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The Impact Of “Wellness Factors” And “Psychological Factors” On Perceived Stress Among Licensed Professional Counselors

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THE IMPACT OF "WELLNESS FACTORS" AND "PSYCHOLOGICAL FACTORS" ON PERCEIVED STRESS AMONG LICENSED PROFESSIONAL COUNSELORS

DISSERTATION

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By

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Texas Southern University, 2023

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The purpose of this study was to evaluate the relationship between "wellness factors" and "psychological factors" on perceived stress among Licensed Professional Counselors. This study was concerned with the predictability of "wellness factors", specifically self-care, other-care, and "psychological factors," including self-esteem, anxiety, and resilience on counselor perceived stress. Counselors in this study are defined as Licensed Professional Counselors, Licensed Professional Counselor Associates (LPC-Associates), and Licensed Professional Counselor Supervisors (LPC-S).

The population of this investigation consisted of counselors at various licensure status' including LPCs, LPC-Ss, and LPC-As that are current and active members of the Texas Counseling Association, Texas School Counseling Association, and urban Counselor organizations in Texas. Counselors were generally clustered in the major metropolitan cities of Texas and surrounding counties. Counselors were contacted via social media, private practice phone calls, and email. A total of 250 counselors participated in this study. The data analysis contained the examination of three null hypotheses tested for this study. Testing of the three hypotheses was accomplished by

using the Standard Multiple Regression Statistical Procedure. All hypotheses were tested at the .01 level or better. All three hypotheses were found to be significant at the .001 level. Regarding hypothesis one, the wellness factors of self-care and other-care were found to be significantly linearly related to perceived stress. The variable self-care was found to be an independent predictor of perceived stress. Regarding hypothesis two, the psychological factors self-esteem, anxiety, depression, and resilience were found to be linearly related to perceived stress. The variables self-esteem and depression were found to be independent predictors of perceived stress. Regarding hypothesis three, the combined wellness and psychological factors of self-care, other-care, self-esteem, anxiety, depression, and resilience were found to be statistically linearly related to perceived stress. The variables self-esteem and depression were found to be independent predictors of perceived stress.

The following recommendations are offered to counselors regarding perceived stress. As counselors continue to expand on various strategies of self-care and work-life balance, counselors may find that some attention given to their current levels of perceived stress, identifying which factors may be contributing to such stress levels, and evaluating coping strategies may be of professional and personal benefit. While counselors are still traditionally trained on the critically supportive nature of counselor-to-client relationships, further interpersonal research relating to the counselor themselves may provide additional support for counselor-related mental health.

Continued research of statistically relevant variables relating to counselor perceived stress may provide a further knowledge base for counseling training programs, and continuing education opportunities to discuss and encourage counselor self-

introspection toward perceived stress throughout the career of the practicing counselor. Additionally, personality cluster studies may also give insight into the types of interpersonal work counselors could be naturally inclined towards or excel in, thereby assisting in the strategic allocation of resources and professional development opportunities. Work done by Kim et al. (2023) highlights that Edwards & Bess, (1998) and McAuliffe & Lovell (2006) find that "counselors' self-awareness of personal traits and their potential impact on the counseling process with clients are considered crucial" (pg. 2). To this end, specifically in relation to counselor, Kim et al. (2023) identified a four-profile model for counselor burnout and personal and professional self-discrepancy in counselor qualities. Further personality profile modeling may assist counseling in identifying similar patterns for perceived stress.

The implications for research in counseling regarding counselor perceived stress is ongoing. It is essential to continue encouraging and informing counselors through ongoing research on stress-related issues. This research equips them with the tools to assess their professional and personal qualities, identify areas in which they may need support, all with the overarching goal of enhancing their self-awareness, well-being, and effectiveness in counseling. Further research is needed to expand on the concepts of counselor self-awareness, how, and what may motivate counselors to this end. Additionally, further research may help counselors identify which interpersonal and wellness factors are critical to their mental health and work lives.

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DEDICATION

This study is dedicated to my mentors. I've somehow, in different chapters of my life, found myself in the company of remarkable people who were/are not only brilliant, but cared enough to share their brilliance with me. They gave their time, patience, and wisdom to me, and many others. They gave me something to imagine that had previously been beyond my imagination. In short, my mentors were giving of themselves, and they gave me something to strive for. This study has been a highly challenging and difficult journey, often difficult to discern, to find myself. This work is dedicated to them. Specifically, I would like to thank the late Grover C. Shaunty, Donica Jones, Dr. Candy Ratliff, and Dr. Ronnie Davis, for what they've shared with me and with so many others. Thank you all.

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CHAPTER 1

INTRODUCTION

"For most psychotherapists, doing therapy is not only a job but also a calling, a vocation, a sense of meaningful activity and personal fulfillment" (Orlinksky & Rønnestad, 2005, p. 11). But what of the stress that counselors perceive in the work of therapy? Stress, and more specifically, perceived stress is a vital factor in counseling mental health as it relates to counselor practitioners. Counselors' perceptions of stress and factors associated with those perceptions may help them to balance the care they provide to others with the care they give themselves.

Statement of the Problem

Stress continues to be a pervasive problem within the mental health provider field. We are encouraged to "take care of yourself" and avoid professional burnout, for example. Relative to this study, psychological stress refers to a particular kind of relationship between person and environment (Lazarus, 1966; Lazarus & Folkman, 1984, 1987). The stress relationship is one in which demands tax or exceed the person's resources (Lazarus, 1990). Counselors have a unique and significant perception of stress, both for their own well-being and for the benefit of the clients they serve. Counselors are licensed mental health professionals who provide services to adults with mental illness and children with emotional disturbances. They typically receive specialized training to work effectively within these specific populations.

The population in this study refers specifically to counselors. Counselors involve various subgroups, specifically Licensed Professional Counselors, or LPC, Licensed

Professional Counselor Associates, or LPC-Associates, and Licensed Professional Counselor Supervisors, or LPC-S. Licensed Professional Counselors are trained to support and process client stress, referred to as the variable "other-stress," in this study. What is less emphasized are the identifying factors associated with perceived stress among counselors themselves, including selected wellness and psychological factors which may relate to counselor perceived stress. Factors identified in this study include self-care and other-care, anxiety, depression, self-esteem, and resiliency in relation to perceived stress.

Counselors will experience stress in their counseling work. Counselors are no less vulnerable to the challenges of living in a complicated world, and, in fact, the nature of counseling often places counselors at greater risk for stressors. In order to be effective, counselors must be aware of their wellness and be active in maintaining it (Lawson et al., 2007). Furthermore, some researchers believe that counselors are inclined to put clients' interests before everything else, including themselves (Ko and Lee, 2021; Skovholt et al., 2001). Because counselors are trained to view matters from other peoples' perspectives, they often overlook their own self-care (O'Halloran & Linton, 2000). O'Halloran and Linton (2000) continue, "Counselors who are trained to care for others often overlook the need for personal self-care that can be helpful in maintaining wellness" (p. 7). The commonly trained emphasis on the needs of the client served misses the opportunity for the counselor to broaden their awareness to include their perceived stress and well-being.

Counseling has historically approached perceived stress as relating to the following: consistent with stress theory (Lazarus, 1966): (a) occupational stressors and (b) occupational stress responses. Occupational stressors refer to "a broad set of

occupational and work demands as well as environment stressors that trigger the stress response" (Quick & Henderson, 2016, p. 2). Systemic issues such as budget cuts (Luther et al., 2017; Morse, Salyers, Rollins, Monroe-DeVita & Pfahler, 2012), and organizational and workplace conditions such as heavy caseloads (Broome, et. al., 2009), excessive paperwork (Rupert, et. al., 2015), and low wages (Luna-Arocas & Camps, 2008) are examples of the types of stressors that have been previously studied as predictors of counselor stress and burnout.

Less research has examined interpersonal stressors, where aspects of interactions with the client are the source of stress, as contributors to counselor stress (Moore, et al., 2019).

Although factors such as counselor burnout, compassion fatigue, and secondary traumatic stress present serious concerns for counselors, empirical research relating to counselor is limited because it does not describe how counselors may respond to stress that occurs in everyday interactions with clients (Moore, et al., 2019). The internal nature within the counselor response, or interpersonal stress, also sits on this stress response continuum, and research is needed to examine counselors' experiences of the severity, duration, and context of interpersonal stress associated with clients from a variety of populations (Moore, et cal., 2019). As these researchers have noted, interpersonal counselor stress factors have been limited in current research.

The closest related research investigating counselors' perceptions of stressful experiences in counseling can be found in research by Orlinsky and Rønnestad (2005), which examines the construct of stressful involvement in therapy.

Orlinsky and Rønnestad determined that therapists engage in three types of work involvement patterns: healing involvement, controlling involvement, and stressful involvement (Moore, et al., 2019). This research has benefited counseling in emphasizing work patterns and the strategies which may increase counselor stress within those work categories.

Specific to the perceived stress of counselors, beyond the Orlinsky and Ronnestad (2005) study, research is currently generally limited. This study explored the relationship between specific psychological factors, i.e., self-esteem, anxiety, and resilience and wellness factors, i.e., self-care and other-care in regard to perceived stress among counselors.

Purpose of the Study

The factors which influence the counselor and stress are not well understood specific to counselors. The purpose of this study was to analyze the predictability of "wellness factors", specifically self-care and other-care and "psychological factors", which included self-esteem, anxiety, depression, and resilience on the perceived stress of counselors.

Significance of the Study

Perceived stress among counselors is an integral construct to the overall awareness of the counselor to identify and understand the stress the counselor is experiencing. Perceived stress to the counselor can be crucial to self-awareness for the counselor as a person and practitioner. This study assisted the field of counseling in identifying which specific wellness or psychological factors may be impacting counselors view of their own perceived stress, therefore, this study hopes to provide a quantitative

study to assist in furthering the research and understanding of counselor-identified stress in this regard and to potentially influence counselors toward valuing themselves.

Moreover, the counselor's perceived stress is typically neglected both during their training and in their professional practice, except for the frequently examined concept of burnout, which has a historical precedence. Burnout, as a construct, relates to the counselors as an outcome mindset, whereas perceived stress is concerned with the present tense of the counselor in their work. The question in perceived stress is, "How am I, as a counselor, perceiving stress at this time in my working life?" This study expands the research in the field of counseling concerning the present interpersonal awareness of counselors as a means toward self-care through improved perceived stress awareness.

Secondarily, counselors, as well as mental health workers, were negatively impacted by the COVID-19 pandemic. This survey is not specific to counselors only, but it was a survey given to healthcare workers as a whole. From June-September 2020, Mental Health America (MHA), a national organization supporting mental health research, hosted a survey on mhascreening.org to listen to the experiences of healthcare workers during the COVID-19 pandemic, and to create better resources to help support their mental health as they continue to provide care.

