A COMPARISON BETWEEN COUNSELORS WHO PRACTICE MEDITATION AND THOSE WHO DO NOT ON COMPASSION FATIGUE, COMPASSION SATISFACTION, BURNOUT AND SELF-COMPASSION

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A COMPARISON BETWEEN COUNSELORS WHO PRACTICE MEDITATION
AND THOSE WHO DO NOT ON COMPASSION FATIGUE, COMPASSION
SATISFACTION, BURNOUT AND SELF-COMPASSION

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Dissertation

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ABSTRACT

One hundred sixty-four professional counselors completed an on-line survey that included the PRO-QOL (Professional Quality of Life Scale) and the SCS (Self-Compassion Scale). Participants also completed a demographic questionnaire that included length of meditation practice and other self-care practices. Results of a MANCOVA revealed that the meditation practice group (N=62) reported significantly higher levels self-compassion, while showing lower levels of burnout than their non-meditating peers (N=102) when controlling for Social Desirability. Further, the current study found that measures of self-compassion were positively associated with measures of compassion satisfaction ($r=0.387$, $p=0.01$) and negatively associated with measures of burnout ($r=-0.525$, $p=0.01$) and compassion fatigue ($r=-0.452$, $p=0.01$). These results are congruent with the promising research that has been conducted on the relatively new construct of self-compassion, suggesting its utility and value to the growing fields of positive psychology and professional wellness. In addition, post hoc analyses (ANCOVA) revealed that self-care time was found to have a significant impact on compassion satisfaction, suggesting that individuals who practice more than 5 hours of self-care per week have higher levels of compassion satisfaction than their colleagues who reported less self-care time. Limitations included a convenience sample of participants (recruited from state associations and professional list serves) and a fairly stringent definition of meditation practice (at least 60 minutes per week, at least 6 months...
of practice). Implications for training and practice, which includes the responsibility of training programs to include formal instruction in self-care practices, are presented along with recommendations for future research.
DEDICATION

This dissertation is dedicated to my family, my friends and my wife. To my parents, Rich and Rose, I want to express my deepest love and appreciation- you never gave up on me, even when I was ready to give up on myself. This work is also dedicated to my students- past, present and future- know that I will never give up on you.
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CHAPTER I
INTRODUCTION

The Problem

As a consequence of living in a society of caring, concerned human beings in a shrinking world, we are more acutely aware of the pain and suffering of others. The media is rife with images of violence, natural disasters, acts of terrorism and human tragedy. Although the average person can “turn off” these intrusive images and reports of misery, counselors, by the very nature of their work, do not have such a luxury. These professionals are psychologically bombarded by the traumatic recollections, emotional suffering, and psychological pain brought by their clients into session. This psychic assault can take a significant physical and psychological toll on the professional. This “cost of caring” (Figley, 2002) has been termed in the literature compassion fatigue or secondary traumatic stress disorder. Common symptoms of compassion fatigue include: headaches, nausea, difficulty sleeping, social isolation, emotional reactivity and a host of other physical and psychological sequelae that often mirror a diagnosis of post traumatic stress disorder.

Each year thousands of people who have been traumatized seek help from counselors, social workers, psychologists and variety of other mental health professionals. These mental health professionals work diligently to help their clients come to terms with the past, find meaning in these traumatic experiences and reduce the
subjective experience of suffering endured by them. This process comes at a considerable emotional price to the therapist or counselor. This price is what Figley (2002) refers to as the “cost of caring.” Unfortunately, this cost often goes unrecognized or is dismissed as an unfortunate side effect of the therapist’s career choice.

As a profession, counseling and psychotherapy can be characterized as emotionally taxing (Simpson, 2005). Counseling the traumatized makes the therapist particularly vulnerable to personal and professional perils that have only recently been expounded upon within the context of the professional literature. When therapeutically engaged with a child or adult who has been traumatized or is suffering from secondary trauma, counseling professionals are particularly at risk for experiencing physical, emotional, spiritual and mental exhaustion. (Figley, 1995; Costa, 2005). Following the therapeutic encounter with the trauma survivor, the clinician may be vulnerable to intrusive thoughts, avoidance, negative affect and impaired psychological functioning (Chrestman, 1995). These symptoms are often seen as parallel to the diagnosis of Post Traumatic Stress Disorder and have been termed Secondary Traumatic Stress Disorder, Vicarious Traumatization and Compassion Fatigue (Figely, 1995; 2002).

**Compassion Fatigue**

Figely (2002) indicates:

Compassion fatigue is a state of tension and preoccupation with the traumatized patients by re-experiencing the traumatic events, avoidance/numbing of reminders, persistent arousal associated with the patient. It is a function of being witness to the suffering of others. p 1435.
Although accounts of biopsychosocial reactions to emotionally traumatic events have been documented as early as Ancient Greece (Beveridge, 1997), Post Traumatic Stress Disorder (or PTSD) was not recognized as a psychiatric diagnosis until 1980, with the publication of the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) (Figley, 1995). Included in the diagnosis of PTSD is the concept of secondary or indirect trauma, which includes “learning about the unexpected or violent death, serious harm or threat of death or injury experienced by a family member or other close associates” (American Psychiatric Association, 2000, p. 463).

In spite of this diagnostic caveat, Figley (1995) indicated that much of the research on PTSD has been methodologically limited in that it typically only addressed the experience of the primary trauma victim/survivor. Figley (1995) concluded that although there had been some attention in the literature directed at the phenomenon of compassion fatigue, without a clear identification of this kind of traumatization, nearly all attention and resources were being directed at the people who directly suffer and did not account for those who worried and cared about them. These supporters also had the possibility to become traumatized as a result of caring for the victim (Figley, 1995).

Meldrum, King and Spooner (2002) found that 27% of a sample of Australian mental health professions who worked with traumatized individuals reported extreme stress from this type of work. Wee and Myers (2002) found that 64.7% of Oklahoma City trauma workers reported some degree of secondary traumatic stress or compassion fatigue following the Oklahoma City Bombing. Specifically, 73.5% of the counselors working with the trauma survivors of the Oklahoma City Bombing reported moderate to
extremely high levels of compassion fatigue as measured by the Compassion Fatigue Self Test for Psychotherapists.

Compassion fatigue in clinicians has the capacity to result in mistakes, misjudgments and blatant clinical errors (Figley, 2002). Baranowsky (2002) indicated that counselors suffering from compassion fatigue could be using an unconscious process known as the silencing response to avoid the client’s traumatic recollections. This silencing response “shuts down” the therapeutic process and impedes communication between the counselor and the client (Baranowsky, 2002). In addition to impaired professional functioning displayed by the fatigued counselor, compassion fatigue may also lead to burnout, personal turmoil, dissatisfaction and professional migration from the field of counseling. Many therapists and researchers have abandoned the treatment and study of the traumatized because of their perceived inability to deal with the pain of others (Figley, 1995). Perhaps more dangerous were the clinicians who did not recognize their level impairment and continued to treat traumatized clients (Monroe, 1995).

Compassion fatigue can also impact the therapist outside of the bounds of professional practice. These impairments may also “bleed” into the therapist’s personal life (Chrestman, 1995). The disempowered psychotherapist may suffer in silence and grow more disillusioned with a field that once held so much promise. He or she may seek a supervisory or training role which would take him or her out of direct contact with clients who desperately need help (Figley, 2002). It becomes imperative that training programs and agencies promote the development of more effective mechanisms to help and support the fatigued counselor.
The term ‘compassion fatigue’ first emerged in the field of nursing in the early 1990’s to describe the stress and emotional burnout that nurses experienced in reaction to their patients and duties (Costa, 2005). Compassion fatigue is synonymous with the term secondary traumatic stress and has been used interchangeably with the concept of vicarious traumatization (Figley, 1995). Although compassion fatigue first entered the psychological literature in the study of Post Traumatic Stress Disorder, compassion fatigue can also reflect the chronic lack of self care on the part of the psychotherapist (Figley, 2002).

The term compassion refers to a feeling of deep sympathy and sorrow for another who is suffering. This feeling of sympathy is accompanied by a strong desire to ameliorate the suffering of the other (Costa, 2005; Gilbert, 2005; Steffen & Masters, 2005; Hutnik, 2005). In terms of the therapeutic relationship and characteristics displayed by the therapist, compassion appears to be related to the construct of affective empathy or the respondent’s ability to experience warm, concerned, compassionate feelings for others (Lawrence et al., 2004). Compassion, in the traditional sense, involves a complex interaction of motivation, emotion, thoughts and behaviors that manifests as caring for the well-being of others which enhances their chances for both health and prosperity (Gilbert, 2005). Therapists, by the very nature of their work, are called on to be compassionate toward their clients on a daily basis.

Figley (1995) indicated that the most frequent and important “cures” for people suffering from trauma and post traumatic stress were personal, and not clinical or medical. These personal treatments included the social support offered by family, friends and professionals who care. Given the prevalence of personal and societal traumas that
people are exposed to, anyone in a personal or familial relationship with another may be at some risk for developing compassion fatigue (Stamm, 2002). This risk for developing compassion fatigue is much higher for those who work with the traumatized on a regular basis as the exposure rate increases exponentially. Figley (2002) identified the therapeutic tools of empathy and emotional energy as the driving forces in effectively helping those who suffer. Ironically, the more compassionate and empathetic a clinician is toward the suffering of the traumatized person, the more vulnerable that therapist is to compassion fatigue.

In his seminal text on the subject, Figley (1995) identified 10 distinct variables that either lead to or mitigate the development of compassion fatigue. These variables included: empathic ability, empathic concern, exposure to the client, empathic response, compassion stress, prolonged exposure and traumatic recollections and life disruptions. Included in Figley’s model were the protective elements of the therapist having a sense of achievement about his or her work and disengagement from clients and work related activities and responsibilities (see Figure 1 in Chapter 2).

Burnout

Related to the construct of compassion fatigue is the notion that those who work intensely with others are particularly vulnerable to burnout. Burnout refers to the feeling of exhaustion that counselors and other mental health professionals may experience when they perceive that they have taken on more than they can handle effectively (Raquepaw & Miller, 1989; Wegeta, 1999). Burnout has both physical and emotional components and may include muscle tension, exhaustion, clumsiness, feelings of anger, sadness and
depression (Wegeta, 1999.) As opposed to compassion fatigue, the feelings that comprise burnout are believed to have a more gradual onset (Stamm, 2005) and may result in negative evaluations of the work environment, clients or colleagues. Raquepaw and Miller (1989) indicated that mental health professionals who work for agencies were more vulnerable to burnout than the private practitioner, which may be a function of the additional paperwork and administrative duties that often accompany employment within an agency. Burnout has also been shown to increase the likelihood that a professional will leave the field prematurely (Raquepaw & Miller, 1989).

**Study Purpose**

Are there practices, activities and qualities that may serve to protect the counselor from the phenomena of compassion fatigue and burnout? Figley (1995) suggested that a sense of professional satisfaction and disengagement from clinical involvement were two protective factors that may impede the subsequent development of compassion fatigue. Stamm (2002) indicated that a helper’s motivation to help others were, in part, shaped by the satisfaction derived from helping others. Maslach (1978) indicated that a sense of accomplishment and purpose in one’s work may be a protective factor against burnout. Simpson (2005) also found that counselors who endorsed higher levels of spirituality reported less vulnerability to compassion fatigue. Steffen and Masters (2005) found that an attitude of compassion for others has the capacity to improve psychological well-being and reduce the subjective experience of stress in those who display compassionate attitudes.
Theory and research have suggested that both compassion fatigue and burnout are impacted by both external factors and internal attitudes or perceptions. One such self-attitude that may dramatically reduce subjective feelings of distress, burnout and compassion fatigue is self-compassion. Self-compassion is a relatively new psychological construct that has its origins in the philosophy and practice of Buddhism. It refers to being open to and moved by one’s own suffering, experiencing feelings of kindness and caring toward oneself, taking an understanding non-judgmental attitude toward one’s inadequacies and failures and recognizing one’s experience as part of the larger human experience (Neff, 2003a). Neff (2003b) asserted that, although research on self-compassion was still in the early stages, there was good reason to believe that having high levels of self-compassion results in greater levels of mental health. Theoretically, self-compassion should be associated with less depression, anxiety, perfectionism and greater life satisfaction (Neff, 2003a). These characteristics may help to mitigate the impact of work related stress, burnout and compassion fatigue.

One strategy for enhancing the development of compassion for self and others is the practice of meditation. Meditation, which originated as a spiritual practice over 3,000 years ago, has been identified as one of the most researched of all psychotherapeutic methods (Walsh & Shapiro, 2006). Research on meditation has shown the effectiveness of meditation practice in reducing anxiety, as an adjunct treatment in cardiovascular disease, pain management and overall mental health and well-being (Shapiro & Walsh, 2003). Initial research has suggested that meditation can benefit both researchers and clinicians who struggle with burnout, stress, job dissatisfaction, anxiety, depression, and diminished professional effectiveness (Shapiro, Austin, Bishop & Cordova, 2005).
Meditation has also been described as benefiting counselors by facilitating the
development of empathy, attention, equanimity and presence (Walsh & Shapiro, 2006;
Lesh, 1970). Neff (2003b) found that practitioners of Buddhist meditation had higher
degrees of self-compassion (self- kindness, common humanity and mindfulness and
lower levels of self-judgment, isolation and over-identification) than a sample of
undergraduates. Although elevated levels of over-identification, self-judgment and
isolation may be risk-factors for the development of compassion fatigue and burnout, no
formal research has been conducted to investigate this potential link. The present study
endeavors to address this discrepancy in the literature.

As the growing body of literature suggests, more effective ways of preventing and
ameliorating the effects of compassion fatigue among mental health professionals need to
be researched and disseminated to therapists who work with the survivors of trauma.
Meditation, one of the most widely researched therapeutic interventions for promoting
mental health and well-being, may offer one avenue for mitigating the impact of
compassion fatigue on the professional counselor as well as improving the counselor’s
levels of compassion satisfaction and self-compassion.

Instrumentation

In addition to demographic questionnaires which included meditation experience and
therapeutic practice, and an abbreviated measure of social desirability (used as a
covariate) this study used the following formal measures:

*The Pro-QOL- The Professional Quality of Life Scale* was developed by Stamm
(2005) and represents the most recent revision of the Compassion Fatigue Self Test
which was originally developed by Figley (1995). The Pro-QOL measures compassion fatigue, compassion satisfaction and the related construct of burnout. Each scale is independent of the other scales and the measure does not yield an overall score.

*The Self-Compassion Scale (SCS).* The SCS was developed by Neff (2003b) to measure self-compassion, a term which is relatively new in the psychological literature. The SCS measures the related constructs of Self-kindness, Common Humanity, and Mindfulness. The SCS does yield an overall score that represents the construct of self-compassion.

**Purpose statement**

The purpose of this study was to determine if a relationship exists between meditation practice, self-compassion and the development of compassion fatigue and burnout in professional counselors. Counselors who actively practice meditation were compared to counselors who do not meditate on the following constructs: compassion satisfaction, compassion fatigue, burnout, and self-compassion.

**Research question**

This study attempted to answer the following research questions: To what extent does a professional counselor’s reported meditation practice relate to self-reports of self-compassion, compassion fatigue, compassion satisfaction and burnout? Does a counselor’s reported level of self-compassion relate to his or her self reported levels of compassion fatigue?
**Definition of terms:**

- **Compassion fatigue:** Is defined as work-related secondary exposure to extremely stressful events (Stamm, 2005). For example, the individual may repeatedly hear stories of traumatic events that happen to other people. The resulting symptoms of compassion fatigue typically have an acute onset and are usually associated with a particular event (Stamm, 2005). Symptoms may include: being afraid, having intrusive images enter the person’s attention, having trouble sleeping, or avoiding situations that remind the individual of the event. According to Figley (1995), Compassion fatigue is synonymous with the construct of secondary traumatic stress.

- **Compassion satisfaction:** The pleasure that an individual derives from being able to do his or her work well (Stamm, 2005). The individual generally feels positively about his or her colleagues and feels like he or she is making a contribution to others and society as a whole.

- **Burnout:** Feelings of hopelessness and difficulties in dealing with work and working effectively (Stamm, 2005). These feelings tend to be gradual in onset and tend to reflect that the individual does not feel effective in his or her work. The individual may feel that the resources available are inadequate or that his/her caseload is too large.

- **Self-compassion:** Feelings of being open to and moved by one’s own suffering. Self-compassion also involves experiencing feelings of caring and kindness toward oneself, taking a nonjudgmental attitude toward one’s limitations, and
recognizing that the individual is one part of the larger human experience (Neff, 2003a).

- Self-kindness: Refers to an attitude of understanding and patience toward all aspects of the individual’s self.

- Self-judgment: Refers toward hostile, negative feelings toward less desirable characteristics displayed by the individual.

- Common humanity: Refers to the individual having the perspective that the experiences of negative events in the individual’s life are part experiences shared by all of humanity.

- Isolation: Refers to the individual feeling alone and cut off from others when confronted with negative performances.

- Mindfulness: Refers to maintaining a sense of emotional balance and equanimity even when confronted with painful circumstances.

- Over-identification: Refers to the individual having the tendency to get overwhelmed by his or her negative feelings.

- Meditation: Refers to a group of related practices that train attention and awareness with the goal of enhancing psychological and spiritual well-being and development (Shapiro & Walsh, 2003). Meditation is typically classified into one of two general varieties which include concentrative and awareness meditations (Shapiro and Walsh, 2003). Concentrative meditation requires the individual to focus attention on one stimuli, such as breath, a mantra, a bell, etc.. Awareness or mindfulness meditation allows the attention to move to a variety of stimuli (i.e.
thoughts and sensations) with the goal of not attaching to any of them (Shapiro & Walsh, 2003).

Summary of Chapter I

This chapter provided a brief overview of the phenomena and etiology of compassion fatigue and its potential impact on counseling professionals. Compassion fatigue, which has also been termed secondary traumatic stress, often mirrors the symptoms of Post Traumatic Stress disorder, except the symptoms are acquired by interacting with individuals who have been traumatized. In addition to providing a brief overview of compassion fatigue, this chapter also reviewed the related construct of burnout, which also has been shown to have a deleterious impact on the work of counselors. This chapter provided a brief introduction to the construct of self-compassion which may serve to ameliorate the phenomena of compassion fatigue and burnout. Meditation, which has been practiced for centuries to enhance compassion for self and others, was also introduced as a mechanism that may enhance self-compassion. The chapter concluded by introducing the research question, which will examine differences between counselors who practice meditation and those who do not. A number of terms specific to this study were delineated creating a common ground for the study.
In this chapter, the author reviews the unique perspective brought by the counseling profession, which since its inception, has displayed a strong connection to the humanistic and person-centered schools of psychotherapy. A preliminary review of the literature on compassion and its relevance to psychological health is presented. The author also reviews the theoretical basis of compassion fatigue and differentiates compassion fatigue from the related phenomenon of vicarious traumatization. The consequences of compassion fatigue are also considered. The author then reviews the relevant empirical research on compassion fatigue in terms of its contribution to the present study. The related constructs of compassion satisfaction and burnout are also briefly addressed. The relatively new psychological construct of self-compassion is introduced along with a description of some of the initial studies that have addressed this variable in the literature and distinguished it from related constructs of psychological well-being. The chapter concludes with a review of meditation which includes its definition, historical context and a review of relevant research related to both mediation and the emerging psychological construct of mindfulness.
The counseling profession

Natural disasters, acts of terrorism, warfare, violent crime, domestic violence and child abuse are unfortunate circumstances that significantly impact life in modern society. These events necessitate the training of professional counselors to effectively treat the trauma associated with these personal and societal crises (J. Rogers, 2007; Bemak & Hanna, 1998). Professional counselors work with diverse populations in a variety of settings from schools to agencies to private practice settings. Counselors assist individuals, groups, families and communities with personal, educational, family, mental health/career decisions and problems (Bureau of Labor Statistics, 2007; Bemak & Hanna, 1998; Vacc & Loesch, 2000).

In 2004, counselors represented the largest mental health service profession in the United States, employing 601,000 individuals, outnumbering the 564,000 social workers and the 179,000 psychologists currently found in the US (Bureau of Labor Statistics, 2007). Although the exact scope of the counselor’s services is contingent on the setting in which the counselor works, all counselors are concerned with helping their clients obtain optimal health and wellness. Smith and Robinson (1995) indicated that counselors bring a unique perspective to the field of mental health. This perspective is often broader than that of psychiatry or clinical psychology, as counselors are less likely to label an individual as “sick.” In addition, the field of counseling as a whole, is concerned with both prevention and wellness and not merely the amelioration of symptoms or deficits (Bemak & Hanna, 1998). Counselors distinguish themselves from other mental health professionals by the applied nature of their work (Vacc & Loesch, 2000).
Carl Rogers, one of the founders of humanistic psychology, has been widely regarded as one of the most influential thinkers in the development of professional counseling (Smith and Robinson, 1995). Roger’s Person-Centered counseling continues to provide the foundation for counseling programs throughout both the country and the world (Wickman & Campbell, 2003). Central to Roger’s theory of counseling are the core facilitative conditions of empathy, genuineness and unconditional positive regard that the therapist displays toward the client. These core conditions form the “backbone” of the Person-Centered approach to counseling and the basis of the therapeutic relationship. Therapeutic empathy on the part of the counselor for his or her client has been found to be one of the most effective common elements in successful therapeutic outcomes (Bohart, Elliot, Greenberg & Watson, 2002; Lambert & Barley, 2001).

The Nature of Compassion

Although empathy has been shown to be a vital ingredient in the therapeutic endeavor, without a genuine desire to help the client, the mere emotional and cognitive understanding of the client’s experience may be insufficient to enact change. Gilbert (2005) argued that sales people and sociopaths can be empathic in terms of understanding the feelings and thoughts of others, but neither have a genuine desire to help alleviate the suffering of individuals in pain. Without the genuine desire to be of assistance to a person in need, psychotherapy and counseling are significantly less likely to be effective. Hutnik (2005), a proponent of humanistic and person-centered approaches, suggested that the practice of psychotherapy and counseling involve the compassionate caring for the
mental health of another person. Inherent in this caring are the constructs of empathy, congruence and unconditional positive regard initially proposed by Rogers.

Gilbert and Proctor (2006) suggested that compassion involves a number of components including a desire to care for the well-being of another (altruism), the ability to detect distress in another (affective empathy), sympathy (being emotionally affected by that distress), distress tolerance (the ability to tolerate the emotional pain of another), cognitive empathy (to understand the reasons for others’ suffering and an understanding of what is necessary to alleviate that suffering), and a non-judgmental stance. These components must be accompanied by an emotional tone of warmth. The lack of any one of these components makes compassion difficult. Ironically, Figley (1995) found that therapists and counselors who display high levels of compassion (which includes empathy) toward their clients were often the most vulnerable to experience compassion fatigue. These compassionate professionals were particularly vulnerable when confronted with the traumatic experiences of their clients.

Compassion Fatigue: Prevalence

Achieving and maintaining this compassionate stance, which includes unconditional positive regard, empathy and genuineness with a client is not easy (Ewen, 2003), but the presence of these core elements is necessary for change to occur. When a counselor is suffering from the effects of compassion fatigue and burnout, these characteristics are nearly impossible to successfully demonstrate for a suffering client. Guy, Poelstra and Stark (1989) reported that in a sample of 318 psychologists, 74.3% reported experiencing personal distress and 36.7% indicated that it significantly reduced
the quality of care that they were able to provide to their clients. Although this study is
almost 20 years old and was limited to a population of psychologists, given the biases
inherent in self-report, these results are likely to be under representations of the actual
phenomena in the current community of mental health care providers.

