




Examining Secondary Trauma as a Result of Clients' Reports of Discrimination

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Abstract

In the current study, we examined the extent to which 86 American clinicians heard reports of discrimination from their clients of color. Findings indicated that 96.5% of clinicians heard at least one report of discrimination from clients of color at least occasionally in counseling. The acts of discrimination most frequently reported by clients of color were: a) being made to feel like outsiders, b) treated unfairly by coworkers and classmates, and c) treated unfairly by teachers and principals. Additionally, we investigated the predictive nature of reports of discrimination from clients of color on clinicians' compassion satisfaction, burnout, and secondary traumatic stress. The three predictor variables (clinicians' age, years counseling, and clients of color's reports of discrimination) did not significantly predict compassion satisfaction or burnout, yet significantly predicted secondary traumatic stress. These results revealed that as reports of discrimination from clients of color increased, so too did clinicians' secondary traumatic stress.

Keywords Clients of color · Secondary trauma · Racial discrimination · Burnout · Compassion satisfaction

Introduction

The risk of secondary trauma, or the emotional effects of empathically listening to the account of another's trauma (Figley 1995, 2002), exists across helping professions. Scholars have referred to this phenomenon as secondary traumatization, compassion fatigue, vicarious trauma, and secondary traumatic stress; and these labels point to the similar experience of being affected by another person's trauma (Fao and Rothbaum 1998; Figley 2002; Pearlman and Saakvitne 1995). The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5;

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American Psychiatric Association [APA], 2013) describes trauma as actual or threatened injury, death, or sexual violence via direct experience, first-hand observation, or learning that the event happened to a significant other. Among a sample of almost 3000 American adults, researchers found that 89.7% had been exposed to at least one traumatic event using DSM-5 criteria (Kilpatrick et al. 2013). Thus, it is likely that most counselors will be exposed to clients' experiences of trauma in their professional work. Some counselors may experience secondary traumatic stress as the result of this exposure. Indeed, among 88 mental health professionals in the United States, researchers found that 22.7% reported secondary trauma (Ivicic and Motta 2017). Additionally, researchers determined the strongest predictors of secondary traumatic stress among 152 Australian mental health professionals were interpersonal support, clinical caseload, and satisfaction with work (Devilley et al. 2009). Counselors are at risk for secondary traumatic stress given that "those who work with suffering, suffer themselves because of the work" (Figley 2002, p. 5).

Counseling Traumatized Clients and Burnout

Along with the risk of secondary traumatic stress, burnout also is a potential consequence of working in the counseling profession. Burnout encapsulates the response to "the chronic emotional strain of dealing extensively with other human beings, particularly when they are troubled" (Maslach 2003, p. 2). Although burnout can occur in a variety of professions, it is particularly linked to the field of counseling given the nature of clinical work with other human beings who are suffering, troubled, or experiencing difficulty. Maslach (2003) identified three key aspects of burnout: a) emotional exhaustion, b) depersonalization, and c) reduced personal accomplishment. Rather than a personality characteristic, burnout is the result of occupational context. Indeed, Thompson et al. (2014) found a strong inverse correlation between American counselors' burnout and perceptions of positive work conditions ($r = -.643$).

With regard to burnout and trauma, results examining the relationship between the two constructs are mixed. For example, among 253 counselors in the United Kingdom working with adult clients with trauma, 25.8% scored in the "high" range of a burnout scale (Sodeke-Gregson et al. 2013). Burnout was less common among therapists who had been counseling longer and those who perceived their management to be more supportive (Sodeke-Gregson et al. 2013). Furthermore, Wilkinson et al. (2017) found that among mental health professionals in American college counseling centers, 19% scored above the cutoff for personal burnout, 15.2% for work burnout, and 2.5% for client burnout. Counselors' perceptions that clients' presenting concerns were increasing in severity significantly, positively correlated with all three types of burnout (Wilkinson et al. 2017). In contrast, Garcia et al. (2016) investigated burnout among 137 clinicians in the United States who provided prolonged exposure or cognitive processing therapy for veterans. Although 50.4% of the sample reported feeling exhausted and 47.4% reported feeling cynical, clients' trauma content did not significantly predict burnout among the clinicians (Garcia et al. 2016).

Although the relationship between client trauma and counselor burnout is mixed, researchers have found significant positive correlations between burnout and secondary traumatic stress (Devilley et al. 2009; Sodeke-Gregson et al. 2013). Additionally, researchers have identified a protective factor against burnout, namely, compassion satisfaction. Stamm (2002) described compassion satisfaction as the positive or rewarding outcomes from working with

traumatized others. Empirically, researchers have found that compassion satisfaction is inversely related to counselor burnout (Thompson et al. 2014).

