8-13-2019

Moral Distress, Wellness, and Professional Quality of Life in Play Therapists

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Recommended Citation

Tolleson, Ashley and Zeligman, Melissa, "Moral Distress, Wellness, and Professional Quality of Life in Play Therapists." Dissertation, Georgia State University, 2019.
doi: https://doi.org/10.57709/15077049

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This dissertation, MORAL DISTRESS, WELLNESS, AND PROFESSIONAL QUALITY OF LIFE IN PLAY THERAPISTS, by ASHLEY TOLLESON, was prepared under the direction of the candidate's Dissertation Advisory Committee. It is accepted by the committee members in partial fulfillment of the requirements for the degree, Doctor of Philosophy, in the College of Education & Human Development, Georgia State University.

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MORAL DISTRESS, WELLNESS, AND PROFESSIONAL QUALITY OF LIFE IN PLAY THERAPISTS

by

ASHLEY TOLLESON

Under the Direction of Dr. Melissa Zeligman

ABSTRACT

Play therapy is a developmentally appropriate form of therapy for children that uses their natural mode of communication-play-to help them process experiences, thoughts, and feelings (Kottman, 2011; Kottman & Meany-Walen, 2016; Landreth, 1991). The unique nature of play therapy, however, is hypothesized to be more emotionally demanding and thus has potential for increased levels of work-related stress (Eastwood & Ecklund, 2008; McGarry et al., 2013; Perron & Hiltz, 2006; Van Hook & Rothenburg, 2009). This study investigated the relationships among moral distress, wellness, and professional quality of life (i.e., compassion satisfaction, burnout, and secondary traumatic stress) in Registered Play Therapists, Registered Play Therapist-Supervisors, and School Based-Registered Play Therapists (N = 161). Results indicated wellness was positively correlated with both burnout and secondary traumatic stress and negatively correlated with compassion satisfaction. Additionally, more experienced play therapists had higher levels of moral distress. Both moral distress and wellness were significant predictors for burnout; however, only wellness was a significant predictor for compassion satisfaction and secondary traumatic stress. Finally, play therapists overwhelmingly indicated creativity as an integral part of their wellness endeavors.

INDEX WORDS: Moral distress, compassion satisfaction, burnout, wellness, play therapy

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A Dissertation

Presented in Partial Fulfillment of Requirements for the

Degree of

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the College of Education and Human Development

Georgia State University

Atlanta, GA
2019

DEDICATION

"If we look at the world conscious of both of our eyes, we will see peace and violence, love and hate, joy and pain… there is a bittersweet taste to this human reality" (Freyd, 1996, p.3).

"How could we have the ability to contribute to a journey of hope and healing and not use it? There is no other work that we would find this meaningful, challenging, and rewarding. What other work would allow us to engage fully – our minds, our hearts, our spirits? How could we choose not to do something that demands our creativity, all of our intellectual capacity, all of our feelings, and our whole humanity?" (Pearlman & Saakvitne, 1995, p. 400)

This dissertation is dedicated to play therapists who are committed to serving and advocating for children and adolescents. I applaud your strength and your passion for helping hold a microphone up to little voices.

ACKNOWLEDGMENTS

I would foremost like to thank my committee chair Dr. Melissa Zeligman and committee members Dr. Catharina Chang, Dr. Franco Dispenza, and Dr. Tiffany McNary for their guidance and support throughout my doctoral program. I would also like to thank my friend and colleague Mary Huffstead for her encouragement, validation, and accountability during the writing process – I truly do not know how I could have done this without her. Next, I would like to thank my partner, Ignacio Garcia, for his unconditional love and support and for helping me to believe in myself. Lastly, I would like to thank my mother Wendy Tolleson, father Glen Tolleson, and brother Chris Tolleson for helping me remember to take care of myself, that family is everything, and that "it'll always work out, it always does."

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CHAPTER 1

MORAL DISTRESS, WELLNESS, AND PROFESSIONAL QUALITY OF LIFE IN PLAY THERAPISTS

Play therapy is a developmentally appropriate form of therapy for child clients (Kottman, 2011; Kottman & Meany-Walen, 2016; Landreth, 1991, 2012). The unique nature of play therapy, however, is hypothesized to be more emotionally demanding and thus brings potential for increased levels of work-related stress (Creamer & Liddle, 2005; Cunningham, 2004; Eastwood & Ecklund, 2008; McGarry et al., 2013; Perron & Hiltz, 2006; The National Child Traumatic Stress Network, 2011; Van Hook & Rothenburg, 2009). Though the importance of professional counselors' wellness and self-care strategies has been extensively researched and endorsed as an ethical obligation by many professional organizations, there are no published quantitative studies to date related specifically to play therapists' wellness attitudes and experiences (ACA Code of Ethics, 2014; ASCA Ethical Standards, 2016; NASW Code of Ethics, 2017; Play Therapy Best Practices, 2012).

Falender and Shafranske (2004) highlighted the impact of the mental state of a counselor on clients by stating it is "essential for clinicians to develop an understanding of all the influences, from conscious beliefs and culturally embedded values to unresolved conflicts at the margin of awareness, that contribute to clinical practice" (p. 81). Further, they suggest a main goal of counselor development is to increase awareness of personal values and beliefs that can influence and guide therapeutic processes. Stoltenberg and McNeill (2010) added to this point by distinguishing advanced counselors from counselors-in-training partially based on a counselor's level of self-awareness.

While counselor beliefs, values, and self-awareness have been studied considerably (Falender & Shafranske, 2004; Stoltenberg and McNeill; 2010), other factors which may impact the process of counseling have received much less attention. One such factor, moral distress (i.e., feeling constrained from acting in accordance with one's beliefs and values due to an organizational setting's conflicting policies or practices), has received very little attention in the counseling literature, especially with counselors who work with children and adolescents (Mathieu, 2012; Nuttgens & Chang, 2013). Given the unique characteristics of counseling this population (e.g., increased emotional demand), which may make play therapists particularly vulnerable to moral distress, this variable has a place when considering play therapist wellness. This study seeks to address this gap in the literature by investigating the relationships among moral distress, wellness, and professional quality of life (i.e., compassion satisfaction, burnout, and secondary traumatic stress) in Registered Play Therapists, Registered Play Therapist-Supervisors, and School Based-Registered Play Therapists.

Play Therapy

Play therapists use children's natural mode of communication – play – to help children process experiences, thoughts, and feelings in a developmentally appropriate way (Kottman & Meany-Walen, 2016). The beneficial outcomes of play therapy and the unique challenges that accompany working with children and adolescents have been established in the literature (Bodenhorn, 2006; Dailor & Jacob, 2011; Garland, McCabe, Yeh, 2008; Hall & Lin, 1995; Koocher, 2008); however, much less is known about the potential consequences it can have on play therapists themselves. Play therapists often work with children or adolescents who have experienced neglect, abuse, and trauma, which increases their likelihood for more significant levels of work-related stress (Meany-Walen, et al., 2018). Webb (2007) argues working with

children can be more emotionally taxing on professional therapists than those working with adult clients because children naturally provoke therapists' desires to protect and nurture. Additionally, play therapists' work is often described as "baring witness" to children's adverse experiences, which may further increase the likelihood to experience symptoms of burnout or vicarious trauma (Webb, 2007). Gil (2006) referenced the work of play therapists specifically as demanding and draining of personal resources, where some end up changing professions and experience periods of depression and fatigue.

Inherent in the nature of working with children and adolescents, play therapists additionally often face ethical dilemmas related to legal and best practice standards, workplace policy, and the managed care system (Turnage-Butterbaugh, 2015). Turnage-Butterbaugh (2015) suggested that these counselors often have significantly less power in providing the best possible care for their child clients, especially when other entities are involved, including Child Protective Services (CPS) or the Division of Family and Children Services (DFCS). Although intended to protect children and adolescents from undue harm, parent assent and the right to access their children's health care procedures and progress, for example, may create a conflict in determining what is in the client's best interest. Those younger than 18 years old are viewed as incompetent in their decision-making skills regarding their mental health treatment, and thus adults often assume responsibility of children by making treatment choices on their behalf (Hall & Lin, 1995). Confidentiality further presents play therapists with difficult decisions regarding the extent and focus of their responsibility (Lawrence & Kurpius, 2000).

The introduction of managed care across the mental health care field has also created substantial ethical challenges for play therapists. The context of mental health care has seen dramatic changes over the last several decades (Kent & Hersen, 2000). Originally aiming to

provide low-cost efficient services, new delivery models have also resulted in a loss of autonomy and an increase in professional demands for counselors. With a focus on cost effectiveness and limited resources, there is a sense that clients receive care based on what the managed care system can provide rather than what is considered best practice (Kent & Hersen, 2000; Turnage-Butterbaugh, 2015). These systemic changes are often exacerbated by the training and clinical orientations that run contradictory to the managed health care model. Counselors increasingly find it difficult to meet ethical aspirations and provide professional care that respects the rights of their clients and helps promote well-being and autonomy (Blanck & DeLeon, 1996).

In working with children and adolescents, issues of autonomy, justice, and beneficence become more pronounced due to the age of the client, developmental processes, family involvement, and vulnerability of the youth (Turnage-Butterbaugh, 2015). Play therapists in particular may find it challenging to follow a child-centered approach, for example, when their place of work and insurance companies require specific evidenced-based interventions. Legal and ethical implications add to the complexity of providing care for youth as individual therapists and multidisciplinary teams attempt to work through complex issues. Ongoing unresolved ethical conflict can impact the functioning of the multidisciplinary team and the care given to the client (Lutzen & Schreiber, 1998; Wilkinson, 1988). Unresolved ethical conflict can also lead to *moral distress*, an experience whereby professionals will set aside values and act in ways that severely compromises their moral integrity (Musto & Schreiber, 2012). If this moral distress is left unresolved, it can accumulate over time and have lasting, negative effects (Webster & Baylis, 2000). Because of the unique challenges accompanying clinical work with children and adolescents (Bodenhorn, 2006; Hall & Lin, 1995; Lawrence & Kurpius, 2000), the current study limits the exploration of moral distress and professional quality of life to

Registered Play Therapists, Registered Play Therapist-Supervisors, and School Based-Registered Play Therapists.

The Association for Play Therapy (APT) defines play therapist as "licensed mental health professionals who have earned a master's or doctorate degree in a mental health field and obtained considerable general clinical experience and supervision." Registered Play Therapists (RPT), Registered Play Therapist-Supervisors (RPT-S), and School Based-Registered Play Therapists (SB-RPT) are licensed professionals who have obtained additional education, training, and supervised experience in the field of play therapy. Specifically, RPT's are professionals who hold a full clinical mental health license (i.e., LCSW, LPC, LMFT, LCP), have accrued at least 500 direct client contact hours of supervised clinical play therapy experience, 50 hours of play therapy supervision, and 150 hours of play therapy specific instruction. RPT-S's meet the requirements for RPT as well as an additional 500 hours of direct client contact hours of supervised clinical play therapy experience, three years and 3,000 direct client contact hours of clinical experience after initial full licensure, at least six hours of play therapy specific supervisor training and 24 hours of supervisor training, and either state board requirements for supervisor training or APT's supervisor requirements. Lastly, SB-RPT's are professionals who hold a license or certification in school counseling or school psychology, have completed two additional years of continuous work in a school setting post licensure or certification, 150 hours of play therapy specific instruction, a minimum of 600 direct client hours utilizing play therapy plus 50 hours of simultaneous play therapy supervision, and must have been supervised by an RPT-S for no less than one year.

In order to maintain these credentials, an RPT/S or SB-RPT must renew annually through the APT, earn at least 18 clock hours of graduate-level play therapy continuing

education every 36 months, and maintain membership with the APT. These factors contribute to the rationale for focusing the present study on this particular population of play therapists, as well as the reasonable assumption described in Meany-Walen, et al.'s (2018) qualitative study of play therapists' wellness perceptions: "professionals with RPT/S status respect and value the therapeutic powers of play and use it in their regular clinical practice with children" (p. 178)

Moral Distress

Nuttgens and Chang (2013) define moral distress as the "experience that follows when one feels constrained from acting according to what one believes to be ethically correct" (p. 284). Specifically, it refers to the organizational setting and its policies and practices that may conflict with the practitioner's own beliefs and values (Mathieu, 2012). For example, working in a time limited setting and offering six sessions to clients with complex problems. This can lead to feelings of helplessness, powerlessness, and disillusionment in the therapist (Ferrell, 2006; Pendry, 2007; Simms & McGibbon, 2016; Wilson, Goettemoeller, Bevan, & McCord, 2013). Additionally, Nuttgens and Chang (2013) point out how power imbalances between nurses and physicians are generally common components of moral distress, similar to the power differential between counseling supervisors and supervisees (Bernard & Goodyear, 2013; Gray, Ladany, Ancis, & Walker, 2001).