In a sample of 161 trauma counselors in British Columbia, Arvay and Uhlemann
(1996) found that 24% of the counselors interviewed perceived life as stressful. Sixteen
percent reported high levels of emotional exhaustion, 4% reported levels of
depersonalization and 26% reported feeling ineffective at work in terms of professional
accomplishment. Fourteen percent of the sample reported traumatic stress levels similar
to PTSD. Arvay and Uhlemann (1996) presented a profile of the impaired counselor
suggested by the results of their study. They indicated that the impaired counselor was in
his or her early 40’s, held less than a master’s degree and was more likely to work for an
agency than in a private setting. Further, their results suggested that the exhausted or
vicariously traumatized therapist had less than 10 years of professional experience,
carried a caseload of between 10 and 26 traumatized clients, which they saw as too many.
These therapists tended to describe their caseloads as “intense” and reported that they
were frequently impacted by the traumatic material reported by their clientele. In terms
of self-care, these individuals reported both exercise and accessing support through
family and friends. Apparently, these self-care mechanisms were not sufficient in
mitigating the stress of their work, as these counselors reported symptoms consistent with
professional burnout.

In a more recent study of 1,121 mental health providers, Sprang, Clark and Whitt-
Woosley (2007) found that female gender, young age, a higher educational degree, less
experience in clinical settings and a higher percentage of clients diagnosed with PTSD predicted elevated levels compassion fatigue in the study’s sample. Sprang et al. found that rural practitioners were more at risk to develop burnout that their urban counterparts and hypothesized that this was due to a number of factors including limited resources, reduced peer support and clients with more advanced symptomology. Among the mental health professionals that were surveyed, psychiatrists reported the highest levels of compassion fatigue. The authors attribute this finding to a number of factors including a shortage of psychiatrists in the state where the survey was conducted (resulting in higher caseloads and less peer support) and the level of disturbance displayed by patients served by psychiatrists. Sprang et al’s study was remarkable in that it was one of the first to study a diverse pool of mental health practitioners outside the context of a catastrophic circumstance. Although the sample size was considerable (1,121 participants), it represented only 19% of the targeted population. This suggests that the respondents may have been qualitatively or quantitatively different than their colleagues who chose not to participate.

Compassion Fatigue: Theoretical considerations

The study of traumatic events and their subsequent impact on human beings has grown considerably over the past two decades (Figley, 1995). Since the early 1980’s, the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) has recognized both acute and Post Traumatic Stress Disorders (PTSD) as identifiable mental health concerns. Included in the diagnosis of Post Traumatic Stress Disorder (PTSD) is the notion that people who are secondarily exposed (through the accounts of a close relation) to trauma
can develop the symptoms of PTSD. Criterion A1 of the PTSD diagnosis indicates “the person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others” (DSM-IV-TR, p. 467). “Confrontation with” traumatic experiences are often the nature of trauma therapy for the therapist. Counselors working in these milieus open themselves up to the suffering of their clients on a daily basis, which makes them especially vulnerable to post traumatic or secondary traumatic stress. Although acknowledged in the DSM-IV, the consequences of this secondary traumatic stress have only recently been researched and discussed in professional circles (Baird & Kracen, 2006). Secondary traumatic stress and compassion fatigue are terms used interchangeably to describe a phenomena that may result when the traumatic experience of an individual is shared with a caring and supportive other. Mental health professionals, counselors in particular, are among these caring others who are often available to support the traumatized survivor. Valent (2002) reported that over the past 20 years, research has demonstrated that people, especially counselors, can be secondarily affected by the distress and suffering of others.

Trauma counseling and therapy are tough and demanding professions and can take a significant toll on the clinician (Miller, 1998). Figley (1995, 2002) indicated that there is often a substantial cost to caring. The intensity of the emotional exchange between the professional counselor and his/her clients contribute to the potentially hazardous nature of the profession (Evans & Villavisani, 1998). High turnover rates, irritability, boredom, loss of energy, interpersonal aggression, feelings of failure, substance abuse and withdrawal from professional and personal relationships were only
some of the perils that may impact the counseling professional (Evans & Villavisanis, 1998; Coster & Schwebel, 1997). Increasingly, counselors are being exposed to stories of violence, abuse, natural disasters, trauma, torture and loss (Hunter & Schofield, 2006). In the last two decades it has become accepted that people can be secondarily affected by the suffering of others (Valent, 2002; Moulden & Firestone, 2007). Counselors who work with the trauma survivors are particularly vulnerable to this suffering and may experience symptoms of avoidance, reliving traumatic material, somatic complaints, and mood instability that mirror the symptoms experienced by their clients whom have survived trauma (Neumann & Gamble, 1995). These symptoms may include headaches, nausea, sleepiness, intrusive imagery, feelings of vulnerability, paranoia, emotional exhaustion and sexual difficulties. In many cases, the symptoms of Secondary Traumatic Stress or Compassion Fatigue are identical to those of Post Traumatic Stress Disorder, the difference is in how the trauma event was experienced (primarily vs. secondarily). Compassion fatigue, like burnout, has the capacity to impact a clinician’s ability to provide effective services and maintain both personal and professional relationships (Collins & Long, 2003). Gentry, Baranowsky and Dunning (2002) described compassion fatigue as the intersection between secondary traumatic stress and burnout.

Vicarious Traumatization

A construct related to compassion fatigue is the concept of vicarious traumatization. Vicarious traumatization reflects constructivist self-development theory and suggests that repeated engagement with traumatized clients has the potential to result in a negative transformation of the counselor’s inner world or schema (McCann &
Although vicarious traumatization and secondary traumatic stress are often represented as a single construct, they are, in fact, two very distinct phenomena with different hypothesized etiologies and outcomes. The changes brought on by vicarious traumatization tend to be pervasive, cumulative and permanent (Baird & Kracen, 2006). Vicarious traumatization is likely to impact a professional’s worldview and identity in 5 broad life domains: safety, trust, esteem, intimacy and control (Baird and Kracen, 2006). Vicarious traumatization, which is linked to both psychodynamic and cognitive theories, focuses on the schema of the therapist and tend to impact the way the therapist perceives his or herself, the surrounding world and its inhabitants. Vicarious traumatization represents a more gradual process where exposure to traumatized clients has a more insidious impact on the therapist (Jenkins & Baird, 2002).

Miller (1998) elaborated on vicarious traumatization by explaining that the traumatic experiences of clients can “rub off” on counselors. The worldview of the trauma therapist is constantly challenged and assaulted by detailed accounts of abandonment, cruelty, sadism, and tragedy as told by his/her clients (Neumann & Gamble, 1995.) Through his/her work with the traumatized, the therapist becomes more likely to see the world through the lens of trauma where innocuous events such as a child’s tearful cries evoke images of the traumatic circumstances experienced by his/her clients (Neumann & Gamble, 1995.) When faced with these disturbing recollections, counselors are likely to feel fear, helplessness, despair and anger. Hence, vicarious traumatization and secondary traumatic stress can co-occur, resulting in considerable impairment to the mental health professional and his or her ability to be with clients.
Schauben and Frazier (1995) found that female counselors who worked with sexual abuse survivors reported higher levels of symptoms of vicarious trauma, PTSD, and disrupted world views. In general, counselors who work with victims of violence reported more emotional disruptions and changes in beliefs. In a review of the research, Moulden and Firestone (2007) found that therapists who worked with sexual offenders also reported elevated levels of vicarious traumatization and secondary traumatic stress indicating that over 50% of sexual offender therapists report some degree of traumatic recollection. Additionally, these therapists report significant changes in their worldview, in that they were more likely to attribute malevolent intent to innocuous interactions (such as being suspicious of an individual who reported that they worked with children) (Moulden & Firestone, 2007). These therapists also reported symptoms of hypervigilance and avoidance that were in the clinically significant range.

Secondary traumatic stress or compassion fatigue focuses on the secondarily acquired symptoms of PTSD that manifest in the therapist. Compassion fatigue/secondary traumatic stress reflects more substantial psychological impairment, as the stress reaction of the therapist has progressed beyond altered cognitions and worldviews (Sprang et al, 2007). Symptoms of STS may include exhaustion, hypervigilance, avoidance and emotional numbing. The focus of STS is not on changes in the therapist’s schema or worldview, but the biopsychosocial experiences that result from secondary exposure to traumatic material. When compared to vicarious traumatization, the symptoms of STS are far more overt and do not necessarily have a gradual onset. Figley (1995) reported that secondary traumatic stress can manifest following one exposure to traumatic material brought by a client.

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The stressors of crisis intervention and trauma counseling may result in feelings of isolation, powerlessness, emotional numbing, anxiety, confusion, tearfulness, feelings of being overburdened by responsibility (Miller, 1998). These overwhelmed therapists may feel exhausted, increase their alcohol use, as well as display somatic complaints such as headaches, gastrointestinal difficulties, sleep disturbances, and/or nightmares. They may also display an increased sensitivity to violence (Miller, 1998). Professionally, they may present themselves as cold or aloof, intellectualize, minimize client problems, or over-identify with their clients’ problems becoming overwhelmed and losing clinical objectivity in the process (Miller, 1998). Although suffering, these therapists may defend against these feelings through the defense mechanism of denial.

Secondary traumatic stress or compassion fatigue is a natural result of having knowledge of a significant other’s traumatic experience and empathetically responding (Figley, 1995). Pearlman and Saakvitne (1995) indicated that both vicarious trauma and compassion fatigue were occupational hazards that do not reflect pathology on the part of the therapist or intentionality on the part of the client. Clinicians who hear stories of fear, sadness, pain and suffering may experience similar feelings as a result of their empathetic engagement with the client (Figley, 1995). While attempting to alleviate the suffering of a client, the counselor absorbs information about the suffering and, in many instances, absorbs the suffering itself. If not treated, compassion fatigue can limit the counselor’s capacity for empathy and compassion, and subsequently lead to depression, withdrawal, boundary violations and professional disillusionment (Neumann & Gamble, 1995).

In order to understand the phenomenon of compassion fatigue, Figley (1995) suggested a number of both predictors and protective factors (see Figure 1). Figley
indicated that through his or her empathetic ability, the counselor becomes aware of the client’s inner turmoil, becomes motivated to act, has direct exposure to the client’s suffering and takes action to relieve the suffering of the other. Compassion stress is the result of this attempt to relieve the client’s suffering and when continually exposed to such material, the counselor’s internal resources have the potential to become depleted and compassion fatigue becomes the likely result. Figley (2001) indicates that the predictive factors that lead to compassion stress include: empathetic ability, empathetic concern, exposure to the client, empathetic response, prolonged exposure, traumatic recollections and life disruptions.

Figure 1: Compassion Fatigue Process (downloaded from www.greencross.org).

According to Figley (2001), empathic ability (displayed by the counselor) referred to the aptitude of the psychotherapist for noticing the pain of others. Whether the empathy is dispositional or learned as a part of the individual’s professional training,
accurately detecting and discerning the emotions of another is a vital component in the
development and maintenance of the therapeutic alliance (Bohart et al, 2001). Ironically,
without empathy, there would be little or no risk of compassion stress or fatigue, as the
individual would be both oblivious and indifferent to the suffering of his or her clients
(Figley, 1995).

Empathic concern refers to the motivation of the therapist to respond to people in
need (Figley, 2001). Empathic concern is the desire to help the client discuss, process and
work through emotionally provocative, confusing, traumatic or potentially painful
memories, thoughts and feelings. Without sufficient empathic concern, the therapist
would not choose to intervene. Although seen as a favorable characteristic for therapists
to display, empathetic concern is a factor that can lead to compassion fatigue.

In order for compassion fatigue or secondary traumatic stress to develop, Figley
indicates that that the therapist must have direct exposure to the client’s traumatic
material. Through direct exposure to the client, the therapist has an experience of the
emotional energy and suffering experienced by the client, which while clinically
valuable, has the potential to significantly impact the counselor. Figley (1995) argued
that one of the reasons why those in direct practice roles pursue careers in training,
supervision and teaching is due to the costs of direct exposure to the suffering client.

Figley (1995) indicated that empathic response refers to the degree to which the
psychotherapist makes an effort to reduce the suffering of the client through empathic
understanding. In Figley’s model, insight into the feelings, thoughts and behaviors of
the client is achieved by putting oneself into the perspective of the client. In order to be
truly empathetic and to maximize the effectiveness of that empathy, the psychotherapist
may vicariously experience the anger, sadness, pain and fear communicated by the client. This level of connection and attunement comes at considerable emotional, physical and psychological cost to the counselor working in service to the client. Unfortunately, this cost is rarely discussed in training programs. Compassion stress refers to the residue of emotional energy from the empathic response to the client displayed by the counselor. This stress also refers to the on-going demand for action to relieve the suffering of the client. With significant intensity, and like other varieties of stress, it can have a significant negative impact on both the human immune system and quality of life of the therapist.

Prolonged exposure is a risk factor that increases the chance that the individual will contract compassion fatigue. This refers to the on-going sense of responsibility for the care of the suffering over a protracted period of time. Figley (2001) indicates that the impact of prolonged exposure can be reduced by frequent breaks and opportunities for renewal on the part of the therapist. Creamer and Liddle (2005) found that mental health professionals working with the survivors of 9/11 reported higher levels of secondary traumatic stress when trauma work was part of their “regular” practice.

Traumatic recollections refer to the memories that trigger the symptoms of PTSD and associated reactions. Secondary traumatic stress (compassion fatigue) was initially identified in the psychotherapeutic literature as a consequence of working with the traumatized. Counselors who work with individuals identified with PTSD often report symptoms that mirror those of PTSD. When re-exposed to clients who present with similar issues, these memories may be from the therapist’s experience with other
demanding or threatening clients who were especially sad or suffering. These memories are events that when recalled result in emotional reactions.

A considerable body of research has explored the hypothesis that therapists who report a personal trauma history are more likely to suffer from vicarious traumatization, secondary traumatic stress and compassion fatigue (Pearlman & Maclan, 1995; Brady, Guy, Poelstra & Brokaw, 1999; Ortlepp & Friedman, 2002; Linley & Joseph, 2007). These results have not been consistent across studies. Pearlman and McIan (1995) reported that therapists who reported a personal history of trauma showed greater disruptions in cognitive schema than their colleagues without a significant history of trauma. Brady et al. (1999) found that therapists who worked more with abuse survivors reported more spiritual and existential satisfaction than their peers who saw less trauma survivors in their work. Ortlepp and Friedman (2002) found that non-work related trauma did not impact the levels of secondary traumatic stress in a population of lay crisis counselors in Africa. Linley and Joseph (2007) found that therapists who reported a personal trauma history actually reported more personal growth as a result of their work with traumatized clients.

Life disruptions are the unexpected changes in schedule, routine, and managing life responsibilities that demand attention on the part of the therapist. Although life disruptions alone are unlikely to result in compassion fatigue, when combined with the other risk factors and a lack of protective factors, these disruptions can increase the risk of compassion fatigue in the counselor.

Figley (2001) also proposed that there are protective factors that may serve to inoculate the clinician from the contagion of client’s traumatic material. Through these
protective factors, the clinician may experience reduced feelings of frustration and burnout and report greater satisfaction in his or role as a professional. Stamm (2005) suggested that professional satisfaction or compassion satisfaction can protect the individual from succumbing to the behavioral and psychological sequelae of burnout, which is one facet of compassion fatigue.

A sense of achievement can be a protective factor that helps the psychotherapist mitigate the effects of compassion stress/fatigue. This sense of achievement refers to the extent that the therapist feels like he/she is having an impact on the positive growth of the client and is satisfied with his or her efforts to perform his or her job successfully. Although the majority of the research associated with trauma work focuses on the risks to therapists, within the literature there are a number of anecdotal accounts that therapists may actually derive a sense of growth and satisfaction from their work with clients (Linley & Joseph, 2007). Stamm (1998) further clarified this protective factor by introducing the term “compassion satisfaction” in the literature on compassion fatigue and traumatology.

Professional disengagement refers to another protective factor that helps to reduce the impact of compassion stress. This variable refers to the extent to which the psychotherapist can distance him/herself from the ongoing misery of the client between sessions. A psychotherapist’s ability to disengage requires the individual to consciously “let go” of the client’s feelings, thoughts and behaviors and establish a degree of professional distance from his or her work. Self-care strategies such as exercise, meditation and vacations can help establish and maintain this professional distance (Pearlman & Saakvitne, 1995).
Valent (2002) asserted that compassion fatigue and vicarious traumatization are the result of a form of countertransference that the therapist develops in response to the maladaptive survival strategies of the client. Valent defined survival strategies as the physiological, social and psychological arousal symptoms that accompany PTSD. Although the two most commonly identified survival strategies are fight (reliving) and flight (avoidance), Valent (2002) proposed six other survival strategies that are particularly relevant in trauma work. These include rescuing (caretaking), attaching, asserting (goal attainment), adapting, competing and cooperating. Clients come to therapy when their survival strategies are insufficient or lead to a degree of impairment in their daily lives. A therapist may unconsciously identify the client’s survival strategy and may subsequently enter the therapeutic alliance with his or her own complementary survival strategy (Valent, 2002).

When the helper’s survival strategies are insufficient to allay the suffering of the survivor, counselors become secondarily traumatized by carrying the both the maladaptive survival strategies of the trauma survivor (with which they unconsciously identify) and their own complimentary survival strategies (which are deemed insufficient.) For example, a client may present with the survival strategy of flight, and the counselor unconsciously takes on the role of the resuer or caretaker. The client’s needs may prove to great for the interpersonal resources of the counselor, resulting in a degree of depletion of the counselor’s internal resources.

When rescuing attempts on the part of the counselor or client are unsuccessful, the resulting emotions are a sense of burden, depletion, self-concern, resentment, neglect and rejection (Valent, 2002). In the client, failed rescue attempts may result in anguish and
guilt associated with not preventing the death or serious injury of another, or even causing the death or injury of another. In the counselor, the distress associated with feelings of not having done enough to avert the suffering of the survivor is a common secondary traumatic reaction (Valent, 2002). The stress of the counselor may have deleterious effects on the therapeutic relationship with the trauma survivor. Valent argued that the counselor may show non-recognition of the client’s experience, fragmented attention, limited empathy, intellectualization, or dehumanization. Conversely, he stated that the counselor may show over-involvement with the client’s trauma, losing his or her professional objectivity in the process. Clients may come to see these therapists as naïve, ignorant, patronizing, unsympathetic or lacking compassion. These “therapeutic” experiences may significantly exacerbate the symptoms of the original trauma (Valent, 2002).

The Consequences of Compassion Fatigue

Secondary traumatic stress affects almost all therapists at some point in their careers (Gentry, Baranowsky & Dunning, 2002). Munroe (1995) cautioned that counselors suffering from secondary traumatic stress or compassion fatigue may be engaged in impaired or unethical practice. Counselors who have been traumatized may feign invulnerability or avoid the discussion of the traumatic content as a means of protecting themselves from further exposure. Such therapists inadvertently hurt their clients by placing their own needs above the needs of the clients. Munroe (1995) indicated that both avoidance and modeling invulnerability comprise a degree of unethical practice as it further isolates the client in his or her psychological pain and
suffering. By avoiding the discussion of the trauma, the client “takes care” of the therapist, which violates the premise of the therapeutic alliance. When the therapist models invulnerability to the trauma, the clinician suggests that he or she would be more equipped to handle the trauma and inadvertently shames the client for being so inept at managing emotionally traumatic events. Through either strategy, the alliance may be irreparably damaged, which results in further suffering for the client and puts the therapist at risk for injuring other clients (Munroe, 1995).

The counselor suffering from compassion fatigue may unconsciously avoid the traumatic material brought by the client in an effort to maintain the integrity of the counselor’s world view. The “silencing response” refers to the counselor’s inability to attend to the client’s traumatic material. Instead, the counselor redirects the conversation to less disturbing material that is more palatable to the counselor (Gentry, Baranowsky & Dunning, 2002). The counselor’s ability to listen with empathy becomes compromised, which weakens the potency of the therapeutic alliance and further isolates both the client and counselor. This unconscious process becomes activated following the full onset of compassion fatigue (Baranowsky, 2002). The impaired counselor is likely to feel more fatigue, isolation, exhaustion and professional dissatisfaction. Compassion fatigue, if left unaddressed, has the potential to rob the professional of his or her sense of well-being, comfort, purpose, empowerment and identity (Gentry, Baranowsky & Dunning, 2002).

The Evolution of Compassion Fatigue

The phenomenon of compassion fatigue includes three major characteristics: 1) Recollections and re-experiencing of the primary survivors traumatic experience; 2)
Avoidance of reminders of the trauma or emotional numbing when confronted with such reminders; 3) Elevated levels of personal arousal. When combined with the potential effects of vicarious traumatization, these global effects may include changes in the counselor’s ability to tolerate painful affect, changes in the counselor’s frame of reference and beliefs, impaired interpersonal relationships, and changes in the counselor’s identity (Figley, 1995).

Following the Oklahoma City Bombing, Wee and Myers (2002) found that mental health trauma workers reported moderate degrees of Post Traumatic Stress Disorder. These PTSD symptoms reported by the sample were reflective of their own trauma and stress following the bombing. In this sample, administrators reported more stress than direct care workers, perhaps due to the complexity, intensity and difficulty of the individual cases brought to the attention of the administrators. These difficult cases and consultations may have lead to subjective feelings of helplessness which are part of the PTSD diagnosis. Of the sample of 34 workers, 49.4% reported levels of compassion fatigue in the high risk to extremely high risk range of severity. These clinicians also reported elevated levels of burnout, with the mean score of the group in the “high risk” range for burnout. Wee and Myers (2002) found that increased length of time working with the bombing survivors was associated with higher degrees of compassion fatigue and burnout. This sample of counselors also reported a variety of personal stress management activities including diversionary activities, family engagement, exercise, prayer, personal therapy and meditation (Wee & Myers, 2002).

Creamer and Liddle (2005) studied secondary traumatic stress in a sample of 80 disaster mental health workers who worked with the traumatized following the events of
September 11th. They found that therapists who discussed their client’s traumas in their own therapy sessions had higher levels of secondary traumatic stress. These results supported Figley’s contention that higher levels of detachment may be helpful in protecting the individual from the development of compassion fatigue. They also found that younger and less experienced therapists were more vulnerable to secondary traumatic stress. A final variable that contributed to the development of STS was length of time the therapist spent deployed in the highly traumatic setting.