There were 1,119 healthcare workers surveyed. They indicated the following:

- Health care workers experiencing stress (93%)
- Reported experiencing anxiety (86%)
- Reported frustration (77%)
- Reported exhaustion and burnout (76%)
- Said they were overwhelmed (75%)

- Emotional exhaustion was the most common answer for changes in how healthcare workers were feeling over the previous three months (82%)
- Trouble with sleep (70%)
- Physical exhaustion (68%)
- work-related dread (63%).
- Changes in appetite (57%)
- Physical symptoms like headache or stomachache (56%)
- Questioning career path (55%)
- Compassion fatigue (52%)
- Heightened awareness or attention to being exposed (52%).
- Not adequate emotional support (39%)
- Among people with children, half reported they are lacking quality time or are unable to support their children or be a present parent (50%).

These figures indicate the types of challenges mental health workers face, particularly during acute times of crisis such as the COVID-19 pandemic.

Additionally, and specific to the impact on counselors from the COVID-19 pandemic, According to Litam et al., (2021), providing mental health care during a pandemic has placed unique burdens on mental health professionals in ways that may compromise their wellness, and increase the likelihood of developing compassion fatigue, burnout, and vicarious trauma.

Litam et al. (2021) additional found that, like their clients, professional counselors are not immune to the onslaught of unending news coverage, social media posts, and interpersonal dialogue related to the COVID-19 outbreak (Gleeson, 2020). The presence of these chronic stressors may prevent professional counselors from achieving self-care goals and maintaining their own psychological wellness (Litam et al., 2021).

Litam et al. (2021) found that, beyond perceived stress, their study was interested in investigating "wellness" as a cohort of similarly selected variables, specifically self-care and other-care. Self-care, or the continued attempt at balancing care for others and the counselor's self-preservation, has not been investigated thoroughly as a construct compared to client-care analyses. The variables that may be associated which significantly impact counselor self-care have also not been well investigated. If counselors better understood or continuously evaluated their self-care status, this may aid the counselor, or the management and or administration of counselors, in better understanding and assisting to meet counselor needs (Litam et al. 2021).

Other-care, or the act or benefit toward others, is generally assumed in the profession of counseling, but has not been well studied in relation to potential wellness and psychological variables, in relation to perceived stress. Counselors choose to study, develop, and practice counseling for the benefit of others and are generally highly motivated toward the benefit of others.

Self-esteem refers to an individual's view of his or her own value as a person (Coopersmith, 1967), or "the individual's positive or negative attitude toward the self as a totality" (Rosenberg et. al., 1995, p. 141). Self-esteem is not typically evaluated in

relation to the counselor themselves, and could therefore be of research-related value as it relates to perceived stress.

Anxiety is an emotion characterized by apprehension and somatic symptoms of tension in which an individual anticipates impending danger, catastrophe, or misfortune. In this study, anxiety in counseling is evoked in stressful or emotion laden counseling situations, as well as understood in the more general sense. The interpersonal experiences of the counselor, including anxiety, are not well researched and this study expands upon anxiety's relationship to perceived stress.

Resilience is understood as the process and outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, and behavioral flexibility and adjustment to external and internal demands. Resilience, as an interpersonal attribute, is not an often-researched variable in relation to counselor perceived stress. This study highlighted counselor awareness of resilience and how this attribute may aid in reducing perceived stress.

Depression is characterized by persistent sadness and a lack of interest or pleasure in previously rewarding or enjoyable activities. According to the World Health Organization (WHO), globally, it is estimated that 5% of adults suffer from the disorder. Depression can also disturb sleep and appetite. Tiredness and poor concentration are also typical in current research. Depression is a leading cause of disability around the world and contributes greatly to the global burden of disease. The effects of depression can be long-lasting or recurrent, and can dramatically affect a person's ability to function and live a rewarding life (WHO, 2023). With these findings in mind, the study found depression to be an important selected factor in perceived stress.

Counselors typically are trained and taught to focus on the relationship, rapport building, and empathy of the clients they treat. Less focus is given to the mental health and life balance of the counselors themselves. This study's findings advocate for greater counselor perceived-stress awareness, specific to each counselors' needs, toward a healthier practicing counselor.

The findings in this study provided quantitative awareness of factors associated with the perceived stress for counselors. Wellness factors such as self-care and other-care and psychological factors such as self-esteem, anxiety, depression, and resilience enhance the counseling field in understanding to what degree, if any, counselors experience perceived stress.

Research Questions

The following research questions guided this investigation:

Q1. Do "wellness factors" (self-care, other-care) have any predictive validity regarding perceived stress among Counselors?

Q2. Do "psychological factors" (self-esteem, anxiety, resilience) have any predictive power regarding perceived stress among Counselors?

Q3. Do the combination of "wellness factors" (self-care, other-care) and "psychological factors (depression, self-esteem, anxiety, resilience) have any significant predictive power regarding perceived stress among Counselors?

Hypotheses

The following research hypotheses were formulated and tested in this investigation:

H_1. There is no statistically significant relationship between combined "wellness factors" (self-care and other-care) and perceived stress among counselors.

H_2. There is no statistically significant relationship between combined "psychological factors" (self-esteem, anxiety, resilience) and perceived stress among counselors.

H_3. There is no statistically significant relationship between the combination of "wellness factors" (self- care and other-care) and "psychological factors" (self-esteem, anxiety, resilience) on perceived stress among counselors.

Assumptions

The following assumptions were made relative to this study.

1. The subjects of this study were representative of the population under investigation.
2. The subjects of this study were honest when responding to the questionnaire.
3. The population under investigation was homogenous.
4. The instruments used were valid and reliable measures for the population under study.

Limitations of the Study

The following limitations were considered in this study.

1. The population selected was limited to Texas, particularly the urban centers as most counselors were located in dense areas, namely Houston, Austin, Dallas, and San Antonio.
2. The sample included predominantly white, with minorities representing Hispanics, Blacks, and Asians.
3. The sample was predominantly female with minorities represented by males and non-binary individuals.
4. The study was limited to counselors only, not social workers or psychologists, despite general similarities in work and clients served.
5. The study was limited to the following six instruments: For self-care: the Mindfulness Self-Care Scale, or B-MSCS brief, for other-care: the 9-SRA Self-Report Scale of Altruism, or the 9-SRA, for psychological factors including the Rosenberg Self-esteem scale, or RSE, for self-esteem, for anxiety and depression, the Four-Item Patient Health Questionnaire, or PHQ-4, and for resilience, the Brief Resiliency Scale, or the BRS, for resilience. Relating to the dependent variable, perceived stress, the PSS-10 will be administered. A descriptive survey was collected to analyze the data as they relate to wellness factors, psychological factors, and perceived stress.
6. This study was limited with regard to time using a cross-sectional design. A cross-sectional design will attempt to investigate individual counselors at a specific point in time.

7. This study was limited in using a purposive sample. This type of sample is a non-probability sample.

Definition of Terms

The following terms were operationally defined for the purposes of this study.

1. Perceived stress - the degree to which situations in one's life are appraised as stressful; specific to this study, the term situations has been replaced by interpersonal attributes or the degree to which "wellness" and "psychological" factors of a counselor's working life are self-appraised as stressful.
2. Self-care - in counseling as a continuing struggle between caring for others and self-preservation, and taking care of one's own needs by maintaining balance between one's individual and professional selves.
3. Other-care - also called altruistic care, refers to acting to benefit others, showing concern for others, adopting the perspectives of others, and considering the interests and needs of other people in various situations.
4. Caring - a continuous process whereby the counselor builds secure empathetic attachments with clients while maintaining attachment by active absorption, then establishing a strong separation from clients by anticipating grief and preparing for loss, and lastly, getting away from work.
5. Burnout - prolonged exposure to long-term emotional and interpersonal stressors on the job, defined by three core dimensions: emotional exhaustion, depersonalization, and feelings of reduced personal accomplishment.

6. Stress - a particular relationship between the counselor and the counselor work environment that is appraised by the counselor as taxing or exceeding his or her resources, and endangering the counselor's well-being.
7. Counseling - a collaborative effort between the counselor and client. Professional counselors help clients identify goals and potential solutions to problems which cause emotional turmoil; seek to improve communication and coping skills; strengthen self-esteem; and promote behavior change and optimal mental health.
8. Counselor – a licensed professional who provides a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals. There are various licensure levels in the field of counseling. This study was specific to Licensed Professional Counselors, Licensed Professional Counselor – Associates, and Licensed Professional Counselor Supervisors.
9. Wellness factors - the physical, mental, and social well-being not merely in the absence of disease. In this study, "wellness factors" were associated with the variables self-care and other-care.
10. Psychological factors - functional factors—as opposed to biological (constitutional, hereditary) factors—that contribute to the development of personality, the maintenance of health and well-being, and the etiology of mental and behavioral disorders.
11. Self-esteem – refers to an individual's view of his or her own value as a person (Coopersmith, 1967), or "the individual's positive or negative attitude toward the self as a totality" (Rosenberg et. al., 1995, p. 141).

12. Anxiety – an emotion, typically future-oriented, characterized by apprehension and somatic symptoms of tension in which an individual anticipates impending danger, catastrophe, or misfortune.
13. Resilience – the process and outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, and behavioral flexibility and adjustment to external and internal demands.
14. Depression - is characterized by persistent sadness and a lack of interest or pleasure in previously rewarding or enjoyable activities.

Organization of the Dissertation

This dissertation was organized into five chapters. Chapter 1 included an introduction, statement of the problem, purpose of the study, significance of the study, research questions, hypotheses, assumptions, limitations of the study, definitions of terms, and the organization of the proposal. Chapter 2 contained a review of the literature related to various study-specific definitions, conceptualizations, and aspects of specific constructs of both wellness and psychological factors. This chapter also contained a review of literature on perceived stress. Chapter 3 described the type of design, the population selected, sampling procedures, instrumentation, data collection procedures, independent and dependent variables, and a statistical analysis. Chapter 4 provided an analysis of data, examination of hypotheses, and a summary of the hypotheses. Chapter 5 contained a summary of findings, discussion, recommendations for further investigation, and recommendations for the field of counseling.

CHAPTER 2

REVIEW OF LITERATURE

Definitions of Wellness Factors: Self-care and Other-Care

"Wellness factors" were presented as a grouped construct in this study. The variables selected within wellness factors will include self-care and other-care.

Self-Care

"I have always been better at caring for and looking after others than I have been at caring for myself. But in these later years, I have made progress" (Rogers, 1980, p. 80). Self-care can be seen as a continuous balance between the needs of the counselor and client in combination with counselor self-awareness.

