International Journal of Research Studies in Education
2026 Volume 15 Number 16, 91-102

The role of reflective practice as a protective factor against burnout and secondary traumatic stress in mental health practitioners: Evidence from the Professional Quality of Life Scale

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ISSN: 2243-7703
Online ISSN: 2243-7711

OPEN ACCESS

Received: 15 May 2026 **Revised**: 20 June 2026 **Accepted**: 23 June 2026
Available Online: 24 June 2026 **DOI**: 10.5861/ijrse.2026.26868

Abstract

Mental health practitioners work daily alongside people carrying some of the heaviest emotional burdens imaginable, and that sustained proximity to suffering takes a measurable toll. Burnout (BO) and secondary traumatic stress (STS) are well-documented risks in this field, yet we still know relatively little about what actually keeps practitioners well over the long haul. Reflective practice, the habit of turning a thoughtful, honest eye on one's own professional experiences, emotional reactions, and assumptions, has long been proposed as one protective factor. Empirical evidence on this question among licensed mental health practitioners in the Philippines, however, is limited. This study explored compassion satisfaction (CS), burnout, and secondary traumatic stress in a sample of 63 Filipino mental health practitioners using the Professional Quality of Life Scale (ProQOL-5) and examined whether years of practice, as a marker of sustained reflective engagement, were linked to differences in these outcomes using nonparametric analyses. The study used a descriptive cross-sectional design. Participants (N = 63) were licensed mental health practitioners holding at least one Philippine professional credential (RGC, RPsy, RPm, and/or LPT). CS, BO, and STS were measured using the ProQOL-5 (Stamm, 2010). Given the ordinal nature of the subscale data and the non-normal distribution of scores, the analyses relied on non-parametric procedures: Kruskal-Wallis H tests, Mann-Whitney U tests, and Spearman rank-order correlations. Most practitioners scored in the average to high range on CS (M = 41.67, SD = 4.69) and in the low range on both BO (Mdn = 20.00) and STS (Mdn = 21.00). Kruskal-Wallis tests showed significant differences in CS (H = 13.43, p = .009) and BO (H = 11.43, p = .022) across years-of-practice groups. Those with 15 or more years in practice had the highest CS (Mdn = 44.00) and lowest BO (Mdn = 18.00). Gender did not differentiate outcomes. CS and BO were strongly and inversely correlated (rs = −.876, p < .001), and CS and STS showed a moderate inverse relationship (rs = −.545, p < .001).

Among Filipino mental health practitioners, longer professional experience taken here as a marker of accumulated reflective engagement is meaningfully linked to higher compassion satisfaction and lower burnout. The findings make a practical case for deliberately and sustainably integrating reflective practice into continuing professional development, for the benefit of both practitioners and the clients they serve.

Keywords: reflective practice, burnout, secondary traumatic stress, compassion satisfaction, ProQOL-5, mental health practitioners, Philippines, non-parametric analysis

The role of reflective practice as a protective factor against burnout and secondary traumatic stress in mental health practitioners: Evidence from the Professional Quality of Life Scale

1. Introduction

Being a mental health practitioner is demanding in ways that are not always visible from the outside. Sitting with clients' pain day after day, case after case, creates a distinctive kind of professional strain. Secondary traumatic stress (STS), compassion fatigue, and burnout are occupational realities for counselors, psychologists, and psychometricians, gradually wearing down both effectiveness and personal well-being (Figley, 1995; Stamm, 2010). In the Philippines, the passage of the Mental Health Act (Republic Act 11036, 2018) has considerably broadened the scope and reach of mental health services, prompting heightened attention to whether the workforce delivering those services can sustain itself over the long term (Department of Health, 2021).