Race-Based Traumatic Stress

Although several examples of trauma are listed in the DSM-5 (e.g., exposure to war, physical attack, childhood physical abuse, sexual trafficking, natural disasters, severe motor vehicle accidents), the description does not include traumatic events motivated by racial discrimination (APA, 2013). Carter (2007) proposed that race-based traumatic stress is a specific type of traumatic stress resulting from race-based incidents that cause psychological pain and distress. Moreover, Ponds (2013) stated, “racial trauma is the physiological, psychological, and emotional damage resulting from the stressors of racial harassment or discrimination” (p. 23). Many scholars purport that experiences of racial discrimination can indeed be traumatic events for people of color (Bryant-Davis and Ocampo 2006; Bryant-Davis 2007; Carter 2007; Nadal 2018; Ponds 2013). Nadal (2018) reported that traumatic discrimination includes a spectrum of behaviors ranging from subtle microaggressions to overt acts of violence. Additionally, Bryant-Davis and Ocampo (2006) noted two aspects that make racist-incident-based trauma unique: a) the fact that the incident was not random, but targeted due to race and b) the incident occurred within a broader context of stigma and stereotypes pertaining to the victim’s racial group. Bryant-Davis (2007) suggested that race-based traumatic stress can cause cognitive, affective, and somatic distress and can lead to negative relational, behavioral, and spiritual consequences.

Along with conceptual evidence for race-based traumatic stress, empirical evidence also exists. In a meta-analysis of 28 studies examining racial discrimination and trauma among American adults, researchers determined that 70% of the associations were positive and significant, indicating that greater levels of racial discrimination associated with greater levels of trauma symptoms (Kirkinis et al. 2018). Moreover, researchers found a significant correlation between perceived discrimination and posttraumatic stress symptoms among 110 Mexican American youth (Flores et al. 2010). Additionally, among 383 Chinese international university students, researchers found that perceived racial discrimination predicted posttraumatic stress scores, even after controlling for general stress (Wei et al. 2012). Finally, researchers found a significant correlation between experiences of racism and posttraumatic stress symptoms among 189 male incarcerated Black American youth (Kang and Burton 2014).

Therefore, given the prevalence of race-based traumatic stress, it is likely that counselors will hear client reports of this specific type of trauma from their clients. Indeed, in the study of 106 mental health and school counselors in the United States, Hemmings and Evans (2018) found that 70.8% of the sample reported working with clients with race-based trauma. Given the risk for secondary traumatic stress and burnout among counselors exposed to clients’ accounts of trauma, it is important to assess whether reports of race-based traumatic stress carry the same risk. Thus, the aim of our study was to examine the effects of clients’ reports of racial discrimination on counselors’ burnout, secondary trauma, and compassion satisfaction levels. Specifically, we sought to answer the following research questions: a) What racial discrimination incidents do licensed counselors hear most often from clients of color? and b) Do clients’ reports of discrimination significantly predict burnout, secondary trauma, and compassion satisfaction among counselors?

Method

Procedure

Utilizing G*Power software (Version 3.1; Faul et al. 2009), we calculated the required sample size needed to obtain sufficient power. With a medium effect size (.15), alpha of .05, power of .80 and three predictor variables with each regression (age, years counseling, and subscale score of the ProQOL-5), our analysis required 77 participants. Upon acquiring approval from the Institutional Review Board (IRB), we obtained our sample of licensed clinicians by using the therapist database on the *Psychology Today* website. Specifically, we utilized the search feature to obtain a list of clinicians with experience working with a general presenting concern, namely, anxiety. To obtain the desired sample size, we identified the first 13 licensed clinicians from each state in the United States, resulting in 650 potential participants. Inclusion criteria consisted of: a) being 18 years of age or older and b) being licensed in one's state. To contact each clinician, we conducted an Internet search to find their professional email addresses. If a clinician's email address could not be found online, we moved to the next clinician listed for that particular state. This process continued until we obtained contact information for 13 licensed clinicians per state, yielding 650 total potential participants.

After obtaining contact information for all 650 potential participants, we emailed our questionnaire link utilizing the Qualtrics survey software. In total, 598 email addresses were deliverable. We sent three email reminders to all participants who had not completed the survey. After three weeks of data collection, we received 102 surveys (17.1% response rate). We removed 11 responses due to missing data and five responses because the participants reported not seeing clients of color within the past six months. Therefore, our final sample included 86 completed surveys from licensed clinicians (14.4% adjusted response rate).