Moral distress is a relatively new concept that has grown in health care research, yet after an extensive literature review, the author found it to be essentially nonexistent within the mental health care literature. Only two studies were found related to moral distress and mental health care; specifically, the researchers examined the experience of moral distress among psychologists and psychiatrists (Austin, et al., 2005; Austin, Kagan, et al., 2005). Wilkson (1988) conducted the first study on moral distress among nurses and developed an exploratory

conceptualization of moral distress, which included its detrimental effects to personal and professional wellness. What has been both speculated about and supported by the literature is that moral distress has both a psychological and physiological impact (Austin et al., 2003; Kelly, 1998; Wilkinson, 1988). Moral distress in nurses has been associated with psychological discomfort and low patient safety standards, for example, dysfunctional communication among clinicians, medication errors, and dysfunctional work attitudes, including burnout, intention to quit the work, and low job satisfaction (Austin, Saylor, & Finley, 2017; Maiden, Georges, & Connelly, 2011). It was originally defined as the feeling that nurses experience when institutional constraints prevent the ethically appropriate course of action from being carried out (Jameton, 1984). Using both qualitative and quantitative methods, researchers have sought to develop a greater understanding of the concept of moral distress and have identified some of the factors that impact the experience of moral distress, as well as the outcomes of moral distress (Austin et al., 2003: Corley, 2002; Corley et al., 2005; Pauly et al., 2009; Redman & Fry, 2000; Wilkinson, 1988).

Corley et al. (2001) were the first to formally identify common situations that caused moral distress. These situations were then included in the construction of the Moral Distress Scale (MDS), which has since been associated with job dissatisfaction, turnover in the workplace, and an overall negative impact to one's professional quality of life (Corley, 2002: de Veer, Francke, Stuijs, & Willems, 2013; Sung, Seo, & Kim, 2012). Corey and colleagues (2001) research showed that 15% of participants left a previous position as a result of the moral distress they were experiencing. Additionally, Hart's (2005) study explored the connection between hospital ethical climate and nurses' turnover intentions and found that ethical climate was an important consideration in nurses' decision to leave a position or the profession overall.

The experience of moral distress has mainly been studied in nurses working on inpatient units or in medical settings within specialty areas such as intensive care, oncology, and medical/surgical units, with little attention given to the area of mental health (Austin et al., 2003; Corley et al., 2001; Corley et al., 2005). The construct of moral distress has now been evolving by including professionals from other disciplines (i.e., police force, education administration, hospital social work, occupational therapy; Ulrich et al., 2007). However, there remains a scarcity of research in the area of mental health and the experience of moral distress.

Feelings of powerlessness is an essential component to moral distress, and one that reveals a connection between the concept of moral distress and clinical work with children and adolescents (Turnage-Butterbaugh, 2015). Serving child and adolescent clients provides a privileged position for the therapist to participate in positive change and growth. However, the actual reality of practice can be quite challenging to play therapists' quality of life as the practitioner aims to offer conditions of unconditional positive regard and safety (Rogers, 1957) to clients while simultaneously witnessing countless negative stories and observing physical and psychological distress (Simms, 2017).

Professional Quality of Life

In working with children and adolescents, play therapists are frequently exposed to contextual factors that present ethical challenges. As a result, such counselors often find it difficult to adhere to ethical or legal standards of care while still doing what is best for the client (Dugger, 2007). Dugger (2007) noted that children lack considerable control over their lives and are vulnerable to the consequences of the decisions made by important adults, therefore creating a complex and delicate counseling process for both counselor and youth client. Juggling aspects of life and work can lead to therapists feeling overwhelmed, which if not identified and

managed, can leave them vulnerable to occupational hazards such as compassion fatigue, burnout, and secondary traumatic stress (Mathieu, 2012).

Professional quality of life is the quality one feels in relation to their work as a helper and can be applied to the work of professional counselors (Stamm, 2010). Both the positive and negative aspects of doing one's job influence one's professional quality of life. It incorporates two aspects: compassion satisfaction and compassion fatigue. Compassion fatigue can be broken down into two parts: burnout and secondary traumatic stress. Professional quality of life is associated with characteristics of the work environment, the individual's personal characteristics, and the individual's exposure to primary and secondary trauma in the work setting.

Compassion Satisfaction

Compassion satisfaction is defined as the pleasure you derive from being able to do your work well or satisfaction felt from helping other people (Radey & Figley, 2007; Stamm, 2009; Stamm, 2002). For example, feeling pleasure or positively about one's work or ability to contribute to society on a larger scale. Researchers have found moral distress can actually have positive consequences, which often includes personal growth (McCarthy & Deady, 2008), increased sense of autonomy (Meaney, 2002), and increased motivation (Weissman, 2009). Play therapists working with children and adolescents after crises or exposures to traumatic events, for example, can experience a high level of compassion satisfaction, especially when they employ self-care strategies that foster their internal and external resources (Webb, 2007).

Compassion Fatigue

On the other side of compassion satisfaction is compassion fatigue, which is the negative aspect of helping those who experience traumatic stress and suffering and the most commonly understood consequence of moral distress (Turnage-Butterbaugh, 2015). According to Stamm

(2009), there are two components: burnout and secondary traumatic stress. The first part (burnout) can include exhaustion, frustration, anger, and depression. Whereas, secondary traumatic stress is a negative feeling driven by fear and work-related trauma (Stamm, 2009).

Compassion fatigue is defined as a state of tension and preoccupation with a traumatized client by re-experiencing the traumatic events (Figley, 2002). Figley (2002) noted that clinicians experiencing compassion fatigue often engage in avoiding/numbing reminders that are associated with the client, causing persistent arousal (e.g., anxiety). It is often referenced as a function of baring witness to the suffering of others, where our capacity or interest in helping reduces (Figley, 2002). Simms (2017) simply defined compassion fatigue as "being tired of listening to sad stories" (p. 48).

Burnout. Burnout is "…. a state of physical, emotional, and mental exhaustion caused by long-term involvement in emotionally demanding situations" (Pines & Aronson, 1988, p. 9). It is one of the elements of compassion fatigue, according to Stamm (2009), and is associated with feelings of hopelessness and difficulties in dealing with work or in doing one's job effectively. These negative feelings tend to have a gradual onset and are often associated with a high workload or a non-supportive work environment.

The core concept of professional burnout is emotional exhaustion, or experiences of psychological fatigue related to work conditions (Turnage-Butterbaugh, 2015). While in this state, one's drive is replaced by tiredness, cynic behavior, and low motivation. Experiences of emotional exhaustion in nurses have been linked with both moral distress and secondary traumatic stress, as well as reduced productivity, low job satisfaction, high rates of resignations and turnover, low patient safety standards, and mental distress (i.e., anxiety and depressive symptoms). It is well documented in the literature that burnout may have serious consequences

for clinicians, their clients, and the larger organizations in which they are employed (Lloyd & King, 2001). Studies using the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1981) have shown burnout among practitioners to be linked to work-related problems such as low morale, absenteeism, and staff turnover (Lloyd & King, 2001; Maslach, 2003). Additionally, Lloyd and King (2001) discovered burnout may also create personal problems including physical exhaustion, insomnia, substance abuse, mental health problems, and martial and family conflict. A study examining perceived training needs of Registered Play Therapist-Supervisors also mentions detecting and addressing burnout in play therapists-in-training as an important issue (Fall, Drew, and Chute, 2007). In sum, burnout is another occupational risk for practitioners who work with children and adolescents after crises and traumatic exposures (Webb, 2015), though research thus far has mainly focused on social workers who work with children (Kraus, 2005; Kruger, Bernstein, & Botman, 1995), school counselors (Collins, 2014), and counselors who work with adults (Savicki & Cooley, 1987; Skovholt & Mathison, 2014).

Secondary Traumatic Stress. The second component of compassion fatigue is secondary traumatic stress (Stamm, 2009). Work-related, secondary exposure to extremely or traumatically stressful events leads to the usually rapid onset of upsetting feelings, including being afraid, having difficulty sleeping, having images of the upsetting events pop into your mind, or avoiding things that remind you of the event (Stamm, 2009). Counselors often hear their clients' stories about traumas they have experienced and can develop problems due to this repeated exposure. Figley (1995) defined secondary traumatic stress as "the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other-the stress resulting from helping or wanting to help a traumatized or suffering person" (p. 7). In particular, the crises, trauma, and loss can create a heightened risk of indirect

or secondary trauma for counselors (Cunningham, 2004; Figley, 1995; Jenkins & Baird, 2002). Lonergan, O'Halloran, and Crane (2004) found secondary traumatic stress was a common bi-product of working with children who have experienced trauma for child therapists in their qualitative study on the developmental process of becoming a trauma specialist. Given the unique characteristics and potentially increased emotional demand of counseling children and adolescents, play therapists may face an increased risk for a decrease in professional quality of life and subsequently overall counselor wellness (Creamer & Liddle, 2005; Cunningham, 2004; Eastwood & Ecklund, 2008; McGarry et al., 2013; Perron & Hiltz, 2006; Pines & Aronson, 1988; The National Child Traumatic Stress Network, 2011; Van Hook & Rothenburg, 2009; Webb, 2007).

Wellness

Wellness is often defined as a state of physical, mental, and social well-being (WHO, 1967). Many conceptualizations of wellness emphasize it as a positive state and not just nonsickness or the absence of disease (Adams et al., 1997; Dunn, 1977; Edlin, 1988). Areas of health or strength are often the focus of wellness, including people's movement toward health and integration of cognitive, emotional, physical, and spiritual dimensions (Egbert, 1980; Meany-Walen, Davis-Gage, & Lindo, 2016). Myers et al. (2000) defined wellness as

> A way of life oriented toward optimal health and well-being, in which body, mind, and spirit are integrated by the individual to live life more fully within the human and natural community. Ideally, it is the optimum state of health and well-being that each individual is capable of achieving (p. 252).

Those who work in a helping profession are often faced with risks to their wellness and occupational hazards that can have tremendous influence on their professional and personal lives

(Meany-Walen et al., 2018). Recently, mental health communities, such as the fields of psychiatry, social work, and counseling, have given great attention to the importance of provider wellness (Bercier & Maynard, 2015; Elwood, Mott, Lohr, & Galovski, 2011; Lawson & Myers, 2011; Lenz & Smith, 2010; Meany-Walen, Davis-Gage, & Lindo, 2016). In addition, ethical standards of several primary helping professions have even identified provider self-care as an ethical obligation (American Counseling Association, 2014; American Psychological Association, 2010; American School Counseling Association, 2016; National Association of Social Workers, 2008).

The field of counseling is a wellness-oriented, strengths-based approach to optimizing human growth and development. Professional counselors in particular seek to encourage wellness through preventative interventions and are trained in a positive, holistic philosophy that advocates for optimum health and wellness in society (Myers & Sweeney, 2005a). The literature emphasizes self-care as an essential strategy to promote the ongoing positive development of practitioners' minds, bodies, emotions, and spirits (Webb, 2015). Saakvitne et al. (2000) suggested counselors should engage in self-care strategies that target their physical, psychological, cognitive, behavioral, interpersonal, and spiritual well-being. For example, adequate sleep and nutrition as well as activities that increase strength, endurance, clarity of mind, and feelings of well-being are vital to maintaining physical and mental health (Saakvitne et al., 2000). However, Cunningham (2004) noted that it is important for practitioners to identify exercises that fit their specific lifestyles.