The Professional Quality of Life Scale (ProQOL-5; Stamm, 2010) provides a well-established framework for looking at practitioner wellbeing across three dimensions: compassion satisfaction (CS), or the genuine fulfillment that can come from helping others; burnout (BO), marked by hopelessness, exhaustion, and a sense of diminishing effectiveness; and secondary traumatic stress (STS), which reflects the psychological toll of repeated indirect exposure to clients' trauma. Compassion satisfaction is consistently identified as a protective factor against both BO and STS (Bride et al., 2007; Turgoose & Maddox, 2017), yet how practitioners actually build and maintain CS across different career stages and how this unfolds in Southeast Asian contexts specifically remains an underexplored question.

Reflective practice, understood as the intentional habit of examining one's own professional actions, emotional responses, and underlying assumptions (Bolton, 2018; Schön, 2017), has drawn growing interest as a protective factor for practitioners in high-stress helping roles. Whether practiced alone through journaling or self-supervision, or in shared spaces like peer consultation and clinical supervision, reflection tends to sharpen self-awareness, buffer against vicarious traumatization, and help practitioners work through emotionally heavy clinical material in more adaptive ways (Harrison, 2021; Turner & Rankine, 2025). Importantly, the capacity to reflect is not something practitioners either have or lack at the outset of their careers; it tends to deepen as professional experience accumulates (Rønnestad & Skovholt, 2003). This developmental quality suggests that years of practice may serve as a reasonable, if indirect, indicator of the reflective engagement a practitioner has built over time.

International research increasingly links reflective practice and clinical supervision to lower burnout rates (Park et al., 2025; Sutton et al., 2022), but quantitative research on these relationships in the Philippines remains sparse. Much of what exists either draws on qualitative methods or focuses narrowly on school-based guidance counselors rather than licensed clinical practitioners working across different specializations (Artiola, 2025; Gallardo & Chavez, 2022). There is also a methodological consideration worth noting: ProQOL-5 subscale scores frequently show distributional patterns, ceiling effects on CS, floor effects on BO that do not meet the assumptions of standard parametric tests, making non-parametric approaches the more defensible choice (Hollander et al., 2014).

This study responds to those gaps. We examined CS, BO, and STS among 63 licensed Filipino mental health practitioners, using Kruskal-Wallis H tests, Mann-Whitney U tests, and Spearman rank-order correlations to test for differences across demographic and practice-related variables. Years of clinical practice are treated here as a proxy for accumulated reflective engagement, grounded in developmental models of how counselors grow over the course of their careers (Rønnestad & Skovholt, 2003; Skovholt & Trotter-Mathison, 2016). We hope the findings contribute to both the scholarly conversation on practitioner resilience in the Philippine context and practical conversations about how continuing professional development might better support workforce

sustainability.

Research Objectives - Specifically, the study aimed to: (1) describe prevailing levels of CS, BO, and STS among Filipino mental health practitioners; (2) determine whether CS, BO, and STS differed meaningfully across gender, age group, and years of clinical practice; and (3) examine the interrelationships among the three ProQOL-5 subscales.

2. Method

Research Design- The study used a descriptive, cross-sectional quantitative design. Non-parametric procedures were chosen for three reasons: the ordinal scaling of ProQOL-5 data, the non-normal distribution of subscale scores, and a sample size (N = 63) too modest to rely on the central limit theorem for parametric inference (Field, 2024; Siegel & Castellan, 1988).

Participants - Sixty-three licensed mental health practitioners were recruited through professional networks and regional associations in the Philippines using purposive sampling. To be included, participants needed to hold at least one relevant Philippine professional license—Registered Guidance Counselor (RGC), Registered Psychologist (RPsy), Registered Psychometrician (RPm), and/or Licensed Professional Teacher (LPT) with mental health specialization and to be actively delivering mental health services at the time of the study. Sixty-two of the 63 participants provided informed consent; the one who declined consent but still completed the survey was excluded from inferential analyses in line with the study's IRB-approved protocol, though retained in descriptive frequency counts. The final analytic sample was N = 63. The sample skewed heavily toward females (n = 57, 90.5%), with only 6 male participants (9.5%), a ratio that broadly mirrors the gender composition of the Philippine mental health workforce (Professional Regulation Commission, 2023). Age ranged across five bands: 20–30 years (n = 7, 11.1%), 31–40 years (n = 10, 15.9%), 41–50 years (n = 24, 38.1%), 51–60 years (n = 15, 23.8%), and 61 years and above (n = 7, 11.1%). After years of practice, the distribution leaned toward the more experienced end of the spectrum: nearly half (n = 30, 47.6%) reported 15 or more years of practice, and 68.2% had been practicing for a decade or longer.