In a study of 223 counseling professionals in Mississippi, Simpson (2005) found that counselors who reported higher levels of spirituality reported lower levels of compassion fatigue. She reported that lower levels of spirituality combined with a caseload that included a high number of traumatized clients were the best predictors of compassion fatigue (Simpson, 2005). She suggested that spirituality may function as a protective element and may bolster the counselor’s resistance to the effects of compassion fatigue. Unlike other researchers and theorists who focus on external mechanisms for coping with compassion fatigue (i.e. taking a vacation, supervision, reduced case load), Simpson’s study is presented an internal strategy for preventing the symptoms of compassion fatigue. Unfortunately, Simpson’s findings were limited to a population of counselors working in Mississippi. In addition, her data did not provide any information about the specific beliefs or practices associated with spirituality that were effective in preventing or mitigating the effects of compassion fatigue in the identified sample of counselors. Such additional information may be helpful in generating targeted practices that could be adopted by counseling professionals of any spiritual orientation.
In a study of 363 Colorado county child protection caseworkers and supervisors, Conrad and Kellar-Guenther (2006) found that 49.9% of professionals interviewed reported high to extremely high risk for compassion fatigue. Of these same professionals, 75% reported high to extremely high chance for compassion satisfaction. Conrad and Kellar-Guenther (2006) reported that those individuals who reported higher levels of compassion satisfaction also reported lower levels of both compassion fatigue and burnout. This study suggested that compassion satisfaction may help prevent the development of burnout in child protection workers. Surprisingly, although workers were at significant risk for compassion fatigue, these workers were not at high risk for burnout. This study was valuable in that it contributed to the literature on compassion fatigue while also acknowledging the protective effects that are provided by the construct of compassion satisfaction. The study also demonstrated that an individual can be significantly impacted by compassion fatigue even if he or she is deriving a degree of professional satisfaction.

In a study of 130 nonprofessional trauma counselors in Africa, Ortlepp and Friedman (2002) found that, in general, these lay counselors did not experience clinical levels of compassion fatigue. In addition, lay counselors in the study reported considerably high levels of compassion satisfaction. Levels of lay counselor compassion satisfaction had significant positive correlations with measures of self-efficacy, commitment, sense of coherence and social support. All of these variables were negatively correlated with reported levels of compassion fatigue and burnout.
The authors attribute these favorable correlations to the specialized training in trauma that each of the lay counselors received prior to assuming their duties (Ortlepp & Friedman, 2002).

**Burnout**

Burnout has been described as a “syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment that can occur in professionals who do people work of some kind.” (Maslach and Jackson, 1986, p. 1). Symptoms of burnout include feelings of emotional numbing, loss of ability and interest to “care” about the concerns of others, trouble concentrating, difficulty sleeping and subjective feelings of hypervigilence (Meldrum, King & Spooner, 2002). Burnout has the potential to erode the values, dignity, spirit and will of the professional (Skovholt, 2001). Although features of burnout are related to compassion fatigue, its onset is more gradual and often results in feelings of professional insignificance and inefficiency (Stamm, 2002).

Jenkins and Baird (2002) indicated that although measures of compassion fatigue have historically incorporated measures of burnout as part of their conceptualization, the burnout associated with compassion fatigue is quantitatively distinct from the concept of burnout suggested by Maslach.

Skovholt (2001), who appears to be addressing the burnout that often accompanies compassion fatigue, referred to two distinct forms of burnout that can develop in the practitioner: meaning burnout and caring burnout. According to Skovholt, meaning burnout occurs when counseling and caring for others no longer gives meaning and purpose to the professional. The counselor no longer receives “psychic income”
from the work of helping others (Skovholt, 2001). Meaning burnout occurs for a variety of reasons including the nature of the work, feelings of futility and ineffectiveness, and no longer feeling satisfied by the profession. Although meaning burnout has the potential to result in decreased levels of motivation, it seems very different than the burnout that typically accompanies compassion fatigue.

Skovholt (2001) identified a second type of burnout called “caring burnout.” According to his theory, caring burnout results from the attachment-involvement-separation process that all counselors engage in with their clients. Research supports the notion that the quality of the attachment (therapeutic relationship) plays a central role in the progress of the client. If the counselor can separate from the client without depletion, then the counselor is free to attach again to another client. If this process of attachment-involvement-separation drains the counselor, even a little each time, the counselor becomes cut off from the life force of professional vitality. Professional counselors must put aside their own needs in counseling and must be willing to feel the negative emotions brought by the client. The counselor must be willing to absorb the client’s anger and accept a sense of aloneness as the client progresses to autonomy from the counselor (Vacc & Loesch, 2000). This constant attachment and separation can have a substantial impact on the counselor’s ability to attach and be empathetic to clients. Caring burnout appears more akin to the characteristic exhaustion that accompanies compassion fatigue. In caring burnout, a counselor’s internal resources are depleted and this depletion has negative consequences for the clinician’s ability to function in the role of therapist.
Compassion Satisfaction

As stated above, compassion is feeling deep empathy and sorrow for the people who are suffering. This feeling of care and sympathy for those who suffer is accompanied by the desire to reduce the suffering experienced by another (Stamm, 2002). Although secondary exposure to traumatic events can have deleterious implications for the supporters of the traumatized, mental health professionals and trauma workers continue to persevere and even thrive in the face of this suffering (Stamm, 2002). Research and common practice indicate that there is a considerable degree of satisfaction found in helping people who have been traumatized. Pearlman (1995) suggested that those who voluntarily engage with the traumatized open themselves up to the possibility of deep personal transformation as well as a deeper connection to others and to the overall human experience. This “payment of caring” (Stamm, 2002) has been termed compassion satisfaction and may serve to protect the clinician from the negative effects of both compassion fatigue and burnout.

Stamm (2002) reported that although 50-60% of Americans reported experiencing the A1 criterion for a diagnosis of Post Traumatic Stress Disorder, only 7.8% of the population subsequently developed the symptomology of PTSD. Due to their exposure to both primary trauma and accounts of trauma, direct care workers, physicians, nurses, police, lawyers, clergy, EMTs, trauma researchers and mental health professionals are particularly at risk for developing PTSD, compassion fatigue or both (Gentry, Baranowsky & Dunning, 2002). Figley (1995, 2001) indicated that professional satisfaction may offer a degree of protection that serves to insulate the counselor from the impact of working with the traumatized.
Linley and Joseph (2007) demonstrated that therapists can find meaning, satisfaction and personal growth through their work with traumatized clients. In a study of 156 therapists, the researchers found that therapists who received or were receiving therapy reported more personal growth and less burnout. Therapists who received clinical supervision and therapists who indicated a positive history of personal trauma reported greater levels of personal growth when engaged with traumatized clients. In terms of gender, female participants reported more personal growth and positive changes as a result of their work with clients. Therapists who espoused humanistic and transpersonal practice orientations reported more positive psychological changes than their colleagues of different theoretical orientations. The authors found that therapists who espoused a cognitive-behavioral orientation were more likely to report higher levels of burnout.

In a study of 441 participants, Steffen and Masters (2005) found that individuals who displayed compassionate attitudes for others were less depressed, had less self-reported stress and reported greater perceived social support and marital satisfaction. Steffen and Masters (2005) suggested that holding compassionate attitudes towards others is the “active ingredient” that contributes to the improved health outcomes found in individuals who score high on measures of intrinsic religiosity. In addition to promoting social connectedness and personal satisfaction, having compassion for others appears to contribute to both psychological and physical health.

The Tibetan word for compassion is *tsewa* and includes compassion for both self and others (Goleman, 2003). People of a western orientation tend to see compassion as related to the construct of altruism, or the motivation to be of benefit to others with no (or
minimal) regard for the self. People of an eastern orientation (i.e. the Dali Lama) tend to see compassion for self and others as the same construct (Goleman, 2003).

Kristeller and Johnson (2005) suggested that compassion for both self and others can be cultivated through meditation. They propose that this occurs through a two stage process. In the first stage, the authors indicate that the meditator becomes more aware of habitual patterns of avoiding fear and seeking reinforcement. Through this awareness, the meditator has the opportunity to disengage from his or her conditioned (or habitual) responses. In this stage of disengagement with the typical way of being, the meditator experiences an increased sense of well-being. In the second stage, with the loosening of attachment to conditioned patterns, the meditator gains the opportunity to develop an awareness of the needs of others. In Buddhist *metta* practice, the meditator begins by extending compassion to his or herself (i.e. May I be free from danger, May I be healthy; May I be happy; May I live with ease) followed by extending the same blessing to others. Kristeller and Johnson (2005) indicate that by extending compassion to the self, hostile emotions such as anger and resentment are disarmed and the individual develops an awareness of inner resources to deal with such negative emotions. Kristeller and Johnson indicate that meditation offers a practitioner a mechanism to systematically disengage with typical thought problems and suspend self-judgment, opening the mind to the possibility of compassion for self and others.

Self-Compassion

Self-compassion refers to an emotionally positive self-attitude that may serve to protect the individual from negative self-evaluations, anxiety and depression (Neff,
Although mental health professionals are skilled at conveying an attitude of concern and compassion for their clients, this attitude of kindliness is often not directed inward. The development of self-compassion has been linked to improved psychological well-being, self-kindness and true self-esteem (Neff, 2003b). Self-compassion may prove to be a valuable component in reducing the experiences of both compassion fatigue and burnout in individuals who work with those who suffer.

A number of therapies recognize the importance of helping individuals develop self-compassion and cultivate their capacity to self-soothe (Gilbert & Proctor, 2006). These therapies include, but are not limited to Dialectal Behavior Therapy (DBT), Acceptance and Commitment Therapy, Mindfulness Based Stress Reduction, Compassionate Mind Training, and certain cognitive therapies designed to combat low self-esteem. Gilbert and Proctor (2006) asserted that self-compassion reduces an individual’s heightened sense of threat and promote feelings of safeness.

Although self-compassion represents a relatively new construct in Western psychology, the concept has been prevalent in Buddhist philosophy for thousands of years (Neff, 2003a). Self-compassion refers to being both affected by and open to the suffering of one’s self, as opposed to avoiding or disconnecting from it (Neff, 2003a). This involves the desire to relieve one’s suffering and to heal oneself with kindness (Neff, 2003a). Self-compassion also includes a non-judgmental stance towards one’s pain, shortcomings and failures as well as the recognition that such suffering is part of the larger human experience (Neff, 2003a).

Anecdotal accounts and common experience suggest that people are often more harsh toward themselves than they are toward others. Although self-compassion tends to
result in less negative self-judgment and appraisals, self-compassion also tends to enhance feelings of kindness and concern toward others. Neff (2003a) hypothesized that the self-compassionate individual has the capacity to see his or her experience in relation to the larger human experience. From this vantage point, suffering, failure and shortcomings are seen as experiences that happen to all people not cause for isolation and self-judgment (Neff, 2003a). Through this less judgmental relationship with the self, the self-compassionate individual demonstrates less negative evaluations towards others. From the view of self-compassionate being, all people are seen as worthy of compassion due to their inner connection to the larger human family.

Neff (2003a) indicated that self-compassion was made up of three interrelated constructs. These constructs included: self-kindness (vs. self-judgment), common humanity (vs. isolation) and mindfulness (vs. overidentification). Self-kindness refers to an attitude of self-acceptance characterized by kindness and understanding rather than negative judgment and self-criticism (Neff, 2003a). Common humanity refers to seeing one’s experience, both positive and negative, as being part of the unfolding human experience as opposed to suffering from feelings of isolation or separation. Mindfulness refers to holding one’s negative thoughts and feelings in balance instead of overidentifying with them and becoming lost in rumination or depression. Neff (2003a) indicated that while these constructs can be seen as distinct, they have the capacity to enhance and support the development of each other (Neff, 2003a).

A growing body of research has linked self-compassion to enhanced psychological well-being (Neff, 2003b). In a sample of 391 undergraduate students, Neff found that self-compassion had a significant negative correlation to depression and
anxiety. She also found a positive correlation between self-compassion and self-reported life satisfaction. She suggested that the development of self-compassion may enhance both resiliency and overall mental health (Neff, 2003b). Neff found that male participants tended to report higher levels of self-compassion than their female counterparts, suggesting that the female participants may have been more self-critical than the men in the study.

In a second sample of 232 undergraduates, Neff found that, again, self-compassion had significant negative correlations with both depression and anxiety. She also found that self-compassion was negatively correlated with rumination and thought suppression, suggesting that individuals who are high in self-compassion are neither overidentifying with their experience nor avoiding thinking about their negative experiences (Neff, 2003b). Neff found that self-compassion had significant positive correlations to emotional processing, emotional coping and moderate correlations with both self-esteem and self-acceptance.

In order to further validate the Self-Compassion Scale (SCS) and assess its utility with specific populations, Neff compared the SCS scores of 43 practicing Buddhists with the scores of the 232 undergraduates used in the prior study. Since self-compassion is a construct derived from Buddhist philosophy, Neff hypothesized that Buddhists would score higher on measures of self-compassion. Sixteen male Buddhists and 27 female Buddhists, with a mean of 7.72 years of meditation experience participated in this study. When comparing the Buddhist sample to the sample of undergraduates, Neff found that the sample of Buddhists reported significantly higher levels of self-compassion ($M = 23.19$) than the undergraduate sample ($M = 18.26$). No difference between male and
female Buddhist participants was found in terms of self-compassion, suggesting that meditation or Buddhist practice may mitigate the effects of self-critical thoughts and beliefs. Neff further reported that length of Buddhist practice also correlated with the reported level of self-compassion \((r = 0.35)\). Neff’s work (2003b) supports the hypothesis of the current study that meditation practice (which Buddhist practice includes) results in higher levels of self-compassion in the practitioner.

Shapiro, Astin, Bishop and Cordova (2005) found that 18 medical professionals who were randomly assigned to an 8-week Mindfulness-Based Stress Reduction (MBSR) program reported significantly higher levels of self-compassion than a control group. Shapiro et al (2005) further reported that self-compassion also significantly predicted positive changes in reported levels of perceived stress. Although participants in the experimental group also reported lower levels of psychological distress, higher satisfaction with life and lower levels of job burnout, these results were not significantly lower than the control. The authors attributed the lack of significant results with these variables to an insufficient sample size (Shapiro et al 2005). This study is valuable to the present research project for two reasons. First, Shapiro et al (2005) showed that self-compassion can be enhanced through participation in even a brief structured meditation or mindfulness program. Secondly, self-compassion was found to result in positive changes in perceived stress.

Recent research has confirmed both the external validity and utility of self-compassion in influencing attitudes toward the self and enhancing overall psychological well-being. In a sample of 91 undergraduate participants, Neff, Kirkpatrick and Rude (2007) found that self-compassion mitigated the effects of anxiety when participants were
faced with the task of identifying personal weaknesses. Participants who indicated higher levels of self-compassion reported significantly less anxiety when asked to describe their greatest weakness in a simulated job interview. The participants who indicated higher levels of self-compassion also used more affiliative (i.e. we, us) pronouns and made more reference to social relationships (friends, family, and other humans). Neff et al (2007) hypothesized that self-compassion involves having a more interconnected and less separate view of the self, even when addressing personal weaknesses. In a related study of 40 undergraduate participants, Neff et al (2007) found that participant’s self-rated self-compassion scores were similar to the self-compassion ratings provided by therapists following a structured therapeutic intervention designed to promote feelings of self-compassion in the participants. Following the intervention, participants also indicated higher levels of self-compassion, supporting the contention that self-compassion can be influenced by external interventions and is not a static characteristic or trait (Neff et al 2007).

In a series of five studies designed to assess the external validity of self-compassion, Leary, Tate, Allen, Adams and Hancock (2007) found that higher levels of self-compassion helped individuals provide more balanced (less negative) accounts of their life experiences and protected participants against negative self-feelings when imagining stressful or negative life situations. Higher self-compassion also mitigated negative emotional reactions following neutral evaluations. Further, individuals who were low in self-compassion tended to view their performances more harshly when performing an ambiguous videotaped task. Leary et al (2007) also were able to experimentally induce a self-compassionate perspective in individuals who rated
themselves low in self-compassion by encouraging participants to reflect upon their experiences through the lens of the three components of self-compassion (self-kindness, common humanity and mindfulness). The authors argued that self-compassion is a valuable construct in terms of overall psychological well-being and appeared to be more robust than self-esteem in terms of its stability in relation to external events or circumstances.

Shapiro, Brown and Biegel (2007) found that an 8 week Mindfulness-Based Stress Reduction (MBSR) program (which included a meditation component) was effective in reducing stress, negative affect, rumination, and anxiety in a sample of 22 graduate counseling students when compared to similar participants in a control condition. The MBSR group also demonstrated significantly higher scores on measures of positive affect and self-compassion (Shapiro et al 2007). Shapiro and her colleagues suggest that MBSR constitutes an effective self-care strategy that can assist beginning counselors manage the intrapersonal and interpersonal stressors that often accompany a career in the field of mental health. Shapiro et al. (2007) report research that supports the contention that therapists who have less self-compassion are more critical and controlling toward both themselves and their clients. This level of self-criticism tends to result in poorer therapeutic outcomes for their clients and may result in higher levels of occupational burnout. Shapiro and her colleagues suggest that the value of introducing mindfulness training as an adjunct component in the training of counseling professionals is considerable. A significant limitation of this study is that it assessed the impact of a short term intervention on the stress levels and interpersonal functioning of masters’ level mental health professionals in training. The study does not address the long-term impact
of meditation or mindfulness training on experienced meditators or seasoned therapists. The present study hopes to address this limitation by studying a population with both professional and meditation experience.

Meditation and Mindfulness

Meditation is one of the most frequently studied psychological interventions in the literature of the mental health professions. For over 2500 years, meditation has been practiced to enhance psychological and spiritual well being and to promote the qualities of compassion, equanimity, and awareness. The benefits of these ancient practices are starting to be realized by western medicine and western mental health. Their inclusion into the self-care practices of mental health professionals may help reduce the phenomena of both burnout and compassion fatigue while enhancing self-compassion and compassion satisfaction.

The emergence of mindfulness and meditation in the psychotherapeutic literature in recent years has lead to their inclusion in a number of humanistic and behaviorally based treatment modalities (Hayes, 2005; Linehan, 1993; Eifert, McKay & Forsyth, 2006; Kabat-Zinn, 2000; Wilber, 2000; West, 1987). Many psychotherapy practitioners and researchers have developed personal and professional interests in meditation and use this practice in their personal lives as well as with their clients (Thomson, 2001; West, 1987). In spite of the impressive outcomes demonstrated by such treatments, the integration of such techniques into therapist training programs has been inconsistent and not well researched. Few studies have suggested mediation may lead to the development of a number of favorable characteristics in therapists including enhanced empathy,
reduced anxiety, enhanced self-acceptance and improved attention (Lesh, 1970; Pearl & Carlozzi, 1994; Neff, 2003a; Fulton, 2005).

Fulton (2005) hypothesized that mindfulness and meditation cultivate several characteristics that are beneficial to the therapeutic relationship and proposed that mindfulness and meditation practice may be untapped mechanisms for training therapists. The recent inclusion of mindfulness and meditation into the cognitive and behavioral paradigm has extended the universality of such techniques for improving the quality of life for clinically identified and non-clinically identified populations. Certainly, it appears the benefits of mindfulness and meditation practice can extend to both the development and well-being of therapists of any theoretical orientation (Fulton, 2005).

Inherent within the traditions of mindfulness and meditation are specific practices that are designed to build compassion for both the self and others. Through an awareness of personal suffering that arises in meditation, the understanding that no one is exempt from suffering develops (Fulton, 2005). This “common human experience” is also highlighted in the work of Neff (2003a) when she proposed the concept of self-compassion. Meditation and mindfulness allow for the development of equanimity where the practitioner comes to value all experience in a nonjudgmental way. Negative affective experiences are not avoided, rather they are accepted and viewed with a stance of inquiry and acceptance. This nonjudgmental and open stance (including openness to experiences of negative affect) is akin to the self-kindness feature found in the construct of self-compassion (Neff, 2003a).
Historical context of Meditation

Historically, the study of mindfulness and meditation has been the province of humanistic and transpersonal psychologists. These researchers tend to view the value of these practices as consistent with their original purposes of maximizing psychological and spiritual well-being and accessing levels of consciousness beyond the scope of the ordinary human experience (Shapiro & Walsh, 2003). Meditation, which originated over 3,000 years ago in India, is viewed as a mechanism that can facilitate the attainment of these transpersonal levels of development (Shapiro & Walsh, 2003; Wilber, 2000). West (1987) indicated that various forms of meditation have been practiced in almost every major religious system in the world. In the last 20 years, cognitive and behavioral theorists and researchers have suggested that the practice of meditation and the quality of mindfulness can be extrapolated from their original spiritual and religious contexts.

These researchers and practitioners believe that it possible for the individual to reap the benefits of mindfulness and meditation without adopting the terminology or the spiritual tradition of Buddhism (Baer et al, 2004; Kabat-Zinn, 2000). Mindfulness skills-based approaches have demonstrated considerable promise in improving the functioning of individuals diagnosed with Borderline Personality Disorder, Depression, chronic pain, adult ADHD, and a number of other mental and physical health concerns (Kabat-Zinn, 2000; Linehan, 1993; Eifert, McKay & Forsyth, 2006; Hayes, 2005). Their application to the training and self-care of therapists of all theoretical and spiritual orientations seem particularly relevant to enhancing both the professional and personal of lives of professional counselors. The current study seeks to explore the utility of meditation and mindfulness practice in reducing the phenomena of compassion fatigue and burnout in a
population of professional counselors. The study also seeks to address the efficacy of meditation practice in enhancing the self-compassion and compassion satisfaction in professional counselors.

Varieties of Meditation

Meditation, defined by Webster’s dictionary as an ‘act of spiritual contemplation,’ has been historically employed by a host of spiritual practices to obtain greater personal awareness, insight and self-understanding. West (1987) defines meditation as an exercise in which the individual directs attention and awareness inward by focusing on a sound, thought, object or bodily experience. The goal of this exercise is the acquisition of greater insight or well-being (West, 1987). Meditation has been more extensively researched than all therapies with the exception of behavioral interventions (Walsh, 1989). From a psychological perspective, meditation includes: relaxation, concentration, an altered state of awareness, suspension of logical thought processes and maintaining a self-observing attitude (Perez-de-Albeniz & Holmes, 2000). The literature consistently identifies two broad forms of meditation which include concentrative meditation and awareness/insight meditation.

Concentrative Meditation

Concentration meditation (which includes Transcendental Meditation) typically involves focusing attention on an internal object (i.e. breath, mantra) or an external object (such as a candle or a mandala) (Brown & Ryan, 2004). In concentrative meditation, the practitioner shrinks his or her field of awareness so that everything is reduced to one element that requires little thought (Delmonte, 1987). The development and
enhancement of concentration is necessary for any form of meditation. This concentration is typically taught by encouraging the novice practitioner to focus on the physical process of breathing, a repeated mantra or an external device such as a candle or a mandala (Roth, 1997). Each time that a practitioner notices his or her attention wandering to past memories, future plans or anxieties, the individual gently, but firmly returns his or her attention to the breath (or mantra, or image). Roth (1997) explained that the breath is traditionally used as the primary focus for meditation because it is always present, ever changing and is the link between the body and the mind. Although the practitioner is paying attention to the breath, in actuality he or she is developing a skill in paying attention to each present moment, and this skill can be applied to other aspects of his or her life. Concentrative meditation is found to produce sensations of enhanced peacefulness, calm and mental serenity.

_Mindfulness Meditation_

Concentrative meditation forms a foundation for awareness or mindfulness meditation (Brown & Ryan, 2004). As the individual’s concentration develops, he or she develops insight which emerges through observing the constant stream of thoughts, emotions and sensations that comprise the totality of one’s experience. Ideally, the practitioner observes all of thought, emotion and sensation without judgment or preference. Delmonte (1987) indicated that mindfulness meditation involves broadening the perceptual field to a more comprehensive view or understanding of the meditator’s world view. From this perspective, the meditator broadens his or her field of awareness so that all thoughts, feelings and sensory experiences are viewed with an attitude of
acceptance and equanimity. This constitutes the core of “mindfulness meditation” and results in a clearer perception of what makes up the practitioner’s conscious experience.