Self-care is generally understood as the practice of taking action to improve one's own health (Oxford reference, 2022). The American Counseling Association (ACA) Code of Ethics (2005) encourages counselors to practice self-care and strive toward self-awareness. When counselors engage in practices that foster wellness and awareness, they are better positioned to provide effective services to clients (Warren et. al., 2010).

Understanding and being aware of self-care can be important for the quality of life and longevity of their careers. According to Posluns and Gall (2019), stress, burnout, and professional impairment are prevalent among mental health professionals and can have a negative impact on their clinical work, whilst engagement in self-care can help promote therapist well-being.

Skovholt (2000) describes self-care in counseling as a continuing struggle between caring for others and self-preservation and taking care of one's own needs by maintaining balance between one's individual and professional selves. Self-care can be

seen as part of a self-renewal process. Skovholt and Trotter-Mathison (2016), find that continuous engagement in self-renewal process which engages the physical, emotional, social, spiritual, and intellectual health will aid in the professional self-care of counselors.

Counselors are ethically obligated to be aware of and engage in self-care. According to the American Counseling Association, or ACA, Code of Ethics (2014), professional responsibilities of counselors are to engage in self-care activities to maintain and promote their own emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities (p. 8).

Similarly, according to the Council for Accreditation of Counseling and Related Educational Programs (2020), or CACREP, within the professional identity training of counselors, CACREP mandates that self-care strategies appropriate to the counselor role be taught as part of professional graduate counseling training. Self-care is then considered a specific ethical, ACA, and training, CACREP, standard in the field of counseling.

Self-compassion can be a lens to view from, and benefit, counselor self-care. According to a narrative study in work done by Patsiopoulos and Buchanan (2011), counselors who participated in the study found that the benefits in relation to a longer-term practice of self-compassion reported improved overall sense of well-being, including physical, psychological, and emotional health, and a deepened existential and/or spiritual sense of connectedness (p. 305).

Compassion, according to Pollack, et al. (2014) means being with others in their suffering. Conversely, self-compassion, according to Neff (2003) and Coaston (2017), can be understood as “being touched by and open to one’s own suffering, not avoiding or

disconnecting from it, generating the desire to alleviate one's suffering and to heal oneself with kindness" (pp. 87, 285). According to Neff (2003), self-compassion also involves offering nonjudgmental understanding to one's pain, inadequacies, and failures, so that one's experience is seen as part of the larger human experience (p. 87).

Further articulating the demands counselors face psychologically and the need for counselor self-care, Guy points out that spending hour after hour with troubled individuals in significant distress can take a toll on us after many years of practice, and can leave our sense of self weak and apathetic, lacking in confidence and energy, thereby hindering our ability to be attentive and effective in helping our clients (Guy, 2000).

Regarding balance, according to Mullenbach and Skovholt (2000), expert practitioners attain balance in these dimensions through nurturing and challenging connections with family, friends, and other social groups that are intimate and rich. Additionally, many use personal therapy as a means of enhancing the process of introspection and self-examination (p. 175). Self-care, as understood currently and historically in the field of counseling, is a broad and challenging concept and has been historically examined in both work and personal lives of counselors.

To be successful in the helping professions, according to Skovholt et. al (2001), counselors must continually maintain professional vitality and avoid depleted caring. Thus, balancing self-care and other-care seems like a universal struggle for those in the helping professions (p. 168).

Skovholt et. al. (2001), created a framework for helping professionals to define their self-care as six avenues for professional and personal self-care: (a) maximizing professional success; (b) creating and sustaining an active, individually designed

development method; (c) increasing professional self-understanding; (d) creating a professional greenhouse at work; (e) minimizing ambiguous professional loss; and (f) focusing on one's own need for balanced wellness (p. 171). Personal care can also contribute to the overall self-care of the counselor. Specific to self-care, personal care is defined as the four personal dimensions, defined as physical, spiritual, emotional, and social Skovholt et. al, (2001). Skovholt and colleagues encourage care-providers to use assertiveness toward these dimensions while striving toward a balance of the four.

Other-care

Other-care, also known as altruistic care, refers to acting to benefit others, showing concern for others, adopting the perspectives of others, and considering the interests and needs of other people in various situations (Pettersen, 2004). Furthermore, other-care can be understood, according to Eisenberg et. al (1999), as "behavior motivated by the concern for others or by internalized values, goals, and self-rewards rather than by the expectation of concrete or social rewards, or the desire to avoid punishment or sanctions" (p. 1360). Counselors are trained to have and maintain an other-care interest in the clients they see and work with. Counselors who may struggle with providing other-care qualities may be experiencing perceived stress with regard to the client. A secondary issue concerning other-care is how burnout may negatively impact the ability of the counselor to engage in empathic work.

Burnout is well researched currently in counseling. Burnout refers to the physical and emotional exhaustion that can occur in the human services fields. According to Moore and Cooper (1996), mental health professionals are subject to severe levels of

stress because of working in an emotionally exhaustive environment (p. 83). The ability of the counselor to provide positive, engaging other-care qualities may be lessened if burnout-related issues are present in the counselor. Another factor that may impact the ability of the counselor to provide other-care is counselor competence. According to a study done by Moore et al. (2020), counselors who find themselves being self-critical of their counseling skills and client-work, and/or doubting their competence and efficacy are encouraged to process these insecurities in counselor supervision (p. 133). Factors such as counselor burnout, negative self-competence, and negative self-efficacy, if elevated, may reduce the counselor's abilities and internal resources to provide other-care to the client in counseling.

Altruism is a more commonly researched term in relation to other-care. Within altruism-related research, Limburg and Robinson (2016) define altruism as an altruistic act involving someone who gives (a benefactor) and someone who receives (p. 128). Two components of altruism, as defined by Piliavin & Charng (1990), are motivation and behavior. Bar-Tal (1985) states that altruistic behavior: "(a) must benefit another person, (b) must be performed voluntarily, (c) must be performed intentionally, (d) the benefit must be the goal by itself, and (e) must be performed without expecting any external reward."

Empathy is considered an important personality trait in counseling. Regarding empathy as it relates to other-care, Bohart and Greenberg (1997) postulate that empathy must involve a genuine interest in entering another's world, gaining a real 'feel for' what it is like to be them, and in essence, developing some sense of 'we' feeling with them" (p. 445).

While other-care counselor traits are considered important, a potentially problematic construct emerges considering counselor self-care versus that of clients. Traditionally, counselor training promotes other-care as the central objective in the helping work that counselors do. For example, Limberg et al. (2016) highlight that other-care values and behaviors are strongly expected in the school counselor role. Counselor training has played an important role in this historic focus.

Regarding counselor training, Lee (2008) suggests that most counselors are trained to take care of others by consistently taking the client's perspective and unconditionally emphasizing the clients. Ko and Lee (2021) further point out the need for counselors to consider their own needs while doing the work and engaged in other care. Failure to do so, in their view, may facilitate a culture of self-sacrifice and heroic syndrome. This, in turn, can facilitate bouts of chronic stress, depression, and burnout for counselors (p. 100).

Regarding counselor stress, Christopher et. al (2006), site the vulnerability of workers in the healthcare sector to burnout and stress overload. Similarly, in relation to healthcare professional stress, Moore and Cooper (1996) find that workers are subject to severe levels of stress due to working in an emotionally exhaustive environment.

Self-esteem

"You need self-esteem in order to live a life that is really meaningful to you, and you won't know what's meaningful to you unless you know yourself," says Katherine Hennessy, a licensed professional counselor (LPC). According to Baumeister et al. (2003), self-esteem is defined by how much value people place on themselves. It is the evaluative component of self-knowledge (p. 2). In relation to counselors, self-esteem can

be seen as an interpersonal evaluation of self which may impact the counselor's experience of perceived stress. A counselor may have high or low self-esteem. Baumeister et al. (2003) describe high self-esteem as a highly favorable global evaluation of self and, conversely, low self-esteem, as an unfavorable definition of the self (pg. 2).

Counselors who have high self-esteem may engage in counseling work with more initiative and more pleasant feelings. Again, according to Baumeister et al. (2003), the benefits of high self-esteem fall into two categories: enhanced initiative and pleasant feelings (pg. 1). Good self-esteem can have a variety of positive impacts on the counselor. According to Dose et al. (2019), good self-esteem favors social integration, productive behaviors, and high performance at work, a feeling of competence, and occupational success (pg. 824). Counselors who feel a sense of high self-esteem may also bring that sense of positivity toward the positive regard and positive thinking of the client. As a potential indicator of lower perceived stress, self-esteem, according to Dose et al. (2019), can be a basis for personal growth through recognition of oneself as being capable of improvement over time, and for seeking fulfillment of one's potential competence (pg. 824). Dose and colleagues refer to prior research which indicates that self-esteem favors individual well-being and better resistance to stress (p. 825). Low self-esteem is associated with possible loss of self-respect, according to Dose and colleagues, and is correlated with professional burnout.

Self-esteem is one's view of oneself, be it positive or negative. According to Baumeister et al (2003), appraisal of self-esteem is complicated to assess. They argue that many with high self-esteem exaggerate their success whereas measurable outcomes do not signify a congruent role. Additionally, Baumeister and colleagues argue that high

self-esteem is also a heterogeneous category, encompassing people who frankly accept their good qualities along with narcissistic, defensive, and conceited individuals. Essentially then, interpreting Baumeister and colleagues' theory on self-esteem, high or low self-esteem is relational to the observers view of themselves.

Counselors often work in agencies with multiple therapists on staff. In relation to counselor teams or groups, collective self-esteem refers to individuals' perceptions of themselves as members of a social (e.g., racial, ethnic, religious, community, or work) group, along with the value and emotional significance of membership in this group (Bettencourt & Dorr, 1997; Luhtanen & Crocker, 1992). Counselors who often work in teams, such as school counselors, co-therapists, and counselors in group practice meet the scope of collective self-esteem. In a study exploring collective self-esteem, Butler and Constantine (2005) found that higher private collective self-esteem was associated with higher feelings of personal accomplishment.

Depression and Anxiety

Depression and anxiety are understood to be interrelated, occurring when one or the other is present. This study will assess using a scale designed for this co-occurring phenomenon, the PHQ-4. Kroenke et. al, (2009), find that the most common mental disorders in both outpatient settings and the general population are depression and anxiety, which frequently coexist.

Counselors can experience anxiety in relation to their work.

Anxiety

Anxiety is defined as a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome. According to Shamoon et al. (2016), therapists who are in-tune with and able to manage their anxiety, are more helpful than those who are not adept at this process (p. 43). Anxiety can be a detrimental factor in the counselor's pursuit of effective therapy. Shamoon and colleagues found that difficult or triggering clients can increase counselor anxiety leading to problematic presentations including poor outcomes, interpersonal relationship breakdowns, avoidance of problems, and poor performance (pp. 43-44).