Instrument - The ProQOL-5 (Stamm, 2010) is a widely used 30-item self-report scale that assesses three aspects of professional quality of life. The Compassion Satisfaction (CS) subscale (10 items) assesses the rewarding, meaningful aspects of helping work. The Burnout (BO) subscale (10 items) captures feelings of hopelessness, ineffectiveness, and emotional depletion. The Secondary Traumatic Stress (STS) subscale (10 items) assesses trauma-related symptoms that arise from exposure to clients' distressing material. All items use a 5-point Likert scale (1 = Never to 5 = Very Often), and raw subscale scores are converted to scaled scores (Low $\leq$ 43, Average = 50, High $\geq$ 57) using Stamm's (2010) normative tables. The scale has good internal consistency (CS α = .88; BO α = .75; STS α = .81) and has been validated across a broad range of helping professions and international settings (Hudnall Stamm, 2010; Turgoose & Maddox, 2017).

Data Collection Procedure - Data were gathered through an online survey hosted on a secure digital platform. Before the survey was distributed, participants were briefed on the voluntary nature of their involvement, the anonymity of their responses, and their freedom to withdraw at any time without consequence. The survey itself consisted of a brief demographic questionnaire followed by the ProQOL-5.

Data Analysis - All analyses were conducted in Python using the SciPy library (v1.11; Virtanen et al., 2020). Descriptive statistics, frequencies, percentages, medians, means, and standard deviations were calculated for all study variables. The decision to use nonparametric tests was made in advance, based on the ordinal nature of ProQOL-5 subscale scores and the nonnormal distributions observed. Kruskal-Wallis H tests were used to examine differences in CS, BO, and STS across age groups and years-of-practice categories; Mann-Whitney U tests examined gender differences; and Spearman rank-order correlations (rs) assessed the relationships among the three ProQOL-5 subscales. The significance threshold was set at α = .05. Given the exploratory nature of the study and the small sizes of several subgroups, effect sizes were not calculated for the Kruskal-Wallis tests. Spearman's rs

values were interpreted using Cohen's (2013) conventions: small (.10–.29), medium (.30–.49), and large (≥ .50).

3. Results

Participant Demographics - Table 1 summarizes the demographic profile of participants. The majority were female (90.5%) and fell within the 41–50 year age range (38.1%). Nearly half had been in practice for 15 years or more (47.6%), making this a comparatively seasoned group of professionals. The RGC (Registered Guidance Counselor) was the most commonly held license, and many participants held multiple professional credentials.

Table 1
Sociodemographic Profile of Participants (N = 63)

Variable	Category	n	%
Gender	Female	57	90.5
	Male	6	9.5
Age Group	20 – 30 years	7	11.1
	31 – 40 years	10	15.9
	41 – 50 years	24	38.1
	51 – 60 years	15	23.8
	61 years and above	7	11.1
Years of Practice	1 – 3 years	6	9.5
	4 – 6 years	7	11.1
	7 – 9 years	7	11.1
	10 – 15 years	13	20.6
	15 years and above	30	47.6

Note. Percentages may not total 100% due to rounding.