Participants

We obtained a national sample of 86 licensed clinicians. The mean age for the participants was 44.67 ($SD = 10.86$), ranging between 26 and 70 years. Participants identified as White ($n = 72$, 83.7%), Black/African American ($n = 6$, 7.0%), Biracial/Multiracial ($n = 3$, 3.5%), other ($n = 3$, 3.5%), and Latino(a)/Hispanic ($n = 2$, 2.3%). Regarding gender, participants identified as female ($n = 72$, 83.7%), male ($n = 12$, 14%), and two participants (2.3%) elected not to respond to this item. Most of the participants identified as heterosexual ($n = 74$, 86%) with fewer participants identifying as bisexual ($n = 5$, 5.8%), queer ($n = 3$, 3.5%), lesbian ($n = 2$, 2.3%), gay ($n = 1$, 1.2%), and other ($n = 1$, 1.2%).

Professional background data revealed a range of highest degree earned and educational field of study. Those participants who earned a master's degree were in the majority ($n = 78$, 90.7%), followed by a doctoral degree ($n = 7$, 8.1%), then a specialist degree ($n = 1$, 1.2%). Participants reported a diverse sample of educational fields of study. The majority of participants studied professional counseling or counselor education ($n = 44$, 51.2%), followed by counseling psychology ($n = 27$, 31.4%), clinical psychology ($n = 7$, 8.1%), other ($n = 6$, 7.0%), and rehabilitation counseling ($n = 2$, 2.3%). Related to licensure, participants identified in the following ways: Licensed Professional Counselor (LPC; $n = 41$, 47.7%), Licensed Mental Health Counselor (LMHC; $n = 17$, 19.8%), Licensed Professional Clinical Counselor (LPCC; $n = 15$, 17.4%), non-listed license ($n = 10$, 11.6%), Licensed Clinical Professional Counselor (LCPC; $n = 11$, 12.8%), Licensed Clinical Mental Health Counselor (LCMHC; $n = 7$, 8.1%),

Licensed Professional Counselor of Mental Health (LPCMH; $n = 4$, 4.7%), Licensed Marriage and Family Therapists (LMFT; $n = 3$, 3.5%), and Licensed Chemical Dependency Counselor (LCDC; $n = 1$, 1.2%). With regard to primary work setting, 75 participants (87.2%) worked in private practice, 4 (4.7%) worked in a community agency, 2 (2.3%) worked in a school, 2 (2.3%) in a setting not listed, and 1 (1.2%) in each of the following: college counseling center, hospital/psychiatric unit, and rehabilitation/treatment center.

All participants currently were seeing clients. We asked participants to consider their client caseload over the past six months and identify the percentage of clients who were members of marginalized racial groups. Participants responded as follows: 10% from marginalized racial groups ($n = 42$, 48.8%), 20% ($n = 17$, 19.8%), 30% ($n = 7$, 8.1%), 40% ($n = 7$, 8.1%), 50% ($n = 4$, 4.7%), 60% ($n = 1$, 1.2%), 80% ($n = 4$, 4.7%), and 90% ($n = 4$, 4.7%).

Measures

Demographic Questionnaire

Participants completed a demographic questionnaire assessing age, primary racial/ethnic group, sexual orientation, and gender. The questionnaire also inquired about participants' clinical background, the populations with which they work, and percentage of clients who identify as members of marginalized racial groups.

Brief Perceived Ethnic Discrimination Questionnaire- Community Version

The Perceived Ethnic Discrimination Questionnaire- Community Version (PEDQ-CV; Brondolo et al. 2005) is a questionnaire adapted from the original version of the Perceived Ethnic Discrimination Questionnaire (PEDQ; Contrada et al. 2001), which was normed on college students. The measure is a self-report questionnaire that focuses on community members' experiences of ethnic discrimination. Researchers tested the original PEDQ-CV using a sample of 301 adult community members. The PEDQ-CV scores demonstrated good internal consistency as well as construct validity informed by factor analysis (Brondolo et al. 2005).

In the current study, we utilized the brief version of the PEDQ-CV comprised of 17 items assessing experiences of ethnic discrimination (Brondolo et al. 2005). Scores on the brief version demonstrated adequate reliability (Cronbach's $\alpha = .87$) and convergent validity with other measures of perceived racism (Brondolo et al. 2005). We worded the instructions of the Brief PEDQ-CV to ask participants to consider the extent to which they have heard these reports of racial discrimination from their clients of color. Answer choices ranged from 1 = *never* to 5 = *very often*. An example item is, *how often in your clinical work with clients of color do you hear reports that others have threatened to hurt them because of their race/ethnicity?* For the current study, Brief PEDQ-CV scores yielded a Cronbach's α of .92, demonstrating good internal consistency.