Psychological and emotional self-care strategies can also reduce practitioners' symptoms of physical arousal (Gamble, 2002; Jenkins & Baird, 2002). Daily relaxation practices, including guided imagery and breathing exercises or spending time in nature, are consistently

recommended in the literature as helpful strategies (Cunningham, 2004; Gamble, 2002; Yassen, 1995). Similarly, self-care strategies can address cognitive and behavioral skill development, including assertiveness training, stress management, time management, and individual and group communication skills training (Yassen, 1995). Spiritual practices, including meditation, have also been shown to be helpful self-care strategies (Brown & Ryan, 2003). Practitioners generally report that such practices increase their feelings of well-being (Cunningham, 2004). Meditation and other spiritual practices have been shown to offer such benefits as lowering blood pressure, improving breathing, relaxing muscles, and increasing feelings of hope and well-being among practitioners (Trippany et al., 2004).

Creative activities can also help practitioners process psychological and emotional reactions, and thus prevent or remediate burnout and secondary traumatic stress (Webb, 2015). Such activities include writing, poetry, drama, photography, cooking, drawing, painting, dancing, playing music, and journal writing (Webb, 2015). It is speculated that different coping skills may be needed to *combat* stressful situations than the skills used to *prevent* stressful situations (Simpson & Starkey, 2006). Relatedly, in an exploratory, qualitative study on play therapist perceptions of wellness and self-care, Meany-Walen et al. (2018) discovered that when asked directly about play therapy strategies used to aid in their wellness endeavors, 97% of participants identified at least one way they used the concepts of play therapy, including coloring, dancing, listening to music, playing games, and doing sandtray. The authors suggested additional research exploring play therapists' self-care strategies and their potentially uniquely creative focus and their relationship to professional impairment.

Implications and Recommendations

In order to effectively serve child clients, Registered Play Therapists need to better conceptualize the stressors involved with being a child and adolescent counselor. There is a need to address gaps in the literature regarding investigating moral distress and professional quality of life in Registered Play Therapists. Yet, after an extensive literature search, no published accounts of quantitative research were found to elaborate specifically on play therapists' wellness attitudes and experiences. Further, no research was found confirming the effectiveness of specific self-care strategies for play therapists in particular. Several notable play therapists have suggested strategies to help maintain or improve play therapists' wellness, for example increasing personal awareness, pursuing training opportunities, having a caseload of varied clients with limited exposure to trauma, maintaining personal relationships and identity, and using a professional support network (Kottman, 2011; Webb, 2007). However, no research articles were found that provided evidence to support those suggestions. Several ideas have been offered to help alleviate or prevent the symptoms of impairment in professional counselors in general, not necessarily specific to those working with children and adolescents; including practicing self-care that involves wellness activities such as being with friends and family, exercising, limiting crisis or trauma clients in one's caseload, consulting with other professionals, and participating in certain cognitive-behavioral interventions designed for therapist who experience vicarious trauma (Bercier & Maynard, 2015; Dunkley & Whelan, 2006; Lonergan et al., 2004; Figley, 2002; Smith & Koltz, 2015).

It is vital play therapists continue to work with their child and adolescent clients with empathy and compassion; however, there is often a stigma associated with discussing personal or professional struggles that may be impacting clinical work. Figley (2002) equated this stigma with the silencing often experienced by clients, "The conspiracy of silence among the profession

about this compassion fatigue is no different than the silence about family violence, racism, and sexual harassment." Therefore, it is essential not only for clinicians themselves to continually reflect on their own mental and physical state, but also supervisors, colleagues, and professional mentors to provide routine opportunities for open communication. Utilizing the Self-Test for Psychotherapists (Stamm & Figley, 1999), for example, can offer a rough estimate of the respondent's level of satisfaction with their work and risk of burnout and compassion fatigue and could be used by play therapists in supervision sessions or on their own time as a platform for checking-in with oneself and creating an effective self-care plan. As previously mentioned, Meany-Walen and Kottman (2018) outlined recommendations for self-care from play therapists in their qualitative study on self-care practices, including time alone without tending to others' needs, engaging in supportive relationships outside of professional relationships, setting boundaries, reducing crisis client load, and attending regular supervision or consultation appointments. Additionally, the authors noted that participants suggested using some aspect of play or creativity in self-care strategies or wellness plans.

With our understanding of moral distress and professional quality of life for a variety of helping professionals and the impacts of wellness and self-care practices, we must begin to look at the work of Registered Play Therapists. Further, it is important to also examine aspects that may buffer the impacts of moral distress. In this case, I recommend researchers look at the ways wellness and self-care practices can buffer symptoms of moral distress. Specific research questions that need to be addressed include investigating the within-group relationships between moral distress, wellness, and professional quality of life. Does moral distress predict professional quality of life? Does wellness moderate the relationships between moral distress and compassion

satisfaction, burnout, or secondary traumatic stress? It would also be important to examine group differences in professional quality of life based on demographic factors.

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CHAPTER 2

INVESTIGATING MORAL DISTRESS, WELLNESS, AND PROFESSIONAL QUALITY OF LIFE IN PLAY THERAPISTS

Introduction

Play therapy is a developmentally appropriate form of therapy for child clients (Kottman, 2011; Kottman & Meany-Walen, 2016; Landreth, 1991, 2012). The unique nature of play therapy, however, is hypothesized to be more emotionally demanding than other forms of counseling and thus has a potential for increased levels of work-related stress (Creamer & Liddle, 2005; Cunningham, 2004; Eastwood & Ecklund, 2008; McGarry et al., 2013; Perron & Hiltz, 2006; The National Child Traumatic Stress Network, 2011; Van Hook & Rothenburg, 2009). Though the importance of mental health workers' wellness and self-care strategies has been extensively researched and endorsed as an ethical obligation by many professional organizations (ACA Code of Ethics, 2014; ASCA Ethical Standards, 2016; NASW Code of Ethics, 2017; Play Therapy Best Practices, 2012), there are no published quantitative studies to date related specifically to play therapists' wellness attitudes and experiences.

While professional counselor beliefs and values have been studied considerably, as well as counselor self-awareness (Falender & Shafranske, 2004; Stoltenberg and McNeill; 2010), other factors which may impact the process of counseling have received much less attention. One such factor, moral distress (i.e., feeling constrained from acting in accordance with one's beliefs and values due to an organizational setting's conflicting policies or practices), has received very little attention in the counseling literature, especially with counselors who work with children and adolescents (Mathieu, 2012; Nuttgens & Chang, 2013). Given the unique characteristics of counseling this population (e.g., increased emotional demand), which may make play therapists

particularly vulnerable to moral distress, this variable has a place when considering play therapist wellness. This study seeks to address this gap in the literature by investigating the relationships among moral distress, wellness, and professional quality of life (i.e., compassion satisfaction, burnout, and secondary traumatic stress) in Registered Play Therapists, Registered Play Therapist-Supervisors, and School Based-Registered Play Therapists.

Play Therapy

Play therapy is a treatment modality which brings the therapist and therapy to the level of the child or adolescent client. Because children's language does not develop at the same rate as their cognitive development, they communicate through play. In play therapy, toys are viewed as the child's words and play as the child's language (Landreth & Bratton, 1999). Virginia Axline (1969) noted in her original work on play therapy, "There is a frankness, and honesty, and a vividness in the way children state themselves in a play situation" (p. 1). In this way, play therapists use play to help children process experiences, thoughts, and feelings in a developmentally appropriate way (Kottman & Meany-Walen, 2016). It offers a way to engage children on *their* terms and gives them an opportunity to, "play through what adults talk through" (Homeyer, 2003, p. 163). By acting out through play a frightening or traumatic experience symbolically, children are able to move toward an inner resolution and are then better able to cope with or adjust to problems (Landreth & Bratton, 1999).

The beneficial outcomes of play therapy and the unique challenges that accompany working with children and adolescents have been established in the literature (Bodenhorn, 2006; Dailor & Jacob, 2011; Garland, McCabe, & Yeh, 2008; Hall & Lin, 1995; Koocher, 2008); however, much less is known about the potential consequences it can have on play therapists themselves. Some argue that working with children can be more emotionally taxing on

professional therapists than those working with adult clients because children naturally provoke therapists' desires to protect and nurture (Webb, 2007). Additionally, play therapists' work is often described as "baring witness" to children's adverse experiences, which may further increase susceptibility to burnout or vicarious trauma (Webb, 2007). Gil (2006) referenced the work of play therapists specifically as demanding and draining of personal resources, where some end up changing professions and experience periods of depression and fatigue.

In working with children and adolescents, issues of autonomy, justice, and beneficence become more pronounced due to the age of the client, developmental processes, family involvement, and vulnerability of the youth (Turnage-Butterbaugh, 2015). Legal and ethical implications add to the complexity of providing care for youth as individual therapists and multidisciplinary teams attempt to work through complex issues. Ongoing unresolved ethical conflict can impact the functioning of the multidisciplinary team and the care given to the client (Lutzen & Schreiber, 1998; Wilkinson, 1988). Unresolved ethical conflict can also lead to *moral distress*, an experience whereby professionals will set aside values and act in ways that severely comprises their moral integrity (Musto & Schreiber, 2012). If this moral distress is left unresolved, it can accumulate over time and have lasting, negative effects (Webster & Baylis, 2000). Because of the unique challenges accompanying clinical work with children and adolescents (Bodenhorn, 2006; Hall & Lin, 1995; Lawrence & Kurpius, 2000), the current study limits the exploration of moral distress and professional quality of life to Registered Play Therapists, Registered Play Therapist-Supervisors, and School Based-Registered Play Therapists.

The Association for Play Therapy (APT) defines play therapist as "licensed mental health professionals who have earned a master's or doctorate degree in a mental health field and

obtained considerable general clinical experience and supervision." Registered Play Therapists (RPT), Registered Play Therapist-Supervisors (RPT-S), and School Based-Registered Play Therapists (SB-RPT) are licensed professionals who have obtained additional education, training, and supervised experience in the field of play therapy. Specifically, RPT's are professionals who hold a full clinical mental health license (i.e., LCSW, LPC, LMFT, LCP), have accrued at least 500 direct client contact hours of supervised clinical play therapy experience, 50 hours of play therapy supervision, and 150 hours of play therapy specific instruction. RPT-S's meet the requirements for RPT as well as an additional 500 hours of direct client contact hours of supervised clinical play therapy experience, three years and 3,000 direct client contact hours of clinical experience after initial full licensure, at least six hours of play therapy specific supervisor training and 24 hours of supervisor training, and either state board requirements for supervisor training or APT's supervisor requirements. Lastly, SB-RPT's are professionals who hold a license or certification in school counseling or school psychology, have completed two additional years of continuous work in a school setting post licensure or certification, 150 hours of play therapy specific instruction, a minimum of 600 direct client hours utilizing play therapy plus 50 hours of simultaneous play therapy supervision, and must have been supervised by an RPT-S for no less than one year.

In order to maintain these credentials, an RPT/S or SB-RPT must renew annually through the APT, earn at least 18 clock hours of graduate-level play therapy continuing education every 36 months, and maintain membership with the APT. These factors contribute to the rationale for focusing the present study on this particular population of play therapists, as well as the reasonable assumption described in Meany-Walen, et al.'s (2018) qualitative study of

play therapists' wellness perceptions: "professionals with RPT/S status respect and value the therapeutic powers of play and use it in their regular clinical practice with children" (p. 178)

Moral Distress

Moral distress is a relatively new concept that has grown in health care research yet is essentially nonexistent within the mental health care literature. Wilkson (1988) conducted the first study on moral distress among nurses and developed an exploratory conceptualization of moral distress, which included its detrimental effects to personal and professional wellness. Moral distress in nurses has been associated with psychological discomfort and low patient safety standards, for example, dysfunctional communication among clinicians, medication errors, and dysfunctional work attitudes, including burnout, intention to quit the work, and low job satisfaction (Austin, Saylor, & Finley, 2016; Maiden, Georges, & Connelly, 2011).

Nuttgens and Chang (2013) defined moral distress as the "experience that follows when one feels constrained from acting according to what one believes to be ethically correct" (p. 284). Specifically, it refers to the organizational setting and its policies and practices that may conflict with the practitioner's own beliefs and values (Mathieu, 2012). For example, working in a time limited setting and offering six sessions to clients with complex problems. Additionally, Nuttgens and Chang (2013) pointed out how power imbalances between supervisors and supervisees can also contribute to situations that cause moral distress. Corley et al. (2001) were the first to formally identify common situations that produced moral distress, which were included in the construction of the Moral Distress Scale (MDS); these situations have since been associated with job dissatisfaction, turnover in the workplace, and an overall negative impact to one's professional quality of life (Corley, 2002; de Veer, Francke, Stuijs, & Willems, 2013; Sung, Seo, & Kim, 2012). The research of Corley and colleagues (2001) showed that 15% of the

participants who were nurses in their study had left a previous position as a result of the moral distress they were experiencing.