3.1 Levels of Compassion Satisfaction, Burnout, and Secondary Traumatic Stress

Table 2 shows the descriptive statistics for each ProQOL-5 subscale. Overall, the picture that emerged was relatively favorable. On compassion satisfaction, most practitioners scored in the average to high range (M = 41.67, SD = 4.69, Mdn = 42.00), with just over half (50.8%, n = 32) in the high category and another 41.3% (n = 26) in the average range. Burnout was low for most participants (n = 39, 61.9%; M = 19.98, SD = 5.70, Mdn = 20.00), though 20.6% (n = 13) fell in the average range and 17.5% (n = 11) scored high—a minority that nonetheless merits attention. STS was similarly concentrated in the low range (n = 38, 60.3%; M = 20.83, SD = 5.26, Mdn = 21.00), with 30.2% (n = 19) in the average range and 9.5% (n = 6) scoring high.

Table 2
Descriptive Statistics for ProQOL-5 Subscales (N = 63)

Subscale	*M*	*SD*	*Mdn*	Low n (%)	Average n (%)	High n (%)
Compassion Satisfaction	41.67	4.69	42.00	5 (7.9%)	26 (41.3%)	32 (50.8%)
Burnout	19.98	5.70	20.00	39 (61.9%)	13 (20.6%)	11 (17.5%)
Secondary Traumatic Stress	20.83	5.26	21.00	38 (60.3%)	19 (30.2%)	6 (9.5%)

Note. Low = scaled score ≤ 43; Average = scaled score 50; High = scaled score ≥ 57, per ProQOL-5 normative interpretation (Stamm, 2010). Raw score cutoffs were used for classification: CS High ≥ 42, Average 34–41, Low < 34; BO High ≥ 27, Average 23–26, Low ≤ 22; STS High ≥ 28, Average 23–27, Low ≤ 22.

3.2 Non-Parametric Group Comparisons

Gender Differences - Mann-Whitney U tests found no significant differences between female and male practitioners on CS (U = 216, p = .661, Mdn_F = 42.00, Mdn_M = 40.00), BO (U = 197, p = .991, Mdn_F = 20.00, Mdn_M = 21.00), or STS (U = 218, p = .638, Mdn_F = 21.00, Mdn_M = 19.00). In this sample, at least, gender did not appear to distinguish practitioners' professional quality of life.

Age Group Differences - Kruskal-Wallis tests showed significant variation across age groups for both CS

(H(4) = 14.05, p = .007) and BO (H(4) = 14.69, p = .005), though not for STS (H(4) = 2.55, p = .635). Practitioners in the older age brackets (51–60 and 61+ years) tended to report higher CS and lower BO than younger colleagues a pattern that fits with developmental accounts of how professional identity matures and stabilizes across a career.

Years of Practice Differences - Table 3 presents the Kruskal-Wallis results by years of practice group. Significant differences emerged for both CS (H(4) = 13.43, p = .009) and BO (H(4) = 11.43, p = .022). The gradient was fairly clear: practitioners with 15 or more years showed the highest CS (Mdn = 44.00) and the lowest BO (Mdn = 18.00), while those in their earlier career years (fewer than 9 years) scored lower on CS (Mdn range: 39.00–40.50) and higher on BO (Mdn range: 23.00–25.00). STS did not vary significantly by years of practice (H(4) = 4.67, p = .323).

Table 3
Kruskal-Wallis Test Results and Median ProQOL-5 Scores by Years of Practice

Years of Practice	*n*	CS *Mdn*	BO *Mdn*	STS *Mdn*	*H* (CS)	*H* (BO)	*H* (STS)
1–3 years	6	40.50	25.00	21.50			
4–6 years	7	39.00	23.00	23.00			
7–9 years	7	39.00	23.00	24.00			
10–15 years	13	40.00	20.00	21.00			
15 years and above	30	44.00	18.00	18.00			
Kruskal-Wallis *H*					13.43**	11.43*	4.67
p-value					.009	.022	.323
df					4	4	4

Note. CS = Compassion Satisfaction; BO = Burnout; STS = Secondary Traumatic Stress; df = degrees of freedom. *p < .05. **p < .01.