Professional Quality of Life Scale

To measure secondary trauma, we used the Professional Quality of Life scale (ProQOL-5; Stamm 2010). The measure consists of three subscales: compassion satisfaction, burnout, and secondary traumatic stress. Compassion satisfaction refers to pleasure resulting from one's

work as a helper, burnout refers to frustration, hopelessness, and negative feelings resulting from one's work as a helper, and secondary traumatic stress refers to negative consequences resulting from exposure to people who have experienced trauma (Stamm 2010). The ProQOL-5 includes 30 questions; 10 for each subscale. Participants responded on a Likert-type scale ranging from 1 = *never* to 5 = *very often* with regard to their experiences within the past 30 days. Example items include: *I am happy that I chose to do this work* and *I feel connected to others*.

Heritage et al. (2018) examined reliability and construct validity of the ProQOL-5 using a sample of 1615 registered nurses. Scores from the three subscales demonstrated acceptable reliability: compassion satisfaction (Cronbach's $\alpha = .90$), burnout (Cronbach's $\alpha = .80$), and secondary traumatic stress (Cronbach's $\alpha = .84$). The authors also found support for the validity of the measure (Heritage et al. 2018). In the current study, two ProQOL subscale scores demonstrated acceptable reliability: Compassion Satisfaction (Cronbach's $\alpha = .88$) and Burnout (Cronbach's $\alpha = .71$). The scores for the Secondary Traumatic Stress subscale fell slightly below the desired .70 alpha score (Balkin & Kleist 2017) with a Cronbach's alpha of .66.

Data Analysis

Using IBM SPSS Statistics 24 software, we answered the first research question by assessing the means of each of the 17 items on the PEDQ-CV instrument. Specially, we sought to examine the frequency in which licensed counselors reported hearing each type of discrimination from their clients of color. To answer the second research question, we employed three simultaneous linear regression models to examine the extent to which reports of client racial discrimination predicted secondary traumatic stress, burnout, and compassion satisfaction among licensed clinicians. Given the existing literature that supports the association between length of time in the counseling profession and burnout (Sodeke-Gregson et al. 2013), we chose to include number of years counseling and clinicians' age in each regression model.

Results

Prior to answering the primary research questions, we first examined the means, standard deviations, and correlations of all study variables (Table 1). All skewness and kurtosis scores were in acceptable range supporting the hypothesis of normality. All significant correlations were moderate and VIF scores for the predictor variables were in acceptable range, indicating that multicollinearity was not an issue (Field 2013). Finally, all Durbin-Watson scores were in acceptable range indicating the assumption of independent errors was met (Field 2013).

Next, we analyzed Brief PEDQ-CV scores. Only three participants (3.5%) reported never hearing any of the discriminatory incidents on the Brief PEDQ-CV from clients of color. Eighty-three participants (96.5%) reported hearing at least one report of discrimination at least occasionally from clients of color. To answer the first research question, we assessed the mean scores of each item of the Brief PEDQ-CV to ascertain which acts of discrimination counselors heard most often from clients of color (see Table 2). The most frequently reported acts of discrimination that our participants heard from clients of color were: a) others made them feel like outsiders who do not fit in due to characteristics related to their race/ethnicity, b) they had been treated unfairly by co-workers or classmates because of their race/ethnicity, and c) they

Table 1 Correlation Matrix of Study Variables

	Brief PEDQ-CV	Compassion Satisfaction	Burnout	Secondary Traumatic Stress
Brief PEDQ-CV				
Compassion Satisfaction	.190			
Burnout	.099	-.659**		
Secondary Traumatic Stress	.296**	-.085	.496**	
Mean	29.10 (9.70)	41.94 (4.61)	16.99 (3.57)	15.02 (2.97)
(standard deviation)				

** = $p < .01$; Brief PEDQ-CV = Brief Perceived Ethnic Discrimination Questionnaire- Community Version

had been treated unfairly by teachers, principals, or other staff at school because of their race/ethnicity.

Finally, we performed three linear regression analyses using each subscale score of the ProQOL-5 as the criterion variable (Table 3). The first regression assessed the predictive nature of age, years counseling, and Brief PEDQ-CV scores on Compassion Satisfaction. The model was not significant, $R^2 = .06$, $R_{adj} = .02$, $F = (3, 82) 1.604$, $p = .195$, indicating that age, years counseling, and frequency of client reports of discrimination did not significantly predict the variance of Compassion Satisfaction. The second regression model assessed the predictive nature of age, years counseling, and Brief PEDQ-CV scores on Burnout Again, the model was not significant, $R^2 = .06$, $R_{adj} = .03$, $F = (3, 82) 1.719$, $p = .170$, indicating that age, years counseling, and frequency of client reports of discrimination did not significantly predict the variance of Burnout. Finally, we conducted a regression model with Secondary Traumatic Stress as the criterion variable. The model included three predictor variables: age, years counseling, and Brief PEDQ-CV scores. The regression model was significant, $R^2 = .10$, $R_{adj} = .07$, $F = (3, 82) 3.157$, $p = .029$, accounting for 10% of the variance in Secondary