The Construct of Mindfulness

Mindfulness plays a vital role in the practice of almost all forms of meditation. Mindfulness is a way of paying attention that originated in Eastern meditation practices (Baer, 2003), which involves bringing one’s attention to internal and external experiences occurring in the present moment. Mindfulness has been described as a form of non-elaborative, non-judgmental, present-centered awareness in which each thought, each feeling that arises is acknowledged and accepted (Bishop et al., 2004). This dispassionate state of self-observation is believed to create a “space” between an individual’s perception and his/her reaction (Bishop et al, 2004). This “space” created by mindfulness is believed to protect the practitioner from over-identifying with his or her thoughts or experiences (Neff, 2003a). Ancient Eastern religious traditions have suggested that mindfulness meditation reduces suffering and increases insight, wisdom and compassion (Baer, Smith & Allen 2004). Fulton (2005) stated that meditation allows an individual to become more open to his/her suffering, and through this openness, the individual surrenders the need to escape and reject the subjective feeling of distress (or suffering).

Modern behavioral theory has adopted mindfulness as a technique to enhance awareness and improve skillful responding to maladaptive thinking and behavior (Bishop et al, 2004). One example of a therapeutic approach that embraces mindfulness is Acceptance and Commitment Therapy (ACT) (Hayes, 2005). This approach stresses the need for clients to embrace all thoughts and feelings, especially the unwanted ones. The
philosophy present in ACT is that clients do not attempt to change or eliminate these experiences, clients learn to recognize and acknowledge them, without acting on them. By not acting on thoughts and emotions, clients are able to let them go by truly accepting them (Eifert & Forsyth, 2005). Acceptance can also serve the therapist by improving the recognition that in spite of the his/her best efforts, there are real limits to what therapy can do to help the client make changes in his or her life (Fulton, 2005). This acceptance may also help the therapist develop the professional detachment suggested by Figley’s model while remaining emotionally attached and engaged with the client’s traumatic material. Improved mindfulness helps the therapist negotiate the tenuous balance between the desire to be of service to the client and the acceptance that the client is personally responsible for his or her self (Fulton, 2005). This compassionate “balance” may allow the counselor to achieve a state of internal equilibrium between care for other and care for self.

From the Buddhist perspective, mindfulness emphasizes the understanding of the mind through an awareness of mental activity without an excessive preoccupation with thoughts, fantasies or emotions that often accompany external and internal events (Murgatroyd, 2001). Inherent in the concept of mindfulness is that it is a skill that can be developed, and that all individuals have the potential for developing behavior that is mindful (Bishop, 2004). In spite of efforts to distance itself from its spiritual underpinnings, this form of mindfulness training inherently asserts that an individual can reclaim his or her “Buddha nature” by awakening to the “truth” of the transitory nature of his or her personal experience.
Zen is one such approach that attempts to teach the student to integrate these two forms of meditation (Kapleau, 1980, as cited in Brown & Ryan, 2004). The student begins by focusing on the breath to strengthen attention and then turns to awareness practice. Zazen or “sitting meditation” encourages practitioners to become aware of the distorted aspects of an overly individualistic view of human experience (Thomson, 2000). In many ways, Zen defies quantitative and qualitative explanation as Thomson (2000) cautions readers that “trying to understand Zen by reading and thinking, but without practicing, is a little like trying to appreciate dogs by examining leashes” (p.534).

Western Psychology’s early understanding of meditation was predicated on a belief system that sees the world in dualistic terms (Wellwood, 2000; Wilber, 2000). Carl Jung, the first transpersonal psychiatrist and depth psychologist (Scotton, 1996), saw meditation as a “Royal Road to the unconscious”. Jung viewed meditation as a process of surrendering to the unconscious mind, where the individual retreats into his own inner life. From the perspective of a Westerner who is concerned with the necessity of ego strength, extraversion and action in the world, this retreat into inner experience is perceived as dangerous to the ego, which is constantly defending itself from unrealized unconscious material. The need to defend against the sexual and aggressive impulses of this “other,” unconscious mind further perpetuates the belief a dual nature of reality. From the perspective of Eastern psychology, this duality is seen as illusionary. Due to his limited experience with the actual practice of mediation, Jung did not conceive that meditation could sharpen the individual’s capacity to be in the world with greater awareness and “bare attention” (Wellwood, 2000). From the perspective of Eastern spiritual traditions, meditation is more accurately seen as a sharpening of attention and
awareness, not a retreat into unconscious material. Through this sharpening of attention to the external and internal world, the individual is more aware of his her own environment and intersubjective relationship to it.

When meditation research began in the early 1970’s, it was viewed with a degree of skepticism by mainstream psychologists and doctors (West, 1987). Considering “mainstream” psychology’s historically adversarial (now ambivalent) relationship to religion, it is not surprising that modern clinicians have sought to extrude the benefits of mindfulness from their larger spiritual context.

Early meditation researchers, in order to gain scientific credibility, focused exclusively on physiologically-based dependent variables such as heart rate, blood pressure, brain waves and body temperature (West, 1987). Researchers then expanded their studies to well-researched personality variables. Early research followed an allopathic, medical model approach where meditation was considered a prescription for a variety of psychological and physiological concerns (West, 1987).

Historically, the most frequently studied practice of meditation by transpersonal researchers has been Transcendental Meditation (TM) (Walsh, 1996). As a reaction to the early prescriptive view of meditation, many humanistic and transpersonal theorists avoid the use of objective tests, formalized assessment and conventional empirical methodologies. These researchers tend to see such modalities as inherently reductionistic and incapable of capturing the true depth and richness of the human experience (MacDonald & Friedman, 2002). In spite of this disdain for empiricism, Walsh (1996) described meditation research as a young and rigorous field and made reference to over
1,500 publications that have demonstrated a substantial number of physiological and psychological benefits.

The Western study of meditation through the lens of empiricism has historically been plagued by a number of limitations. One limitation in the scientific study of meditation is that researchers typically utilize novice practitioners as participants. Although this approach to research is often effective in measuring short term physiological effects, the use of novice meditation practitioners limits the ability to study meditation’s long-term impact on personality traits. This difficulty is further compounded by the fact that over two-thirds of individuals who start to practice meditation discontinue the practice within 3 to 6 months (West, 1987). Given the relatively stable nature of personality, several researchers have called for meditation research that focuses on the personality changes and personality characteristics of more experienced practitioners. This study purports to use a population of practitioners who have engaged in regular meditation practice for a period of 6 months or more.

In a review of the literature, Shapiro and Walsh (2003) indicated that a small number of pioneering studies have attempted to discern an understanding of the link between meditative practice and the cultivation of empathy, attention, presence and psychological well-being in the general population. Pearl and Carlozzi (1994) found that a clinically standardized meditation protocol reduced anxiety in a sample of 60 randomly assigned individuals with no prior experience with meditation. However, this study was limited by the small number of individuals, and the lack of meditative experience among the practitioners. Beitel, Ferrer and Cecero (2005) found that self-reported mindfulness had significant correlations with self-reports of empathy and the construct of
psychological mindedness in a sample of undergraduates. The researchers indicated that although psychological mindedness (the capacity to be aware of psychological processes and to reflect upon behavior, thoughts and feelings of others) and mindfulness were correlated, they were found to be independent constructs (Beitel et al, 2005). These authors suggested that their study should be replicated with therapists, clients and meditators with varying degrees of experience.

Although counseling programs emphasize the need for students to develop and maintain self-care practices, such programs rarely provide any formal training in self-care practices for the clinician (Christopher, Christopher, Dunnagan & Schure, 2006). In order to address this need Christopher et al (2006) developed a course that introduced counseling trainees to the practices of meditation, yoga, mindfulness and tai chi chuan. Eleven counseling trainees enrolled in a mainstream university participated in a semester long course on mind-body self-care and mindfulness. Following the course, the authors conducted focus groups with the participants. Participants described feeling more focused, aware, patient, and conscious. Students also described the ability to be more present with themselves and their experiences and speculated that they would be able to carry that presence into the therapy session (Christopher et al, 2006). The authors indicated that many of the students involved in the class reported the ability to deal more effectively with the stressors that accompany both professional and personal lives. Although this study may have been biased by the personal investment of the participants, one could hypothesize that these trainees are more equipped to proactively address personal and professional stress in their lives.
Shapiro, Schwartz and Bonner (1998) found similar results with a sample of 78 medical students enrolled in an 8 week course that utilized Mindfulness Based Stress Reduction (MSBR). Following the intervention, the participants reported lower levels of state and trait anxiety, less depression, higher levels of empathy and spirituality than controls. These effects were replicated for the control sample and support the efficacy of mindfulness training within training programs for health care professionals. Shapiro et al (1998) caution readers that their participants may have shown some degree of social desirability. These individuals may have also been qualitatively different than individuals who did not volunteer to participate in the study.

Summary of Chapter II

Compassion fatigue and secondary traumatic stress have the potential to result in substantial degrees of professional and personal hardship for the counselor. A number of authors have indicated that, if not addressed, compassion fatigue may lead to symptoms of avoidance, reliving traumatic material, somatic complaints, and mood instability that mirror the symptoms experienced by their clients whom have survived trauma (Neumann & Gamble, 1995). Self-care strategies that enhance professional and personal satisfaction, self-kindness and personal meaning may be effective in mitigating the effects of these stressors and promoting an enhanced sense of well-being. Self-compassion, a relatively new construct in Western Psychology, has been shown to be negatively correlated with stress, negative affect, feelings of isolation and feelings of harsh self-judgment in undergraduates, medical students and masters-level mental health trainees. One such mechanism that has been studied extensively in the clinical literature is meditation.
Eastern religious perspectives have historically emphasized the power of meditation in developing the quality of compassion for self and others. Recent research suggests that self-compassion can be enhanced through meditation and even short term mindfulness practice (Neff, 2003a; Shapiro et al, 2007). Meditation has the capacity to result in greater emotional, physical and spiritual well-being. This study purports to examine the relationship between meditation practice in professional counselors and the variables of compassion fatigue, compassion satisfaction, self-compassion and burnout.
CHAPTER III
METHODOLOGY AND DESIGN

Introduction

This study used a between-subjects comparative research design, where professional counselors who actively practice meditation were compared with similarly trained and experienced professional counselors who do not practice meditation. These participants were compared on the dependent variables of compassion fatigue, burnout and compassion satisfaction. Participants were also compared on the variable of self-compassion (which includes self-kindness, mindfulness and common humanity). In addition, the effect of length of meditation experience was analyzed on all four variables.

Participants were part of a convenience sample based on membership and participation in professional email-lists that were specific to counselors. Of the total 164 participants, 62 reported that they actively practiced meditation, and 102 indicated that they did not practice meditation.

As additional (post hoc) studies, the sample of counselors was further analyzed to determine if amount of self-care time type, and gender had an impact on the dependent variables.
Independent and Dependent Variables

In the present study, the participant demographic factors of interest are:

- Age
- Gender
- Years of experience as a professional counselor
- Theoretical orientation (Person-Centered/Existential/ Gestalt; Cognitive-Behavioral; Transpersonal/Integral; Psychodynamic/Jungian).
- An estimate of the number of clients identified with Post Traumatic Stress Disorder or Acute Stress Disorder served per year by the counselor.
- Professional training: Master’s degree or Doctoral Degree
- Area of specialization (i.e. school counseling, marriage and family counseling, community counseling, mental health counseling, art therapy/ counseling, music therapy/ counseling, rehabilitation counseling, counseling psychology, counselor education and supervision).
- Race.

The primary Independent Variables examined in the study were:

- Active Meditation practice (Meditation/Non-Meditation)
- Length of Meditation experience

Secondary independent variables examined were:

- Amount of Self-Care Time
- Gender

The following dependent variables were considered in this study:

- Compassion Fatigue (as measured by the Pro-QOL)
• Burnout (as measured by the ProQOL)
• Compassion Satisfaction (as measured by the ProQOL)
• Global Self Compassion (as measured by the Self Compassion Scale)
• Social Desirability (as measured by an abbreviated version of the Marlowe-
  Crowne Social Desirability Scale, identified as a covariate)

Participants

In order to be included in the study, all participants self-reported that they were
“licensed professional counselors” and were actively engaged in professional counseling
in the United States. Although exact nomenclature varied from state to state (e.g.,
Marriage and Family Counselor, Professional Counselor), all participants reported being
licensed in their respective state of employment. In addition to licensure, all participants
completed at least a Master’s degree in one of the following disciplines: community
counseling, counseling psychology, school counseling, rehabilitation counseling,
marriage and family counseling/therapy, art therapy/counseling, music
therapy/counseling, counselor education and supervision, and wilderness
therapy/counseling.

An initial 193 completed responses were obtained. Of the 193 responses
obtained, 25 participants did not meet inclusion criteria for participation in the meditation
group (they reported less than six months of experience or meditating for less than 60
minutes per week). Three participants were identified as statistical outliers through
calculation of the Mahalanobis distance measure (Mertler & Vannatta, 2005). A final
total of 164 participants were ultimately used in this study. All participants met the
overall inclusion criteria in order to be part of the study. Of the total, 62 participants who reported active engagement in a regular meditation practice were included in the meditation group, and 102 participants, who reported no meditation practice or experience, were placed in the non-meditation group.

**Meditation group**

In order to be included in the meditation group, participants must have been engaged in an active and ongoing meditation practice. For the purposes of this study, “active and ongoing meditation practice” was defined as the individual reporting that he or she was engaged in at least 60 minutes meditation per week. The individuals in the meditation group reported engaging in this practice for a period of at least six consecutive months.

Those participants included in the meditation group were also asked to report adherence to a particular style or technique of meditation. Meditation styles that were addressed by this study included the two broad categories consistently recognized in the literature on meditation: Concentration meditation and Mindfulness/awareness meditation (Boorstein, 1996; Shapiro & Walsh, 2003). Concentration meditation requires the individual to focus on a mantra, external stimuli (mandalas or candles), or a specific physiological event (e.g., breathing). The most widely researched form of concentration meditation is Transcendental Meditation (Walsh, 1996.) Mindfulness meditation or awareness meditation, which plays a central role in Buddhist practice, encourages the individual to keep a wide focus of attention on all current experiences both internal and external. The individual is encouraged to develop awareness to these ever changing
states without reacting to them (Boorstein, 1996). Individuals who were included in the meditation group were also asked to provide the following information:

- Months of meditation practice (how long have you been engaged in this practice?)
- Minutes per week spent in meditation practice.

Non-meditation group

In order to be included in the non-meditation group, an individual must have self-reported no experience with any formal meditation practice for a period of at least 6 months prior to his or her participation in the current study.

Participant demographic information can be found in Table 1.

Table 1: Frequency Distributions for Demographic Factors

<table>
<thead>
<tr>
<th>Group of Participants</th>
<th>Meditation group ( (n = 62) )</th>
<th>Non-meditation group ( (n = 102) )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Male</td>
<td>19</td>
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<tr>
<td>Female</td>
<td>41</td>
<td>67.2</td>
</tr>
<tr>
<td>Transgender</td>
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<td>1.6</td>
</tr>
<tr>
<td>Age of participant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24 to 29</td>
<td>2</td>
<td>3.3</td>
</tr>
<tr>
<td>30 to 35</td>
<td>4</td>
<td>6.6</td>
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<td>36 to 41</td>
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<td>18.0</td>
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<td>42 to 47</td>
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<td>13.1</td>
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<td>60 to 65</td>
<td>7</td>
<td>11.5</td>
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<tr>
<td>66-71</td>
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<td>0</td>
</tr>
<tr>
<td>Race of participant</td>
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<td></td>
</tr>
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<td>Black/ African Amer.</td>
<td>2</td>
<td>3.3</td>
</tr>
<tr>
<td>Hispanic</td>
<td>2</td>
<td>3.3</td>
</tr>
<tr>
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Table 1: Frequency Distributions for Demographic Factors (continued)

Experience (in years)
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<td>13</td>
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<td>21.0</td>
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<td>6.4</td>
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Theoretical orientation
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Trauma history
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Level of formal training
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<td>Specialist’s degree</td>
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<td>3.2</td>
<td>3</td>
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</tbody>
</table>

Procedures

In order to obtain participants, the researcher contacted existing list-serves that were established for counseling professionals and students in counseling programs. The researcher also solicited participation from members of state counseling organizations through list-serves provided by state counseling associations. The researcher established a web-based survey for volunteer participants. Participants received notice of the study through an email, and a link to the survey through their membership in their respective state counseling association’s list-serve.

Participants were asked to volunteer for a project to measure the general effects of stress-levels and stress-reduction techniques on personality variables in
counselors/therapists. A copy of a letter of informed consent accompanied the survey (see Appendix A). Participants were informed of the voluntary nature of participation in the study and the potential risks that accompanied participation in the study. These risks included becoming more aware of subjective experiences of feeling overwhelmed, exhausted, stressed or dissatisfied with current employment. Participants were also at risk of becoming more aware of self-critical opinions that they hold for themselves in relation to stressful circumstances. All participants were provided with contact information for the researcher, and a means of accessing additional support (i.e., www.Counseling.org) in the event that they experienced distress in relation to their participation in the study.

Participants were required to check a box acknowledging their informed consent before proceeding with the survey. It should be noted that participants were unable to access the survey unless the affirmative box is checked. Participants were also instructed to print a copy of the informed consent (which included the researcher’s contact information) for their own records. At no time did the researcher have access to the respondents’ email or contact information.

Participants completed demographic/participant information (age, gender, years of experience in the field of counseling, license status, experience with meditation practice, theoretical orientation, estimated number of clients served dealing with trauma) on web-based survey established by the researcher (see Appendix B). Participants who indicated an active meditation practice were also asked to identify how many months they had engaged in a meditation practice. These participants were also asked to identify the style of meditation that they practice. Two broad categories of meditation
(concentrative and mindfulness practices) were provided, and were accompanied by examples of each type.

Participants were also asked to complete an abbreviated measure of social desirability, the Pro-QOL and the Self-Compassion Scale. The time to complete the entire survey for an average participant was estimated between 15-20 minutes. After completing the survey, participants submitted their results on-line through a secured website. Participants who did not meet inclusion criteria for the study were screened out based on their response to certain items (e.g., “Are you a licensed counselor/therapist?”, “Do you see clients in a counseling/therapeutic capacity?”). In addition, participants completed a measure of social desirability in order to account for the potential biases inherent in self-report studies (as measured by an abbreviated version of the Marlowe-Crowne Social Desirability Scale) (Fischer & Fisk, 1993).

As stated above, all participants were provided with a mechanism for contacting the researcher. Participants who were distressed about their levels of burnout, compassion fatigue or self-compassion during or after their participation in the study were provided with referral information (www.Counseling.org) so that they could contact a licensed mental health provider within their designated geographic location.

Survey Instruments

Marlowe-Crowne Social Desirability Scale (used as a covariate)

Social desirability bias refers to the inclination of individuals to present themselves in ways that will be viewed favorably by others. The presence of this bias often limits the validity of self-report measures and acts as a confounding variable. In
order to address this concern that often accompanies self-report measures, a social
desirability scale was used in the present study. Lawrence, Shaw, Baker, Baren-Cohen
and David (2004) recommended the use of a social desirability measure to address a
general problem with self-report measures, which is that people tend to respond
according to how they would like to appear (e.g., highly empathetic, mindful,
courageous) rather than how they truly are. Crowne and Marlowe’s Social Desirability
Scale (MCSDS) is a well validated and empirically established (Lawrence et al, 2004)
measure of social reactivity. The MCSDS, which taps an individual’s tendency to
respond to items in a socially desirable way, is scored with 1 point for each item
endorsed. Scores range from 1 to 33, with a higher score indicating participants who are
prone to give answers to represent themselves in a more favorable light.

One identifiable practical concern with the MCSDS is the length of the measure
(Fischer & Fick, 1993). This concern led to the subsequent development of a number of
short forms of the original Marlowe-Crowne Scale (Fischer & Fick, 1993). Straham and
Gerbasi (1972) developed a 10 item measure based off the original 33 item scale, which
was endorsed by Fischer and Fick (1993) as having the highest level of internal
consistency and the highest correlation with the original 33 item measure.

Participants in the current study completed a brief version of the Marlowe-
Crowne Social Desirability Scale, which represents the most commonly used tool for
assessing social desirability bias. The items on the MCSDS represent behaviors that are
either socially desirable, but uncommon or behaviors that are not socially approved, but
very common (Leite & Beretvas, 2005). The authors of the original scale based their
scale on a single construct that the authors termed “need for approval.” Individuals who
indicate higher levels of Social Desirability are believed to be higher on this personality characteristic (Leite & Beretvas, 2005). In a review of the literature on the MCSDS, Leite and Beretvas (2005) indicate that it is common practice for researchers to correlate the focal scale (in this case, the ProQOL and the Self Compassion Scale) with the MCSDS. On the abbreviated MCSDS developed by Strahan and Gerbasi (1972), the researchers reported a mean score of 4.5, with a standard deviation of 2.1. Fisher and Fick (1993) suggested that the 10 item MCSDS had adequate internal consistency (0.88). The present study used an abbreviated version of the MCSDS as a means of assessing the potential impact of social desirability on participants’ self-reported self-compassion, burnout, compassion fatigue and compassion satisfaction.

**The Professional Quality of Life Scale (ProQOL) (dependent variables of Compassion Fatigue, Compassion Satisfaction and Burnout)**

The Professional Quality Of Life Scale (ProQOL) represents the third revision of the Compassion Fatigue test originally developed by Charles Figley in the mid 1990s to assess compassion fatigue/ secondary traumatic stress in professionals who work with traumatized populations and helpers in general (Stamm, 2005). The author indicates that this revision is superior to earlier editions of the Compassion Fatigue Test by distinguishing the construct of Burnout from Compassion Fatigue/ Secondary Traumatic Stress. The scale also was reduced from 66 items to 30 to reduce the burden on the respondent (Stamm, 2005). The ProQOL was developed from the reported results of over 1000 participants obtained over the course of multiple studies. Stamm (2005) indicated that only the most theoretically sound items were retained for the degree to
which they represented each of the three theoretical constructs. Quantitative analysis included Cronbach’s alpha, factor analysis and multigroup factorial invariance (Stamm, 2005). The ProQOL measures three distinct and independent constructs which include Compassion Fatigue (secondary traumatic stress), Burnout and Compassion Satisfaction. Items are rated by the participant to the degree to which the provided statement matches his or her experience. Participants rate responses on a Likert Scale (i.e. Never; Rarely; A Few Times; Somewhat Often; Often; Very Often.) For scoring purposes a response of “Never” is always assigned a value of “0”. A response of “Rarely” is typically assigned a value of 1 (unless the item is reverse scored as indicated in the scoring instructions, in which case “Rarely” would be given a value of 5). A response of “A Few Times” would be assigned a value of 2 or 4 depending the scoring directions for the item. Initial data suggests that the scales have excellent internal consistency (Stamm, 2005).