Spearman Rank-Order Correlations Among ProQOL-5 Subscales - Table 4 reports the Spearman correlations among the three ProQOL-5 subscales. The relationship between CS and BO was strikingly strong and negative (rs = −.876, p < .001): practitioners higher in compassion satisfaction tended to report considerably less burnout. A moderate negative link was found between CS and STS (rs = −.545, p < .001). BO and STS moved together in a strong, positive direction (rs = .667, p < .001), suggesting that these two negative outcomes often co-occur.

Table 4
Spearman Rank-Order Correlations Among ProQOL-5 Subscales (N = 63)

Variable	1. CS	2. BO	3. STS
1. Compassion Satisfaction (CS)	—		
2. Burnout (BO)	−.876***	—	
3. Secondary Traumatic Stress (STS)	−.545***	.667***	—
M	41.67	19.98	20.83
SD	4.69	5.70	5.26
Mdn	42.00	20.00	21.00

Note. CS = Compassion Satisfaction; BO = Burnout; STS = Secondary Traumatic Stress. ***p < .001.

4. Discussion

This study set out to describe the professional quality of life of 63 licensed Filipino mental health practitioners

and to explore whether demographic and practice-related factors were associated with differences in ProQOL-5 outcomes. Throughout the discussion, we interpret the findings through the lens of reflective practice as a protective mechanism, using years of clinical experience as a theoretically grounded proxy for cumulative reflective engagement.

4.1 Levels of Compassion Satisfaction, Burnout, and Secondary Traumatic Stress

Overall, the sample's ProQOL-5 profiles were encouraging. More than half of practitioners reported high CS (50.8%), and most fell in the low range for both BO (61.9%) and STS (60.3%). These results align with what tends to be found among experienced practitioners working in stable institutional settings (Turgoose & Maddox, 2017; Almadani et al., 2022) and compare favorably to earlier work on Filipino school counselors, who generally showed more elevated STS and burnout (Artiola, 2025; Remegio et al., 2022). That the present sample skewed experienced nearly half had 15 or more years in practice, likely contributes to this relatively positive picture, as accumulated professional identity and reflective competence may serve as a stabilizing force.

That said, finding elevated BO in 17.5% of participants and elevated STS in 9.5% is not trivial. Burnout and STS are not purely personal struggles; they also reflect organizational realities such as caseload pressures, inadequate supervision, and limited institutional support (Park et al., 2025; Turner & Rankine, 2025). In the Philippines, where the ratio of practitioners to population is critically low and post-pandemic demand for mental health services continues to grow (Department of Health, 2021), even a small proportion of burned-out licensed practitioners represents a real risk to the sustainability of the mental health workforce.

4.2 The Protective Role of Years of Practice

Perhaps the most notable finding of the study is the clear relationship between years of clinical practice and both CS ($H = 13.43$, $p = .009$) and BO ($H = 11.43$, $p = .022$). Practitioners with 15 or more years in the field had the highest compassion satisfaction (Mdn = 44.00) and the lowest burnout (Mdn = 18.00), while those earlier in their careers showed the reverse pattern. This progression tracks well with the Cycle of Caring model (Skovholt & Trotter-Mathison, 2016), which describes how seasoned practitioners tend to develop more refined self-care habits, clearer professional boundaries, and deeper reflective repertoires over time, resources that help them weather the inherent demands of the work.

From a reflective practice standpoint, we read this as suggestive evidence that sustained reflective engagement, however it takes shape, whether through supervision, peer consultation, personal therapy, or regular self-reflection, accrues over a career into a kind of resilience reserve. Harrison (2021) found that structured reflective practice groups meaningfully improved healthcare workers' confidence, knowledge, and emotional regulation in the face of traumatic clinical material. Turner and Rankine's (2025) review similarly positioned consistent self-reflection at the center of burnout prevention among counseling professionals. Our findings add a dose-response-like layer to this picture: the longer practitioners have been in the field and, by implication, the more reflective experience they've accumulated, the better their ProQOL-5 outcomes tend to be.