Table 2 Brief PEDQ-CV Item Mean Scores and Standard Deviations

Act of Discrimination Reported by Clients of Color	Mean	Standard Deviation
Made to feel like an outsider due to dress or characteristics	2.42	1.193
Treated unfairly by co-workers or classmates	2.15	.976
Treated unfairly by teachers or principles	2.14	.960
Treated unfairly by police	1.97	1.045
Not trusted by others	1.87	.915
Ignored by others	1.86	.990
Others say bad things behind their backs	1.83	.972
Treated unfairly by bosses or supervisors	1.79	.914
Others thought they were lazy	1.77	.923
Others thought they were incompetent or incapable	1.69	.936
Others thought they were dishonest	1.60	.898
Made to feel like an outsider due to language differences	1.60	.778
Threatened to be hurt by others	1.37	.614
Others thought they were dirty	1.31	.598
Others threatened to damage their property	1.30	.555
Physically hurt by others	1.27	.541
Property damaged by others	1.18	.441

Each item corresponded with a Likert-type scale ranging from *never* (1) to *very often* (5). Participants reported the extent to which they heard these reports from their clients of color

Table 3 Three Regression Models Examining Variance of Compassion Satisfaction, Burnout, and Secondary Traumatic Stress Explained by Predictor Variables

	Predictor Variables	<i>B</i>	<i>SE B</i>	β	<i>t</i>	<i>R</i> ²	<i>R</i> ² _{adj}
Model 1: Compassion Satisfaction	Age	.067	.054	.159	1.252	.055	.021
	Years Counseling	-.166	.410	-.05	-.406		
	Brief PEDQ-CV	.092	.051	.193	1.798		
Model 2: Burnout	Age	-.076	.042	-.230	-1.814	.059	.025
	Years Counseling	.035	.317	.014	.112		
	Brief PEDQ-CV	.036	.039	.096	.900		
Model 3: Secondary Traumatic Stress	Age	-.027	.034	-.098	-.797	.104*	.071*
	Years Counseling	-.086	.257	-.041	-.334		
	Brief PEDQ-CV	.091	.032	.297	2.836*		

* = $p < .05$; Brief PEDQ-CV = Brief Perceived Ethnic Discrimination Questionnaire- Community Version

Traumatic Stress. Beta scores indicated that Brief PEDQ-CV scores accounted for the variance explained in the model ($B = .09$, $\beta = .30$, $t = 2.84$, $p = .006$). Thus, counselors who heard more client reports of racial discrimination had higher Secondary Traumatic Stress scores.

Discussion

Race-based traumatic stress negatively impacts the mental and emotional well-being of people of color (Bryant-Davis 2007; Carter 2007; Ponds 2013). Professional counselors are at risk for secondary traumatic stress and burnout when exposed to clients' traumatic experiences in counseling, which may include incidents of racial discrimination. Therefore, we sought to determine whether clients' reports of racial discrimination significantly predicted burnout, secondary trauma, and compassion satisfaction among counselors. Our study also explored the most common forms of racial discrimination reported by clients of color in counseling.

Several important findings emerged from our empirical investigation. Similar to other studies, we found that compassion satisfaction among counselors was inversely related to burnout (Thompson et al. 2014) and secondary traumatic stress was positively correlated with burnout (Devilly et al. 2009; Sodeke-Gregson et al. 2013). Thus, it appears that compassion satisfaction can be a protective factor against counselor burnout, while the experience of secondary traumatic stress can contribute to burnout.

Another critical finding of this study was that the majority of counselors (96.5%) heard reports of racial discrimination from their clients of color. The most frequently reported incidents included those in which clients were made to feel like outsiders and when clients were treated unfairly due to their race/ethnicity. The fact that all but three participants heard at least one account of racial discrimination from a client of color supports statistics related to the frequency of racial discrimination in the United States. In a recent study by the Pew Research Center (2019), 26% of Hispanics, 29% of Asians, and 49% of Blacks indicated they had been treated unfairly in promotions, hiring, or compensation, and 46% of Hispanics, 53% of Blacks, and 61% of Asians reported being the victim of slurs or jokes. Thus, our findings corroborate statistics indicating that racial discrimination is prevalent in the United States and add that racist incidents are topics of discussion in counseling among clients of color. Counselors

should be prepared to address racial discrimination in counseling, yet training to that end may be inconsistent. Indeed, Hemmings and Evans (2018) found that only 18.9% of the counselors in their sample received training related to addressing race-based trauma in clinical work. Along with utilizing culturally appropriate clinical interventions and techniques, counselors should be familiar with advocacy competencies (Toporek et al. 2009) and guidelines (World Health Organization 2003) in order to effectively advocate with and on behalf of their clients of color.