Compassion fatigue or secondary traumatic stress has been defined as work-related secondary exposure to extremely stressful events (Stamm, 2005). For example, the individual may repeatedly hear stories of traumatic events that happen to other people. The resulting symptoms of compassion fatigue typically have an acute onset and are usually associated with a particular event (Stamm, 2005). Symptoms may include: being afraid, having intrusive images enter the person’s attention, having trouble sleeping, or avoiding situations that remind the individual of the event. The Compassion Fatigue (CF) scale consists of 10 separate items which address the individual’s response to traumatic or disturbing material brought by his or her clients. An example of an item on the Compassion Fatigue (CF) scale is “I am losing sleep over the traumatic
experiences of a person I help.” A person who would score high on the (CF) scale would be more likely to rate this item as “Often” or “Very Often.”

The average score on the CF scale is 13 (SD = 6.3, alpha reliability is 0.80). Stamm (2005) indicated that individuals who reported scores above 17 are considered elevated and may benefit from some form of intervention.

Compassion Satisfaction refers to the pleasure that an individual derives from being able to do his or her work well (Stamm, 2005). A high level of compassion satisfaction suggests that the individual generally feels positively about his or her colleagues and feels like he or she is making a contribution to others, his or her profession and society as a whole. The Compassion Satisfaction (CS) scale consists of 10 items and reflects positive emotions and thoughts that a helper may experience in reaction to his or her work with clients. An example of an item on this scale is “I feel invigorated after working with those I help.” A person who would score high on this scale would be more likely to rate this item as “Often” or “Very Often.” The average score on this measure is 37 (SD = 7, alpha reliability is 0.87). A score above 42 suggests that the individual derives a considerable amount of pleasure and fulfillment from his or her work. A score below 33 indicates that the individual may derive satisfaction from activities that are not associated with work, but does not find work particularly satisfying.

Burnout refers to feelings of hopelessness displayed by the respondent due to difficulties in dealing with work and working effectively (Stamm, 2005). These feelings tend to be gradual in onset and tend to reflect that the individual does not feel effective in his or her work. The individual may feel subject to inadequate levels of support, inadequate resources or that their caseload is too large and overwhelming. An example
of an item on the Burnout scale is “I feel overwhelmed by the amount of work or the size of my caseload I have to deal with.” Individuals who would report elevated levels of Burnout would be more likely to rate this item “Often or Very Often.” The average score on the Burnout scale is 22 (SD = 6, alpha reliability = .72). A score below 18 suggests that the individual has positive feelings about his or her capacity to be effective at work. A score above 22 may be mood contingent or may indicative of deep dissatisfaction or feelings of professional inadequacy.

**Self Compassion Scale (dependent variable of Self-Compassion)**

Similar to the notion of compassion, self-compassion involves feelings of being open to and moved by one’s own suffering. Self-compassion also involves experiencing feelings of caring and kindness toward oneself, taking a nonjudgmental attitude toward one’s limitations, and recognizing that the individual’s struggles and triumphs are part of the larger human experience (Neff, 2003a).

Neff (2003a) indicated that self-compassion is related to feelings of compassion for others, and being self-compassionate does not constitute being self-centered, selfish or prioritizing one’s needs above the needs of others. Self-compassion involves recognizing suffering and feelings of inadequacy as part of the larger of the human experience and that all people, including the self, are worthy of compassion (Neff, 2003a). Self-compassion is also distinguished from self-pity in that the self-compassionate individual does not over-identify with his or her suffering (Neff, 2003a).
Neff (2003a) indicated that self-compassion involves three related components:

1) Showing kindness, support and understanding to oneself rather than criticism and harsh self-judgment.

2) Seeing one’s experience as part of the general human condition and not isolating or withdrawing from others.

3) Keeping one’s painful thoughts in balanced awareness rather than becoming over-identified with them.

The factor structure of the Self-Compassion Scale (SCS) reflects these constructs. The scale is comprised of 6 factors, three of which are indicative of the positive qualities of self compassion and the other three which reflect the negative feelings that manifest when an individual is not demonstrating self-compassion.

*Self-kindness versus self-judgment subscale:* Self-kindness refers to an attitude of understanding and patience toward all aspects of the individual. Self-judgment refers toward hostile, negative feelings toward less desirable characteristics displayed by the individual. The five items that comprise the Self-kindness subscale demonstrate an internal consistency reliability of 0.78. The five items that comprise the self-judgment subscale showed an internal consistency of 0.77.

*Common humanity versus isolation subscale:* Common humanity refers to the individual seeing his or her experience of negative events as experiences shared by all of humanity. Isolation refers to the individual feeling alone and cut off from others when confronted with negative performances. The four items that comprise the common humanity subscale demonstrated an internal consistency reliability of .80. The four items that made up the isolation subscale showed an internal consistency reliability of .79.
Mindfulness versus over-identification subscale: Mindfulness refers to maintaining a sense of emotional balance and equanimity even when confronted with painful circumstances. Over-identification refers to the individual having the tendency to get overwhelmed by his or her negative feelings. Internal consistency for the 4 item mindfulness subscale was 0.75. Internal consistency reliability for the Over-identification subscale was 0.81.

Neff (2003b) indicated that in the development of the SCS, a higher order confirmatory factor analysis was conducted to determine if a single higher-order factor of self-compassion would explain the inter-correlations between the six factors. The model was found to fit the data marginally well. Internal consistency for the 26-item SCS was 0.92.

Derivation of the Hypotheses

Can regular meditation practice reduce the experience of compassion fatigue endured by counselors who work with the traumatized? Does meditation practice have the capacity to enhance counselors’ ability to tolerate negative affect and generate more balanced self-perceptions? Figley (1995, 2001, 2002) suggested that both professional detachment and satisfaction are protective factors that may mediate the effects of compassion fatigue in therapists. Fulton (2005) anecdotally suggested that mindfulness and meditation are a mechanism by which a therapist can compassionately detach from the suffering of his or her clients. Shapiro et al (2007) found that counseling trainees who participated in an 8 week Mindfulness Based Stress Reduction program (which included a meditation component) reported lower stress levels and higher levels of self-compassion than participants in the control condition. These results were similar to a
study conducted with medical students, where a structured mindfulness practice was associated with lower levels of state and trait anxiety, less depression, higher levels of empathy and spirituality (Shapiro et al, 1998). Researchers concluded that mindfulness training represents an effective self-care strategy that can assist counselor trainees and medical students in managing the intrapersonal and interpersonal stressors that often accompany a career in the field of mental and physical health care. Neff (2003b) found that Buddhist participants reported higher levels of self-compassion than a sample of undergraduates, and in the Buddhist sample, self-compassion was not impacted by gender (in other populations female participants tended to have lower self-compassion). Simpson (2005) found that mental health practitioners who endorsed higher ratings on measures of spirituality were found to have lower levels of compassion fatigue and burnout. Steffen and Masters (2005) found that individuals who hold compassionate attitudes reported lower levels of negative psychological symptoms (including lower levels of stress and depression), and greater perceived social support. Steffen and Masters suggested that “compassionate attitude” was the active ingredient in the construct of intrinsic religion (spirituality) that lead to more positive mental health outcomes. The above research suggests that meditation practice may have the capacity to positively impact the development of self-compassion and compassion satisfaction, while reducing the deleterious effects of burnout and compassion fatigue. In addition, Neff (2003b.) found that self-compassion was associated with a number of positive mental health outcomes. Hence, the present study sought to address the following research hypotheses:

Hypothesis I: Counselors who practice meditation will display higher levels of compassion satisfaction (Pro-QOL) and self-compassion (SCS), and lower levels of
compassion fatigue and burnout (Pro-QOL). Length of meditation practice will be positively correlated with self-compassion and compassion satisfaction, and negatively correlated with compassion fatigue and burnout.

*Hypothesis II:* Measures of self-compassion will be positively correlated with measures of compassion fatigue, and negatively correlated with measures of compassion fatigue and burnout.

**Data Analysis Methods**

Haase and Ellis (1987) recommend the use of MANOVA when multiple dependent variables are of interest to the researcher. The MANOVA test of statistical significance allows a researcher to examine the effects of independent variables in much the same way as a univariate analysis of variance (ANOVA), including main effects, interaction effects, contrast analyses, and covariance, the difference being that MANOVA allows for multiple dependent variables and ANOVA only allows for one dependent variable (Weinfurt, 1995). Weinfurt (1995) indicates that researchers use MANOVA for one of two reasons: to control for type I error, and to provide a multivariate analysis of the effects by considering correlations between the dependent variables of interest. By providing an overall omnibus test of significance first (before running subsequent individual ANOVAs), the researcher is guarding against the chance of committing a Type I error that might occur with multiple ANOVAs (Weinfurt, 1995).

Stamm (2005) indicates that the ProQOL is made up of three distinct scales (Compassion fatigue, Burnout and Compassion Satisfaction), which do not yield a composite score. She further indicates that each scale is psychometrically unique and cannot be combined with other scores (Stamm, 2005). Given the documented
correlations between compassion fatigue, compassion satisfaction and burnout (Stamm, 2005; Collins & Long, 2003) and the hypothesized correlation between self-compassion and these variables, the use of multiple ANOVAs would be seen inappropriate to the variables of interest in this study. Statisticians also caution against the use of multiple ANOVAs due to the accumulation of Type I error rate (Weinfurt, 1995; Haase and Ellis, 1987). Given the multiple dependent variables proposed by this study, with alpha level set at .05, the experiment-wide bias was estimated at 0.35, indicating approximately a 1 in 3 chance of incorrectly rejecting a null hypothesis.

Preliminary analyses were conducted in which the scale means, standard deviations and internal-consistency reliability were ascertained. Then, to address Hypothesis 1, a multivariate analysis was performed. Since a significant correlation was found (Table 4, Chapter IV) between Social Desirability and two of the variables of interest (Self-compassion and Burnout), the multivariate analyses used a Multivariate Analysis of Covariance (MANCOVA) procedure with social desirability as a covariate, to parcel out the potential influence of social desirability. Weinfurt (1995) indicates that MANCOVA is used when a covariate (in this case social desirability) is known to affect the dependent variables. The MANCOVA was performed to determine if counselors who practiced meditation reported differing levels of compassion fatigue, compassion satisfaction, burnout and self compassion (which includes self-kindness, common humanity and mindfulness), when compared to those counselors who do not practice meditation. Further, a correlation matrix was generated to assess the relation between length of meditation experience and the dependent variables of interest (compassion satisfaction, burnout, compassion fatigue and self-compassion).
To address Hypothesis 2, a correlation matrix between Self-Compassion, Compassion Fatigue, Compassion Satisfaction, Burnout (and Social Desirability and Length of Meditation experience, as noted above) was generated (see Table 4).
CHAPTER IV
RESULTS

The purpose of this study was to examine whether differences in compassion fatigue, compassion satisfaction, burnout, and self-compassion, existed between counselors who practice meditation and those counselors who do not practice meditation. This chapter presents the statistical results of the research findings, and is organized in three parts: data screening, descriptive statistics, and the results of the inferential statistical analyses designed to test the research hypotheses.

Data Screening and Tests for Normality

Data were screened to confirm that participants met criteria for membership in their respective groups. Twenty-six participants who indicated they practiced meditation were eliminated from the data set because they did not meet a priori criteria, namely, 1) they reported meditating for less than 60 minutes per week; or 2) they reported practicing meditation for an interval of less than 6 months. Three additional participants were removed from the final data set as their scores were identified as multivariate outliers using the Mahalanobis distance measure (Mertler & Vannatta, 2005), via a regression of the participant number against the variables of interest (i.e., compassion satisfaction, compassion fatigue, burnout, and self-compassion.) The removal of these outliers
promotes the homogeneity and normality of the data and increases the power of the results. The final number of valid participants was 164.

When the MANCOVA was performed, a Box’s M Test of Equality of Covariance Matrices was conducted to investigate the sphericity of the covariance matrix (see below). The results of the Box Test were not significant (Box’s $M = 12.65$, $F = 1.23$, and $p = 0.267$), suggesting that the basic assumptions of normality, linearity, and homoscedasticity were not violated. Hence, additional statistical procedures to further transform the data as suggested by Merlter and Vannatta (2005) were not used.

### Descriptive Statistics

Descriptive statistics (including unadjusted means, standard deviation, skewness and kurtosis) for the dependent variables of interest are reported in Table 2. On the Compassion Fatigue (CF) subscale of the Pro-QOL, participants ($N = 62$) who met criteria for inclusion in the meditation group (those individuals who reported meditating for a minimum of 6 months and for 60 or more minutes per week) had a mean score of 9.5 ($SD = 3.99$.) Participants who reported no meditation practice ($N = 102$) had a mean CF score of 10.71 ($SD = 5.29$). On the Compassion Satisfaction (CS) subscale of the Pro-QOL, participants who reported meditation practice had a mean score of 42.04 ($SD = 6.41$) and non-meditating participants obtained a mean CS score of 40.26 ($SD = 6.18$). On the Burnout subscale of the Pro-QOL, participants who reported meditation practice had a mean score of 15.85 ($SD = 5.12$) and non-meditating participants obtained a mean Burnout score of 18.83 ($SD = 5.85$). Since the Pro-QOL measures three discrete
constructs (Compassion Fatigue, Compassion Satisfaction and Burnout), a global score was neither available nor appropriate (Stamm, 2005).

On the Self-Compassion Scale (SC), participants who reported meditation practice obtained a mean score of 3.87 ($SD = 0.57$), as compared to non-meditating participants who obtained a mean SC score of 3.48 ($SD = 0.72$). Although individual subscales of the Self-Compassion Scale are available, these subscale scores were not calculated in the omnibus multivariate test. Data for all of the administered scales (the Pro-QOL and the Self-Compassion Scale) were normally distributed, with the exception of the Compassion Satisfaction subscale which had a slight leptokurtic distribution with a Kurtosis = 1.080 (See Table 2).

Table 2: Descriptive Statistics of the Sample Population

<table>
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<td>N</td>
<td>Unadj. Mean</td>
<td>SD</td>
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<td></td>
</tr>
<tr>
<td>Satisfaction</td>
<td>62</td>
<td>42.05</td>
<td>6.41</td>
</tr>
<tr>
<td>PQ: Compassion Fatigue</td>
<td>62</td>
<td>9.50</td>
<td>3.99</td>
</tr>
<tr>
<td>PQ: Burnout</td>
<td>62</td>
<td>15.85</td>
<td>5.12</td>
</tr>
<tr>
<td>SCS: Self Compassion</td>
<td>62</td>
<td>3.87</td>
<td>.57</td>
</tr>
</tbody>
</table>

To determine the reliability of the instruments used in this study, Cronbach’s alpha internal-consistency estimates were calculated (Table 3). The internal-consistency reliability for the Compassion Satisfaction subscale of the Pro-QOL scale was 0.89, the alpha reliability for the Compassion Fatigue subscale was 0.81, and for the Burnout subscale, the obtained alpha reliability was 0.76. These alpha coefficients are similar to the results obtained by Stamm (2005), who reported alpha reliabilities ranging from 0.72
to 0.89. As Stamm (2005), indicates, the Pro-QOL is comprised of three distinct scales, which do not yield a composite score.

The internal-consistency reliability estimates for the Self-Compassion Scale (SCS) were 0.87 for the Self-judgment subscale, 0.86 for the Overidentification subscale, and 0.86 for the Isolation subscale. The internal-consistency reliability estimate for the Common Humanity subscale of the SCS was 0.74, for the Self-kindness subscale, an alpha reliability of 0.83 was obtained, and for the Mindfulness subscale of the SCS, an alpha estimate of 0.76 was obtained. The overall internal consistency reliability estimate for the composite Self-Compassion Scale was 0.95. These alpha coefficients are comparable to the results obtained by Neff (2003b), the author of the Self-Compassion Scale, who reported alpha coefficients ranging from 0.77 to 0.92 (See Table 3).

Table 3: Cronbach’s Alpha Internal Consistency Reliability Estimates of Instruments

<table>
<thead>
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<th>Instrument Subscales</th>
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<tr>
<td>Compassion Fatigue</td>
<td>10</td>
<td>0.81</td>
<td>0.80</td>
</tr>
<tr>
<td>Burnout</td>
<td>10</td>
<td>0.76</td>
<td>0.71</td>
</tr>
<tr>
<td>Self-Compassion Scale (SCS)</td>
<td>26</td>
<td>0.95</td>
<td>0.92</td>
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</tbody>
</table>
Results for the Hypotheses

The measure of effect size used when conducting the inferential statistical procedures was Partial Eta Squared ($\eta^2$). Whereas $\eta^2$ refers to the ratio of effect variance to the total variance, partial $\eta^2$ is the proportion of the effect plus the error variance that can be attributed to the effect. According to Cohen’s taxonomy of standard effect sizes (Cohen, 1988), a large effect is equal to an $\eta_p^2 \geq 0.138$, a medium effect ranges from an $\eta_p^2 = 0.059$ to an $\eta_p^2 = 0.137$ and a small effect is an $\eta_p^2 < 0.059$.

Results for Research Hypothesis 1

Table 4: Correlations for Compassion Satisfaction (CS), Compassion Fatigue (CF), Burnout (BO), Self-Compassion (SC), Social Desirability (SD), and Months of Experience with meditation (MEx)

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CS (n=164)</td>
<td>$r$</td>
<td>1</td>
<td>-0.292**</td>
<td>0.667**</td>
<td>0.387**</td>
<td>0.123</td>
</tr>
<tr>
<td></td>
<td>$p$ (2-tailed)</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.116</td>
<td>0.304</td>
</tr>
<tr>
<td>2. CF (n=164)</td>
<td>$r$</td>
<td>1</td>
<td>0.567**</td>
<td>-0.452**</td>
<td>-0.081</td>
<td>0.037</td>
</tr>
<tr>
<td></td>
<td>$p$ (2-tailed)</td>
<td>0.000</td>
<td>0.000</td>
<td>0.302</td>
<td>0.765</td>
<td></td>
</tr>
<tr>
<td>3. BO (n=164)</td>
<td>$p$ (2-tailed)</td>
<td>1</td>
<td>-0.525**</td>
<td>-0.175*</td>
<td>-0.146</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$r$</td>
<td>0.000</td>
<td>0.025</td>
<td>0.237</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. SC (n=164)</td>
<td>$p$ (2-tailed)</td>
<td>1</td>
<td>0.204**</td>
<td>0.228</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$r$</td>
<td>0.009</td>
<td>0.063</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. SD (n=164)</td>
<td>1</td>
<td>0.075</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. MEx (n=62)</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

** Correlation is significant at the 0.01 level (2-tailed)
* Correlation is significant at the 0.05 level (2-tailed)
A correlation matrix was generated for the four dependent variables, and also for social desirability and length of meditation experience. The results of these correlations are presented in Table 4.

Research Hypothesis 1 states that professional counselors who practice meditation would report significantly higher levels of self-compassion and compassion satisfaction, while reporting statistically significant lower levels of burnout and compassion fatigue when compared to counselors who do not practice meditation.

Multivariate analysis of covariance (MANCOVA) was conducted to compare counselors who practice meditation to those who do not, on the variables of compassion satisfaction, compassion fatigue, burnout and self-compassion. Since the Box’s M Test of covariance was not statistically significant, Wilks’ λ was used as the test statistic. Mertler and Vannatta (2002) indicate that if equal variances are assumed, Wilks’ λ is the most commonly used and reported MANOVA statistic.

Results were as follows: the main effects of Meditation (Wilks’ λ = 0.899, F(3, 163) = 4.428, p = 0.002, multivariate partial η² = 0.101, pwr = 0.932) indicate a significant effect on the combined DV. Subsequent univariate ANOVA results are in Table 5. The results of the between-subjects ANOVAs indicate a significant effect of meditation on the DVs of Burnout (F(1, 163) = 10.63, p = 0.001, partial η² = 0.062, pwr = 0.90) and Self-Compassion (F(1,163) = 13.312, p < 0.001, partial η² = 0.076, pwr = 0.95). Both Burnout (F(1, 163) = 4.685, p = 0.029, partial η² = 0.029) and Self-Compassion (F(1,163) = 6.778, p = 0.010, partial η² = 0.040) were also significantly affected by the covariate of Social-Desirability, but at lower power than the standard threshold of 0.8 (0.59, 0.74, respectively).
Table 5: ANOVA Results for Pro-QOL, SCS and SDS Differences Between Participant Groups for Meditation

<table>
<thead>
<tr>
<th>Source</th>
<th>Dependent Variable</th>
<th>Df</th>
<th>F</th>
<th>Partial $\eta$ squared</th>
<th>P</th>
<th>Observed Power</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept</td>
<td>Compassion Satisfaction</td>
<td>1</td>
<td>941.08</td>
<td>0.85</td>
<td>0.00</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>Compassion Fatigue</td>
<td>1</td>
<td>122.29</td>
<td>0.43</td>
<td>0.00</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>Burnout</td>
<td>1</td>
<td>299.51</td>
<td>0.65</td>
<td>0.00</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>Self-compassion</td>
<td>1</td>
<td>615.63</td>
<td>0.79</td>
<td>0.00</td>
<td>1.00</td>
</tr>
<tr>
<td>SDS</td>
<td>Compassion Satisfaction</td>
<td>1</td>
<td>2.31</td>
<td>0.01</td>
<td>0.13</td>
<td>0.327</td>
</tr>
<tr>
<td></td>
<td>Compassion Fatigue</td>
<td>1</td>
<td>0.96</td>
<td>0.01</td>
<td>0.33</td>
<td>0.164</td>
</tr>
<tr>
<td></td>
<td>Burnout</td>
<td>1</td>
<td>4.87</td>
<td>0.65</td>
<td>0.001</td>
<td>0.592</td>
</tr>
<tr>
<td></td>
<td>Self-compassion</td>
<td>1</td>
<td>6.78</td>
<td>0.79</td>
<td>0.01</td>
<td>0.735</td>
</tr>
<tr>
<td>Meditation</td>
<td>Compassion Satisfaction</td>
<td>1</td>
<td>0.294</td>
<td>0.02</td>
<td>0.09</td>
<td>0.399</td>
</tr>
<tr>
<td></td>
<td>Compassion Fatigue</td>
<td>1</td>
<td>2.28</td>
<td>0.01</td>
<td>0.13</td>
<td>0.323</td>
</tr>
<tr>
<td></td>
<td>Burnout</td>
<td>1</td>
<td>10.63</td>
<td>0.062</td>
<td>0.001</td>
<td>0.900</td>
</tr>
<tr>
<td></td>
<td>Self-compassion</td>
<td>1</td>
<td>13.31</td>
<td>0.076</td>
<td>0.000</td>
<td>0.952</td>
</tr>
</tbody>
</table>
Table 5: ANOVA Results for Pro-QOL, SCS and SDS Differences Between Participant Groups for Meditation (Continued)

<table>
<thead>
<tr>
<th>Error</th>
<th>Compass Satisfaction</th>
<th>Compass Fatigue</th>
<th>Burnout</th>
<th>Self-Compassion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>161</td>
<td>(35.98)</td>
<td>(23.41)</td>
<td>(30.49)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(0.431)</td>
</tr>
</tbody>
</table>

Table 6 lists the marginal (adjusted) means for the meditation group and non-meditation group on the dependent variables of compassion satisfaction, compassion fatigue, burnout and self-compassion. When adjusted for social desirability, the meditation group obtained a mean score of 42.01 on measures of compassion satisfaction, compared to non-meditation group that obtained a mean score of 40.29. On compassion fatigue, the non-meditation group obtained a mean score of 10.7, compared to the meditation group who obtained a mean score of 9.52. Non-meditating counselors obtained a mean score of 18.80 on measures of burnout compared to meditating counselors who obtained a mean score of 15.90. Finally, on the self-compassion variable, the non-meditation group obtained a mean score of 3.48 compared to the meditation group who obtained an adjusted mean score of 3.87.