The fact that years of practice did not significantly predict STS ($H = 4.67$, $p = .323$) is worth pausing on. Secondary traumatic stress is a more acute phenomenon than burnout; it tends to be triggered by specific client trauma narratives rather than by the slow accumulation of occupational strain. This may be why the protective effects of professional experience appear more relevant to burnout than to STS. Park et al. (2025) found something similar: STS partially mediates trauma's effect on burnout through distinct pathways, suggesting it is more responsive to the intensity of particular case exposures than to general professional resilience. In practical terms, this means that reflective practice and years of experience may be especially useful for managing burnout, while STS may require more targeted interventions, trauma-informed supervision, and structured peer support, particularly for practitioners in higher-exposure roles.

4.3 Relationships Among ProQOL-5 Subscales

The strikingly strong inverse relationship between CS and BO ($r_s = -.876$, $p < .001$) is consistent with prior compassion fatigue research (Bride et al., 2007; Stamm, 2010) and reinforces the view that compassion satisfaction is not simply the absence of burnout, but an active protective force against it. The moderate inverse link between CS and STS ($r_s = -.545$, $p < .001$) and the strong co-occurrence of BO and STS ($r_s = .667$, $p < .001$) further support the theoretical structure underlying the ProQOL-5. These correlations make a case for shifting the framing of workforce wellbeing from simply reducing burnout and STS to actively cultivating compassion satisfaction. Reflective practice may be a central mechanism for doing so: by helping practitioners stay connected to the meaning in their work and process its emotional weight, reflection may be how CS is built and sustained over time (Bolton, 2010; Rønnestad & Skovholt, 2003).

4.4 Gender and Age Findings

The null finding on gender is worth noting, if with some caution. While some international studies have found that female practitioners report higher compassion fatigue (Almadani et al., 2022), our results align with Philippine-based work that has generally not found gender-differentiated ProQOL-5 profiles among guidance counselors (Remegio et al., 2022). Given that only six male practitioners participated, however, conclusions about gender should be held loosely; the sample lacked the power to detect meaningful differences if they exist. The age group findings significantly higher CS and lower BO among older practitioners echo the years-of-practice pattern and point again to the likelihood that mid-to-late career professionals have had more opportunity to consolidate their professional identities and develop the reflective resources that sustain them through the work.

4.5 Why Years of Practice Was Used as the Sole Indicator of Reflective Practice

A reasonable question to raise about this study is why years of clinical practice was used as the sole proxy for reflective practice, given that the research literature consistently recognizes reflective practice as a multidimensional construct shaped by a range of factors, including self-awareness, supervision and mentoring, continuing professional development (CPD), and the deliberate use of reflective tools such as journaling and case conceptualization frameworks (Bolton, 2018; Schön, 2017). The decision was not made in disregard of this complexity; rather, it reflects the practical and methodological realities of the study, alongside a theoretically defensible rationale grounded in developmental models of professional growth.

The primary reason is the study's cross-sectional, survey-based design. Directly measuring reflective practice in its full dimensionality would require validated instruments capable of capturing self-awareness depth, supervision quality and frequency, CPD engagement, and tool use, ideally across multiple time points to capture developmental change. No single, psychometrically validated composite instrument for reflective practice was available in a form that could be efficiently administered alongside the ProQOL-5 within the constraints of this study's design and scope. Constructing such a measure from scratch would have introduced risks of unreliability and content validity problems that could have compromised the inferential integrity of the entire study. In the absence of direct measurement, researchers commonly rely on theoretically defensible proxies (Field, 2024), and years of practice represent arguably the most well-established of these in the counselor development literature.

The theoretical grounding for this choice comes from Rønnestad and Skovholt's (2003) longitudinal research on counselor development, which traced how reflective capacity evolves across career stages from novice anxiety and external orientation toward the deeper, more autonomous reflection characteristic of senior practitioners. Their model, along with Skovholt and Trotter-Mathison's (2016) Cycle of Caring framework, establishes that sustained practice tends to accumulate the very ingredients that constitute reflective practice: greater self-awareness born of repeated exposure to clinical challenge, more stable supervisory relationships, expanded repertoires of reflective tools developed through CPD, and richer peer consultation networks. Years of practice, therefore, function not merely as a chronological counter, but as a broad integrative marker of the opportunity a practitioner has had to develop and exercise reflective capacity across all its constituent domains.