Fears and anxieties experienced by the counselor are present in the therapeutic journey with a client. Shamoon and colleagues suggest counselors experience fears of being too emotionally engaged with clients, the arousal of unresolved issues mirroring client content, and wanting validation from clients (p. 44). Shamoon and colleagues find that therapists may avoid anxieties such as group work for personal and not therapeutic reasons (p. 44). Of major concern in their study is the counselor's internal anxieties and how they may play a role in client reactive and avoidant responses (p. 44). Additionally, according to Posluns and Gall (2019), the practitioner counselor, in relation to this study, requires attention and care to protect their own health and the quality of care for the client (p. 2). Awareness of factors such as internal anxiety and depression can be understood as critical then to client responses, and is the primary factor for why this study is being proposed.

Depression

Depression can impact counselors and mental health providers. Depression is a common mental disorder. Globally, it is estimated that 5% of adults suffer from the disorder. It is characterized by persistent sadness and a lack of interest or pleasure in previously rewarding or enjoyable activities. It can also disturb sleep and appetite. Tiredness and poor concentration are common. According to the World Health Organization, WHO (2023), depression is a leading cause of disability around the world and contributes greatly to the global burden of disease. The effects of depression can be long-lasting or recurrent, and can dramatically affect a person's ability to function and live a rewarding life. According to Rhodes, et al (2016), in a study done by the British Psychological Survey, 46 % of psychologists and psychotherapists suffered from depression, and 49.5 % reported that they felt they were failures (Mace, 2016). An APA survey found that 87 % of psychology graduate students reported experiencing anxiety, and 68% reported symptoms of depression according to Cassandra Willyard, a writer in New York City.

Further historical research into depression statistics and counselors is extremely limited. Counselors might encounter stigma and negative reactions if certain groups become aware of their experiences with depression. This can have implications for job security, coupled with misconceptions about their profession, such as the false belief that being a mental health worker can shield them from their own mental health challenges.

Both depression and anxiety will be assessed in the counselor survey battery to determine if these factors may be significant in counselor perceived stress.

Resilience

Resilience was defined in this study as one's ability to bounce back or recover from stress. This is the primary view of the authors of the Brief Resiliency Scale, or BRS, from which counselors will be evaluated in the proceeding survey (Smith et al., 2008). Smith and colleagues found from evidence resulting from the BRS, that, as the instrument is framed with negative events in mind such as stressful or difficult times, its effects were specific to reducing negative outcomes like anxiety and depression (p. 199).

Resilience is an important factor in the counselor's decisions toward client health. Resilience can be understood in a variety of ways. Ward (2003) found resilience to be the ability to cope in the face of adversity. Fink-Samnick (2009) found professional resilience for mental health providers as a commitment to achieve balance between occupational stressors and life challenges, while fostering professional values and career sustainability (p. 331). According to Litum et. al. (2021), cultivating resilience can reflect active decisions that orient individuals toward wellness and health.

Counselors are encouraged to practice self-care qualities as a way to promote the probability of greater resilience. Lambert and Lawson (2013) found that counselors who practiced self-care activities were more likely to experience lower levels of compassion fatigue, burnout, and vicarious traumatization than those who did not practice self-care strategies (p. 266). Wellness practices can also benefit resilience. As cited by Lambert and Lawson (2016), Venart et al. (2007), suggested wellness strategies for counselors including maintaining physical health, emotional health, cognitive wellness, and interpersonal relationships (p. 51).

Resilience can be enhanced by the counselor's attention and engagement in wellness. Resilience can be defined as the capacity to withstand or to recover quickly from difficulties, toughness. Additionally, resilience can be understood as the ability of a substance or object to spring back into shape, elasticity. One model which addresses wellness is the Wheel of Wellness Model developed by Whitmer, Sweeney, and Myers (2005), which includes 12 components of wellness with spirituality being the central component of the model (Myers & Sweeney, 2005). Venart et al. (2007), believe that a counselor's wellness provides the foundation for her or his work with clients (p. 50). Venart and colleagues assert that, in order to transform the wellness of clients as a whole, counselors are to take individual responsibility for their own health including engaging in and building self-awareness in physical health, emotions, intellect, interpersonal relationships, and spirituality (p. 51).

These models and perspectives on wellness can bolster the potential resiliency of counselors. Venart and colleagues encourage counselors to step outside of their general milieu and experiment with new ideas that may generate wellness growth within themselves (p. 63).

Perceived Stress

Perceived stress is the feeling or thoughts that an individual has about how much stress they are under at a given point in time, or over a given time period. According to Phillips (2013), it is not measuring the types or frequencies of stressful events which have happened to a person, but rather how an individual feels about the general stressfulness of their life and their ability to manage such stress.

Lazarus and Folman (1984) emphasize the relationship between the person and the environment, considering the characteristics of the person and the nature of the environment (p. 21). Lazarus and Folkman go on to expand on psychological stress as a relationship between the person and the environment that is appraised by the person as taxing, or exceeding his or her resources, and endangering his or her well-being. The judgement that a particular person-environment relationship is stressful is deduced by cognitive appraisal of the person in question (p. 21).

Appraisal is a key aspect of perceived stress according to Lazarus and Folkman (1984). Individual persons may perceive their environment to be threatening or overwhelming to their well-being with individual factors such as personality, coping strategies, and support as potential associations to the individual perceiver and environment. (p. 23).

Counselor perceived stress is the ability of the counselor to be aware of and attempt interpersonal balance, or the ability to be both emotionally involved with the client yet emotionally distant. According to Skovholt (2005), when counselors struggle to achieve interpersonal balance, counselors can become depleted, potentially over-experiencing the client's pain, and can become vulnerable to the overall counseling process.

Perceived stress within the therapeutic environment has been investigated in relation to counselor stressful involvement in work by Orlinsky and Rønnestad (2005). They suggest that stressful involvement in counseling can occur from some combination of "avoiding therapeutic engagement in the face of difficulties, low current skillfulness,

high total difficulties, and tending to feel anxiety or boredom during the counseling session" (p. 82).

Moore, et., al (2020) investigated counselor interpersonal stress and how counselors respond to interpersonal stressors. Moore and colleagues found areas of strain that occur in counseling relationships and how these dynamics negatively affect the counselor. In Moore and colleagues' study, 13 counselors were interviewed. They identified client characteristics such as unpredictability, manipulation, and impulsivity, relationship dynamics including countertransference, intensity, and counselor-client match, and counselor responses like coping, questioning professional judgment, and efficacy. The study also found that personal versus professional self played a role in contributing to interpersonal stress (p. 131). Their report found it critical for counselors to pay special attention to how they are managing challenging client and relational dynamics (p. 133).

Managing challenging client characteristics can also be challenging for counselors and impact perceived stress. Moore and colleagues concluded in their study, when counselors are unable to manage the challenging client characteristics or relational circumstances, they may be more likely to question their professional efficacy and experience negative cognitive, emotional, and physiological reactions (p. 133). Potential negative outcomes due to counselor management could increase perceived stress in counselor practitioners.

Perceived stress is commonly measured as the frequency of such feelings via a questionnaire such as the Perceived Stress Scale (Cohen et. al., 1983). In relation to this

study, counselors were given the Perceived Stress Scale – 10, or PSS-10, to determine counselor participant perceived stress.

Theoretical Orientation of the Study

The theoretical orientation of this prospective study was based on the transactional model of stress and coping as developed by Lazarus and Folkman (1984). According to the Lazarus and Folkman's transactional model, stress response occurs when perceived demands exceed an individual's coping abilities. Lazarus and Folkman (1983) define psychological stress as a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being (p. 19). Fye et al. continue, "The transactional model of stress and coping is a theoretical framework that suggests a stress response occurs when perceived demands exceed an individual's coping abilities (Fye et al., 2018, p. 350; Lazarus & Folkman, 1984). Counselors are then, in relation to their work, subject to the individual identification of stress as they see it, or their own perception of stress. There is, then, according to transactional theory, a transactional relationship between the counselor's perceived demands and the coping abilities of the counselor.

Continuing stress theory, according to Lazarus and Folkman's (1984) stress and coping framework, stress results from the disparity between the demands placed upon individuals and their resources to cope with the demands. In relation to Lazarus's theoretical model of stress, "Stress is concerned with unsatisfactory situations of life that we want to change for the better, and emotions come and go quickly with changes in circumstances" (Lazarus, 2006, p.16). Within the confines of this study, the

unsatisfactory situations are the contextual work and personhood of the counselor within the counseling context.

Counselor perceived stress will be investigated as part of a battery of instruments within this study. According to Cohen et al. (1983), perceived stress is commonly measured as the frequency of such feelings via a questionnaire such as the Perceived Stress Scale. Perceived stress was investigated for any significant correlations upon the variables self-care, other-care, self-esteem, anxiety, depression, and resilience.

Similar investigations have found the Lazarus and Folkman transactional model useful. According to Owen's work on adolescent coping (1997), this paradigm consists of perceived stress (a relationship between the person and environment that is appraised as exceeding available resources), appraisal (one's perception and assessment of social support in the situation), and coping (effortful or purposeful thoughts and actions to manage or overcome stressful situations. Theoretical, then, the transactional model is interested in, not only perception of stress, but additionally the social support within a given situation known as appraisal, and finally the counselor's thoughts and actions toward overcoming stressful situations, or the counselor's coping skills. To further illustrate, perceived stress is not merely assessing stressful life events but assessing the degree to which life situation are considered stressful, which is the primary appraisal (Lazarus and Folkman, 1984). According to Lazarus and Folkman, 1984, p. 2-3, this primary appraisal, i.e., perceived stress, determines the degree of confidence individuals possessed regarding their ability to cope with stressful situations (i.e., secondary appraisal.

Appraisal in Lazarus and Folkman's theoretical model is conditional to the counselor's take on a given situation. Primary appraisal is the process in which individuals evaluate situations as threatening, neutral-positive, or not-relevant whereas secondary appraisal is explained as the process in which individuals assess their coping resources in response to the primary in appraisal evaluation (Folkman and Lazarus, 1985). In the present study, the secondary appraisal variables self-care, other-care, self-esteem, anxiety, depression, and resilience will be investigated on their potential effects on the primary appraisal, or perceived stress. This study investigated the reverse causation of the theory's original intention within the scope of counselors and their work in counseling.

CHAPTER 3

DESIGN OF THE STUDY

The purpose of this study was to analyze the predictability of "wellness factors," specifically self-care and other-care and "psychological factors", including self-esteem, anxiety, depression, and resilience on perceived stress of counselors.