Table 6: Marginal (adjusted) Means comparing non-meditators and meditators on Compassion Satisfaction (CS), Compassion Fatigue (CF), Burnout (BO) and Self-compassion (SC)

<table>
<thead>
<tr>
<th>Dependent variable</th>
<th>Meditation status</th>
<th>Mean</th>
<th>Std. Error</th>
<th>95% confidence interval</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Lower bound</td>
<td>Upper bound</td>
<td></td>
</tr>
<tr>
<td>CS</td>
<td>No practice</td>
<td>40.287 (a)</td>
<td>39.067</td>
<td>41.508</td>
</tr>
<tr>
<td></td>
<td>Practice</td>
<td>42.011 (a)</td>
<td>40.445</td>
<td>43.577</td>
</tr>
<tr>
<td>CF</td>
<td>No practice</td>
<td>10.695 (a)</td>
<td>9.748</td>
<td>11.641</td>
</tr>
<tr>
<td></td>
<td>Practice</td>
<td>9.519 (a)</td>
<td>8.305</td>
<td>10.732</td>
</tr>
</tbody>
</table>
Table 6: Marginal (adjusted) Means comparing non-meditators and meditators on Compassion Satisfaction (CS), Compassion Fatigue (CF), Burnout (BO) and Self-compassion (SC) (Continued)

<table>
<thead>
<tr>
<th></th>
<th>No practice</th>
<th>Practice</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>BO</td>
<td>18.804 (a)</td>
<td>15.902 (a)</td>
<td>0.547</td>
<td>0.702</td>
</tr>
<tr>
<td>SC</td>
<td>3.479 (a)</td>
<td>3.865 (a)</td>
<td>0.065</td>
<td>0.083</td>
</tr>
</tbody>
</table>

(a) Covariates appearing in the model are evaluated at the following values: Scores on Social desirability= 4.7561.

Results for Research Hypothesis 2

Research Hypothesis 2 states that measures of self-compassion (as measured by the SCS) would be positively and significantly correlated with compassion satisfaction (as measured by the Pro-QOL) and negatively correlated with compassion fatigue and burnout (also measured by the Pro-QOL). Multiple partial correlation analyses were conducted between self-compassion, burnout, compassion fatigue and compassion satisfaction. The results of these partial correlations are in Tables 7-10. The significant results include: when controlling for Compassion Satisfaction, Self-Compassion shows a significant negative correlation with Burnout ($r = -0.389, p < 0.001$) and Compassion Fatigue ($r = -0.384, p < 0.001$) (See Table 10). When controlling for Compassion Fatigue, Self-compassion is positively and significantly correlated with Compassion Satisfaction ($r = 0.298, p < 0.001$) and negatively correlated with Burnout ($r = -0.365, p < 0.001$) (see Table 9). When controlling for Burnout, Self-Compassion is negatively and significantly correlated with Compassion Fatigue ($r = -0.217, p = 0.005$) (see Table 8).
When controlling for Self-compassion, Compassion satisfaction displays a
significant negative correlation with Burnout ($r = -0.591$, $p < 0.001$). When controlling
for Compassion Fatigue, Compassion Satisfaction showed a significant negative
correlation with Burnout ($r = -0.636$, $p < 0.001$) (See Table 7).

Table 7: Partial correlations for Compassion Satisfaction (CS), Burnout (BO) and
Compassion Fatigue (CF) when controlling for Self-compassion (SC)

<table>
<thead>
<tr>
<th>Control Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-compassion (SC)</td>
<td></td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>1 CS</td>
<td>1.000</td>
<td>-0.144</td>
<td>-0.591</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0.067</td>
<td>0.000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0</td>
<td>161</td>
</tr>
<tr>
<td>2 CF</td>
<td></td>
<td>R</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.000</td>
<td>0.439</td>
</tr>
<tr>
<td></td>
<td></td>
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</tr>
<tr>
<td>3 BO</td>
<td></td>
<td>R</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1.000</td>
</tr>
</tbody>
</table>

Table 8: Partial correlations for Compassion Satisfaction (CS), Compassion Fatigue (CF)
and Self-Compassion (SC) when controlling for Burnout (BO)

<table>
<thead>
<tr>
<th>Control Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burnout (BO)</td>
<td></td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>1 CS</td>
<td>1.000</td>
<td>0.143</td>
<td>0.057</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0.068</td>
<td>0.466</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0</td>
<td>161</td>
</tr>
<tr>
<td>2 CF</td>
<td></td>
<td>R</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.000</td>
<td>-0.217</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3 SC</td>
<td></td>
<td>R</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1.000</td>
</tr>
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<td></td>
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<td>0</td>
</tr>
</tbody>
</table>
Table 9: Partial correlations for Compassion Satisfaction (CS), Burnout (BO) and Self-Compassion (SC) when controlling for Compassion Fatigue (CF)

<table>
<thead>
<tr>
<th>Control Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compassion Fatigue (CF)</td>
<td>1 CS</td>
<td>2 BO</td>
<td>3 SC</td>
</tr>
<tr>
<td></td>
<td>R</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td></td>
<td>1.000</td>
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<td>1.000</td>
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<td></td>
<td>-0.636</td>
<td>-0.365</td>
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<td>161</td>
</tr>
<tr>
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<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
</tr>
</tbody>
</table>

Table 10: Partial correlations for Compassion Fatigue (CF), Burnout (BO) and Self-Compassion (SC) when controlling for Compassion Satisfaction (CS)

<table>
<thead>
<tr>
<th>Control Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compassion Satisfaction (CS)</td>
<td>1 CF</td>
<td>2 BO</td>
<td>3 SC</td>
</tr>
<tr>
<td></td>
<td>R</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td></td>
<td>1.000</td>
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<td>0.527</td>
<td>-0.389</td>
<td>0.000</td>
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<td></td>
<td>-0.384</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td></td>
<td>161</td>
<td>161</td>
<td>161</td>
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</tr>
<tr>
<td></td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
</tr>
</tbody>
</table>

Summary of the Results for the Research Hypotheses

This chapter included demographic statistics for the two participant groups that were sampled (counselors who report meditation practice and those who do not report meditation practice), and descriptive statistics related to the Pro-QOL (Compassion Satisfaction, Compassion Fatigue and Burnout) (Stamm, 2005) and the Self-Compassion Scale (Neff, 2003b). Initial data screening resulted in the removal of 26 participants who...
did not meet criteria for inclusion in the meditation group. Further data screening resulted in the removal of three participants who were identified as statistical outliers through the calculation of Mahalanobis distance. This yielded a valid sample of 164 participants.

Following the data screening, scores from the three subscales of the Pro-QOL and the Self-compassion Scale (SCS) were statistically analyzed using a multiple analysis of covariance (MANCOVA) with an abbreviated measure of social desirability as the covariate. Results of the MANCOVA (Research Hypothesis 1) yielded a statistically significant effect of meditation practice, and univariate ANOVAs then determined which scales of the Pro-QOL and the Self-Compassion Scale showed statistical significance.

Results of the Univariate ANCOVAs indicate that counselors who practice meditation scored significantly lower than their non-meditating counterparts on measures of burnout, and significantly higher on self-compassion. ANOVAs also indicated that the covariate of social desirability has a significant effect on both Burnout and Self-compassion.

Results for Hypothesis 2 indicate that when controlling for Compassion Satisfaction, Self-compassion shows a negative and significant correlation with both Burnout and Compassion fatigue. When controlling for Compassion Fatigue, Self-compassion is significantly and positively correlated with Compassion Satisfaction, and negatively and significantly correlated with Burnout. Partial correlations further reveal that when controlling for Self-compassion, Compassion satisfaction is significantly and negatively correlated with Burnout. These results are similar to those reported by Stamm (2005).
In order to address the potential confounding variable of self-care time, two additional (post-hoc) MANCOVAs were conducted (see Tables 12-14). Although results of the multivariate test were not overall significant, between-subjects ANOVAs indicate that self-care time has a significant impact on Compassion Satisfaction. Consistent with the previous MANCOVAs, the covariate of Social Desirability was found to have a significant effect on both burnout and self-compassion. Results of the factorial MANCOVA with meditation and self-care time as independent variables reveal significant main effects for meditation. Follow-up ANOVAs confirmed the findings of the prior MANCOVAs. Specifically, the ANOVAs indicate significant main effects for meditation on both burnout and self-compassion, and between-subjects effects for self-care time on compassion satisfaction. Follow-up ANOVAs further confirmed that the covariate of social desirability has a significant impact on both burnout and self-compassion.

Post Hoc Results

In order to address the potential confounding variables of gender and self-care time, additional (post-hoc) MANCOVAs were conducted. The present study did not a significant multivariate difference between males and females on the variables of self-compassion, compassion fatigue, compassion satisfaction or burnout (Wilks’ λ = 0.961, F(1, 163) = 0.793 p = 0.609, multivariate partial η² = 0.020). Results of the ANOVA between gender and the dependent variables were not significant (see Table 11.)

Although results of the multivariate test for self-care time were not overall significant, between-subjects ANOVAs indicate that self-care time has a significant impact on Compassion Satisfaction (see Table 13). Consistent with the previous
MANCOVAs, the covariate of Social Desirability was found to have a significant effect on both burnout and self-compassion. Results of the factorial MANCOVA with meditation and self-care time as independent variables reveal significant main effects for meditation. Follow-up ANOVAs confirmed the findings of the prior MANCOVAs. Specifically, the ANOVAs indicate significant main effects for meditation on both burnout and self-compassion, and between-subjects effects for self-care time on compassion satisfaction (see Table 14). Follow-up ANOVAs further confirmed that the covariate of social desirability has a significant impact on both burnout and self-compassion.

Table 11: ANOVA Results for Pro-QOL, SCS and SDS Differences Between Participant Groups on Gender

<table>
<thead>
<tr>
<th>Source</th>
<th>Dependent Variable</th>
<th>Df</th>
<th>F</th>
<th>Partial ( \eta ) squared</th>
<th>P</th>
<th>Observed power</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept</td>
<td>Compassion satisfaction</td>
<td>1</td>
<td>379.31</td>
<td>0.705</td>
<td>0.00</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>Compassion Fatigue</td>
<td>1</td>
<td>30.41</td>
<td>0.161</td>
<td>0.00</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>Burnout</td>
<td>1</td>
<td>98.91</td>
<td>0.384</td>
<td>0.00</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>Self-compassion</td>
<td>1</td>
<td>204.55</td>
<td>0.56</td>
<td>0.00</td>
<td>1.00</td>
</tr>
<tr>
<td>SDS</td>
<td>Compassion Satisfaction</td>
<td>1</td>
<td>1.997</td>
<td>0.012</td>
<td>0.16</td>
<td>0.29</td>
</tr>
<tr>
<td></td>
<td>Compassion Fatigue</td>
<td>1</td>
<td>0.633</td>
<td>0.004</td>
<td>0.427</td>
<td>0.124</td>
</tr>
<tr>
<td></td>
<td>Burnout</td>
<td>1</td>
<td>4.68</td>
<td>0.029</td>
<td>0.032</td>
<td>0.575</td>
</tr>
<tr>
<td></td>
<td>Self-compassion</td>
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<td>6.83</td>
<td>0.041</td>
<td>0.010</td>
<td>0.736</td>
</tr>
</tbody>
</table>
Table 11: ANOVA Results for Pro-QOL, SCS and SDS Differences Between Participant Groups on Gender (Continued)

<table>
<thead>
<tr>
<th>Gender</th>
<th>Compassion Satisfaction</th>
<th>Error</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Compassion Satisfaction</td>
<td>2</td>
<td>0.93</td>
<td>0.012</td>
<td>0.396</td>
</tr>
<tr>
<td></td>
<td>Compassion Fatigue</td>
<td>2</td>
<td>1.97</td>
<td>0.024</td>
<td>0.143</td>
</tr>
<tr>
<td></td>
<td>Burnout</td>
<td>2</td>
<td>0.512</td>
<td>0.006</td>
<td>0.600</td>
</tr>
<tr>
<td></td>
<td>Self-compassion</td>
<td>2</td>
<td>0.167</td>
<td>0.002</td>
<td>0.846</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In order to assess self-care time, participants were binned into three approximately equal groups. Participants who reported less than 1 hour of self care time (N = 56) were binned into one group. Participants who reported between 1 hour and 6 hours of self-care time (N = 64) were binned into a second group and participants (N = 44) who reported over 6 hours of self-care time were binned into a third group. The mean group scores on the dependent variables of interest are reported in Table 12.
Table 12: Descriptive statistics of the Self-Care groups

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Comp Sat</th>
<th>Comp Fat</th>
<th>Burnout</th>
<th>Self-comp</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 1 hour of self-care</td>
<td>56</td>
<td>41.68</td>
<td>10.20</td>
<td>16.89</td>
<td>3.66</td>
</tr>
<tr>
<td>1 hour to 5 hours</td>
<td>64</td>
<td>39.03</td>
<td>10.84</td>
<td>19.06</td>
<td>3.49</td>
</tr>
<tr>
<td>&gt; 6 hours of self-care</td>
<td>44</td>
<td>42.77</td>
<td>9.45</td>
<td>16.77</td>
<td>3.78</td>
</tr>
</tbody>
</table>

In order to test the impact of self-care time on the dependent variables of interest (compassion satisfaction, compassion fatigue, burnout and self-compassion), a second MANCOVA was conducted with social desirability as a covariate. The Box’s M test of equality of covariance was not significant, suggesting that the assumptions of linearity, homogeneity and homoscedasticity were not violated. The main effects of self-care time (Wilks’ λ = 0.924, F(4, 163) = 1.97, p = 0.128, multivariate partial η² = 0.039) did not indicate a significant main effect on the combined DV. The covariate of Social Desirability also did not significantly influence the combined DV (Wilks’ λ = .952, F(4, 163) = 1.97, p = 0.083, multivariate partial η² = 0.048).

Univariate ANOVA results (see Table 13) indicate that the DV of Compassion Satisfaction (F(2, 163) = 5.22, p = 0.006, partial η² = 0.061) was significantly affected by amount of self-care practice. Consistent with the results of the earlier meditation MANCOVA, both Burnout (F(1, 163) = 4.48, p = 0.036, partial η² = 0.027) and Self-Compassion (F(1, 163) = 6.69, p = .011, partial η² = 0.040) were significantly affected by the covariate of Social-Desirability.
Table 13: ANOVA Results for Pro-QOL, SCS and SDS Differences Between Participant Groups On Self-Care Time

<table>
<thead>
<tr>
<th>Source</th>
<th>Dependent Variable</th>
<th>Df</th>
<th>F</th>
<th>Partial $\eta$ squared</th>
<th>P</th>
<th>Observed power</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept</td>
<td>Compassion satisfaction</td>
<td>1</td>
<td>987.87</td>
<td>0.861</td>
<td>0.00</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>Compassion Fatigue</td>
<td>1</td>
<td>123.56</td>
<td>0.436</td>
<td>0.00</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>Burnout</td>
<td>1</td>
<td>294.85</td>
<td>0.648</td>
<td>0.00</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>Self-compassion</td>
<td>1</td>
<td>569.46</td>
<td>0.781</td>
<td>0.00</td>
<td>1.00</td>
</tr>
<tr>
<td>SDS</td>
<td>Compassion Satisfaction</td>
<td>1</td>
<td>2.07</td>
<td>0.013</td>
<td>0.152</td>
<td>0.299</td>
</tr>
<tr>
<td></td>
<td>Compassion Fatigue</td>
<td>1</td>
<td>0.990</td>
<td>0.006</td>
<td>0.321</td>
<td>0.167</td>
</tr>
<tr>
<td></td>
<td>Burnout</td>
<td>1</td>
<td>4.481</td>
<td>0.027</td>
<td>0.036</td>
<td>0.557</td>
</tr>
<tr>
<td></td>
<td>Self-compassion</td>
<td>1</td>
<td>6.692</td>
<td>0.040</td>
<td>0.011</td>
<td>0.730</td>
</tr>
<tr>
<td>Self-care</td>
<td>Compassion Satisfaction</td>
<td>2</td>
<td>5.215</td>
<td>0.061</td>
<td>0.006</td>
<td>0.825</td>
</tr>
<tr>
<td></td>
<td>Compassion Fatigue</td>
<td>2</td>
<td>1.031</td>
<td>0.013</td>
<td>0.359</td>
<td>0.228</td>
</tr>
<tr>
<td></td>
<td>Burnout</td>
<td>2</td>
<td>2.665</td>
<td>0.032</td>
<td>0.073</td>
<td>0.523</td>
</tr>
<tr>
<td></td>
<td>Self-compassion</td>
<td>2</td>
<td>2.268</td>
<td>0.028</td>
<td>0.107</td>
<td>0.456</td>
</tr>
<tr>
<td>Error</td>
<td>Compassion Satisfaction</td>
<td>160</td>
<td>(37.464)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Compassion Fatigue</td>
<td>160</td>
<td>(23.58)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Burnout</td>
<td>160</td>
<td>(31.656)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Self-compassion</td>
<td>160</td>
<td>(0.457)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
In order to determine if meditation and self-care time had a mutual (interactive) influence on the variables of interest, a factorial MANCOVA was conducted with meditation practice and self-care time as the independent factors, and compassion satisfaction, compassion fatigue, burnout and self-compassion as the dependent variables. As in the prior MANCOVAs, Social Desirability was maintained as a covariate. The result of the Box’s M test of Equality was significant, suggesting that the assumption of homoscedasticity was violated. Hence, Pillai’s Trace was selected for its robustness in the face of violation of assumptions. The results of this analysis were similar to the previous results obtained, with the main effect of meditation indicating a significant effect on the combined DV (Pillai’s Trace = 0.09, F(1,154) = 3.81, p = 0.006, partial η² = 0.09). Results of Univariate ANOVAs indicated that Meditation had a significant effect on burnout and self-compassion, and self-care time had a significant effect on compassion satisfaction. As with prior results, the covariate of social desirability had a significant effect on burnout and self-compassion (see Table 14.)

Table 14: ANOVA Results for Pro-QOL, SCS and SDS Differences Between Participant Groups On Meditation and Self-Care Time

<table>
<thead>
<tr>
<th>Source</th>
<th>Dependent Variable</th>
<th>Df</th>
<th>F</th>
<th>Partial η squared</th>
<th>P</th>
<th>Observed power</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept</td>
<td>Compassion Satisfaction</td>
<td>1</td>
<td>972.48</td>
<td>0.861</td>
<td>0.00</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>Compassion Fatigue</td>
<td>1</td>
<td>118.321</td>
<td>0.430</td>
<td>0.00</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>Burnout</td>
<td>1</td>
<td>292.899</td>
<td>0.651</td>
<td>0.00</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>Self-compassion</td>
<td>1</td>
<td>617.242</td>
<td>0.797</td>
<td>0.00</td>
<td>1.00</td>
</tr>
</tbody>
</table>
Table 14: ANOVA Results for Pro-QOL, SCS and SDS Differences Between Participant Groups On Meditation and Self-Care Time (Continued)

<table>
<thead>
<tr>
<th>SDS</th>
<th>Compassion Satisfaction</th>
<th>1</th>
<th>1.902</th>
<th>0.012</th>
<th>0.170</th>
<th>0.278</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Compassion Fatigue</td>
<td>1</td>
<td>0.992</td>
<td>0.006</td>
<td>0.321</td>
<td>0.168</td>
</tr>
<tr>
<td></td>
<td>Burnout</td>
<td>1</td>
<td>4.325</td>
<td>0.027</td>
<td>0.039</td>
<td>0.543</td>
</tr>
<tr>
<td></td>
<td>Self-compassion</td>
<td>1</td>
<td>3.302</td>
<td>0.046</td>
<td>0.007</td>
<td>0.776</td>
</tr>
<tr>
<td>Self-care</td>
<td>Compassion Satisfaction</td>
<td>2</td>
<td>4.205</td>
<td>0.051</td>
<td>0.017</td>
<td>0.732</td>
</tr>
<tr>
<td></td>
<td>Compassion Fatigue</td>
<td>2</td>
<td>0.598</td>
<td>0.008</td>
<td>0.551</td>
<td>0.148</td>
</tr>
<tr>
<td></td>
<td>Burnout</td>
<td>2</td>
<td>1.476</td>
<td>0.018</td>
<td>0.232</td>
<td>0.312</td>
</tr>
<tr>
<td></td>
<td>Self-compassion</td>
<td>2</td>
<td>0.655</td>
<td>0.008</td>
<td>0.521</td>
<td>0.158</td>
</tr>
<tr>
<td>Meditation</td>
<td>Compassion Satisfaction</td>
<td>1</td>
<td>1.315</td>
<td>0.008</td>
<td>0.253</td>
<td>0.207</td>
</tr>
<tr>
<td></td>
<td>Compassion Fatigue</td>
<td>1</td>
<td>1.672</td>
<td>0.011</td>
<td>0.198</td>
<td>0.250</td>
</tr>
<tr>
<td></td>
<td>Burnout</td>
<td>1</td>
<td>8.474</td>
<td>0.051</td>
<td>0.004</td>
<td>0.825</td>
</tr>
<tr>
<td></td>
<td>Self-compassion</td>
<td>1</td>
<td>10.864</td>
<td>0.065</td>
<td>0.001</td>
<td>0.906</td>
</tr>
</tbody>
</table>

| Self-care* meditation | Compassion Satisfaction | 2     | 0.296 | 0.004 | 0.744 | 0.096 |
|                       | Compassion Fatigue        | 2     | 0.107 | 0.001 | 0.899 | 0.155 |
|                       | Burnout                   | 2     | 0.638 | 0.008 | 0.530 | 0.155 |
|                       | Self-compassion           | 2     | 1.486 | 0.019 | 0.229 | 0.314 |
Table 14: ANOVA Results for Pro-QOL, SCS and SDS Differences Between Participant Groups On Meditation and Self-Care Time (Continued)

<table>
<thead>
<tr>
<th>Error</th>
<th>Compassion Satisfaction</th>
<th>157</th>
<th>(37.747)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compassion Fatigue</td>
<td>157</td>
<td>(23.758)</td>
<td></td>
</tr>
<tr>
<td>Burnout</td>
<td>157</td>
<td>(30.459)</td>
<td></td>
</tr>
<tr>
<td>Self-compassion</td>
<td>157</td>
<td>(0.428)</td>
<td></td>
</tr>
</tbody>
</table>
CHAPTER V
ANALYSIS AND DISCUSSION

The purpose of this study was to compare professional counselors who practice meditation with those professional counselors who do not practice meditation, on the dependent variables of Compassion Satisfaction, Compassion Fatigue, Burnout, and Self-compassion. The correlations among length of meditation experience and the four dependent measures were obtained. Finally, some post-hoc follow-up tests were performed to explore the effect of self-care time and gender differences on the dependent measures. Included in this chapter are the discussion and the interpretation of the findings of this research study, a comparison of the results of this study in the context of the existing literature, limitations and conclusions, implications of the findings, and recommendations for future research and a summary of the findings.