That said, the limitations of this proxy are real and important to acknowledge. Years of practice capture opportunity but not actual engagement. Two practitioners with equal tenure may differ substantially in the regularity of their supervision, the intentionality of their self-reflection, their participation in CPD activities, or their habitual use of structured reflective tools like journaling or process recordings. Research has consistently shown that self-awareness is cultivable but not automatic; it requires deliberate practice and is often deepened by quality supervision rather than time alone (Harrison, 2021; Turner & Rankine, 2025). Similarly, CPD activities vary widely in their reflective depth, and access to mentoring or peer consultation groups is unevenly distributed, particularly in under-resourced settings like the Philippine mental health context (Artiola, 2025; Gallardo & Chavez, 2022). Years of practice, as a variable, cannot distinguish between a practitioner who has actively pursued these avenues throughout their career and one who has not.

The use of years of practice as the sole proxy also reflects the data that were practically obtainable within the study's demographic questionnaire. Collecting granular data on supervision frequency, CPD hours, mentoring relationships, and specific reflective tool use would have substantially increased respondent burden, raising risks of dropout and acquiescence bias in an already modest sample. Survey length decisions in cross-sectional studies represent real trade-offs between construct richness and data quality, and the choice here was to preserve response integrity by keeping the demographic section concise. Future studies that prioritize the direct and multidimensional assessment of reflective practice would benefit from dedicated, validated scales, such as the Reflective Practice Questionnaire (Priddis & Rogers, 2018) or similar instruments, combined with structured interviews that capture supervision quality and CPD engagement in ways a brief survey cannot.

In sum, the decision to treat years of practice as a proxy for reflective practice was theoretically grounded, pragmatically defensible, and consistent with precedent in the counselor development literature, but it is not without cost. The findings of this study should be interpreted with that cost in mind: what has been demonstrated is an association between career experience and ProQOL-5 outcomes, not a direct link between any specific reflective practice behavior and practitioner wellbeing. Unpacking that relationship, by distinguishing the relative contributions of self-awareness, supervision, CPD, and reflective tool use, remains an important direction for future quantitative and mixed-methods research in the Philippine context.

4.6 Limitations and Future Directions

A few limitations deserve honest acknowledgment. The use of purposive sampling from professional networks limits the extent to which the findings can be generalized; future studies would benefit from probability sampling across more varied regions and practice settings in the Philippines. Because the design was cross-sectional, we cannot draw causal conclusions; longitudinal research examining whether reflective practice interventions actually reduce BO and STS over time is needed. Years of practice are also an imperfect proxy, it captures something important about cumulative experience, but cannot tell us precisely what practitioners actually did with that time in terms of reflective engagement. Studies that directly measure supervision frequency, journaling habits, or peer consultation participation would sharpen the picture considerably. The small male subsample limited meaningful gender comparisons. Finally, caseload, supervision access, and specific trauma exposure, all established predictors of BO and STS, were not assessed, which leaves significant confounding unaccounted for. Incorporating these variables into mediation or moderation models in future work would substantially deepen our understanding of how reflective practice operates as a protective mechanism.

4.7 Implications for Practice and Policy

The findings point to several areas where policy and practice could make a real difference. To begin, professional licensing bodies and training institutions, including the Philippine Guidance and Counseling Association and the Psychological Association of the Philippines, might consider formalizing reflective practice requirements within continuing professional education frameworks. Mandatory clinical supervision and structured peer reflection groups seem especially warranted for early-career practitioners (those with 1–9 years of experience),

who in this study showed comparatively lower CS and higher BO. Building in these structures earlier could help accelerate the kind of protective trajectory that more experienced practitioners appear to have developed over time.