Type of Design

The design selected for this study was regression analysis, specifically multiple regression. Segrin (2010), defines multiple regression as a general and flexible statistical method for analyzing associations between two or more independent variables and a single dependent variable. Multiple regression, according to Segrin, can be employed to predict values of a particular variable based on knowledge of its association with other variables, and used to test scientific hypotheses about whether, and to what extent, certain independent variables explain variation in a dependent variable of interest.

Population

This study consisted of Licensed Professional Counselors (LPC), Licensed Professional Counselor Supervisors (LPC-S), and Licensed Professional Counselor Associates (LPC-A) in Texas with particular emphasis on the urban regions of Texas including Houston, Dallas, Austin, and San Antonio. Counselors were sought particularly if they are current and active members of the Texas Counseling Association, Texas School Counseling Association, and urban Counselor organizations in Texas. Counselors were contacted via email with requested permissions and invitations to complete a cross-sectional survey. A total of 150 counselors of various credentialed statuses were sought to participate in this study.

Frequency tables were generated to illustrate and compare the distribution of participants including demographic data consisting of counselor credential type, licensure status, age, length of time practicing in counseling, relationship status, number of children, number of dependents, race, ethnicity, citizenship status, educational background, current level of employment, average hours working per week, physical health, mental health, spiritual or religiosity, and overall stress rating in counseling.

Frequency distribution tables were compared, for example, gender and age were illustrated including age distribution found in the data, male and female percentages, and total combined.

Methodology

This research employed a descriptive (survey) study design utilizing several survey questionnaires to collect and analyze data obtained by participants. A simultaneous (standard) multiple regression procedure was used to examine the predictability of "wellness factors," and "psychological factors" on perceived stress. Wellness factors were grouped into two categories including self-care and other-care. Psychological factors were grouped into three categories including self-esteem, anxiety, and resilience.

Sampling Procedure

The sampling method implemented for this study was purposive sampling. Counselors were sought out from Texas with higher urban centers being of higher percentage than that of rural. A purposive sample, specifically homogeneous, will be employed in order to collect data from Counselors. Participants in the sample were recruited from counselor-affiliated organizations, workplaces, and educational

institutions via emails and notices placed within the professional organizations in large metropolitan areas of Texas. Specifically, these included professionals in the fields of Counseling with LPC-A, LPC, and LPC-S licenses.

Purposive sampling, also referred to as judgment sampling, is the process of selecting a sample that is believed to be representative of a given population (Gay et al., 2012, p. 141). Purposeful sampling is a technique widely used in qualitative research for the identification and selection of information-rich cases for the most effective use of limited resources (Palinkas et al., 2015). The criterion to select a sample participant was drawn purposively from LPCs, LPC-Ss, and LPC-As that are current and active members of the Texas Counseling Association, Texas School Counseling Association, urban Counselor organizations in Texas, and Counseling graduate programs in Texas. Purposive sampling is a non-probability sampling procedure and generalizations, therefore, should be taken with caution.

Instrumentation including validity and reliability of the Instruments

The following instruments were used in this study: for self-care: MSCS brief, for other-care: 9-SRA, for psychological factors including the Rosenberg Self-esteem scale for self-esteem, for anxiety, the PHQ-4, and for resilience, the BRS. Relating to the dependent variable, perceived stress, the PSS-4 was administered. A descriptive survey was used to collect and analyze the data as they relate to wellness factors, psychological factors, and perceived stress. The study used a cross-sectional survey design. A cross-sectional survey design is one in which data is collected from selected individuals at a specific point in time (Gay, 2012). Cross-sectional survey designs have been described as snapshots of the populations about which they gather data (Lavrakas, 2008).

Mindfulness Self-Care Scale - Brief (B-MSCS)

The B-MSCS is a 24-item scale that measures the self-reported frequency of behaviors that measure self-care behavior developed by Catherine Cook-Cottone, Ph.D. The MSCS was used in the present study to evaluate the counselor's self-care and additionally, a component of mindful awareness. The MSCS scale is intended to help individuals identify areas of strength and weakness in mindful self-care behavior as well as assess interventions that serve to improve self-care. The MSCS addresses six domains of self-care including mindful relaxation, physical care, self-compassion and purpose, supportive relationships, supportive structure, and mindful awareness.

An analysis of the B-MSCS completed by Hotchkiss and Cook-Cottone (2019) found that, using Cronbach's alphas, reliability scores ranged from 0.79 to 0.86. Alphas were tested as Physical Care (0.76, 0.77); Supportive Relationships (0.79, 0.77); Mindful Awareness (0.82, 0.86); Self-Compassion and Purpose (0.84, 0.78); Mindful Relaxation (0.79, 0.74); and Supportive Structure (0.79, 0.79).

Construct and concurrent validity, for the B-MSCS analysis, were evaluated by calculating correlation coefficients for the MSCS total and various well-being measures including the subscales of the MSCS, B-MSCS, SWLS, and the ProQOL. Validation research found that compassion satisfaction and life satisfaction had moderate-to-strong positive correlations with all MSCS factors. Additionally, the negative well-being factors: secondary traumatic stress had weak negative correlations, and burnout had moderate-to-strong negative correlations with all mindful self-care factors except physical care that had a weak negative correlation. The B-MSCS was found to score at a

similar pattern within a +-10% variation indicating the B-MSCS can be validated as similar in evaluation to previously validated MSCS total.

Regarding goodness of fit, the MSCS full had good fit to the data with all indicators in acceptable ranges (chi-square/df = 3.08, df (480), $p < 0.01$, root mean square error of approximation = 0.059, comparative fit index = 0.915, Tucker and Lewis's index of fit = 0.907). Regarding the shorter B-MSCS, the B-MSCS uses rigorous CFA methodology and considered both psychometric and conceptual criteria. The results of the B-MSCS were found to be similar to the MSCS full in that chi-square/df was nearly identical, RMSEA was slightly lower. In summary, the brief MSCS model had improved fit relative to the longer version and provided validation for the developing theoretical model of healthcare professional wellness (p. 7).

9-SRA Self-Report Scale of Altruism (9-SRA)

The 9-SRA Scale: A Simplified 9-Items Version of the SRA Scale to Assess Altruism is a simplified version of the original Self-Report Scale for Altruism (SRA) which is a 20-item scale. The 9-SRA, developed by Manzur and Olavarrieta (2021), found that the scale shows adequate reliability, at 0.77, and validity, pro-social behaviors could be shown to be predictive, and represents a more parsimonious instrument to assess altruism and for use in empirical studies focused on human and prosocial behavior (Manzur & Olavrrieta, 2021, pg. 1, pg. 9).

The Self-Report Altruism (SRA) scale developed by Rushton and colleagues was designed to be easily administered and to reflect consistent differences among individuals regarding the altruism concept through responses to specific statements regarding past behavior (Manzur, 2021, pg. 3).

In their classic study, Rushton et al. obtained high internal consistency scores (alpha:0,89) and positive correlations between this scale and social responsibility, empathy, organ donation, sensitive attitudes, and prosocial individual values, providing evidence for the reliability and validity of the SRA scale. Since this seminal paper, many studies have studied the SRA scale with other measures of altruism or prosocial behavior constructs.

Regarding goodness of fit, a CFI higher than 0.90, and an AASR (average absolute standardized residuals) of 0.06 or less indicate a good fit (Noar, 2003). Consistent with the exploratory factor analysis of the 2-factor models, Model D (Chi2/df: 2.13; CFI = 0.95; AASR = 0.56) and Model E (Chi2/df: 2.22; CFI = 0.95; AASR = 0.56) show acceptable goodness of fit levels (Manzur & Olavrrieta, 2021, pg. 7).

Rosenberg Self-Esteem Scale (RSE)

The Rosenberg Self-Esteem Scale, or RSE, developed by Rosenberg (1965), a 10-item scale that measures global self-worth by measuring both positive and negative feelings about the self. The scale is believed to be unidimensional. All items are answered using a 4-point Likert scale format ranging from strongly agree to strongly disagree (Rosenberg, 1965).

According to Martin-Albo et. al. (2007), self-esteem is considered a component of self-concept and defines it as an individual's set of thoughts and feelings about his or her own worth and importance in relation to a global perspective or attitude toward oneself (p. 459).

Grey-Little et., al. (1997), found in their item-response theory analysis of the RSE, that the average score on the RSE Scale was 3.81 (SD 0.67), with scores ranging from 1.2 to 5.0. The interitem Pearson correlations ranged from [r.sub.4,9] = .21 to [r.sub.1,2] = .66, and item-total correlations ranged from [r.sub.T,4] = .61 to [r.sub.T,6] = .76. Cronbach's alpha for the 10-item test was [[Alpha].sub.C] = .88, and the standard error of measurement for the 10-item test was 0.23, on a (averaged) summed-score scale ranging from 0 to 5.0 (p. 3). Grey-Little and colleagues (1997), positively concluded in their analysis that the RSE Scale deserves its widespread use and continued popularity: This scale provides a highly reliable and internally consistent measure of global self-esteem. The IRT analyses reported here show that although the 10-items of the RSE Scale are not equally discriminating, they define a unidimensional trait and provide information across the self-esteem continuum (p. 6).

Patient Health Questionnaire – 4 (PHQ-4)

The Patient Health Questionnaire – 4 (PHQ-4) was designed as an adaptation from the original Patient Health Questionnaire (PHQ) which was designed as an efficient tool for measuring anxiety. The primary objective of the PHQ-4 was to create an assessment tool for both anxiety with the addition of assessing depression with greater efficiency.

Kroenke, et al. (2009), found that, regarding factor validity, principal-component analysis of a set of four items (i.e., PHQ–4) that includes the two depression items of the PHQ–2 and the two anxiety items of the GAD–2, indicated that 84% of the total variance was explained by the first two factors (pg. 617). In relation to construct validity, Kroenke, et al. (2009) found that construct validity was demonstrated by the fact that

increasing PHQ–4 scores were strongly associated with multiple domains of functional impairment (p. 618).

Of primary importance to Kroenke, et al. (2009), colleagues found that the results indicate that anxiety has a substantial independent effect on functioning, and even more so when comorbid with depression. Therefore, screening for both anxiety and depression, rather than either alone, is advisable (p. 618).

Kroenke, et al. (2009), recommended that the PHQ– 4 may be particularly useful as a brief screening scale for busy clinicians interested in identifying potential cases of depression and anxiety. The value of this scale is supported by the internal reliability, construct validity, and factorial validity established in this study, as well as the reliability, and criterion, construct, and procedural validity of its two subscales, the PHQ–2 and GAD–2 (p. 618).