Discussion and Interpretation of the Statistical Results

The participants in this research study (N = 164) were comprised of two groups of licensed professional counselors: those who reported that they practice meditation and those who reported that they do not practice meditation. Both groups of participants, those who reported meditation practice (N = 62) and those who not (N = 102) were obtained through their membership and participation in national and state counseling list
serves. The participants in this study completed an on-line version of the Professional Quality of Life Scale (Pro-QOL; Stamm, 2005) to measure Compassion Fatigue, Compassion Satisfaction and Burnout. Participants also completed an on-line version of the Self-Compassion scale (SCS; Neff, 2003b) in order to assess their self-reported level of self-compassion. In order to address a limitation that is frequently found in self-report measures, an abbreviated measure of social desirability was included in the on-line survey (SDS; Fisher and Fisk, 1993). Lastly, participants completed a demographic questionnaire that was developed for this study, and included the variables of gender, race, number of clients diagnosed with PTSD, reported self-care time and whether or not the participant practiced meditation (See Appendix C).

A number of factors were unique to the present study. Participants in the present study were derived exclusively from a national sample of licensed counselors. Other studies that have addressed compassion fatigue, burnout and compassion satisfaction have included social workers, psychologists and an array of other mental health practitioners in the participant sample (Conrad & Keller-Guenther, 2006; Simpson, 2005). Although compassion fatigue and burnout impact a broad range of mental health practitioners, counselors represent the single largest category of mental health professionals employed in the United States. In addition, counselors, by the nature of their training, are also more likely to be “on the front lines” where they are most vulnerable to these phenomena. The sample of counselors in the present study also displayed some unique features: the overwhelming majority of participants were female (N= 123; 71.5%) and self-identified as white (N=148; 85.5%).
A sizable portion of the sample was also relatively inexperienced, with 30.2% reporting less than 7 years of professional experience in the role of a professional counselor. Approximately one-half of the sample reported some degree of personal trauma (50.9%). Slightly less than one-half of the sample was trained at the doctoral level (47.9%). In terms of theoretical or working orientation, the majority reported a Person-Centered or Existential perspective (47.6%), followed by a Cognitive-Behavioral orientation (39.3%), with counselors of a Psychodynamic orientation (4.8%) or a Transpersonal/Integral orientation (8.3%) comprising the remainder of the sample.

Of the counselors who met the criteria for inclusion in the meditation group, 68.9% of the respondents reported a history of personal trauma compared to 40.9% of the counselors in the non-meditation group with a trauma history. In addition, 62.3% of counselors who were included in the meditation group reported a Person-Centered/Existential or Transpersonal/Integral working orientation, compared to 52.3% in the non-meditation group who reported the same orientations. Linley and Joseph (2007) reported that therapists who were receiving clinical supervision and reported a personal history of trauma reported greater levels of personal growth when working with traumatized clients. Linley and Joseph further reported that therapists of a humanistic or transpersonal working orientation were more likely to report growth as a result of their work over therapists of a cognitive behavioral orientation. In the present study, a higher percentage of counselors in the meditation group had a personal trauma history, suggesting that these individuals may be more receptive to the personal growth that is hypothesized to accompany meditation practice. These findings offer an intriguing avenue for research in post traumatic growth.
Thirty-six percent of the sample (N = 62) met criteria for inclusion in the meditation group. Of those 62 counselors who were included in the meditation group, 39 reported that they practiced awareness meditation, with 22 participants who reported practicing concentrative meditation (one participant did not indicate a type of meditation practice). Given the small sample sizes, statistical comparisons between the two types of meditation are not reported.

In terms of reported levels of self-care, 34.9% of participants reported less than 1 hour of self-care time per week, 39.5% reported between 1 and 5 hours of self-care time per week and 25.6% reported over 6 hours of self-care time per week. As stated later in this chapter, a tremendous amount of variability existed in the amount of reported self-care time, with participants indicating between 5 minutes and 20 hours.

Research Hypothesis 1 stated that professional counselors who met criteria for inclusion in the meditation group would report significantly lower levels of burnout and compassion fatigue, while reporting significantly higher levels of self-compassion and compassion satisfaction. Statistical analyses partially confirmed this hypothesis. Results of a MANCOVA indicated that counselors who practice meditation displayed significantly different scores on measures of burnout and self-compassion than their non-meditating counterparts. Follow-up analyses revealed that, specifically, counselors who practice meditation had significantly lower scores on measures of burnout, and significantly higher scores on measures of self-compassion. Results of the initial MANCOVA also found that the covariate of social desirability had a significant effect on both burnout and self-compassion. Although the findings were statistically significant, and of sufficient power, these results must be viewed in the context of the effect sizes that
were obtained. The effect sizes for group differences on the Pro-QOL ranged from small to medium according to Cohen’s standard effect sizes. The effect size of Partial $\eta^2 = 0.029$ for the effect of Social Desirability on Burnout constitutes a small effect size, whereas the Partial $\eta^2$ of .062 for Meditation’s effect on Burnout and .076 for Meditation’s effect on Self-compassion constitute medium effect sizes (See Table 4). On measures of compassion fatigue and compassion satisfaction, no significant differences were found between counselors who were in the mediation group and counselors in the non-meditation group (See Table 4).

Research Hypothesis 2 indicated that scores on measures of self-compassion would be positively correlated with measures of compassion satisfaction, while being negatively correlated with measures of compassion fatigue and burnout. As predicted, partial correlation analyses revealed that when controlling for burnout, self-compassion was significantly and negatively associated with compassion fatigue. Further, when controlling for compassion fatigue, self-compassion had a significant and positive correlation with compassion satisfaction and a negative, significant correlation with burnout. Partial correlations were selected over bi-variate correlations due to the conservative nature of the statistical test and to limit the accumulation of error.

Post Hoc Analyses

Neff (2003b) found that among the normative sample of the Self-Compassion Scale, male participants reported significantly higher levels of self-compassion when compared to their female counterparts. The present study found that male, female and transgender participants were statistically similar on the variables of interest (see Table 4).
11). In all likelihood, the normative sample obtained by Neff, which consisted of undergraduate participants, was dramatically different that the sample utilized in the present study. Participants in the present study were all licensed professional counselors, had higher levels of education and were significantly older than the normative sample. There is a strong possibility that apparent gender differences in self-compassion diminish with age, life experience and education.

Queener (2007) suggested that overall self-care time or competing self-care practices, rather than a single, specific self-care practice (e.g., meditation), may account for any observed differences in compassion satisfaction, compassion fatigue, burnout and self-compassion, in the sample of counselors. Hence, counselors with more reported self-care would experience less Compassion Fatigue and Burnout, while reporting higher levels of Compassion Satisfaction and Self-Compassion. In order to address this potential competing hypothesis, the researcher obtained information on participant-reported self-care time. Due to tremendous variability in the amount of self-care time reported by participants (less than 1 hour to over 20 hours per week) and due to the sparseness of the data across the variable of reported self-care time, self-care time was binned into three approximately equal-size groups (see Table 12).

Results of subsequent MANCOVAs found that participants who reported over five hours of self-care time had statistically higher scores on measures of compassion satisfaction. Self-care time did not have a significant effect on burnout, self-compassion or compassion fatigue.
Results of the factorial MANCOVA that included meditation practice and self-care time as independent variables confirmed the findings that meditation had a significant multivariate effect, while meditation, self-care time and social desirability had significant between-subject effects on the variables of interest.

The results of this MANCOVA confirm the unique contribution of meditation to self-compassion and burnout. Pearlman (1995) asserted that self-care strategies may serve to minimize the impact of compassion fatigue on the practitioner. Her contention was not supported by the present study, as neither self-care time nor meditation practice had a significant effect on the variable of compassion fatigue. Meditation, however, did have a significant effect on burnout, suggesting that meditation may serve to ameliorate a degree of the symptoms of burnout. Further, in follow-up ANCOVAs, self-care time had a significant effect on compassion satisfaction, suggesting that individuals who reported six or more hours of self-care time reported significantly more compassion satisfaction that participants who reported less than 6 hours of self-care.

Discussion of the Results and Related Research

Of the counselors who reported meditation practice, this study was unique in that it focused on meditating counselors who reported at least 6 months of practice. West (1987) indicated that a considerable amount of the research that addresses meditation practice has focused on the impact of meditation on novice practitioners. The long term changes in personality, patterns of responding, and unique perspectives that have long thought to accompany sustained meditation practice are often unavailable to researchers who study novice meditators. Shapiro, Astin, Bishop and Cordova (2005) found that a
brief 8 week mindfulness-based intervention was sufficient to significantly improve self-compassion in a small group of health professionals, but long term changes were not available in their analysis. The results of this study suggest that improvements in self-compassion can be sustained with continued meditation practice.

Shapiro, Schwartz and Bonner (1998) found that 73 pre-med and medical students who completed an 8 week Mindfulness-Based Stress Reduction elective reported lower levels of self-reported depression, state and trait anxiety, higher levels on measures of both empathy and spirituality. Shapiro et al (1998) reported that these improvements in functioning persisted, even when the participants were exposed to exam periods. Although this study supports the value of mindfulness and meditative based intervention on non-clinical populations, it was limited to the impact of a short-term practice on functioning. The current study found lower burnout scores in professional counselors who have practiced meditation for a period of at least six months, suggesting that the enhanced psychological functioning reported by Shapiro et al (1998) can be maintained. These findings suggest that meditation can be a cost effective mechanism for enhancing the personal and professional quality of life for counselors and counselors in training.

In a more recent study, Shapiro, Oman, Thoresen, Plante and Flanders (2008) found that increases in mindfulness were sustained eight-weeks after the completion of the intervention. In their study of 44 undergraduates, they found that both a mindfulness training program (i.e. MBSR) and concentrative meditation training programs (i.e. Easwaran’s Eight Point Program) were approximately equal in cultivating mindfulness as measured by the MAAS (Mindful Attention and Awareness Scale). In addition, participation in one of the meditation training programs reduced rumination and stress.
The results of the present study suggest that in addition to potential gains in mindfulness, meditation practice can enhance self-compassion while reducing the phenomenon of burnout, the latter of which is often accompanied by a significant (often debilitating) stress component.

This study was also the first known research study to address the relationship between self-compassion and the variables of compassion fatigue, compassion satisfaction and burnout. Simpson (2005) found that spirituality had an inverse relationship with compassion fatigue, but her study did not address the potential contribution of self-compassion to reducing the impact of compassion fatigue. Simpson’s study also employed an older version of the Pro-QOL, an instrument known as the Compassion Satisfaction/Fatigue Self-Test for Helpers. Further, Simpson’s analysis did not include a measure of social desirability, suggesting that her sample may have been biased in their self-report. Unlike the present study, Simpson employed a regression design and found that as spirituality increased compassion fatigue decreased.

Conrad and Keller-Guenther (2007) found that in Colorado child protection workers, compassion satisfaction and compassion fatigue were not associated with burnout. They reported that although 49.9% of their participants were at risk for compassion fatigue, they were not at significant risk for burnout. They further found that 75% of their sample was in the high range of compassion satisfaction, suggesting that the relationship between compassion satisfaction and compassion fatigue is far more complex than an inverse correlation. In the present study, 6.5% of the total participants reported a compassion fatigue score in the “clinical range” or the range where Stamm (2005) recommends some form of intervention. The present study also found that 13.5%
of the participants reported a Compassion Satisfaction score below 33, suggesting that 86.5\% of the sample of counselors in the present study were deriving a degree of satisfaction from their work as a professional counselor. Stamm (2005) reported that on the Burnout subscale of the Pro-QOL, approximately 25\% of the normative sample scored above 27. In the present study, only 5.3\% of the participants obtained a burnout score equal to or above 27, suggesting that the professionals in the present study reported lower levels of burnout than Stamm’s normative sample.

The results of the present study were also unique in that social desirability had a significant effect on self-compassion, which is contrary to results reported by Neff (2003b). When initially researching the validity of the Self-Compassion Scale, Neff (2003b) conducted a Pearson correlation to determine if self-compassion was associated with social desirability. She reports that her results indicated that the Social Desirability Scale was not significantly correlated with Self-Compassion scale ($r=0.05, p=0.34$). The present study found a positive, significant correlation between the Social Desirability Scale and Self-Compassion Scale ($r = 0.204, p = 0.009$) (see Table 4). A number of factors could potentially account for this finding. First, the sample employed by Neff included 391 undergraduate students. The present study employed 164 professional counselors. Given the highly social nature of the counseling profession, with its emphasis on empathy, unconditional positive regard and warmth, it is very likely that professional counselors may have a greater tendency to respond in a socially desirable manner when compared to college undergraduates. Secondly, the mean age of the normative sample was 20.91 ($SD=2.27$), compared to the mean age of the present study ($M=44.74, SD=11.27$). It is very possible that younger respondents are less concerned
about social convention and more likely to respond in a socially unconventional manner. Neff, Kirkpatrick & Rude (2007) also reported significant positive correlations between measures of conscientiousness, agreeableness and Self-Compassion, and suggested that self-compassion may lead to more responsible behavior and thoughts, hence leading to more socially desirable thoughts and feelings.

In addition to being significantly correlated with self-compassion, social desirability was also significantly and negatively correlated with burnout. No known prior research study had addressed the impact of social desirability on burnout, compassion fatigue and compassion satisfaction. Lawrence et al (2004) indicated that social desirability refers to the inclination of an individual to portray him or herself in a way that allows them to be seen in a favorable light by others. Stamm (2005) indicated that burnout refers to feelings of hopelessness and feelings that an individual is not doing his or her job in an effective manner. One could reason that an individual who is concerned with presenting him or herself in a favorable manner would be unlikely to report these negative feelings, even within the context of anonymity. Since the items that comprise the burnout measure reflect negative internal experiences, it is not surprising that social desirability would be negatively correlated with burnout.

Results of a MANCOVA indicated that counselors who practice meditation displayed significantly different scores on measures of burnout and self-compassion than their non-meditating counterparts. Follow-up analyses revealed that specifically, counselors who practice meditation had significantly lower scores on measures of burnout and significantly higher scores on measures of self-compassion. Results of the MANCOVA further indicated that the covariate of social desirability had a significant
effect on both burnout and self-compassion. Wegela (1999) indicates that burnout refers to a type of exhaustion or a feeling of being overwhelmed that helping professionals sometimes feel when they have taken on more than they believe they can comfortably or appropriately handle. Figley (2002) indicates that burnout results from long term involvement in emotionally demanding situations. Figley (2002) further distinguishes burnout from compassion fatigue by stating that compassion fatigue is the result of specific exposure to the trauma and suffering of a particular client. This feeling of exhaustion can result in muscle tension, reactivity, sadness, anger and depression. Wegela (1999) further suggests that burnout is the result of a desynchronization of mind and body. A number of studies have documented the beneficial effects of meditation on anxiety (Shapiro, Schwartz & Bonner, 1998), attention (Chambers, Chuen Yee Lo, & Allen, 2008), and relaxation (Jain, Shapiro, Swanick, Roesch, Mills, Bell & Schwartz, 2007). Given the positive outcomes documented in these studies, one could hypothesize that meditation could be instrumental as a mechanism for re-calibrating the body and the mind.

Although these results were significant, one must consider the small effect sizes that the MANCOVA yielded. At best, meditation had a medium effect size on burnout and self-compassion, suggesting that a number of other variables may exert more influence on these variables. Linley and Joseph (2007) found that the “sense of coherence” personality construct was the most salient protective factor against compassion fatigue and burnout. Sense of coherence refers to an overall orientation to life in which an individual feels that he/she possesses the confidence to deal with internal and external threats and problems. In their interviews with “well-functioning” psychologists,
Coster and Schwebel (1997) found that peer support and stable interpersonal relationships were crucial for minimizing the impact of stress on professional effectiveness. These factors were not assessed in the present study, and suggest that social connectedness may account for an important protective factor for mental health providers when navigating the challenges and rigors of the profession. The same interviewees (Coster & Schwebel, 1997) reported that “leading a balanced life” was an important component for maintaining their well-functioning status. The findings of the present study suggest that meditation practice and self-care time can help in the establishment of a balanced life.

Neff (2003b) found that the Self-Compassion Scale was negatively and significantly correlated with the Beck Depression Inventory (partial $r = -0.21$) and the Spielberger Trait Anxiety Inventory (partial $r = -0.33$). In addition, Neff (2003b) found a significant positive partial correlation with the Satisfaction with Life Scale (partial $r=0.20$). The present study found a negative correlation between burnout and self-compassion and a significant positive partial correlation between self-compassion and compassion satisfaction. Burnout has the potential to result in feelings of sadness, exhaustion, and depression (Wegala, 1999). Compassion satisfaction reflects a degree of professional satisfaction (an important life domain) experienced by a person in relation to his or her work. The results of the present study support the Neff’s contention that self-compassion is associated with positive mental health outcomes and negatively correlated with measures of pathology. Neff, Kirkpatrick & Rude (2007) further report that the Self-compassion Scale had a significant positive association with measures of optimism,
happiness, wisdom, agreeableness and extraversion and was negatively correlated with negative affect and neuroticism as measured by the NEO Five-Factor Inventory. The results of the present study lend further support to those findings.

Discussion of the Results and Related Theory

Wallace and Shapiro (2006) indicated that in Buddhist psychology, frustration, depression and anxiety are all symptoms of an unbalanced mind. Meditation or “skillful sustained mental training” (Wallace & Shapiro, 2006, p. 693) may offer one remedy for returning the individual’s mind to a state of relative balance. The subjective experience of burnout refers to “feelings of hopeless and difficulties in dealing with work or in doing one’s job effectively” (Stamm, 2005, p. 12). From the context of Buddhist psychology, burnout may be considered an imbalance in one’s work life, and the feelings associated with that work life. The remedy suggested by Buddhism would be meditation. Shapiro, Carlson, Astin and Freedman (2006) suggest that the re-perceiving that accompanies mindfulness or meditative practice allows the practitioner to attend to internal events without becoming over identified or fused with them. For example, from their perspective, the mindfulness practitioner can view burnout from the context of another arising state without seeing herself as “being burned out.” The results of the present study suggest that while meditation may be helpful in preventing higher levels of burnout, it is certainly not a panacea as evidenced by the relatively low effect sizes obtained by the researcher. Neff (2003a) indicates that a certain degree of mindfulness is necessary for self-compassion to occur in order to allow the individual to experience
some distance from his or her negative experience, suggesting that mindfulness and self-compassion are inherently interrelated constructs.

The findings of the present study suggest that the cultivation of self-compassion, and not solely the practice of meditation, may be associated with lower levels of burnout and compassion fatigue and higher levels of compassion satisfaction. Indeed, Shapiro et al. (2006) indicate that the promotion of “non-judgmental attention leads to connection, which leads to self-regulation and ultimately to greater order and health” (p. 380).

Although adherence to a specific meditation practice can vary from individual to individual, the cultivation of self-compassion (which includes being less judgmental and viewing oneself in the context of being a part of a common humanity) leads to improved outcomes in terms of practitioner mental health. Neff (2003a) indicates that, in theory, it should be easier to improve an individual’s self-compassion than his or her self-esteem, in that self-compassion is not dependent on external evaluation or the need to adopt unrealistic expectations of one’s self. Leary, Tate, Adams, Allen and Hancock (2007) indicate that the positive self-feelings displayed by individuals who are high in self-compassion are not associated with narcissism or self-inflation that is often typical of individuals who are considered to have “high self-esteem”). Leary et al. (2007) also found that low self-compassion had a unique contribution to depression and anxiety, even after controlling for self-esteem. Hence, facilitating the development of self-compassion has the capacity to result in improved self-attitudes and buffer against feelings of depression and anxiety. The findings of the current study found that counselors who met criteria for inclusion in the meditation group had higher levels of self-compassion than their non-meditating colleagues, and suggest that meditation may be one way to facilitate the
development of self-compassion. Given the rigors of the counseling field and the frequent ambiguity in terms of personal and professional evaluation, it seems that mechanisms to facilitate the development of self-compassion would prove fruitful.

Figley (1995, 2002) suggested that the professional’s capacity to detach from the experience of his/her client’s traumatic material is protective factor in the development of compassion fatigue. Fulton (2005) suggested that meditation and mindfulness practices may offer one way in which a therapist can detach from the suffering of his or her clients. In the present study, counselors who practiced meditation did not report significantly different levels of compassion fatigue when compared to their non-meditating colleagues, suggesting that the detachment suggested by Figley and the ability to detach suggested by Fulton are not synonymous definitions.

Within the construct of self-compassion is the aspect of “common humanity” which represents the belief that problems are a part of everyone’s life and that one’s challenges are no greater than anyone else’s problems (Leary, Tate, Adams, Allen & Hancock, 2007). This sense of common humanity may serve to shield that self-compassionate individual from the feelings of isolation, helplessness and stress that comprises the experience of burnout.

Individuals high in self-compassion were also found to be more likely to make themselves feel better and be less hard on themselves following negative events (Leary et al 2007). This attitude of self-kindness serves to protect the professional from an over identification with feelings of shame or incompetence following a challenging or negative professional experience.
Implications for Practice and Training

Given the growing emphasis on self-care in the professional literature, it seems that counselors appear to be struggling to fulfill their obligations to themselves and ultimately their clients. Of the 164 participants, 57 reported self-care time of less than 1 hour per week. Christopher et al (2006) indicate that although mainstream, accredited counseling programs emphasize the need for self-care to prevent burnout, the demands of the curriculum and clinical training leave little room for teaching self-care strategies. This lack of specific training may have been reflected in the report of the study’s sample. Without specific instruction in the self-care practices, counselors and counselors-in-training are left to fend for themselves and find opportunities to investigate new self-care approaches. Formal instruction in self-care practices as suggested and researched by Christopher et al (2006) may provide counselor educators with a “jumping off point” in terms of including a presentation of these practices into the formal curricula of counseling programs. Given the increasing demand placed on counselors in terms of number and diversity of client needs, it becomes incumbent on training programs to continue to encourage their students to seek meaningful mechanisms to engage in deliberate and intentional self-care on a daily basis. A growing body of research (which this study contributes to) suggests that mindfulness and meditation training and practice offers a cost effective strategy that results in substantial improvements in both mental and physical well-being.

Coster and Schwebel (1997) defined impairment as “the decline in a professional’s functioning that results in consistently substandard performance” (p. 5). Although all professionals occasionally make mistakes and errors in clinical judgment,
Coster and Schwebel assert that consistent substandard performance is believed to be the result of exposure to intolerable stress. They asserted that such stress results from the developmental and situational experiences of being both a person and a mental health professional. As a person, the impaired professional is exposed to the daily and developmental crises that all people endure as part of their on-going lives. As a professional, the mental health provider is subject to the stressors of maintaining an adequate client base, documentation, professional development, demonstrating professional accountability and integrity in the face of a financially driven system of care, and dealing with the traumatic and stressful material brought by their clients. The present study asserts that meditation and the development of self-compassion may be viable and cost-effective mechanisms for promoting the well-functioning of professional counselors. Meditation practice and the development of self-compassion that accompanies such practice can result in greater feelings of connection (e.g. common humanity) in the face of developmental and situational crises. The development of self-compassion can also serve to place the daily dramas endured by mental health professionals within the context of a more balanced perspective (e.g. mindfulness).