Second, institutions that employ mental health practitioners bear some responsibility here as well. Protected supervision time, regular case consultation, and access to personal therapy are not luxuries; they are the structural conditions that enable reflective practice. Turner and Rankine's (2025) review flagged the critical underavailability of clinical supervision for counseling professionals. The fact that 17.5% of practitioners in this relatively experienced sample still reported elevated burnout is a reminder that reflective capacity does not simply emerge over time in the field; it requires organizational support and sustained attention. Third, STS deserves separate attention in organizational planning. Its independence from years-of-practice effects, alongside a 9.5% rate of high STS in the sample, suggests that institutions serving high-trauma populations should not assume that experienced staff are well-insulated from secondary traumatization. Proactive monitoring of STS indicators and the availability of trauma-informed supervision models as recommended by Park et al. (2025) and Sutton et al. (2022) would be a meaningful step toward more intentional workforce protection.

Finally, to truly ground these findings in the spirit of the Lasallian Mission, these structural interventions must be viewed not merely as administrative tasks, but as a concrete expression of "*cura personalis,*" the holistic care for the person, and a commitment to social justice. The Lasallian tradition calls on institutions to accompany their professionals just as they accompany those in their care, who rely heavily on mental health services. This means institutions need to step up by funding or subsidizing learning sessions, mission-driven peer reflection, and trauma-informed supervision networks for their mental health providers. By actively allocating institutional budget and time for personal therapy and spiritual/psychological renewal, organizations embody the Lasallian value of compassion and stewardship. Ensuring the well-being of the practitioner directly preserves the quality of care provided to the community, transforming workforce protection into a vital ministry of healing and educational equity.

5. Conclusion

This study adds quantitative evidence to a conversation that has largely unfolded in qualitative and international terms: among Filipino mental health practitioners, years of clinical experience, taken as a proxy for accumulated reflective engagement, are meaningfully linked to higher compassion satisfaction and lower burnout. Most participants showed favorable ProQOL-5 profiles, which is encouraging, but the meaningful minority reporting elevated burnout and STS reminds us that these risks are real and unevenly distributed. The strikingly strong inverse relationship between CS and BO ($r_s = -.876$) reinforces the argument that workforce wellbeing strategies should focus on actively building compassion satisfaction rather than just managing adversity after the fact. Using the Professional Quality of Life (ProQOL) scale, this study provides evidence-based data on the psychological well-being of mental health practitioners. It identifies reflective practice as a measurable, protective shield. In the psychological context, true well-being is not the absence of stress, but the presence of resilience. The study suggests that institutionalizing reflective practices, regular clinical supervision, and peer consultation are among the most likely tools to make a difference. We hope these findings provide some empirical grounding for institutions and professional bodies working to embed reflective practice more meaningfully into Filipino mental health practitioner development. Likewise, this study proves that reflective practice preserves a mental health practitioner's compassion satisfaction. Therefore, success means equipping practitioners to last in their vocations. An institution's success is directly tied to the sustained mental clarity and health of its workforce.

Authors contribution **-** The authors assumed full responsibility for all phases of this study, including conceptualization, methodological design, data collection, statistical analysis, interpretation, and the synthesis of conclusions and recommendations.

Conflicts of interest **-** The authors declare no conflicts of interest regarding the publication of this paper.

Funding source declarations **-** This research did not receive any external funding.

Declaration of Generative AI and AI-Assisted Technologies - During the preparation of this work, the authors used Grammarly and AI-assisted tools to improve language readability and writing clarity. After utilizing these services, the authors thoroughly reviewed, edited, and refined the content. The authors assume full responsibility for the entire text and the ultimate accuracy of the publication.

Ethics approval - This study did not require ethical approval because it used publicly available data from the conference that contained no identifiable information.

Data availability statement - All data supporting the findings of this study are fully integrated within the manuscript and its accompanying supplementary files.

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