The experience of moral distress has mainly been studied in nurses, but the construct has since been evolving by including professionals from other disciplines (i.e., police force, education administration, hospital social work, occupational therapy; Ulrich et al., 2007). However, there is a scarcity of research in the area of mental health and the experience of moral distress, with even less focus on counselors who work with children and adolescents. Only five studies were found related to moral distress and mental health care; specifically, the researchers examined the experience of moral distress among psychologists (Austin, Kagan, Rankel, & Bergum, 2005) and psychiatrists (Austin, Kagan, Rankel, & Bergum, 2007; Deady & McCarthy, 2010; Musto & Schreiber, 2012; Ohnishi et al., 2010). Additionally, only one study on moral distress and child and adolescent counselors was found (Turnage-Butterbaugh, 2015); however, no empirical studies on play therapists and moral distress exist in the literature to date.

Serving child clients provides a privileged position for the therapist to participate in positive change and growth. Yet, the actual reality of practice can be quite challenging to play therapists' quality of life. Play therapists encounter contextual factors (i.e., confidentiality and assent with a minor client) that frequently present ethical challenges in their work with children and adolescents (Bodenhorn, 2006; Hall & Lin, 1995; Lawrence & Kurpius, 2000). As a result, such counselors often find it difficult to adhere to ethical or legal standards of care while still doing what is best for the client (Dugger, 2007). For example, Dugger (2007) notes that children lack considerable control over their lives and are vulnerable to the consequences of the decisions made by important adults, therefore creating a complex and delicate counseling process for both counselor and youth client. This ongoing, work-related stress, which if not identified and

managed, can leave play therapists vulnerable to occupational hazards such as compassion fatigue, burnout, and secondary traumatic stress (Mathieu, 2012).

Professional Quality of Life

Professional quality of life is the quality one feels in relation to their work as a helper and can be applied to the work of professional counselors (Stamm, 2010). Both the positive and negative aspects of doing one's job influence one's professional quality of life. Professional quality of life incorporates two aspects: compassion satisfaction and compassion fatigue (Stamm, 2010). Compassion fatigue can then be further broken down into two parts: burnout and secondary traumatic stress (Stamm, 2010). Professional quality of life is associated with characteristics of the work environment, the individual's personal characteristics, and the individual's exposure to primary and secondary trauma in the work setting.

Compassion Satisfaction

Compassion satisfaction is defined as the pleasure you derive from being able to do your work well or satisfaction felt from helping other people (Radey & Figley, 2007; Stamm, 2009; Stamm, 2002). For example, feeling pleasure or positively about one's work or ability to contribute to society on a larger scale. Researchers have found moral distress in nurses can actually have positive consequences, which often includes personal growth (McCarthy & Deady, 2008), increased sense of autonomy (Meaney, 2002), and increased motivation (Weissman, 2009). Practitioners who work with children or adolescents after crises or exposures to traumatic events, for example, can experience a high level of compassion satisfaction, especially when they employ self-care strategies that foster their internal and external resources (Webb, 2015).

Compassion Fatigue

On the other side of compassion satisfaction is compassion fatigue, which is the negative aspect of helping those who experience traumatic stress and suffering and the most commonly understood consequence of moral distress (Turnage-Butterbaugh, 2015). According to Stamm (2009), there are two components: burnout and secondary traumatic stress. The first part (burnout) can include exhaustion, frustration, anger, and depression. Whereas, secondary traumatic stress is a negative feeling driven by fear and work-related trauma (Stamm, 2009).

Compassion fatigue is defined as a state of tension and preoccupation with a traumatized client by re-experiencing the traumatic events (Figley, 2002). Figley (2002) notes that clinicians experiencing compassion fatigue often engage in avoiding/numbing reminders that are associated with the client, causing persistent arousal (e.g., anxiety). It is often referenced as a function of baring witness to the suffering of others, where our capacity or interest in helping reduces (Figley, 2002). Simms (2017) simply defined compassion fatigue as "being tired of listening to sad stories" (p. 48).

Burnout. Burnout is "…. a state of physical, emotional, and mental exhaustion caused by long-term involvement in emotionally demanding situations" (Pines & Aronson, 1988, p. 9). It is one of the elements of compassion fatigue, according to Stamm (2009), and is associated with feelings of hopelessness and difficulties in dealing with work or in doing one's job effectively. These negative feelings tend to have a gradual onset and are often associated with a high workload or a non-supportive work environment.

The core concept of professional burnout is emotional exhaustion, or experiences of psychological fatigue related to work conditions (Turnage-Butterbaugh, 2015). While in this state, one's drive is replaced by tiredness, cynic behavior, and low motivation. Experiences of emotional exhaustion in nurses have been linked with both moral distress and secondary

traumatic stress, as well as reduced productivity, low job satisfaction, high rates of resignations and turnover, low patient safety standards, and mental distress (i.e., anxiety and depressive symptoms). It is well documented in the literature that burnout may have serious consequences for clinicians, their clients, and the larger organizations in which they are employed (Lloyd & King, 2001). Studies using the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1981) have shown burnout among practitioners to be linked to work-related problems such as low morale, absenteeism, and staff turnover (Lloyd & King, 2001; Maslach, 2003). Additionally, Lloyd and King (2001) discovered burnout may also create personal problems including physical exhaustion, insomnia, substance abuse, mental health problems, and martial and family conflict. A study examining perceived training needs of Registered Play Therapist-Supervisors also mentions detecting and addressing burnout in play therapists-in-training as an important issue (Fall, Drew, and Chute, 2007). In sum, burnout is another occupational risk for practitioners who work with children and adolescents after crises and traumatic exposures (Webb, 2015), though research thus far has mainly focused on social workers who work with children (Kraus, 2005; Kruger, Bernstein, & Botman, 1995), school counselors (Collins, 2014), and counselors who work with adults (Savicki & Cooley, 1987; Skovholt & Mathison, 2014).

Secondary Traumatic Stress. The second component of compassion fatigue is secondary traumatic stress (Stamm, 2009). Work-related, secondary exposure to extremely or traumatically stressful events leads to the usually rapid onset of upsetting feelings, including being afraid, having difficulty sleeping, having images of the upsetting events pop into your mind, or avoiding things that remind you of the event (Stamm, 2009). Counselors often hear their clients' stories about traumas they have experienced and can develop problems due to this repeated exposure. Figley (1995) defined secondary traumatic stress as "the natural consequent

behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other-the stress resulting from helping or wanting to help a traumatized or suffering person" (p. 7). In particular, the crises, trauma, and loss can create a heightened risk of indirect or secondary trauma for counselors (Cunningham, 2004; Figley, 1995; Jenkins & Baird, 2002). Lonergan, O'Halloran, and Crane (2004) found secondary traumatic stress was a common bi-product of working with children who have experienced trauma for child therapists in their qualitative study on the developmental process of becoming a trauma specialist. Given the unique characteristics and potentially increased emotional demand of counseling children and adolescents, play therapists may face an increased risk for a decrease in professional quality of life and subsequently overall counselor wellness (Creamer & Liddle, 2005; Cunningham, 2004; Eastwood & Ecklund, 2008; McGarry et al., 2013; Perron & Hiltz, 2006; Pines & Aronson, 1988; The National Child Traumatic Stress Network, 2011; Van Hook & Rothenburg, 2009; Webb, 2007).

Wellness

Wellness is often defined as a state of physical, mental, and social well-being (WHO, 1967). Areas of health or strength are often the focus of wellness, including people's movement toward health and integration of cognitive, emotional, physical, and spiritual dimensions (Egbert, 1980; Meany-Walen, Davis-Gage, & Lindo, 2016). Myers et al. (2000) defined wellness as

> A way of life oriented toward optimal health and well-being, in which body, mind, and spirit are integrated by the individual to live life more fully within the human and natural community. Ideally, it is the optimum state of health and well-being that each individual is capable of achieving (p. 252).

Those who work in a helping profession are often faced with risks to their wellness and occupational hazards that can have tremendous influence on their professional and personal lives (Meany-Walen et al., 2018). Recently, mental health communities, such as the fields of psychiatry, social work, and counseling, have given great attention to the importance of provider wellness (Bercier & Maynard, 2015; Elwood, Mott, Lohr, & Galovski, 2011; Lawson & Myers, 2011; Lenz & Smith, 2010; Meany-Walen, Davis-Gage, & Lindo, 2016). In addition, ethical standards of several primary helping professions have even identified provider self-care as an ethical obligation (American Counseling Association, 2014; American Psychological Association, 2010; American School Counseling Association, 2016; National Association of Social Workers, 2008).

The field of counseling is a wellness-oriented, strengths-based approach to optimizing human growth and development. Professional counselors in particular seek to encourage wellness through preventative interventions and are trained in a positive, holistic philosophy that advocates for optimum health and wellness in society (Myers & Sweeney, 2005). The literature emphasizes self-care as an essential strategy to promote the ongoing positive development of practitioners' minds, bodies, emotions, and spirits (Webb, 2015). Saakvitne et al. (2000) suggest counselors should engage in self-care strategies that target their physical, psychological, cognitive, behavioral, interpersonal, and spiritual well-being. Creative activities can also help practitioners process psychological and emotional reactions, and thus prevent or remediate burnout and secondary traumatic stress (Webb, 2015). Relatedly, in an exploratory, qualitative study on play therapist perceptions of wellness and self-care, Meany-Walen et al. (2018) discovered that when asked directly about play therapy strategies used to aid in their wellness endeavors, 97% of participants identified at least one way they used the concepts of play therapy,

including coloring, dancing, listening to music, playing games, and doing sandtray. The authors suggested additional research exploring play therapists' self-care strategies and their potentially uniquely creative focus and their relationship to professional impairment.

Present Study

This study examined the relationships between professional quality of life, wellness, and moral distress in play therapists. More specifically, I will focus on the following research questions in a sample of participants who are Registered Play Therapists, Registered Play Therapist-Supervisors, or School Based-Registered Play Therapists: (1) What are the relationships among moral distress, wellness, and professional quality of life (i.e., compassion satisfaction, burnout, and secondary traumatic stress)? (2) What are the relationships among demographic factors (e.g., play therapy credential held, professional experience, work setting, gender identity) and the study variables (moral distress, wellness, professional quality of life)? (3) Do moral distress and wellness significantly predict professional quality of life (i.e., compassion satisfaction, burnout, and secondary traumatic stress)?

Method

Procedure

Upon receiving approval from the university's institutional review board (IRB), potential participants were contacted via email communication. Contact information of play therapists was accessed through permission of the APT. A recruitment script was included that contained a brief description of the survey and rationale for the study, informed consent, and a link to the survey instruments. A second request for participation was sent out two weeks following the initial communication. In all, 2, 971 Registered Play Therapists, Registered Play Therapist-Supervisors, and School Based-Registered Play Therapists in the United States were contacted for inclusion in

the data collection period. Upon receipt of completed surveys, all personally identifying information was removed (i.e., IP addresses, Qualtrics ID number, geographic coordinates). Due to the length of the measurements, three attention checks (e.g., choose the answer "A" for this question) were included throughout the online survey to help ensure data quality (Oppenheimer, Meyvis, & Davidenko, 2009). Participants needed to miss no more than one attention check in order to be included in the final data analysis.

Participants

The G*Power 3.1 program was used to determine minimum sample size required for this research study (Faul, Erdfelder, Buchner, & Lang, 2009). In order to reach an appropriate statistical power level for a moderate effect size of .15, an alpha of .05, and with my subscale predictors, the recommended sample size is 89 participants after addressing outliers and missing data (Cohen, 1988). Participants were recruited through the Association for Play Therapy 2019 Directory (APT Membership and Registration Directory, 2019) and specifically included only members who are Registered Play Therapists (RPT), Registered Play Therapist-Supervisors (RPT-S), or School Based-Registered Play Therapists (SB-RPT) in the United States (n = 2, 971) Our total sample size included 389 participants (response rate of 13.1%), with 161 (5.4% of recruited participants) used in the analysis after addressing outliers and missing data.