With regard to the second research question, we found that hearing reports of client experiences of racial discrimination significantly predicted secondary traumatic stress among participants, but not burnout or compassion satisfaction. It appears that counselors may be affected by the accounts of racial trauma described by clients of color. It is interesting to note that the majority of our participants identified as White (83.7%) and more accounts of racial discrimination reported from clients of color predicted higher levels of secondary traumatic stress among these clinicians.

There are several possible reasons why client reports of racial discrimination did not predict compassion satisfaction or burnout among our participants. For example, researchers have conceptualized burnout as a consequence of the work environment (Thompson et al. 2014; Maslach 2003), thus the specific content of the counseling session may not be as important as perceptions of work conditions. Almost 88% of the counselors in our study worked in private practice, and results may differ among counselors working in other settings. Additionally, empirical results related to the relationship between burnout and trauma are mixed (Garcia et al. 2016; Sodeke-Gregson et al. 2013) and our study contributes to data indicating that specific accounts of client trauma do not predict counselor burnout. With regard to compassion satisfaction, or positive feelings that result from helping (Stamm 2010), the frequency of client accounts of racial discrimination also was not a significant predictor. It is important to note that possible scores on the compassion satisfaction subscale ranged from 10 to 50, and our participants averaged 41.9. Thus, our sample demonstrated overall strong levels of compassion satisfaction and client accounts of racial discrimination did not appear to significantly account for variance among scores.

Implications for Counselors

This study has several implications for counselors who provide counseling services to people of color. First, counselors must recognize that racial discrimination is prevalent in the United States (Pew Research Center 2019) and can be traumatic for clients of color (Bryant-Davis and Ocampo 2006; Carter 2007). To offer competent services to clients, counselors should adhere to the Multicultural and Social Justice Counseling Competencies (MSJCC; Ratts et al. 2016). Specifically, counselors should work to gain awareness of their own cultural identities and accompanying values, biases, and assumptions (Ratts et al. 2016). Additionally, counselors should work to understand the unique worldview and the effects of racial discrimination among clients of color. Counselors should be comfortable and competent when broaching the subject of race with clients (Day-Vines et al. 2007) and examining how experiences of discrimination may influence the counseling relationship (Ratts et al. 2016). Moreover, counselors can best serve clients by identifying and addressing race-based trauma. Effective interventions include acknowledging the racist incident, engaging in supportive listening, enhancing client

safety, self-care and coping strategies, processing grief, loss, and anger resulting from the incident, and addressing self-blame, internalized racism, and shame (Bryant-Davis and Ocampo 2006).

Counselors also should be aware of the potential for secondary traumatic stress when empathically listening to client accounts of racial discrimination. Self-care strategies to mitigate the effects of secondary traumatic stress may include pursuing clinical supervision, engaging in group or individual counseling, taking part in a professional peer group (Catherall 1999) or mindfulness practices (Gorski 2015). However, more research is needed regarding the efficacy of coping strategies for secondary trauma. Specifically, researchers found that despite counselors' general beliefs in the usefulness of specific coping strategies (i.e., self-care, leisure, and supervision) for trauma symptoms, no significant associations existed between time allotted for these coping strategies and acute distress (Bober and Regehr 2006). Therefore, future researchers can test and identify effective methods of coping with secondary traumatic stress among counselors. For example, given the nature of race-based trauma, a possible means of addressing this type of secondary traumatic stress may be through engaging in activism and social justice efforts to address systemic racism.

Limitations

Readers should consider the findings of the current study in light of several limitations. First, we obtained participants via an online database (*Psychology Today*) and thus the sample represents only those registered with the site. Future researchers may consider acquiring a sample of licensed participants through diverse means. Second, the majority of participants identified as White, heterosexual females working in private practice settings. Thus, the outcomes cannot be generalized to all clinicians. Future researchers should replicate the study with a more diverse sample of counselors. Additionally, it is possible that clients of color underreported experiences of racial discrimination in their work with primarily White counselors to avoid further discrimination. Finally, one of the Brief ProQOL subscales, namely, secondary traumatic stress, demonstrated only minimally acceptable internal consistency.

Conclusion

Among a national sample of 86 licensed clinicians, reports of racial discrimination from clients of color significantly predicted secondary traumatic stress. Our study identified the types of racial discrimination most frequently reported by clients of color in counseling, and emphasized the importance of counselor preparedness to address race-based trauma. Our results add to the literature related to secondary traumatic stress and racial trauma and can help counselors understand how to better serve clients of color. Additionally, the findings emphasize the importance of self-care practices among counselors who hear reports of racial discrimination.