Brief Resiliency Scale (BRS)

The Brief Resiliency Scale, or BRS, was developed by Smith, et al. (2008), to assess the ability to bounce back or recover from stress. Resilience, according to Smith and colleagues, is the ability to bounce back or recover from stress. The BRS's psychometric characteristics were examined in four samples, including two student samples and samples with cardiac and chronic pain patients (p. 194).

According to Smith and colleagues (2008), the BRS was reliable and measured as a unitary construct. It was predictably related to personal characteristics, social relations, coping, and health in all samples. It was negatively related to anxiety, depression, negative affect, and physical symptoms when other resilience measures and optimism, social support, and Type D personality (high negative affect and high social inhibition)

were controlled (p. 194). According to Smith and colleagues (2008), internal consistency was found to be good in that the BRS was given twice in two samples with a test-retest reliability (ICC) of .69 for one month in 48 participants from Sample 2, and .62 for three months in 61 participants from Sample 3 (p. 197). Similarly in the Smith and colleagues (2008) study, convergent validity was supported in that the study showed zero-order correlations between the BRS and personal characteristics, social relations, coping, and health outcomes for each sample (p. 197).

Smith and colleagues (2008) found that the BRS demonstrated good internal consistency and test-retest reliability. Additionally, the BRS would represent one factor, would be related to resilience resources and health-outcomes, and would predict health outcomes beyond resilience resources were supported (p. 199).

Perceived Stress Scale (PSS)

Cohen et al. (1983) developed the Perceived Stress Scale (PSS) which is a 14-item self-report instrument designed to measure "the degree to which situations in one's life are appraised as stressful" (Cohen et al., 1983). Cohen and colleagues' theoretical orientation was influenced by Lazarus's theory of stress appraisal (Lazarus, 1966; Lazarus & Folkman, 1994). The PSS, according to Cohen et al. (1983), showed adequate reliability and was correlated with life event scores, depressive, and physical symptomatology (p. 385).

Cohen and Williamson (1988) developed the PSS-10, which measures the degree to which one perceives aspects of one's life as uncontrollable, unpredictable, and overloading. The PSS-10 initially revealed a succinct measure of perceived stress that could be used with a broad range of populations.

To assess the convergent validity of the PSS-10, according to analysis done by Roberti and colleagues (2006), Pearson product-moment correlations were computed between the PSS-10 and the following measures: STAI Total score, STAI-A factor, and the MHLC. The PSS-10 had a high correlation with the STAI Total Score, STAI-A, and STAI-D factors and a low to moderate correlation with the scores on the MHLC Chance subscale and the MHLC Powerful Others subscale (p. 141 – 143).

According to Roberti et al. (2006), in their study specific to college students, the PSS-10 was found to have normative results, internal consistencies, and construct validity. Roberti and colleagues found that the PSS-10 is a reliable and valid instrument for assessment of perceived stress (p. 135). Additionally, Roberti and colleagues (2006), support a two-factor model and are consistent with prior findings with the PSS-14 (p. 143).

Data Collection Procedures

Counselors were invited to complete the perceived stress survey battery via email for purposes of academic research, with search criteria to locate various professional counselors from online communities, including counselor-specific Facebook groups, and internet presence including marketing counselor locations, private practice websites, professional organization boards including the Texas Counseling Association, the Texas School Counselors Association, and various urban Counselor organizations specifically requesting permission to email their members for this study. Once individual participant permission is granted, a purposive survey including a seven-instrument battery which will be administered via online email request to each counselor. Once completed and submitted, the data provides counselors the ability to remain completely anonymous.

Once the purposive survey, seven-instrument battery, and cross-sectional survey are complete, the data will be emailed back, compiled, and analyzed for research purposes, and identifying data will be kept secure and then terminated.

Independent and Dependent Variables

The purpose of this study will be to analyze the predictability of "wellness factors," specifically self-care and other-care, and "psychological factors," including self-esteem, anxiety, depression, and resilience on perceived stress of counselors. The independent or predictive variables will consist of two artificial groupings, one being "wellness factors" and the other being "psychological factors." The dependent or criterion variable of this study will be perceived stress, as measured by the Perceived Stress Scale 10 or PSS-10.

Regarding the independent variables, the artificial grouping "wellness factors" will include self-care, as measured by the Mindfulness Self-Care Scale (MSCS), and other-care, as measured by the Self-Report Altruism Scale (9-SRA).

The second artificial grouping "psychological factors," will include self-esteem, as measured by the Rosenberg self-esteem scale (RSS), anxiety and depression will be measured using the same scale, the Patient Health Questionnaire-4 (PHQ-4), and resilience, as measured by the Brief Resiliency Scale (BRS).

Statistical Analysis

Multiple linear regression analysis was the statistical procedure used to analyze the data and test each of the hypotheses. Multiple regression analysis is used to predict the value of a variable based on the value of two or more independent variables. According to Laerd (2022), multiple regression allows you to determine the overall fit, or

variance explained, of the model and the relative contribution of each of the predictor variables, or (b), to the total variance, or (R2). The model also provides statistical significance.

Multiple regression requires the following eight assumptions: (1) the dependent variable, perceived stress, must be measured on a continuous scale, either interval or ratio; (2) two or more independent variables, this study will create two artificial categories including "wellness factors" and "psychological factors," which can be either continuous, an interval or ratio variable, categorical, or an ordinal or nominal variable; (3) independence of observation, or independent of residuals; (4) a linear relationship between the dependent variable and each of the independent variables, and the dependent variable and the independent variables collectively; (5) homoscedasticity, or that the variances along the line of best fit remain similar; (6) mustn't show multicollinearity, or a high correlation between two or more independent variables; (7) no significant outliers, or data points that may be deemed highly unusual; and (8) residual errors are normally distributed, or checking for a normal curve in the data.

In the present study, multiple linear regression analysis was used to examine the ability of the predictor variables, "wellness factors," including self-care and other-care, and "psychological factors," including self-esteem, anxiety, depression, and resilience to predict the criterion variable: perceived stress among various licensed professional counselors. All hypotheses will be tested at a .01 alpha level.

CHAPTER 4

ANALYSIS OF THE DATA

The purpose of this study was to examine the predictable relationship between two sets of independent variables, "wellness factors," "psychological factors," and the perceived stress of counselors. Specifically, this study was concerned with relationships and predictability of the independent variable sets (1) wellness factors, i.e., self-care and other care, and (2) psychological factors, i.e., self-esteem, anxiety, depression, and resilience on perceived stress among counselors. This study investigated the following questions:

1) Do wellness factors, i.e. (self-care and other-care), have any predictive validity regarding perceived stress among counselors?
2) Do psychological factors, i.e. (self-esteem, anxiety, depression, and resilience), have any predictive validity regarding perceived stress among counselors?
3) Do the combination of wellness factors (self-care and other-care), and psychological factors (self-esteem, anxiety, depression, and resilience) have any predictive validity regarding perceived stress among counselors?

The sample population for the present study consisted of 141 counselors from the southwest region of the United States. The results for this study were categorized into four main sections. The first section consisted of the demographic characteristics of the counselors who participated in the study. Section two discusses the independent (predictor) and dependent (criterion) variables, offering a comprehensive exploration of their definitions, measurements, and the relationships crucial to the study's focus. The third section dealt with the intercorrelations between the independent and

dependent variables. The fourth and final section tested the three null hypotheses generated in the study.

Additionally, standard multiple regression, multiple correlation, and multiple determination procedures were employed to analyze the data. All three null hypotheses were tested at the .05 level of significance or better.

Demographic Profile of the Counselors in the Study

There were 141 counselors who participated in this study. The counselors were described demographically by ethnicity, age, level of education, current licensure status, work experience in counseling and work hours per week practicing counseling.

Ethnicity

The variable, 'ethnicity,' was categorized into eight (8) subgroups. There were (3) or 2.1% of the counselors who identified their ethnic status as Asian, and (17) or 12.1% indicated their ethnic background as African American. Likewise, (20) or 14.2% of the counselors reported their ethnic identity as Hispanic, and (94) or 66.7% revealed their ethnic background as white. In addition, (4) or 2.8% of the counselors acknowledge their ethnicity as multiracial, and (2) or 1.4% expressed their ethnic status as "other". Finally, (1) or .7% of the counselors indicated their ethnicity as American Indian. See Table 1 for these results.

Table 1
Frequency Distribution of Participants by Ethnicity

Ethnicity	Number	Percent
American Indian	1	.7
Asian	3	2.1
African American	17	12.1
Hispanic	20	14.2
Native American	0	0.0
White	94	66.7
Multi-racial	4	2.8
Other	2	1.4
Total	141	100.0

Age

The variable, 'age,' was classified into seven (7) groups. There were (5) or 3.5% of the counselors surveyed who reported their age between (18) and (24), and (42) or 29.8% indicated their age was between (25) and (34). On the other hand, (49) or 34.8% of the counselors surveyed expressed their age was between (35) and (44), and (34) or 24.1% acknowledged their age was between (45) and (54). Additionally, (8) or 5.7% of the counselors surveyed reported their age was between (55) and (64). Finally, (3) or 2.1% indicated their age was 65 or older. See Table 2 for these results.

Table 2
Frequency Distribution of Participants by Age

Age	Number	Percent
18 – 24	5	3.5
25 – 34	42	29.8
35 -44	49	34.8
45 -54	34	24.1
55 – 64	8	5.7
65+	3	2.1
Total	141	100.0

Level of Education

The variable, 'level of education,' was measured in three groups for this study. There were (14) or 9.9% of the counselors who had obtained a bachelor's degree and (119) or 84.4% of them who had received a master's degree. Finally, (8) or 5.7% of the counselors surveyed had obtained a doctoral degree. See Table 3 for these findings.

Table 3
Frequency Distribution of the Participants by Level of Education

Variable	Number	Percent
Bachelor's	14	9.9
Master's	119	84.4
Doctoral	8	5.7
Total	141	100.0

Current Licensure Status

Regarding the variable, 'current licensure status,' (72) or 51.1% of the counselors surveyed reported their licensure status as LPC, and (26) or 18.4% indicated their licensure status as LPC Associate. In comparison, (28) or 19.9% of the counselors surveyed indicated their licensure status as LPC-S. Finally, (15) or 10.6% of the counselors surveyed indicated they were not licensed.

Table 4
Frequency Distribution of the Participants by Current Licensure Status

Variable	Number	Percent
LPC	72	51.1
LPC-Associate	26	18.4
LPC-S	28	19.9
Not Licensed	15	10.6
Total	141	100.0

Work Experience in Counseling

The variable, 'work experience in counseling,' was measured in six categories. There were (2) or 1.4% of the counselors who indicated they had no work experience in counseling, and (31) or 22% indicated they had between (1) month and (2) years of work experience. Likewise, (32) or 22.7% of the counselors surveyed revealed that they had between (3) and (5) years of work experience. Additionally, (22) or 15.6% of counselors surveyed indicated they had between (9) and (12) years of working experience. Finally, (36) or 25.5% of the counselors surveyed expressed they had (19) or more years of experience in counseling.