The final sample used in this research consisted of 161 play therapists, 90.7% (n = 146) female, 8.7% (n = 14) male, and 0.6% (n = 1) transgender. Within the sample, 88.3% (n = 142) identified as White/European-American, 4.3% (n = 7) identified as Hispanic/Latinx, 2.5% (n = 4) identified as Multiracial, 1.9% (n = 3) identified as American Indian/Alaska Native, 1.2% (n = 4) identified as Biracial, 1.2% (n = 2) identified as Black/African-American, and 0.6% (n = 1) identified as Native Hawaiian/Pacific Islander. Participants ranged in age from 27 to 73 years old

(*M* = 46.5, *SD* = 11.55) and identified as predominately heterosexual/straight (92.5%, *n* = 149). Most participants identified as Christian/Catholic (65.4%, *n* = 105) with smaller percentages identifying as Agnostic (14.2%, *n* =23), Jewish (4.3%, *n* = 7), Buddhist (3.7%, *n* =6), Atheist (2.5%, *n* = 4), Pagan (1.9%, *n* =3), and other (8%, *n* =13; i.e., Native American spirituality and Baha'i). A summary of participant demographic characteristics may be found in Table 1 below.

Table 1
Demographic Data for Participants

Variable	*n*	%
Age (years)		
Range: 27 – 73		
M = 46.5, *SD* = 11.55		
Gender Identity		
Female	146	90.7%
Male	14	8.7%
Transgender	1	0.6%
Race/Ethnicity		
White/European-American	142	88.3%
Hispanic/Latinx	7	4.3%
Multiracial	4	2.5%
American Indian/Alaska Native	3	1.9%
Black/African-American	2	1.2%
Biracial	2	1.2%
Native Hawaiian/Pacific Islander	1	0.6%
Sexual Identity		
Straight/Heterosexual	145	90.1%
Bisexual	4	2.5%
Questioning	4	2.5%
Lesbian	3	1.9%
Pansexual	3	1.9%
Gay	1	0.6%
Queer	1	0.6%
Religion/Spirituality		
Christian/Catholic	105	65.4%
Agnostic	23	14.2%
Other (i.e., Baha'i)	13	8.0%
Jewish	7	4.3%
Buddhist	6	3.7%

Atheist	4	2.5%
Pagan	3	1.9%

Play therapist participants identified Clinical Mental Health (51.6%, *n* =83) or Social Work (20.5%, *n* = 33) as their primary professional discipline and the majority of participants identified master's degree as their highest degree earned (76.4%, *n* =123). Most participants are currently a Registered Play Therapist-Supervisor (RPT-S; 51.6%, *n* = 83), while 46.5% are a Registered Play Therapist (RPT, *n* = 75), and 1.9% hold the School Based-Registered Play Therapist (SB-RPT, *n* = 3) credential. Of those currently practicing as a play therapist (95.7%, *n* = 154), most selected private practice as their primary work setting (63.4%, *n* = 102) and see on average 17 child or adolescent clients per week (*M* = 17.28, *SD* = 8.81). Participants ranged in time professionally practicing from three to 50 years (*M* = 15.8, *SD* = 9.72). Play therapist participants identified trauma (34.8%, *n* = 56) and anxiety (26.1%, *n* = 42) as the primary concerns of their child or adolescent clients, with family-related issues as a frequent secondary concern (16.1%, *n* = 25). In terms of the participants' wellness practices, 95.7% (*n* = 154) selected at least one creative self-care strategy, including music (67.1%, *n* = 108), playing games (62.1%, *n* = 99), art (56.5%, *n* = 90), sand tray (32.9%, *n* = 52), and dance/movement (18.6%, *n* = 29). Additional creative self-care strategies identified by participants included cooking, crafting, writing, and playing with children/grandchildren. Of those who did not select a creative self-care strategy (4.3%, *n* = 6), deep breathing, hiking, humor, running, and yoga were identified as their primary self-care strategies. A summary of participant professional information may be found in Table 2 below.

Table 2
Participant professional information

Variable	*n*	%	*M* (SD)
Professional Discipline			
Clinical Mental Health	83	51.6%	
Social Work	33	20.5%	
Marriage & Family Therapy	23	14.3%	
Psychology	10	6.2%	
School Counseling	6	3.7%	
Other (i.e., pastoral counseling)	6	3.7%	
Graduate Degree			
Master's	123	76.4%	
Doctoral	19	11.8%	
Specialist	19	11.8%	
Years in Practice			15.8 (9.72)
Play Therapy Credential			
RPT-S	83	51.6%	
RPT	75	46.5%	
SB-RPT	3	1.9%	
Child/Adolescent Clients Seen Per Week			17.28 (8.81)
In practice for 15 years or less	93	58%	18.65 (8.93)
In practice for more than 15 years	68	42%	15.27 (8.11)
Primary Practice Setting			
Private Practice	102	63.4%	
Community Clinic/Agency	26	16.1%	
School-Based	16	9.9%	
Other (i.e., Dept. of defense)	10	6.2%	
Primary Client Concern			
Trauma	56	34.8%	
Anxiety	42	26.1%	
Adjustment Issues	18	11.2%	
Family-Related Issues	15	9.3%	
Creative Self-Care Strategies*			
Music	108	67.1%	
Playing Games	100	62.1%	
Art	91	56.5%	
Sand Tray	53	32.9%	
Dance/Movement	30	18.6%	

Note. *Question allowed multiple answer selection.

Measures

Demographic Questionnaire. The demographic questionnaire collected a variety of information related to the participants' racial and ethnic identity, gender identity, sexual identity, relationship status, and religious/spiritual affiliation, among others. The questionnaire also asked participants to identify their highest degree earned, years of experience as a play therapist, professional practice setting, play therapy credential, primary and secondary client concerns, and creative self-care strategies.

Moral Distress Scale for Counselors-Child and Adolescent Form. The Moral Distress Scale for Counselors-Child and Adolescent Form (MDSC-CA; Turnage-Butterbaugh, 2015) is a 63-item modified version of the Moral Distress Scale-Revised, Adult Version developed by Hamric et al. (2012). Participants are asked to indicate the level and frequency to which certain situations working with children and adolescents have caused distress. The intensity scale ranges from 1 (*none*) to 5 (*irrelevant*) while the frequency scale ranges from 1 (*never*) to 7 (*always*). Questionnaire items include "because I assumed conflicting organizational roles, I was led to cross professional boundaries," "I did not inform a legal guardian about a client's situation because I thought it would make things worse for the client," and "the quality of care I was providing decreased because I was overwhelmed by my clinical responsibilities." The questionnaire contains eight domains, including adaptability, fear of consequences, inexperience, lack of support, institutional restrictions, lack of objectivity, well-being, and vulnerability. Within each domain are at least two sub-themes that further describe the nature of distress experienced by the participant. Turnage-Butterbaugh (2015) established acceptable face and content validity in his preliminary study as well as reliability for the overall instrument ($\alpha = .93$); however, there is currently limited data on the overall psychometric properties of this measure

due to both the lack of research on moral distress and child counselors and the fairly recent creation of the Child and Adolescent Form of the Moral Distress Scale for Counselors. In the present study, $\alpha = .96$ for items on the overall instrument and was .77 or higher for all domains.

Professional Quality of Life Scale. The Professional Quality of Life Scale (ProQOL-5; Stamm, 2009) is a 30-item self-report measure of three subscales, including compassion satisfaction, burnout, and secondary traumatic stress. These three subscales assess respondents' self-perception, reactions to and beliefs regarding their role as a professional counselor and experiences of traumatic symptoms due to this role. The scale uses a five-point Likert scale to rate the frequency of the participants' experiences, from (1) *never* to (5) *very often.* Construct validity for this measure is supported by over 200 peer-reviewed articles (as reviewed by Stamm, 2005). Items include "I believe I can make a difference through my work" (compassion satisfaction scale), "I feel trapped by my job as a helper" (burnout scale), and "I avoid certain activities because they remind me of frightening experiences of the patients I have cared for" (secondary traumatic stress scale). The average score for each of the ProQOL-5 subscales is 50. A score of 43 or below is considered *low* and a score of 57 or more is *high* (Stamm, 2010). Higher scores on each scale indicate greater satisfaction (compassion satisfaction scale) and/or increased risk for burnout and secondary traumatic stress (compassion fatigue scale). Thomas and Otis (2010) reported alpha coefficients for compassion satisfaction, burnout, and secondary traumatic stress, as .91, .78, and .86, respectively. Internal consistency for the instrument has been further supported in other students with compassion satisfaction and fatigue having Cronbach's alphas of .88 and .81, respectively (Gallavan & Newman, 2013). In the present study, the scales were also found to be reliable (compassion satisfaction, $\alpha = .86$; burnout, $\alpha = .77$; secondary traumatic stress, $\alpha = .80$).

The Five Factor Wellness Inventory. The Five-Factor Wellness Inventory-Adult (5F-WEL-A; Myers & Sweeney, 2005b) is an evidence-based tool used to assess wellness characteristics. It was developed and validated using structural equation modeling analysis of a large database from the Wellness Evaluation of Lifestyle (WEL) and measures the higher order Wellness factor, 5 second-order factors, and 17 discrete scales as illustrated in the Indivisible Self: An Evidence-based Model of Wellness (Myers & Sweeney, 2004). The 17 subscales can be grouped into five dimensions of self (creative, coping, social, essential, and physical) that comprise the main outcome variable, total wellness. The measure includes 91 attitudinal and behavioral statements that respondents rate their agreement with using a 4-point Likert scale, from 1 (*strongly agree*) to 4 (*strongly disagree*). Items include, "I am an active person and I believe in the existence of a power greater than myself" and "I eat a healthy diet." Alpha coefficients for the five factors measured by the inventory range from .89 to .96, with an alpha level of .98 for the total wellness score (Abrahams & Balkin, 2006). In the present study, the alpha coefficients for the five sub-scales ranged from .87 to .90, with an alpha level of .95 for the total wellness score.

Results

Descriptive statistics were used to determine the relationships between moral distress, wellness, and professional quality of life. We conducted multiple analyses, including correlation and regression analysis. A series of t-tests and one-way analysis of variance (ANOVA) were also conducted to examine group differences based on demographic information. In order to determine how much variance in our dependent variable (Professional Quality of Life) was explained by independent variables (Moral Distress and Wellness), we conducted separate regressions for each subscale of Professional Quality of Life (i.e., Compassion Satisfaction,

Burnout, and Secondary Traumatic Stress). Multiple regressions allowed us to determine the statistical significance of the results, in terms of both the model and the individual predictor variables.

Preliminary Analysis

Data was downloaded from Qualtrics into SPSS and was screened for outliers, missing data, and failed responses to validity questions. Additionally, data was screened for potential violation of assumptions, including normality (i.e., skewness and kurtosis), linearity, homoscedasticity using scatter plots, and independence of residuals. No concerns were encountered in the data distribution (e.g., skewness and kurtosis levels were all between -1 and +1; Weston & Gore, 2006).

The present study contacted 2,971 play therapists through the APT directory and obtained 389 total responses (13.1%), of which 218 were deleted for having significant amounts of missing data. An additional ten participants were removed for missing two attention check questions (i.e., Professional Quality of Life Scale question 21 prompted participants to choose "4" as their response), resulting in 161 total participants for the study. Two outliers were identified using box plots; however, the outliers did not appear to be impacting the overall mean scores with the 5% trimmed mean differences being less than .5. Therefore, the outliers were kept in the data. The result of Little's MCAR test (Little, 1988; Fichman & Cummings, 2003) demonstrated a nonsignificant result, (x^2 = 877.67, *df* = 11968, *p* = 1.00), indicating the data was missing completely at random. The data set included < 2% missing data. Expectation Maximization (EM) was used to fill in the data that was missing at random (Dempster, Laird, & Rubin, 1977; Schafer & Graham, 2002).

Descriptive statistics (i.e., means and standard deviations) and Cronbach's alpha coefficients for internal consistency were calculated for the study measurements and subscales. A summary of descriptive statistics for the measurements is included in Table 3 below. According to DeVellis (2012), the Cronbach alpha coefficient of a scale should be above .70. Therefore, the internal consistency for all of the measurement scales are acceptable.

