quinn can be contacted via email at amyquinn@nnu.edu. If for some reason you do not wish to do this, you may contact Dr. Heidi Curtis, Doctoral Committee Chair at Northwest Nazarene University, via email at hcurtis@nnu.edu, or by writing: 623 University Drive, Nampa, Idaho, 83686.

G. CONSENT
You will be emailed a copy of this consent form to keep.

PARTICIPATION IN RESEARCH IS VOLUNTARY. You are free to decline to be in this study, or to withdraw from it at any point.

I give my consent to participate in this study:

_____

Signature of Study Participant, Date

THE NORTHWEST NAZARENE UNIVERSITY HUMAN RESEARCH REVIEW COMMITTE HAS REVIEWED THIS PROJECT FOR THE PROTECTION OF HUMAN PARTICIPANTS IN RESEARCH.

Appendix F

IRB Approval

From: Northwest Nazarene University
To: Amy Quinn
Subject: RE: [Northwest Nazarene University] 04022020 - BURNING OUT IN THE BEGINNING: MENTAL HEALTH PROVIDERS PROFESSIONAL QUALITY OF LIFE
Dear Amy,

The IRB has reviewed your protocol: 04022020 - BURNING OUT IN THE BEGINNING: MENTAL HEALTH PROVIDERS PROFESSIONAL QUALITY OF LIFE. You received "Full Approval". I do want you to look over your attached forms to make sure you have correctly identified your dissertation chair. Lynn Bohecker is listed throughout the proposal but Bethany Studabaker is listed on one of the forms. Congratulations, you may begin your research. If you have any questions, let me know.

Northwest Nazarene University
Kimberly Lowe
IRB Member
623 S University Blvd
Nampa, ID 83686

Appendix G

ACRP Certificate

Association of
Clinical Research
Professionals

CERTIFIES THAT

Amy Quinn

Has Successfully Completed

Ethics and Human Subject Protection (No CEU)

Certification Date:
January 24, 2019

Appendix H

Social Media Announcement

I am Amy Quinn, a Doctoral Student at Northwest Nazarene University studying graduate education in clinical psychology programs. This research has been approved by the Human Research Review Committee at Northwest Nazarene University. If you are willing to participate, please click on the link and take the survey. This survey includes 47 multiple choice and Likert scale questions and 5 open-ended questions. It will take you approximately 20 minutes to complete. You may withdraw from this study at any time. At the end of the survey, you will be asked to enter your email for an opportunity to win one of three $50 dollar gift cards to Amazon.com. If you do not want to participate in the opportunity drawing you can decline. If you have questions or concerns about participation in this study, you should first talk with the researcher. Amy Quinn who can be contacted via email at amyquinn@nnu.edu. You may also contact Dr. Heidi Curtis, Dissertation Chair by writing: hcurtis@nnu.edu. Thank you, Amy Quinn, Northwest Nazarene University.

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