Table 5
Frequency Distribution of Participants by Work Experience in Counseling

Work Experience	Number	Percent
None	2	1.4
1 month – 2 years	31	22.0
3 years – 5 years	32	22.7
6 years – 8 years	18	12.8
9 years – 12 years	22	15.6
13 years and above	36	100.0

Work Hours Per Week

The variable, 'work hours per week,' practicing counseling was classified into seven categories for this study. (3) or 2.1% of the counselors surveyed reported they work no hours per week practicing counseling, and (11) or 7.8% indicated they worked

between (1) and (10) hours per week practicing counseling. Moreover, (21) or 14.9% of the counselors surveyed indicated they worked between (11) and (20) hours per week practicing counseling, and (33) or 23.4% indicated they worked between (21) and (30) hours per week practicing counseling.

Additionally, (38) or 27% of counselors revealed they worked between (31) and (40) hours per week practicing counseling, and (30) or 21.3% indicated they worked between (41) and (50) hours per week in counseling. Finally, (5) or 3.5% of the counselors reported they worked (51) hours or more per week in counseling. See Table 6 for these analyses.

Table 6
Frequency Distribution of Participants by Work Hours Per Week

Work Hours Per Week	Number	Percent
None	3	2.1
1 – 10	11	7.8
11-20	21	14.9
21 – 30	33	23.4
31 – 40	38	27.0
41 – 50	30	21.3
51 and Above	14	100.0

Mean and Standard Deviation Results Regarding Independent and Dependent Variables

The mean and standard deviation results were calculated for the independent and dependent variables utilized in the regression model. Counselors who participated in the study had a mean self-care score of 20.41 (SD = 2.81), and mean other care score of 26.34 (SD=5.29).

Additionally, counselors who participated in the present study had mean self-esteem and anxiety scores of 31.92 (SD = 5.10) and anxiety 2.19 (SD =1.65), respectively. In addition, counselors had a mean depression score of 3.57 (SD =2.56), and a mean resilience score of 6.77 (SD =3.49). Finally, on average, counselors involved in this study had a perceived stress score of 16.69 (SD = 6.13).

See Table 7 for these results.

Table 7

Mean and Standard Deviation Results Regarding Independent and Dependent Variables

Variables	Mean	SD
Self-Care	20.41	2.81
Other -Care	26.34	5.29
Self-Esteem	31.92	5.10
Anxiety	2.19	1.63
Depression	3.57	2.56
Resilience	6.77	34.90
Perceived Stress	16.69	6.13

Intercorrelation Results Regarding Independent and Dependent Variables

The Pearson Product Moment Correlation procedure was calculated to assess the intercorrelations between independent (predictor) variables and dependent (criterion) variables. Among the two wellness factors, self-care was found to be negatively related to perceived stress among counselors (r = -.451).

Furthermore, three of the four psychological factors were found to be statistically significant to perceived stress among counselors. Of significance, the variables anxiety (r = .633) and depression (r =.690) were found to be positively related to perceived stress. In addition, the variable, self-esteem, was found to be negatively related to perceived stress.

Based on the above correlational results, counselors who have low self-care, low self-esteem, and a high degree of anxiety and depression were the counselors surveyed most likely to have higher levels of perceived stress.

Table 8
Intercorrelational Analyses Regarding Independent and Dependent Variables

Independent Variables	Dependent Variable Perceived Stress
Wellness Factors	
Self-Care	-.451***
Other-Care	-.061
Psychological Factors	
Self-Esteem	-.572***
Anxiety	.633***
Depression	.690***
Resilience	.033

***Significant at the .001 level**

Examination of Hypotheses

HO_1: There is no statistically significant relationship between wellness factors (self-care and other-care) and perceived stress among counselors.

The Standard Multiple Regression Statistical Procedure was calculated to examine the predictable relationship between wellness factors (self-care and other-care) and the perceived stress scores among counselors. Shown in Table 9, the regression model yielded a multiple correlation coefficient of (.451). The variables self-care and other-care together accounted for 20.3% (adjusted=19.2%) of the variance in the perceived stress among counselors.

A statistically linear relationship was found to exist between the wellness factors of self-care, other-care, and the perceived stress scores (F (2,138) = 17.617, P <.001) of counselors. Moreover, when the variable other-care was controlled, the variable self-care (t (138) = -5.881, P <.001) contribute significantly to the perceived stress of counselors. In addition, self-care uniquely predicted about 19.9 percent of the variance in perceived stress when the variable other-care was statistically controlled. Thus, the hypothesis was rejected.

Table 9

Standard Multiple Regression Results Regarding the Relationship Between Wellness Factors and Perceived Stress Among Counselors

Model	B	SE	Beta	t	P
(Constant)	37.023	3.931			
Self-care	-.981	.167	-.450	-5.881	.000***
Other-care	-.012	.089	-.010	-.134	.894

Note: R =.451; R Square = .203; Adjusted R Square = .192; df = 2, 138; F = 17.617; P =.000***
***** Significant at .001 level**

HO_2: There is no statistically significant relationship between psychological factors (self-esteem, anxiety, depression, and resilience) and perceived stress among counselors.

Presented in Table 10 was the standard multiple regression analysis concerning the predictable relationship between psychological factors (self-esteem, anxiety, depression, and resilience) and the perceived stress scores of counselors. The regression model yielded a multiple correlation coefficient of (.731). The four psychological variables combined, explained 53.4% (adjusted = 52.0%) of the variance in perceived stress among counselors.

A statistically significant relationship was found to exist between psychological factors (self-esteem, anxiety, depression, and resilience) and the perceived stress scores among counselors at the .001 level ($F(4, 136) = 38.909$, $P<.001$). The variable self-esteem ($t(136) = -3.949$, $P <.001$) was found to contribute significantly to perceived stress when anxiety, depression, and resilience were controlled. Also, the variable depression ($t(136) = 3.442$, $P <.001$) was found to be an independent predictor of perceived stress when the variables self-esteem, anxiety, and resilience were controlled.

Additionally, the variable self-esteem uniquely predicted about 5% of the variance in perceived stress when anxiety, depression and resilience were statistically controlled. In addition, the variable depression uniquely predicted about 4% of the variance in perceived stress when self-esteem, anxiety, and resilience. Therefore, hypothesis 2 was rejected.

Table 10
Standard Multiple Regression Results Regarding the Relationship Between Psychological Factors and Perceived Stress Among Counselors

Model	B	SE	Beta	t	P
(Constant)	22.648	3.10			
Self-Esteem	-.333	.084	-.278	-3.949	
.000***					
Anxiety	.440	.454	.117	.968	.335
Depression	1.044	.303	.435	3.442	
.001***					
Resilience	-.002	.010	-.009	-.160	.873

Note: R =.731; R Square =.534; Adjusted R Square =.520; df = 4, 136; F = 38.909; P =.000***

HO_3: There is no statistical relationship between the combination of wellness factors (self-care and other-care), psychological factors (self-esteem, anxiety, depression, and resilience), and perceived stress among counselors.

Reported in Table 11 were the standard multiple regression findings regarding the predictable relationship between the combination of wellness factors, psychological factors, and the perceived stress scores of counselors. The multiple regression model yielded a multiple correlation coefficient of (.741). The wellness and psychological factors collectively accounted for 55% (adjusted =53%) of the variance in perceived stress of counselors.

A significant linear relationship existed between the wellness and psychological factors of self-care, other-care, self-esteem, anxiety, depression, and resilience in relation to the criterion variable perceived stress scores among counselors ($F(6,134) = 27.284$, $P < .001$) at the .001 level. When the variable self-care, other-care, anxiety, depression, and resilience were controlled, the variable self-esteem ($t(134) = -3.322$, $P < .001$) was found to contribute significantly to perceived stress among counselors. Furthermore, the variable depression ($t(134) = 3.162$, $P < .01$) was found to contribute significantly to perceived stress among counselors, when self-care, other-care, self-esteem, anxiety, and resilience were controlled.

Additionally, the variable self-esteem uniquely predicted about 4% of the variance in perceived stress when controlling for self-care, other-care, anxiety, depression, and resilience. As a result, hypothesis 3 was rejected.

Table 11
Standard Multiple Regression Results Regarding the Relationship Between Wellness Factors, Psychological Factors and Perceived Stress Among Counselors

Model	B	SE	Beta	t	p
(Constant)	23.268	4.273			
Self-care	-.261	.148	-.120	-1.765	.080
Other-care	.093	.069	.81	1.363	.175
Self-Esteem .001***	-.290	.087	-.241	-3.322	
Anxiety	.505	.451	.135	1.120	.265
Depression	.964	.305	.402	3.162	.002**
Resilience	.000	.010	-.001	-.013	.989

Note: R =.742; R Square = .550; Adjusted R Square =.530; df =6,134; F =27.284; P=.000***
****Significant at the .01 level**
*****Significant at the .001 level**

Summary of Hypotheses Tested

Three null hypotheses were analyzed in the present study. The three hypotheses were formulated to test the predictable relationship between two sets of independent variables (wellness and psychological) and the dependent variable (perceived stress). All three hypotheses were found to be significant at the .001 level.

Regarding hypothesis one, the wellness factors of self-care and other-case were found to be significantly linearly related to perceived stress. The variable self-care was found to be an independent predictor of perceived stress.

Moreover, with regard to hypothesis two, the psychological factor self-esteem, anxiety, depression, and resilience were found to be linearly related to perceived stress.

The variables self-esteem and depression were found to be independent predictors of perceived stress.

Finally, with respect to hypothesis three, the combined wellness and psychological factors of self-care, other-care, self-esteem, anxiety, depression, and resilience were found to be statistically linearly related to perceived stress. The variables self-esteem and depression were found to be independent predictors of perceived stress. See Table 12 for these results.

Table 12
Summary of Null Hypotheses Tested

Hypotheses	R	R^2	F	df	P	Conclusion
HO_1	.451	.203	17.617	2,138	.000	Significant***
HO_2	.731	.534	38.909	4,136	.000	Significant***
HO_3	.742	.550	27.284	6,134	.000	Significant***

*****Significant at the .001 level**

CHAPTER 5

SUMMARY, DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS

The purpose of this study was to explore the relationship between specific psychological factors and wellness factors regarding perceived stress among counselors. Specifically, this study was concerned with how particular wellness factors, i.e., self-care and other-care, and selected psychological factors. i.e., self-esteem, anxiety, depression, and resilience, may influence perceived stress among counselors using the following instruments: the Mindfulness Self-Care Scale; Rosenberg Self-Esteem Scale; 9-SRA Scale of Self Report Altruism; 4-Item Patient Health Questionnaire for Anxiety and Depression; Brief Resiliency Scale; Perceived Stress Scale. The following hypotheses were tested for this research study:

$Ho_{1:}$ There is no statistically significant relationship between combined "wellness factors" (self-care and other-care) and perceived stress among counselors.