Table 3
Descriptive Statistics and Reliability of Study Instruments

Study Instruments	Cronbach α	No. of Items	M (SD)
Professional Quality of Life Scale	N/A	30	N/A
Compassion Satisfaction (CS)	.86	10	42.99 (4.42)
Burnout (BO)	.77	10	20.12 (4.46)
Secondary Traumatic Stress (STS)	.80	10	20.87 (4.84)
Moral Distress Scale for Counselors-C&A	.96	63	250.28 (74.38)
Adaptability	.77	6	23.04 (8.65)
Fear of Consequences	.89	10	37.47 (14.25)
Inexperience	.85	6	22.15 (7.30)
Lack of Support	.87	10	43.50 (13.54)
Institutional Restrictions	.87	10	41.56 (13.59)
Lack of Objectivity	.80	6	21.43 (7.09)
Well-Being	.90	7	29.62 (11.27)
Vulnerability	.90	8	32.82 (14.39)
Five Factor Wellness Inventory	.95	91	69.71 (15.87)
Creative Self	.88	21	39.85 (7.58)
Coping Self	.87	19	47.27 (8.88)
Social Self	.87	8	34.03 (9.37)
Essential Self	.84	16	42.81 (10.48)
Physical Self	.90	10	51.71 (15.77)
Contextual Variables	.78	15	39.95 (7.16)
Life Satisfaction Index	N/A	1	40.26 (15.78)

Main Analysis

Correlations. Correlation analyses were run to address the first research question: What are the relationships among moral distress, wellness, and professional quality of life (i.e.,

compassion satisfaction, burnout, and secondary traumatic stress) in play therapists? Table 4 below presents the correlations found between study variables. Five Factor Wellness Inventory (5F-WEL) total wellness scores were significantly negatively correlated with compassion satisfaction (r = -0.438, p < .01), positively correlated with burnout (r = 0.556, p < .01), and positively correlated with secondary traumatic stress scores (r = .168, p < .05) on the Professional Quality of Life (ProQOL) measure. Additionally, the ProQOL burnout scores were significantly positively correlated with total moral distress scores on the Moral Distress Scale for Counselors-Child and Adolescent Version (MDSC-CA; r = .209, p <.01). Specifically looking at correlations within the Professional Quality of Life measure, we found secondary traumatic stress scores were negatively correlated with compassion satisfaction scores (r = -.259, p < .01) and positively correlated with burnout scores (r = .501, p < .01). Lastly, compassion satisfaction scores were negatively correlated with burnout scores (r = -.645, p < .01).

Table 4
Correlations Between Study Variables Total Scores

Variables	1	2	3	4	5
1. MDSC-CA	__				
2. 5F-WEL	.076	__			
3. ProQOL_CS	-.003	-.438**	__		
4. ProQOL_BO	.209**	.556**	-.645**	__	
5. ProQOL_STS	.116	.168*	-.259**	.501**	__

Note. *p < .05. **p < .01. Abbreviations: CS = Compassion Satisfaction; BO = Burnout; STS = Secondary Traumatic Stress.

Correlation analyses were also run to explore the relationships between *subscale* scores for the study variables. ProQOL burnout scores were significantly positively correlated with MDSC-CA lack of support subscale scores (r = .185, p = .01), institutional restrictions subscale scores (r = .158, p = .04), lack of objectivity subscale scores (r = .182, p = .02), well-being

subscale scores (r = .386, p < .01), and vulnerability subscale scores (r = .168, p = .03). ProQOL secondary traumatic stress scores were also significantly positively correlated with MDSC-CA institutional restrictions subscale scores (r = .157, p = .04), lack of objectivity subscale scores (r = .177, p = .02), and well-being subscale scores (r = .255, p < .01). There were no significant correlations between ProQOL compassion satisfaction scores and MDSC-CA subscale scores.

ProQOL compassion satisfaction scores were significantly negatively correlated with 5F-WEL creative self subscale scores (r = -.500, p < .01), coping self subscale scores (r = -.370, p < .01), social self subscale scores (r = -.327, p < .01), essential self subscale scores (r = -.194, p = .01), and physical self subscale scores (r = -.179, p = .02). ProQOL burnout scores were significantly positively correlated with 5F-WEL creative self subscale scores (r = .535, p < .01), coping self subscale scores (r = .572, p < .01), social self subscale scores (r = .399, p < .01), essential self subscale scores (r = .329, p < .01), and physical self subscale scores (r = .308, p < .01). ProQOL secondary traumatic stress scores were significantly positively correlated with 5F-WEL creative self subscale scores (r = .192, p = .01), coping self subscale scores (r = .332, p < .01), and physical self subscale scores (r = .177, p = .02). Table 5 below presents the correlations between study variable subscale scores.

Table 5

Correlations Between Study Variable Subscale Scores

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1.ProQOL_CS	---															
2.ProQOL_BO	-.645**	---														
3.ProQOL_STS	-.259**	.501**	---													
4.WEL_Creative	-.500**	.535**	.192*	---												
5.WEL_Coping	-.370**	.572**	.332**	.620**	---											
6.WEL_Social	-.327**	.399**	.049	.671**	.436**	---										
7.WEL_Essential	-1.94*	.329**	.064	.475**	.346**	.379**	---									
8.WEL_Physical	-.179*	.308**	.177*	.245**	.457**	.251**	.292**	---								
9.MD_Adapt	.053	.103	.055	-.044	.036	-.049	.070	.150	---							
10.MD_FOC	.048	.064	-.023	-.020	.056	-.029	.106	.121	.795**	---						
11.MD_Inexp	-.065	.141	-.035	.026	.008	.039	.063	.068	.516**	.581**	---					
12.MD_LOSup	-.011	.185*	.089	.062	.112	.048	.152	.090	.615**	.703**	.633**	---				
13.MD_InstRes	-.014	.158*	.157*	-.021	.042	-.045	.079	.056	.537**	.624**	.599**	.774**	---			
14.MD_LOObj	.014	.182*	.177*	.055	.160*	-.016	.136	.086	.416**	.570**	.551**	.591**	.654**	---		
15.MD_WB	-.060	.386**	.255**	.098	.322**	.067	.141	.157*	.368**	.531**	.453**	.655**	.649**	.553**	---	
16.MD_Vuln	-.003	.168*	.086	-.011	.113	-.015	.103	.178*	.665**	.781**	.525**	.779**	.703**	.561**	.660**	---

Note. *$p < .05$. **$p < .01$. Abbreviations: CS = Compassion Satisfaction, BO = Burnout, STS = Secondary Traumatic Stress, WEL = 5F-WEL-A measure, MD = MDSC-CA measure, Adapt = Adaptability, FOC = Fear of Consequences, Inexp = Inexperience, LOSup = Lack of Support, InstRes = Institutional Restrictions, LOObj = Lack of Objectivity, WB = Well-Being, Vuln = Vulnerability

T-Test's and ANOVA's. To address the second research question, an independent samples t-test was conducted to compare total moral distress scores (MDSC-CA), total wellness scores (5F-WEL), and professional quality of life subscale scores (ProQOL; compassion satisfaction, burnout, and secondary traumatic stress) across play therapy credential (Registered Play Therapist and Registered Play Therapist-Supervisor), years of experience (15 years or less and more than 15 years), practice setting (private practice and agency/school), gender identity (men and women), and self-care strategy (creative and not creative). The years of experience groups were formed based on the mean years of experience in the sample (M = 15.8).

There were significant mean differences on 5F-WEL total wellness scores between those who are Registered Play Therapists (n = 75, M = 62.93, SD = 18.84) and Registered Play Therapist-Supervisors (n = 83, M = 62.58, SD = 17.92; t (155) = 2.50, p = .01, two-tailed). There

were no significant group differences ($p > .05$) on professional quality of life subscale scores or moral distress total scores between participants who are RPT or RPT-S. There were also no significant group differences ($p > .05$) on any study variable total score between those who work in private practice and those who work at an agency or school. There were significant mean differences on ProQOL compassion satisfaction scores between those who have been practicing professionally for 15 years or less ($n = 93$, $M =$, $SD =$) and those who have been practicing for more than 15 years ($n = 68$, $M =$, $SD =$; t () = , $p = .04$, two-tailed). However, there were no significant group differences ($p > .05$) on ProQOL burnout subscale scores, ProQOL secondary traumatic stress subscale scores, 5F-WEL total scores, or MDSC-CA total scores for years professionally practicing.

There was also a significant mean difference on ProQOL secondary traumatic stress scores between men ($n = 14$, $M = 17.00$, $SD = 4.13$) and women ($n = 146$, $M = 21.22$, $SD = 4.76$; t (158) = -3.20, $p < .01$, two-tailed). Given the drastically unequal sample sizes for men and women in this analysis, a one-sample t-test was also conducted to confirm the significant result. The gender variable was compared against the 5% trimmed mean for the secondary traumatic stress scale ($M = 20.73$), where a significant result was found ($p < .01$). Additionally, the Mann-Whitney U Test was conducted as a non-parametric test for differences between the two groups, which revealed a significant difference on secondary traumatic stress scores between men ($Md =$ 16, $n = 14$) and women ($Md = 21$, n = 146), $U = 1552$, $z = 3.207$, $p < .01$, $r = .0.25$There were no significant group differences ($p > .05$) on 5F-WEL or MDSC-CA scores for gender identity. Additionally, there was a significant mean difference on ProQOL compassion satisfaction scores between creative self-care strategies ($n = 153$, $M = 42.79$, $SD = 4.41$) and non-creative self-care strategies ($n = 8$, $M = 46.93$, $SD = 2.52$; t (159) = -2.602 $p < .01$, two-tailed). Lastly, there was a

significant mean difference on ProQOL burnout scores between creative self-care strategies (n = 153, M = 20.31, SD = 4.36) and non-creative self-care strategies (n = 8, M = 16.50, SD = 4.98; t (159) = 2.391 p = .01, two-tailed). Given the drastically unequal sample sizes for creative self-care groups in this analysis, a one-sample t-test was performed to verify the significant result. The creative self-care variable was compared against the 5% trimmed mean for the compassion satisfaction scale (M = 43.18) and burnout scale (M = 20.03), where significant results were found (p = < .01). Additionally, the Mann-Whitney U Test was conducted as a non-parametric test for differences between the two groups, which revealed a significant difference on burnout scores between creative self-care strategies (Md = 20, n = 153) and non-creative self-care strategies (Md = 15.5, n = 8), U = 357, z = -1.99, p = .04, r = .16.There were no significant mean differences (p > .05) on ProQOL secondary traumatic self scores, 5F-WEL total wellness scores, or MDSC-CA total moral distress scores for self-care strategy groups.

T-tests were also run to compare study variable *subscale* scores across various demographic variables. There were significant mean differences on 5F-WEL creative self subscale scores between RPT (n =75, M = 41.26, SD = 7.25) and RPT-S (n = 83, M = 38.86, SD = 7.69; t (155) = 2.00, p = .04, two-tailed) and on coping self subscale scores between RPT (n =75, M = 48.78, SD = 9.40) and RPT-S (n = 83, M = 45.93, SD = 8.30; t (155) = 2.01, p = .04, two-tailed). There were significant mean differences on 5F-WEL coping self subscale scores between those who have been practicing for 15 years or less (n = 93, M = 49.66, SD = 9.18) and those who have been practicing for more than 15 years (n = 68, M = 46.17, SD = 8.55; t (159) = 2.35, p = .02, two-tailed). Additionally, there were significant mean differences on 5F-WEL essential self subscale scores between those who have been practicing for 15 years or less (n = 93, M = 46.70, SD = 10.52) and those who have been practicing for more than 15 years (n = 68,

M = 41.00, *SD* = 10.00; *t* (159 = 3.30, *p* < .01, two-tailed). There were also significant mean differences on 5F-WEL physical self subscale scores between those who have been practicing professionally for 15 years or less (*n* = 93, *M* = 55.88, *SD* = 14.13) and those who have been practicing professionally for more than 15 years (*n* = 68, *M* = 49.78, *SD* = 16.17; *t* (159) = 2.31, *p* = .02, two-tailed).