Compliance with Ethical Standards

Conflict of Interest The authors declared that they have no conflict of interest.

References

- American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). American Psychiatric Association.
- Balkin, R. S., & Kleist, D. M. (2017). *Counseling research: A practitioner-scholar approach*. American Counseling Association.
- Bober, T., & Regehr, C. (2006). Strategies for reducing secondary or vicarious trauma: Do they work? *Brief Treatment and Crisis Intervention*, 6, 1–9. <https://doi.org/10.1093/brief-treatment/mhj001>.
- Brondolo, E., Kelly, K. P., Coakley, V., Gordon, T., Thompson, S., Levy, E., Cassells, A., Tobin, J. N., Sweeney, M., & Contrada, R. J. (2005). The perceived ethnic discrimination questionnaire: Development and preliminary validation of a community version. *Journal of Applied Social Psychology*, 35(2), 335–365.
- Bryant-Davis, T. (2007). Healing requires recognition: The case for race-based traumatic stress. *The Counseling Psychologist*, 35, 135–143. <https://doi.org/10.1177/0011000006295152>.
- Bryant-Davis, T., & Ocampo, C. (2006). A therapeutic approach to the treatment of racist-incident-based trauma. *Journal of Emotional Abuse*, 6, 1–22. <https://doi.org/10.1300/J135v06n04-01>.
- Carter, R. T. (2007). Racism and psychological and emotional injury: Recognizing and assessing race-based traumatic stress. *The Counseling Psychologist*, 35, 13–105. <https://doi.org/10.1177/0011000006292033>.
- Catherall, D. R. (1999). Coping with secondary traumatic stress: The importance of the therapist's professional peer group. In B. H. Stamm (Ed.) *Secondary traumatic stress: Self care issues for clinicians, researchers, and educators* (2nd ed.), (pp. 80–94). Sidran Press.
- Contrada, R. J., Ashmore, R. D., Gary, M. L., Coups, E., Egeth, J. D., Sewell, A., Ewell, K., Goyal, T. M., & Chasse, V. (2001). Measures of ethnicity-related stress: Psychometric properties, ethnic group differences, and associations with well-being. *Journal of Applied Psychology*, 31(9), 1775–1820.
- Day-Vines, N. L., Wood, S. M., Grothaus, T., Craigen, L., Holman, A., Dotson-Blake, K., & Douglass, M. J. (2007). Broaching the subjects of race, ethnicity, and culture during the counseling process. *Journal of Counseling & Development*, 85, 401–409.
- Deville, G. J., Wright, R., & Varker, T. (2009). Vicarious trauma, secondary traumatic stress, or simply burnout? Effect of trauma therapy on mental health professionals. *The Australian and New Zealand Journal of Psychiatry*, 43, 373–385. <https://doi.org/10.1080/00048670902721079>.
- Fao, E. B., & Rothbaum, B. O. (1998). Treating the trauma of rape: Cognitive behavioral therapy for PTSD. Guilford Press.
- Faul, F., Erdfelder, E., Buchner, A., & Lang, A.-G. (2009). Statistical power analyses using G*power 3.1: Tests for correlation and regression analyses. *Behavior Research Methods*, 41, 1149–1160. <https://doi.org/10.3758/BRM.41.4.1149>.
- Field, A. (2013). *Discovering statistics using IBM SPSS statistics* (4th ed.). Thousand Oaks: Sage.
- Figley, C. R. (1995). Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized. Routledge.
- Figley, C. R. (2002). Treating compassion fatigue. Brunner-Routledge.
- Flores, E., Tschann, J. M., Dimas, J. M., Pasch, L. A., & de Groat, C. L. (2010). Perceived racial/ethnic discrimination, posttraumatic stress symptoms, and health risk behaviors among Mexican American adolescents. *Journal of Counseling Psychology*, 57, 264–273. <https://doi.org/10.1037/a0020026>.
- Garcia, H. A., McGeary, C. A., Finley, E. P., McGeary, D. D., Ketchum, N. S., & Peterson, A. L. (2016). The influence of trauma and patient characteristics on provider burnout in VA post-traumatic stress disorder specialty programmes. *Psychology & Psychotherapy: Theory, Research & Practice*, 89, 66–81. <https://doi.org/10.1111/papt.12057>.
- Gorski, P. C. (2015). Relieving burnout and the “martyr syndrome” among social justice education activists: The implications and effects of mindfulness. *The Urban Review*, 47, 696–716. <https://doi.org/10.1007/s11256-015-0330-0>.
- Hemmings, C., & Evans, A. M. (2018). Identifying and treating race-based trauma in counseling. *Journal of Multicultural Counseling & Development*, 46, 20–39. <https://doi.org/10.1002/jmcd.12090>.
- Heritage, B., Rees, C. S., & Hegney, D. G. (2018). The ProQOL-21: A revised version of the professional quality of life (ProQOL) scale based on Rasch analysis. *PLoS One*, 13(2), e0193478. <https://doi.org/10.1371/journal.pone.0193478>.
- Ivicic, P., & Motta, R. (2017). Variables associated with secondary traumatic stress among mental health professionals. *Traumatology*, 23, 196–204. <https://doi.org/10.1037/trm0000065>.
- Kang, H. K., & Burton, D. L. (2014). Effects of racial discrimination, childhood trauma, and trauma symptoms on juvenile delinquency in African American incarcerated youth. *Journal of Aggression, Maltreatment, & Trauma*, 25, 1109–1125. <https://doi.org/10.1080/10926771.2014.968272>.