$Ho_{2:}$ There is no statistically significant relationship between combined "psychological factors" (self-esteem, anxiety, resilience) and perceived stress among counselors.

$Ho_{3.}$ There is no statistically significant relationship between the combination of "wellness factors" (self- care and other-care) and "psychological factors" (self-esteem, anxiety, resilience) on perceived stress among counselors.

Findings and Discussion

Hypothesis One was found to have a statistically significant influence on perceived stress among counselors. Among the two wellness factors, self-care and other-care, self-care was found to be negatively related to perceived stress among counselors. Self-care in this study was defined as the counselor's ability to take care of one's own needs by maintaining balance between one's individual and professional selves.

The concept of other-care encompasses the counselor's actions aimed at promoting the well-being of others, showing concern for others, adopting the perspectives of others, and considering the interests and needs of other people in various situations. These findings associate with Lazarus and Folkman's stress and coping theory in that Lazarus and Folkman were interested in the relationship between a person's coping strategies and personal resources.

Self-care, in this study, was seen as a coping strategy in relation to perceived stress. Self-care, as a coping strategy, involves both emotional and problem-focused strategies. The counselor is emotionally engaged in self-awareness, or mindfulness-based, abilities while using problem-focused strategies in targeted areas of attending to one's physiological and emotional needs. These findings were consistent with research conducted by Kristofferzon et al. (2018), which investigated the sense of coherence, emotion-focused coping, problem-focused coping, coping efficiency, and mental quality of life (QoL) in patients with chronic illness using Lazarus' and Folkman's stress and coping theory as a basis for their analysis. Kristofferzon and colleagues found that self-perceived effective coping strategies are the most important mediating factors between sense of coherence and quality of life in patients with chronic illness. Their findings

support Lazarus and Folkman's stress and coping theory as well. Counselors who viewed, engaged, and reliably supported their self-care as an effective coping strategy reported lower perceived stress.

While the primary focus of the Kristofferzon and colleagues' study was to examine the mediating factors between coherence—defined as the extent to which individuals believe that life events are comprehensible, manageable, and meaningful—and mental quality of life, the research highlighted the significance of self-perceived effective coping strategies. According to the study's findings, these coping strategies played a crucial role in influencing the quality of life. The model proposed in the study demonstrated its explanatory power by accounting for 39% of the variance in mental quality of life, as indicated by the adjusted R-squared value of 0.368. Self-care, understood as a successful coping strategy, was also found to have a negative correlation to perceived stress among counselors ($r = -.451$).

Hypothesis Two was found to have a statistically significant relationship between three of the four selected psychological factors in relation to perceived stress. Specifically, the data indicated that the variables anxiety ($r = .633$), and depression ($r = .690$), were found to be positively related to perceived stress. The variable self-esteem ($r = -.572$), was found to be negatively related to perceived stress. Regarding the variable anxiety, Shamoon et al. (2016), found that, "effective therapists need to be able to effectively manage their emotions, especially their anxiety, in order to truly help their clients" (p. 123). Shamoon and colleagues suggest that counselors practice personal introspection and affect regulation. According to Lazarus and Folkman's stress and coping theory, stress is a condition or feeling experienced when a person perceives that

the, “demands exceed the personal and social resources the individual is able to mobilize” (Lazarus & Folkman, 1984, p. 21).

Stress as it relates to anxiety, then, is based on the individual’s perception of a given psychological situation, particularly thinking based on impending danger or future-oriented stress. Cognitive appraisal, in a future-oriented context then, can impact levels of stress and successful coping. The data indicated that higher anxiety scores increase as perceived stress scores increase.

Regarding the variable depression, this research found congruent findings with prior research which indicated that depression is of concern for therapy-related professionals. The variable depression ($t(136) = 3.442$, $P < .001$) was found to be an independent predictor of perceived stress when the variables self-esteem, anxiety, and resilience were controlled. These findings add support to prior data noted by Mace (2016), who added that depression has impacted as much as 46% of psychologists and psychotherapists. Additionally, Mace posited that high rates of depression may be associated with feelings of failure.

Furthermore, according to the American Counseling Association (2023), depression is, “a serious mood disorder that causes severe symptoms that can affect the way an individual feels, thinks and handles daily activities such as sleeping, eating or working” (para. 1). According to the transactional model of stress and coping as defined by Lazarus and Folkman (1984), coping strategies are the constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing on or exceeding the resources of the person. Depression, seen as an internal demand, would then require depression coping strategies which tax the resources of the individual, and the counselor to manage successfully. Additionally, coping interventions for the counselor may warrant further research including strategies such as

distraction, relaxation, and acceptance, as noted in potential pain coping strategies found by Radat and Koleck (2011). The variable self-esteem was found to be negatively related to perceived stress. Additionally, along with the variable depression, self-esteem was found to be an independent predictor of perceived stress among counselors. Additionally, self-esteem uniquely predicted about 4% of the variance in perceived stress when self-care, other-care, anxiety, depression, and resilience were statistically controlled. These findings support prior research by Dose, et al. (2019), and Oyserman et al. (2004) who found that self-esteem favors individual well-being and better resistance to stress.

Additionally, Dose and colleagues found indirect effects of relatedness, competence, and autonomy linking self-esteem to well-being. Dose added that, "self-esteem, then, is a necessary ingredient of psychological well-being because it maintains a positive balance at work" (p. 833). Furthermore, as cited by Dose (2019), prior research by Leary et al. (1995) found that self-esteem is seen as a strength from the individual's point of view and from colleagues of their social value, their ability to implement skills, their ability to work autonomously, and to cope with demands of work (p. 833).

According to the transactional model of stress and coping by Lazarus and Folkman (1984), coping resources are used in the appraisal process of perceived stress. Self-esteem can be seen as a potential coping resource for counselors when the counselor's self-esteem is perceived as positive or congruent. The variable resilience ($t(136) = -.160$, $P < .001$), was found to have a negative linear relationship to perceived stress among counselors. According to Lazarus and Folkman (1984), coping strategies

are introduced when stress is perceived. Resilience can be seen then as a potential positive coping strategy for the counselor to mitigate or reduce perceived stress.

Hypothesis three, the combined wellness and psychological factors of self-care, other-care, self-esteem, anxiety, depression, and resilience, were, in combination, found to be statistically linearly related to perceived stress. In relation to transactional model of stress and coping, self-care, other-care, self-esteem, and resilience can be understood as coping factors which are then relational to the individual counselor's perception of stress in a given situation and time. Anxiety is the individual counselor's perception of future perceived stress and can be considered a coping strategy in the future-sense.

Higher scores of depression are critical to counselor self-examination in that strategies to support depressed counselors can potentially decrease depression symptoms and increase the counselor's effectiveness. Moreover, specific to the combined variables analyzed, the variables self-esteem and depression were found to be independent predictors of perceived stress.

Conclusions

The following conclusions were generated from the results of the study:

1. In general, every one-point increases in self-care, perceived stress among counselors decreases .981 units.
2. It appeared that any regression model employed to predict perceived stress among counselors should include the wellness factors of self-care and other-care.
3. Every time the self-esteem score increases one-point, perceived stress among counselors decreases one-third of a point.

4. Any regression model developed to predict perceived stress among counselors should include the psychological factors of self-esteem, anxiety, depression, and resiliency scores.
5. Every time the depression score of counselors increases one point, the perceived stress scores increase 1.04 points.

Finally, a regression model employed to predict perceived stress among counselors should include both wellness and psychological factors.

Implications for Counselors

Counseling, as defined by the American Counseling Association 20/20 consensus, is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals (ACA, 2023). The American Counseling Association Code of Ethics (2014) states that, in section A.1.a. Primary Responsibility, the primary responsibility of counselors is to respect the dignity and promote the welfare of clients. In both directives, counselors are trained to primarily give their skill, support, and effort toward the benefit of their clients. Less training and attention are generally given to the mental and emotional health of the counselor themselves.

Counselors are not widely encouraged to explore and self-exam potentially critical attributes within themselves that may indicate higher degrees of perceived stress. This study explored wellness and psychological factors that relate to counselor-perceived mental health in an effort to explore the importance and value of counselor self-knowledge. Ultimately, if counselors are to find their work in counseling and, to a

broader extent, their perception of stress in their lives as a whole, encouraging an introspective analysis of factors such as self-care, anxiety, depression, resilience, and self-esteem could assist counselors in directing their attention and supportive energy toward a perception of self that is, on the whole, less stressed so that they may thrive.

Recommendations for Further Research

Research for the reduction of perceived stress for counselors is ongoing. As counselors continue to expand on various strategies of self-care and work-life balance, counselors may find that some attention given to their current levels of perceived stress, identifying which factors may be contributing to such stress levels, and evaluating coping strategies may be of professional and personal benefit. While counselors are still traditionally trained on the critically supportive nature of counselor to client relationships, further interpersonal research relating to the counselor themselves may provide additional support for counselor-related mental health.

Continued research of statistically relevant variables relating to counselor perceived stress may provide a further knowledge base for counseling training programs, and continuing education opportunities to discuss and encourage counselor self-introspection toward perceived stress throughout the career of the practicing counselor. Additionally, personality cluster studies may also give insight into the types of interpersonal work counselors could be naturally inclined towards or excel in, thereby assisting in the strategic allocation of resources and professional development opportunities. Work done by Kim et al. (2023), highlights that Edwards & Bess (1998), and McAuliffe & Lovell (2006), find that, “counselors’ self-awareness of personal traits

and their potential impact on the counseling process with clients are considered crucial" (pg. 2). To this end, specifically in relation to counselors, Kim et al. (2023), identified a four-profile model for counselor burnout and personal and professional self-discrepancy in counselor qualities (p. 10). Further personality profile modeling may assist counseling in identifying similar patterns for perceived stress.

The implications for continued research in counselor perceived stress is ongoing. It remains critical that counselors are encouraged and assisted with further research which enables them to monitor professional and personal interpersonal qualities, areas of needs or support, with overall intention to improve counselor self-awareness, health, and counseling effectiveness. Further research is needed to expand on the concepts of counselor self-awareness, how, and what may motivate counselors to this end. Additionally, further research may help counselors identify which interpersonal and wellness factors are critical to their mental health and work lives.

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