Lastly, there were significant mean differences on MDSC-CA institutional restrictions subscale scores between those who have been practicing for 15 years or (*n* = 93, *M* = 38.01, *SD* = 13.01) and those who have been practicing for more than 15 years (*n* = 68, *M* = 43.20, *SD* = 13.60; *t* (159) = -2.28, *p* = .02, two-tailed). There was a significant mean difference on MDSC-CA lack of objectivity subscale scores between men (*n* = 14, *M* = 17.82, *SD* = 7.70) and women (*n* = 146, *M* = 21.68, *SD* = 6.89; *t* (158) = -1.98, *p* = .04, two-tailed). There were no significant group differences on any study variable subscale score for practice setting. Further, there was a significant mean difference on ProQOL creative self subscale scores between creative self-care strategies (*n* = 153, *M* = 40.12, *SD* = 7.52) and non-creative self-care strategies (*n* = 8, *M* = 34.67, *SD* = 7.40; *t* (159) = 1.99, *p* = .04, two-tailed). There were no other significant mean differences on study variable subscale scores for self-care strategy groups (*p* > .05).

A one-way between-groups analysis of variance (ANOVA) was conducted to explore the impact of religious/spiritual affiliation, relationship status, and race/ethnic identity on the study variables (MDSC-CA, 5F-WEL, ProQOL). There were no statistically significant mean differences in study variable total scores between religious/spiritual affiliation, relationship status, or racial/ethnic identity groups (*p* > .05). ANOVA's were also run to compare study variable *subscale* scores across various demographic variables. There was a statistically significant difference at the *p* < .05 level between religion spirituality groups for the 5F-WEL

essential self subscale scores: F (6, 153) = 9.55, $p < .01$. The effect size, calculated using eta squared, was .27. Post-hoc comparisons using the Tukey HSD test indicated the mean score for Christian/Catholic participants (M = 38.51, SD = 9.50) was significantly different from Atheist (M = 55.07, SD = 9.57), Agnostic (M = 52.77, SD = 6.80), and participants that chose none of the above (M = 45.83, SD = 9.36). There was also a statistically significant difference at the $p < .05$ level between groups for the 5F-WEL physical self subscale scores: F (6, 153) = 2.94, p = .01. The effect size, calculated using eta squared, was .10. Post-hoc comparisons using the Tukey HSD test indicated the mean score for Christian/Catholic participants (M = 48.99, SD = 15.20) was significantly different from Agnostic participants (M = 61.07, SD = 18.55).

Multiple Linear Regressions. The final research question looked at the predictive nature of moral distress and wellness on professional quality of life in play therapists. Tables 6, 7, and 8 present multiple linear regression models that were used to assess the ability of two measures (Moral Distress Scale for Counselors-Child and Adolescent and Five Factor Wellness Inventory) to predict the three different scales of professional quality of life (compassion satisfaction, burnout, and secondary traumatic stress scales). Prior to running the regressions, multicollinearity was checked by running collinearity statistics. Variance inflation factors for each variable were less than two, proving there were no issues with collinearity (Stein, 1995).

First looking at the predictive nature of moral distress and wellness on compassion satisfaction, moral distress and wellness together significantly explained 19.3% of the variance in the compassion satisfaction scale of professional quality of life ($F_{(2, 158)}$ = 18.81, $p < .01$, R^2 = .193). Specifically, wellness significantly contributed to explaining compassion satisfaction (b = .44, $p < .01$) whereas, moral distress did not significantly contribute to the model (b = .03, p = .67). Therefore, moral distress was dropped from the final model chosen to predict compassion

satisfaction. When using just wellness as a predictor in this model, it significantly explained 19.2% of the variance in compassion satisfaction ($F_{(1, 159)} = 37.78$, $p < .01$, $R^2 = .192$).

When looking at the predictive nature of moral distress and wellness on burnout, moral distress and wellness significantly explained 33.7% of the variance in the burnout scale of professional quality of life ($F_{(2, 158)} = 40.14$, $p < .01$, $R^2 = .337$). Specifically, wellness made the strongest unique contribution to explaining burnout ($b = .54$, $p < .01$). However, moral distress also made a statistically significant contribution ($b = .16$, $p = .01$). When looking at the predictive nature of moral distress and wellness on secondary traumatic stress, moral distress and wellness significantly explained 3.9% of the variance in the secondary traumatic stress scale of professional quality of life ($F_{(2, 158)} = 3.19$, $p = .04$, $R^2 = .039$). Specifically, wellness significantly and uniquely contributed to the model ($b = .16$, $p = .04$). However, moral distress did not significantly contribute to the model ($b = .10$, $p = .18$). Therefore, moral distress was dropped from the final model chosen to predict secondary traumatic stress. When using just wellness as a predictor in this model, it significantly explained 2.8% of the variance in secondary traumatic stress ($F_{(1, 159)} = 4.60$, $p = .03$, $R^2 = .028$). The tables below present the regression models that represent variables which significantly contributed to the outcome variable while still maintaining a significant regression equation.

Table 6

Multiple Linear Regression Model for Compassion Satisfaction scale of ProQOL

Variable	Unstandardized β	Std. Error	Standardized β	*t*	95% CI	*p*-Value	*VIF*
5F-WEL	-.103	.017	-.438	-6.147	-.137 – -.070	.000	1.00

Note. ProQOL = Professional Quality of Life scale; 5F-WEL = Five Factor Wellness Inventory

Table 7
Multiple Linear Regression Model for Burnout scale of ProQOL

Variable	Unstandardized β	Std. Error	Standardized β	*t*	95% CI	*p*-Value	*VIF*
5F-WEL	.129	.015	.543	8.361	.099 – .160	.000	1.00
MDSC	.010	.004	.167	2.577	.002 – .018	.011	1.00

Note. ProQOL = Professional Quality of Life scale; 5F-WEL = Five Factor Wellness Inventory; MDSC = Moral Distress Scale for Counselors-Child and Adolescent version

Table 8
Multiple Linear Regression Model for Secondary Traumatic Stress scale of PRoQOL

Variable	Unstandardized β	Std. Error	Standardized β	*t*	95% CI	*p*-Value	*VIF*
5F-WEL	.043	.020	.168	2.147	.003 – .083	.033	1.00

Note. ProQOL = Professional Quality of Life scale; 5F-WEL = Five Factor Wellness Inventory

Since moral distress was a significant predictor of burnout, multiple linear regressions were also run to look at the moral distress subscales more specifically. The well-being and fear of consequences subscales significantly predicted 17.6% of the variance in burnout ($F_{(2, 158)}$ = 16.91, $p < .01$, $R^2 = .176$). Specifically, well-being made the strongest unique contribution to explaining burnout ($b = .49$, $p < .01$), while fear of consequences also made a statistically significant contribution ($b = .19$, $p = .02$). The table below presents the significant regression model.

Table 9
Multiple Linear Regression Model for MDSC-CA subscales and Burnout scale of ProQOL

Variable	Unstandardized β	Std. Error	Standardized β	*t*	95% CI	*p*-Value	*VIF*
MDSC_WB	.194	.034	.490	5.750	.127 – .260	.000	1.39
MDSC_FOC	-.061	.027	-.196	-2.304	-.11 – -.009	.023	1.39

Note. ProQOL = Professional Quality of Life scale; MDSC = Moral Distress Scale for Counselors-Child and Adolescent version; MDSC_WB = Well-Being subscale; MDSC_FOC = Fear of Consequences subscale

Given the creative context of the sample, we ran additional multiple linear regressions to assess the ability of the creativity subscale of the 5F-WEL inventory to predict the three different scales of professional quality of life (compassion satisfaction, burnout, and secondary traumatic stress). The regression indicated creative wellness significantly predicted 25% of the variance in compassion satisfaction ($F_{(1, 159)} = 52.91$, $p < .01$, $R^2 = .250$), 28.7% of the variance in burnout ($F_{(1, 159)} = 63.90$, $p < .01$, $R^2 = .287$), and 3.7% of the variance in secondary traumatic stress ($F_{(1, 159)} = 6.06$, $p = .01$, $R^2 = .037$). The tables below present the significant regression models.

Table 10
Multiple Linear Regression Model for Compassion Satisfaction scale of PRoQOL

Variable	Unstandardized β	Std. Error	Standardized β	*t*	95% CI	*p*-Value	*VIF*
CW	-2.92	.040	-.500	-7.274	-3.71 – -.212	.000	1.00

Note. ProQOL = Professional Quality of Life scale; CW = Creative Wellness subscale of Five Factor Wellness Inventory

Table 11
Multiple Linear Regression Model for Burnout scale of PRoQOL

Variable	Unstandardized β	Std. Error	Standardized β	*t*	95% CI	*p*-Value	*VIF*
CW	.315	.039	.535	7.994	.237 – .393	.000	1.00

Note. ProQOL = Professional Quality of Life scale; CW = Creative Wellness subscale of Five Factor Wellness Inventory

Table 12
Multiple Linear Regression Model for Secondary Traumatic Stress scale of PRoQOL

Variable	Unstandardized β	Std. Error	Standardized β	*t*	95% CI	*p*-Value	*VIF*
CW	.122	.050	.192	2.463	.024 – .220	.015	1.00

Note. ProQOL = Professional Quality of Life scale; CW = Creative Wellness subscale of Five Factor Wellness Inventory

Discussion

The wellness experiences of play therapists continue to be underrepresented in counseling research. This study considers both the potentially rewarding and challenging aspects of practicing as a play therapist. The full range of experiences is important to investigate in order to understand better the realities of working with children and families and its impact on play therapists' personal and professional well-being. Gaining a clearer picture of how play therapists are coping with work-related struggles can also add to the conceptualization of the unique nature of being a child and adolescent counselor.

Based on the results of this study, wellness was positively correlated with both burnout and secondary traumatic stress and negatively correlated with compassion satisfaction. Therefore, play therapists' wellness may include boundary setting that subsequently decreases positive feelings about their ability to help. These clinicians may feel a push and pull between their self-care and caring for their clients, where their wellness decreases as they feel more satisfied with their work with clients. Results from correlation analyses on subscale scores further support the total score correlations, where various self-care strategies (i.e., creative, coping, social, physical) were positively correlated with burnout and secondary traumatic stress and negatively correlated with compassion satisfaction. It appears play therapists call upon a broad range of strategies to aid in their overall wellness when experiencing burnout or secondary stress. Though some research has found inverse relationships between wellness and burnout or secondary traumatic stress in mental health professionals (i.e., Lloyd & King, 2001), these results are consistent with findings from Puig et al.'s (2012) study on counselor wellness, which indicated counselors may increase self-care and disconnect from clients as a defense when experiencing symptoms of compassion fatigue.

In addition, moral distress was positively correlated with burnout; specifically, lack of support, institutional restrictions, lack of objectivity, vulnerability, and well-being subscale scores were factors in play therapists' experience of burnout. These findings are in line with previous research highlighting the overall negative impact of moral distress on healthcare professionals' professional quality of life (Corley, 2002; de Veer, Francke, Stuijs, & Willems, 2013; Sung, Seo, & Kim, 2012), including burnout (Austin, Saylor, & Finley, 2017; Maiden, Georges, & Connelly, 2011). Additionally, these results highlight the importance of support in a work environment for play therapists, which is often emphasized in research on moral distress (Etzion, 1984; Leiter & Maslach, 1988).

Compared to Registered Play Therapists (RPT), Registered Play Therapist-Supervisors (RPT-S) had lower total wellness scores, specifically creative and coping self subscale scores. Additionally, those who had been practicing professionally for more 15 years or more had statistically significant lower coping, essential, and physical self subscale scores than those who had been practicing less than ten years. These results indicate experienced play therapists may encounter a steady level of stress over a longer period of time, which could cause a strain on their ability to utilize certain self-care strategies. More experienced play therapists also had statistically significant higher scores for institutional restrictions subscale scores on the moral distress measure (MDSC-CA), which is in line with the theory that more time spent in the field may lend itself to more exposure to difficult work-related circumstances. Austin, Saylor, and Finley (2017) further support this claim by suggesting in their study with experienced health care workers that risk for moral distress and burnout was highest near ten years of working.

Interestingly, job satisfaction in their sample was also highest after ten years of working in health care. Though more experienced play therapists did not have statistically significant

higher levels of compassion satisfaction than less experienced play therapists in the current sample, their mean scores indicate near average levels of compassion satisfaction according to the ProQOL scoring manual (Stamm, 2010), suggesting although play therapists demonstrated an overall positive feeling about their work with child clients, they are simultaneously experiencing some level of distress.