- Kilpatrick, D. G., Resnick, H. S., Milanak, M. E., Miller, M. W., Keyes, K. M., & Friedman, M. J. (2013). National estimates of exposure to traumatic events and PTSD prevalence using DSM-IV and DSM-5 criteria. *Journal of Traumatic Stress*, 26, 537–547. <https://doi.org/10.1002/jts.21848>.
- Kirkinis, K., Pieterse, A. L., Martin, C., Agiliga, A., & Brownell, A. (2018). Racism, racial discrimination, and trauma: A systematic review of social science literature. *Ethnicity & Health*, 1–21. <https://doi.org/10.1080/13557858.2018.1514453>.
- Maslach, C. (2003). *Burnout: The cost of caring*. Malor Books.
- Nadal, K. L. (2018). *Microaggressions and traumatic stress: Theory, research, and clinical treatment*. American Psychological Association.
- Pearlman, L. A., & Saakvitne, K. W. (1995). Treating therapists with vicarious traumatization and secondary traumatic stress disorders. In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 150–177). Routledge.
- Pew Research Center (2019). *Race in America 2019*. Retrieved from <https://www.pewsocialtrends.org/2019/04/09/race-in-america-2019/>.
- Ponds, K. T. (2013). The trauma of racism: America's original sin. *Reclaiming Children & Youth*, 22, 22–24.
- Ratts, M. J., Singh, A. A., Nassar-McMillan, S., Butler, S. K., & McCullough, J. R. (2016). Multicultural and social justice counseling competencies: Guidelines for the counseling profession. *Journal of Multicultural Counseling & Development*, 44, 28–48. <https://doi.org/10.1002/jmcd.12035>.
- Sodeke-Gregson, E. A., Holtum, S., & Billings, J. (2013). Compassion satisfaction, burnout, and secondary traumatic stress in UK therapists who work with adult trauma clients. *European Journal of Psychotraumatology*, 4, 1–10. <https://doi.org/10.3402/ejpt.v4i0.21869>.
- Stamm, B. H. (2002). Measuring compassion satisfaction as well as fatigue: Developmental history of the compassion satisfaction and fatigue test. In C. R. Figley (Ed.), *Treating compassion fatigue* (pp. 107–119). New York: Brunner-Routledge.
- Stamm, B. H. (2010). The concise ProQOL manual. Retrieved from: https://proqol.org/uploads/ProQOL_Concise_2ndEd_12-2010.pdf
- Thompson, I. A., Amatea, E. S., & Thompson, E. S. (2014). Personal and contextual predictors of mental health counselors' compassion fatigue and burnout. *Journal of Mental Health Counseling*, 36, 58–77. <https://doi.org/10.17744/mehc.36.1.p61m73373m4617r3>.
- Toporek, R. L., Lewis, J. A., & Crethar, H. C. (2009). Promoting systemic change through the ACA advocacy competencies. *Journal of Counseling & Development*, 87, 260–268.
- Wei, M., Wang, K. T., Heppner, P. P., & Du, Y. (2012). Ethnic and mainstream social connectedness, perceived racial discrimination, and posttraumatic stress symptoms. *Journal of Counseling Psychology*, 59, 486–493. <https://doi.org/10.1037/a0028000>.
- Wilkinson, C. B., Infantolino, Z. P., & Wacha-Montes, A. (2017). Evidence-based practice as a potential solution to burnout in university counseling center clinicians. *Psychological Services*, 14, 543–548. <https://doi.org/10.1037/t62096-000>.
- World Health Organization (2003). *Advocacy for mental health*. Retrieved from https://www.who.int/mental_health/policy/services/1_advocacy_WEB_07.pdf?ua=1

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