Neff, Kirkpatrick and Rude (2007) found that self-compassion acted as buffer against anxiety in self-evaluative situations. Individuals who are highly self-compassionate tend to view self-perceived weaknesses and character flaws in a less critical manner, which promotes greater self-acceptance and less intrapersonal turmoil. In addition to modeling these healthy self-attitudes for their clients, the self-compassionate counselor is more open to their client’s experience when not wrestling with their own demons. They suggest that self-compassion also results in more affiliate
self-references (e.g. use of “we” instead of “I”) suggesting higher levels of social
connectedness. Professional psychologists interviewed by Coster and Schwebel (1997)
indicated that social connectedness (e.g. stable interpersonal relationships and peer
support) are protective factors against professional impairment. The development of self-
compassion may represent one way to build (or highlight) a sense of connection to others.

Shapiro, Schwartz and Bonner (1998) found that an 8 week Mindfulness Based
Stress Reduction protocol was helpful in reducing the stress and enhancing empathy in
pre-medical and medical students. In addition, Shapiro et al (2007) found that
mindfulness training had a positive impact on psychological functioning in counseling
students. Taken along with findings of the present study, these results suggest that
meditation and mindfulness training components may offer substantial benefit to both
counseling trainees and counseling professionals. The standardized, eight week training
protocol suggested by Shapiro and Kabot-Zinn represent relatively small investments in
terms of time and energy when considering the potential benefits to practitioners.

Given the changing demands of the counseling profession, professionals are faced
with constant challenges and threats to their both psychological well-being and
professional self-esteem. Neff (2003a) indicates that self-compassion may be a more
useful construct than self-esteem and easier to foster. She and her colleagues further
assert the value of self-compassion in reduced pathology and improved psychological
functioning (Neff, Kirkpatrick & Rude, 2007). Meditation and mindfulness training offer
relatively cost-effective mechanisms to enhance the development of self-compassion
(Shapiro et al 2005) and promote positive psychological outcomes. This study further gives credence to the development of self-compassion through meditation and mindfulness practice.

Implications for Future Research

Shapiro et al (2006) indicated that the study of mindfulness is still in its infancy, although meditation practice is one of the most widely researched topics in Western psychological research (Walsh, 1996). In spite of the impressive amount of research that has been conducted, Kelly (2008) indicated that more randomized trials are needed to formally confirm the beneficial nature of meditation. This study sought to assess the potential value of long-term meditation and mindfulness training to counselors and counselor educators and show its utility in maintaining professional health for counselors. It is recommended that future research continue in this vein and potentially include both a broader range of mental health practitioners and outcome measures. It would also be beneficial to study meditation in the context of treating individuals who have already been identified as having burnout. In addition, future research should also seek to gain a better understanding of which self-care practices offer the greatest utility in terms of efficiency and palatability.

In addition to the value of meditation in promoting self-care, future research could further explore the relationship between mindfulness practice and the enhancement of empathy, warmth and mindfulness in counselors and counselors-in-training. Although this topic was initially researched by Lesh (1970) and subsequently Christopher et al (2006) and Shapiro et al (2007), more studies are needed to assess the potential utility of
integrating meditation and mindfulness training into mainstream counselor training programs. In addition, counselor education programs are encouraged to research the value of formal instruction in self-care to their trainees in terms of retention and professional satisfaction rates.

Future research should also consider the impact of spirituality in the context of meditative and mindfulness practice. Shapiro et al. (2006) indicated that extrapolating mindfulness practice from its spiritual context risks losing some of the essential qualities (referred to as axioms) which make it a potent process for cultivating compassion. Shapiro et al. (2006) identified three fundamental axioms of mindfulness practice which include: intention, attention and attitude. Without knowledge of these axioms, mindfulness practice can become just another type of relaxation training. The present study did not assess these core underlying principals when questioning meditating participants about their practice. Future studies are encouraged to assess the degree to which practitioners seek to adhere to these axioms and what effect their adherence has on outcome variables.

In addition to studying the impact of spirituality on meditation and mindfulness practice, examining the relationship between measures of spirituality and religiousness and self-compassion represents an interesting avenue for future research. Neff, Kirkpatrick and Rude (2007) indicate that little is known about the individual variance in self-compassion prior to intervention. In short, why do some people start out with higher levels of self-compassion than others? The degree to which an individual espouses religious and spiritual values may represent one source of variability.
Limitations and Recommendations

The present study had several limitations. First, the two groups of participants were comprised of volunteers who were obtained from their membership in national counseling list serves. These participants represent a sample of convenience and were not randomly selected. Counselors and counselor educators who were not members of these list serves did not have the opportunity to participate in the study which limits the generalizability of the results. In addition, completion of the survey took between 10 and 15 minutes, suggesting that counselors who were “truly” overwhelmed would not have completed the inventory due to the competing demands of their work.

Secondly, meditation practice was narrowly defined between contemplative and awareness approaches. One participant emailed the researcher, indicated that he practiced “Christian contemplative practice” but did not know how to conceptualize that practice in terms of the two identified categories. Although examples of differing “types” of meditation were offered, participants may have mis-categorized their practices. The researcher had a very limited ability to interface with participants due to the nature of the survey (which was designed to maximize confidentiality.) If type of practice was included in the analysis, specific recommendations about “best practice” in terms of mediation and its impact on the variables of interest could have been made available.

When developing the scale, Neff (2003b.) found a gender difference with male participants scoring higher than female participants on measures of self-compassion. Of note, these gender differences were not apparent between Buddhist practitioners, which may suggest that the meditation group would not have been impacted by the gender imbalance. More gender diversity may have resulted in different results.

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Approximately one-half of the participants self-reported a significant personal trauma history. In all likelihood, trauma survivors were overrepresented in the sample of the present study. In addition, a greater percentage of meditation practitioners reported a significant trauma history suggesting that they may be more susceptible to compassion fatigue (Figley, 1995). Conversely, Linley and Joseph (2006) reported that therapists who were also trauma survivors were more likely to report personal growth from their work as helpers. The demographic question that assessed trauma was intentionally left open to interpretation as the *a priori* contention was that personal trauma is a subjective evaluation made by the person who experienced the incident. Asking about the nature of the trauma did not seem appropriate or valuable to the outcome of the study.

Almost one-half of the sample had earned a doctoral degree, which is not indicative of the demographic of the profession. Current statistics on the profession suggest that the field is comprised primarily of master’s level practitioners. With higher levels of education and training, one could hypothesize that counselors acquire a certain level of skill in terms of establishing and maintaining professional boundaries.

Prior research has also found that years of experience in a profession are negatively correlated with burnout. The present study did not assess this relationship as part of the formal results.

When assessing for Burnout, Conrad and Kellar-Guenther (2006) indicated the importance of assessing for social support. Due to the number of other demographic items that the researcher queried, social support, including marital status was omitted, which may account for more of the variance in burnout than meditation or self-care.
practice. Future research that uses burnout as a dependent variable should include some measure of social support to assess this important variable.

Summary of the Discussion and Contributions

Meditation practice and the development of self-compassion have the potential to contribute to the personal and professional wellness of counselors and counselor educators. These practices and self-attitudes have the potential to result in improved therapeutic outcomes for the clients and students of meditating and self-compassionate counselors. The current study found that counselors who were experienced meditation practitioners reported higher levels of self-compassion and lower levels of burnout than their non-meditating colleagues. Further, the current study found that measures of self-compassion were positively associated with measures of compassion satisfaction and negatively associated with measures of burnout and compassion fatigue. These results are congruent with the promising research that has been conducted on the relatively new construct of self-compassion, suggesting its utility and value to the growing fields of positive psychology and professional wellness. Self-compassionate attitudes may reduce the development of impairment by reducing the individual’s reaction to the personal and professional stressors that he or she is subject to on a daily basis. Meditation practice represents one mechanism for fostering the development of self-compassion.

In addition, self-care was found to have a significant impact on compassion satisfaction, suggesting that individuals who practice more than 5 hours of self-care per week have higher levels of compassion satisfaction than their colleagues who reported less self-care time. Surveyed counselors were found that have a great deal of variance in
the amount of self-care reported. A large portion of the sample reported less than one hour of self-care time per week. Given the daily challenges inherent in the field of counseling and the profession’s emphases on wellness and balanced living, it seems that counselors would be models and self-care and wellness for their clients. The results of the present study call into question this presumption and suggest that counselors and counselors-in-training would benefit from formal instruction in self-care practices and its value in maintaining professional well-functioning.

In all analyses, social desirability had significant effects on burnout and self-compassion. It is believed that counselors, as a group, may represent a more socially desirable sample than undergraduates. In addition, counselors and the counseling profession, challenges its members to espouse socially benevolent perspectives and attitudes. Holding these values as guiding principles is likely to distinguish counselors from the general populace.

The results of this study contribute to the existing research on the value of meditation practice among mental health practitioners and its contribution to their professional health and well-being. The current study also contributes to the growing body of research that promotes the value of self-compassion as a contributing factor in the development of mental health and improved function. Secondarily, the present study also contributes to the growing body of literature on self-care practices among mental health providers and the relative value of those practices in terms of counselor well-being. Recommendations for future research include replicating these results with a more diverse sample of mental health practitioners and using meditation as a treatment for professionals who have already been identified as “having burnout.” Limitations of the
present included a non-random sample who were obtained through voluntary participation in an on-line survey, a fairly homogeneous sample which consisted primarily of Caucasian, female participants, and the limitations inherent in survey-based data collection.
REFERENCES


Wegela, K. K. (1999). Burnout! *Shambhala Sun, 8*(1), 77-78.


APPENDIX A

PRO-QOL R-IV

PROFESSIONAL QUALITY OF LIFE SCALE

Compassion Satisfaction and Fatigue Subscales—Revision IV

[Helping] people puts you in direct contact with their lives. As you probably have experienced, your compassion for those you [help] has both positive and negative aspects. We would like to ask you questions about your experiences, both positive and negative, as a [helper]. Consider each of the following questions about you and your current situation. Select the number that honestly reflects how frequently you experienced these characteristics in the last 30 days.

0=Never 1=Rarely 2=A Few Times 3=Somewhat Often 4=Often 5=Very Often

1. I am happy.
2. I am preoccupied with more than one person I [help].
3. I get satisfaction from being able to [help] people.
4. I feel connected to others.
5. I jump or am startled by unexpected sounds.
6. I feel invigorated after working with those I [help].
7. I find it difficult to separate my personal life from my life as a [helper].
8. I am losing sleep over traumatic experiences of a person I [help].
9. I think that I might have been “infected” by the traumatic stress of those I [help].
10. I feel trapped by my work as a [helper].
11. Because of my [helping], I have felt “on edge” about various things.
12. I like my work as a [helper].
13. I feel depressed as a result of my work as a [helper].
14. I feel as though I am experiencing the trauma of someone I have [helped].

15. I have beliefs that sustain me.

16. I am pleased with how I am able to keep up with [helping] techniques and protocols.

17. I am the person I always wanted to be.

18. My work makes me feel satisfied.

19. Because of my work as a [helper], I feel exhausted.

20. I have happy thoughts and feelings about those I [help] and how I could help them.

21. I feel overwhelmed by the amount of work or the size of my case [work] load I have to deal with.

22. I believe I can make a difference through my work.

23. I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].

24. I am proud of what I can do to [help].

25. As a result of my [helping], I have intrusive, frightening thoughts.

26. I feel “bogged down” by the system.

27. I have thoughts that I am a “success” as a [helper].

28. I can't recall important parts of my work with trauma victims.

29. I am a very sensitive person.

30. I am happy that I chose to do this work.
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© B. Hudnall Stamm, 1997-2005. Professional Quality of Life: Compassion Satisfaction and Fatigue Subscales, R-IV (ProQOL). http://www.isu.edu/~bhstamm. This test may be freely copied as long as (a) author is credited, (b) no changes are made other than those authorized below, and (c) it is not sold. You may substitute the appropriate target group for [helper] if that is not the best term. For example, if you are working with teachers, replace [helper] with teacher. Word changes may be made to any word in italicized square brackets to make the measure read more smoothly for a particular target group.

Disclaimer

This information is presented for educational purposes only. It is not a substitute for informed medical advice or training. Do not use this information to diagnose or treat a health problem without consulting a qualified health or mental health care provider. If you have concerns, contact your health care provider, mental health professional, or your community health center.

Self-scoring directions, if used as self-test

1. Be certain you respond to all items.

2. On some items the scores need to be reversed. Next to your response write the reverse of that score (i.e. 0=0, 1=5, 2=4, 3=3). Reverse the scores on these 5 items: 1, 4, 15, 17 and 29. Please note that the value 0 is not reversed, as its value is always null.

3. Mark the items for scoring:
   a. Put an X by the 10 items that form the Compassion Satisfaction Scale: 3, 6, 12, 16, 18, 20, 22, 24, 27, 30.
   b. Put a check by the 10 items on the Burnout Scale: 1, 4, 8, 10, 15, 17, 19, 21, 26, 29.
   c. Circle the 10 items on the Trauma/Compassion Fatigue Scale: 2, 5, 7, 9, 11, 13, 14, 23, 25, 28.

4. Add the numbers you wrote next to the items for each set of items and compare with the theoretical scores.
APPENDIX B

SELF-COMPASSION SCALE

To Whom it May Concern:

Please feel free to use the Self-Compassion Scale in your research. You can e-mail me with any questions you may have. I would also ask that you please e-mail me about any results you obtain with the scale, and would appreciate it if you send me a copy of any article published using the scale. The appropriate reference is listed below.

Best,

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Reference:

Coding Key:
Self-Kindness Items: 5, 12, 19, 23, 26
Self-Judgment Items: 1, 8, 11, 16, 21
Common Humanity Items: 3, 7, 10, 15
Isolation Items: 4, 13, 18, 25
Mindfulness Items: 9, 14, 17, 22
Over-identified Items: 2, 6, 20, 24

Subscale scores are computed by calculating the mean of subscale item responses. To compute a total self-compassion score, reverse score the negative subscale items - self-judgment, isolation, and over-identification - then compute a total mean.

(This method of calculating the total score is slightly different than that used in the article referenced above, in which each subscale was added together. However, I find it is easier to interpret the scores if the total mean is used.)
HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

<table>
<thead>
<tr>
<th>Almost never</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Almost always</th>
<th>5</th>
</tr>
</thead>
</table>

_____ 1. I’m disapproving and judgmental about my own flaws and inadequacies.
_____ 2. When I’m feeling down I tend to obsess and fixate on everything that’s wrong.
_____ 3. When things are going badly for me, I see the difficulties as part of life that everyone goes through.
_____ 4. When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world.
_____ 5. I try to be loving towards myself when I’m feeling emotional pain.
_____ 6. When I fail at something important to me I become consumed by feelings of inadequacy.
_____ 7. When I'm down and out, I remind myself that there are lots of other people in the world feeling like I am.
_____ 8. When times are really difficult, I tend to be tough on myself.
_____ 9. When something upsets me I try to keep my emotions in balance.
_____ 10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.
_____ 11. I’m intolerant and impatient towards those aspects of my personality I don’t like.
_____ 12. When I’m going through a very hard time, I give myself the caring and tenderness I need.
_____ 13. When I’m feeling down, I tend to feel like most other people are probably happier than I am.
_____ 14. When something painful happens I try to take a balanced view of the situation.
_____ 15. I try to see my failings as part of the human condition.
16. When I see aspects of myself that I don’t like, I get down on myself.
17. When I fail at something important to me I try to keep things in perspective.
18. When I’m really struggling, I tend to feel like other people must be having an easier time of it.
19. I’m kind to myself when I’m experiencing suffering.
20. When something upsets me I get carried away with my feelings.
21. I can be a bit cold-hearted towards myself when I'm experiencing suffering.
22. When I'm feeling down I try to approach my feelings with curiosity and openness.
23. I'm tolerant of my own flaws and inadequacies.
24. When something painful happens I tend to blow the incident out of proportion.
25. When I fail at something that's important to me, I tend to feel alone in my failure.
26. I try to be understanding and patient towards those aspects of my personality I don't like.
APPENDIX C

DEMOGRAPHIC QUESTIONNAIRE

(please note that these questions were presented electronically using a survey measurement tool called Survey Monkey. Respondents were routed to certain questions based on their answers on earlier items. Answer options are bolded)

Are you a licensed professional counselor, a professional counselor, a professional clinical counselor or a licensed professional clinical counselor? Yes or no * if not exited the survey

Age (fill in)

Gender (female; male; transgender)

Race/ethnicity (Asian; Black; Hispanic; Native American; White; Other)

Including internship, how many years have you worked as a professional counselor? (fill in)

Please indicate the theoretical/ working orientation that most closely aligns with your therapeutic approach? (Psychodynamic/ Jungian; Person-centered/ existential; cognitive/behavioral; transpersonal integral)

Provide an estimate of the number of clients that you see (on a monthly basis) who meet diagnostic criteria for Post Traumatic Stress Disorder (fill in)

Do you have trauma in your personal history? (yes or no)

Please indicate your highest level of professional training in the field of counseling (MA; M Ed; Ed S; PhD)

Describe the nature of your graduate program’s focus- please select only one area of specialization (Counselor Education and Supervision; School counseling; Community counseling; Mental health counseling; Art therapy; Music Therapy; Wilderness therapy; Rehabilitation counseling; counseling psychology; other)

Indicate which (if any) of the following self-care practices you have done in the past 2 weeks (check all that apply) (Personal therapy; Clinical supervision; Meditation; yoga/Tai Chi/ Qi Gong; Running; Walking; Art; Music (listening/ creating); journaling; poetry; weight training; reading for pleasure)

Of the choices you indicated, what is the total amount of time you spend engaged in those practices per week? (fill in)

Meditation questions (if participants checked that they practiced meditation, they were routed to a separate meditation page, which asked the following:}
How would you best describe your practice? (Concentrative; Awareness)

How long have you been practicing meditation (in months)? (fill in)

How much time per week do you spend practicing meditation? (fill in)
APPENDIX D

ABBREVIATED MARLOWE-CROWNE SOCIAL DESIRABILITY SCALE

(STRAHAM & GERBASI, 1972)

All items are marked either “true” or “false” by the respondent.

1. I never hesitate to go out of my way to help someone in trouble.*
2. I have never intensely disliked anyone.*
3. When I don’t know something I don’t at all mind admitting it.*
4. I am always courteous, even to people who are disagreeable.*
5. I would never think of letting someone else be punished for my wrongdoings.*
6. I sometimes feel resentful when I don’t get my way.**
7. There have been times when I felt like rebelling against people in authority even when I knew they were right.**
8. I can remember “playing sick” to get out of something.**
9. There have been times when I was quite jealous of the good fortune of others.**
10. I am sometimes irritated by people who ask favors of me.**

• *when these items are marked “true” score 1
• **when these items are marked “false” score 1
APPENDIX E

IRB EXEMPTION AND INFORMED CONSENT

January 31, 2008

Ron Ringenbach
2600 W. 103rd Ave., Apt. 1018
Federal Heights, CO 800250

Mr. Ringenbach:

Your request for exemption for the protocol entitled "A Comparative Analysis between Professional Counselors with Prior Sexual and Professional Counselors with No Prior Sexual Experience" was approved on January 30, 2008. The IRB application number assigned to this project is 20080114. The protocol represents minimal risk to subjects and matches the following federal category for exemption:

☐ Exemption 1 - Research conducted in established or commonly accepted educational settings, involving normal educational practices.

☐ Exemption 2 - Research involving the use of educational tests, survey procedures, interview procedures, or observation of public behavior.

☐ Exemption 3 - Research involving the use of educational tests, survey procedures, interview procedures, or observation of public behavior not exempt under category 2, but subjects are elected or appointed public officials or candidates for public office.

☐ Exemption 4 - Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens.

☐ Exemption 5 - Research and demonstration projects conducted by or subject to the approval of department or agency heads, and which are designed to study, evaluate, or otherwise examine public programs or benefits.

☐ Exemption 6 - Taste and food-quality evaluation and consumer acceptance studies.

Annual continuation applications are not required for exempt projects. If you make changes to the study's design or procedures that increase the risk to subjects or include activities that do not fall within the approved exemption category, please contact the PRED office within 30 days. The new application must be submitted. Any such changes or modifications must be reviewed and approved by the IRB prior to implementation.

Please retain this letter for your files. If the research is being conducted for a master's thesis or doctoral dissertation, the student must file a copy of this letter with the thesis or dissertation.

Sincerely,

Sharon Nechuceru
Associate Director

Approved consent forms are attached

Cc: Patricia E. Parr, Advisor
    Rosalie Hall, IRB Chair

Office of Research Services and Sponsored Programs
Akron, OH 44325-2102
930 375-1160, 930 375-6079 (FAX)

The University of Akron is an Equal Education and Employment Institution
1. Informed consent

INFORMATION: If you are a licensed professional counselor with over three years of professional experience, you have been invited to participate in this research study. The purpose of this study is to determine if there are self-care strategies and personal attitudes that can assist counselors manage the effects of professional stress on their performance and personal lives. We would like as many responses as possible and are hoping for at least 100 participants.

The first set of questions reflect your personal demographics, working orientation, and specific self-care strategies that you currently access. This section is followed by the formal assessment which consists of 56 Likert-scale items that you respond to by clicking on a "button" on the web page, followed by another 10 items that can be rated true or false by clicking on the button that applies.

The entire assessment should take between fifteen (15) and thirty-five (35) minutes. This assessment will be fully anonymous, and we will not request any of your personal identifiers to ensure anonymity.

POTENTIAL RISKS: Participants will be asked to answer a number of questions about themselves, their work environments, and attitudes that they hold. Given the non-intrusive nature of the study (i.e. survey) and the significant nature of this study, participants experience any distress in relation to their participation in this study, they are encouraged to contact a colleague or access the ACA website (www.counseling.org) to find a counselor.

BENEFITS: Knowing more about effective self-care strategies and personal attitudes can influence the development of curricular and professional development opportunities for counselors. These opportunities can foster the well-being of professional counselors and subsequently enhance the quality of services they are able to provide to their clients.

CONFIDENTIALITY: No names will be asked during the survey. The software program will not ask for your e-mail address. I will not receive your e-mail address, and there will be no way to tell whether or not you have participated in the survey. Each response will be coded, but it will not be linked back to your ID.

The researcher retains the right to use and publish non-identifiable data. The data from the study will be included in the experimenter's doctoral dissertation, scholarly presentation, and publication. All data will be presented in confidential aggregate form. A hard copy of the data will be secured in a locked filing cabinet in the researcher's locked office. The actual data will be stored and analyzed on the researcher's password protected office computer. All data will be stored in a secure location only accessible to the researcher. Final aggregate results will be made available to participants upon request.

CONTACT: If you have questions at any time about the study or the procedures, you may contact Ron Ringenbach rjr3@uakron.edu or write to him at the University of Akron, c/o Patricia Parr, Ph.D., Department of Counseling, College of Education, Akron, OH 44325-5007.

If you feel you have not been treated according to the descriptions in this form, or your rights as a participant in research have not been honored during the course of this project, you may contact the Institutional Research Board c/o the Office of Research Services, The University of Akron, 302 Buchtel Commons, Akron, Ohio 44325-2101, or call (330) 972-7666.

PARTICIPATION: Your participation in this study is voluntary. You may refuse to participate without penalty. If you decide to participate, you may withdraw from the study at any time without penalty. If you withdraw from the study before data collection is completed your data will be destroyed. Please print a copy of this consent for your records.

APPROVED
IRB 130/08
Date 1/30/08
The University of Akron