Both moral distress and wellness were significant predictors for burnout; however, only wellness was a significant predictor for compassion satisfaction and secondary traumatic stress. These results are in line with the existing literature on the importance of wellness for counselors and its potentially protective qualities (Myers & Sweeney, 2005a). In addition, this study adds to the gap in the literature by empirically supporting wellness' impact on play therapists' professional quality of life (i.e., experiences of compassion satisfaction, burnout, and secondary traumatic stress) and the existence of secondary traumatic stress and burnout as an outcome of overall wellness. The seemingly conflicting results from studies on burnout and secondary traumatic stress as it relates to wellness have a long history in the healthcare literature and appears to be consistent with results from the current study (Arthur, 1990; Austin, Saylor, & Finley, 2017; Simpson & Starkey, 2006). However, as previous studies have concluded, helping professionals consistently report moderate to high levels of accomplishment or satisfaction with their work despite moderate to high levels of emotional exhaustion and depersonalization (Austin, Saylor, & Finley, 2017; Goldberg et al., 1996; McNeeley, Perez, & Chew, 2013). Thus, play therapists in this study may also be simultaneously experiencing similar levels of overall wellness as they are symptoms of compassion fatigue and moral distress.

Though moral distress was not found to be a significant predictor for compassion satisfaction or secondary traumatic stress, it is important to note its impact on burnout and related

outcomes (i.e., high turnover, mental health problems, low morale/job satisfaction; Lloyd & King, 2001; Maslach, 2003; Webb, 2015). An unhealthy or dysfunctional work environment appears to be predictive of play therapists' experiences of burnout. Specifically, well-being (i.e., when problematic work-related factors affect both personal and work life; Turnage-Butterbaugh, 2015) and fear of consequences (i.e., restriction from engaging in moral action due to fear of consequences for oneself, others, or clients; Turnage-Butterbaugh, 2015) subscales on the moral distress measure were significant predictors. The relationship between well-being, distressing work environments, and burnout has been well documented in the literature (Austin, Saylor, & Finley, 2017; Corley, 2002; de Veer, Francke, Stuijs, & Willems, 2013; Maiden, Georges, & Connelly, 2011; Sung, Seo, & Kim, 2012); however, fear of consequences as it relates to clients is less researched and hypothesized to be unique to counselors (Turnage-Butterbaugh, 2015). The presence of fear of consequences as a predictor of burnout in play therapists in the current study supports this theory and is in line with Turnage-Butterbaugh's (2015) exploratory study of moral distress and child and adolescent counselors, suggesting play therapists may experience this fear for their clients as a barrier to moral action more often than other counselors due to the unique nature of working with child clients. These findings further confirm the importance of considering work environment as a crucial component of the wellness experiences of play therapists and suggest working with child and adolescent clients present exceptional challenges (Bodenhorn, 2006; Hall & Lin, 1995; Lawrence & Kurpius, 2000).

In this study, play therapists overwhelmingly specified creativity as an integral part of their wellness endeavors, supporting findings of the exploratory study by Meany-Walen et al. (2018). Creative wellness was also found to be a significant predictor of compassion satisfaction, burnout, and secondary traumatic stress in this sample. Thus, their increased use of creative self-

care strategies during times of high work-related stress also suggests play therapists gravitate towards creativity as a powerful tool both in counseling sessions and as a personal resource, where their uniquely creative focus may be the key in helping creative practitioners process psychological and emotional reactions. Despite the presence of moral distress, burnout, and secondary traumatic stress, the majority of play therapists indicated similar level of wellness and compassion satisfaction. These results are in line with previous research in that moral distress can result in positive consequences, including a high level of compassion satisfaction, personal growth, and motivation (McCarthy & Deady, 2008; Webb, 2015; Weissman, 2009).

It is important to note, however, that although play therapists within the sample identified ways to cope creatively with serious work-related distress, these coping attempts did not address the distress-causing agents themselves (i.e., work environment or challenging caseload). Similarly, these results do not imply that if play therapists are experiencing moral distress, burnout, or secondary traumatic stress they therefore have poor coping strategies. This narrative perpetuates stigma often associated with discussing professional struggles that may be impacting clinical work (Figley, 2002). Instead, the results imply a broader perspective on self-care may be beneficial when considering play therapists' wellness.

Clinical Implications

The current study found experienced play therapists may encounter a steady level of stress as more time is spent practicing in the field, which lends itself to more exposure to work-related challenges. Therefore, it may be important for professional agencies and training programs to develop strategic ways for play therapists to be educated on the signs of moral distress and compassion fatigue at different professional stages. Specifically, beginning play therapists could learn about these constructs in their graduate degree programs and maintain this

knowledge through professional development courses and conferences throughout their career. Additionally, self-assessments could be made a requirement during practicum/internship and available at each APT credential renewal period. Utilizing the Self-Test for Psychotherapists (Stamm & Figley, 1999), for example, could offer a rough estimate of the play therapists' level of satisfaction with their work and risk of burnout and secondary traumatic stress. This information could then be used in supervision sessions or on their own time as a platform for checking-in with oneself and creating an effective self-care plan. Given the uniquely creative component of play therapists' self-care strategies, APT could also provide ideas for ways to creatively cope with work-related stress and offer a platform for play therapists to develop or join support groups for helping professionals. Similar to the wellness booth cited in Goldberg et al.'s (1996) study, APT's annual conference could have the previously mentioned self-assessments made readily available for attendees and provide "self-care stations" that could help play therapists practice and possibly take home resources on creative strategies to de-stress.

Play therapist supervisors and counseling training programs would benefit from not only focusing on creative coping tools but also acknowledging the challenging nature of the work of a play therapist and its naturally occurring potential for compassion fatigue as well as moral distress in toxic work environments. Young and Lambie (2011) emphasize healthy work environments as a means to improve counselor wellness and cite a shift in the counseling literature towards researching how the structure of an organization contributes to the wellness or impairment of the counseling professional. Specifically, they suggest advocating for systemic change by altering organizations' policies and procedures to promote wellness in their employees who are delivering wellness services.

Shifting efforts to a more community-based and advocacy-focused model could help lessen the burden on individual play therapists to be solely responsible for overcoming and coping with work-related stress. For example, Valerio and Wahl (2019) suggested community care as another form of self-care that does not place the onus of compassion on a single individual. They define community care as "people committed to leveraging their privilege to be there for one another in various ways" (p. 1). Additionally, Valerio and Wahl (2019) believed that in order to maximize wellness, a community-based system of care and support is critical. Thus, training programs and play therapy-focused conferences and workshops should include components of activism and awareness about unhealthy work environments and opportunities for creating and building free or low-cost support and consultation groups. Education for supervisors and clinicans on how to assess the development of moral distress or compassion fatigue and ways to collaborate with peers and supervisors when in distress could also be helpful in routine discussions or trainings in peer consultation groups, staff training sessions, or supervision meetings (Simpson & Starkey, 2006).

Additionally, training programs and counseling organizations could adopt Maslach's (2003) theoretical framework for understanding counselor impairment, for it incorporates both individual and systemic factors. Within this model, individuals and organizational factors are conceptualized as interacting. It is the degree of match or mismatch between counselors and their organizational systems that defines the counselor's level of wellness. Thus, a counselor's wellness is best fostered in a supportive environment where they are respected and appreciated while negative characteristics are minimized (Lambie, 2006; Leiter & Maslach, 1988). For example, mental health organizations can enhance wellness through improving counselor health and removing barriers to wellness caused by personal and occupational stress. It is through

promoting healthy lifestyles, redesigning task structures (i.e., routine paperwork), adopting a collaborative management style, improving teamwork, offering or promoting continuing education, using long-term plans for counselor support instead of reactive solutions, and implementing safety procedures and policies that organizations can help begin developing a healthy workplace with a "culture of wellness" (Hillier, Fewell, Cann, & Shephard, 2005, p. 428). These systemic changes can provide play therapists a positive work environment and create more opportunities to engage in self-care and self-monitoring as a means to respond to work-related stress (Puig, et al., 2012; Bhagat & Allie, 1989).

Limitations and Future Research

Despite the wide range of ages and professional experience in this sample, participants overwhelmingly identified as White/European American (88.3%) and female (90.7%). According to a national survey of Association for Play Therapy (APT) members conducted by Ryan, Gomory, and Lacasse (2002), the majority of their sample (n = 891) was also White/European American (89.7%) and female (92.1%). A follow up study by Nalavany, Ryan, Gomory, and Lacasse (2005) found similar demographics in their sample of APT members, where 87.7% identified as female and 90.2% identified as White/Non-Hispanic. Additionally, a recent qualitative study on RPT/S wellness experiences (n = 219) was comprised of mostly White/European American (82%), female (93.5%) participants (Meany-Walen, et al., 2018). Though our sample is consistent with previous surveys of the demographics of APT members, the generalizability of the results may increase in future studies if the sample were to include play therapists or counselors who primarily work with children and adolescents who are not APT members, RPT/S, or SB-RPT. Similarly, future studies could explore similarities and differences across the study variables for child and adolescent counselors who are credentialed play

therapists through APT (i.e., RPT, RPT-S, SB-RPT) and those who are not. This may help the field of child and adolescent counseling better understand the impact increased training, education, and practice has on professional counselors' overall wellness.

Another limitation is the study's correlational design. No inferences of causality can be made; thus, future research should consider experimental design with random selection and assignment of play therapists in practice to further explore the relationships among these multidimensional constructs. Additionally, the sample was composed of self-selected play therapists and self-report instruments. Thus, participants may be vulnerable to social desirability bias, and the results may be reflective of play therapists who are particularly struggling with wellness or have a special interest in the topic. Future studies could include surveying supervisors to compare self-report to the perceptions of supervisors on play therapist wellness.

Last, this study relied on lengthy self-report measurements, which should be considered when interpreting results. A large number of participants (218) were dropped from the study due to significant amounts of missing data. Since there were 184 total questions in the survey (including all three study measurements) about potentially distressing memories or situations related to clinical work, it can be assumed many respondents discontinued participation due to test fatigue. In future studies, researchers can choose to focus on one aspect of moral distress, wellness, or professional quality of life to minimize the number of surveys used. Alternatively, different, shorter measurements could be used to evaluate the constructs, or a mixed-method approach could be employed to allow participants to give voice to their experiences in a possibly less demanding format.

Conclusion

Although empathy and compassion are essential for counselors, they are also the very factors that make counselors vulnerable to compassion fatigue and its negative effects (Figley, 1995). Play therapists in particular can be deeply impacted by the children and adolescents they serve due to the interactive and participatory nature of play therapy, where play therapists are often "bearing witness" to the pain and distress of little ones played out in session (Copley, 2013). A stressful work environment can also play a role in play therapists' wellness and professional quality of life. Poor supervision, lack of support, institutional constraints, burdensome administrative tasks, and heavy caseloads can all contribute to the development of moral distress, which has been associated with job dissatisfaction, turnover in the workplace, and experiences of compassion satisfaction, burnout, and secondary traumatic stress (Corley, 2002; DeVeer, Francke, Struijs, & Willems, 2013; Sung, Seo, & Kim, 2012).

The results of this study shed needed light on play therapists' wellness as it relates to these constructs and provides a framework for interpreting the results in various contexts. Specifically, results indicated play therapists increase their use of self-care strategies as they experience more symptoms of burnout and secondary traumatic stress; however, they also feel tension between their self-care and caring for their clients, which more time in the field appeared to cause additional strain on this relationship. Interestingly, play therapists also had similar levels of compassion satisfaction as they did moral distress and compassion fatigue, suggesting they are pleased with their ability to help children and adolescents while simultaneously experiencing chronic distress related to job stressors. Though creativity seemed to be a uniquely important component of play therapists' wellness, it was not enough to prevent the presence and impact of moral distress and compassion fatigue. Thus, focusing efforts on broader, systemic changes could act as a more substantive and long-term aid in play therapists' wellness. In sum, it is

through a larger sense of support, meaning, and connection that play therapists at all levels of experience can heal and grow, which will allow this unique group of professional counselors to continue doing the work they love (Pearlman & Saakvitne, 1995).

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