THE RELATIONSHIP BETWEEN SELF-CARE PRACTICES, BURNOUT, COMPASSION FATIGUE, AND COMPASSION SATISFACTION AMONG PROFESSIONAL COUNSELORS AND COUNSELORS-IN-TRAINING

A dissertation submitted to the Kent State University College and Graduate School of Education, Health, and Human Services in partial fulfillment for the requirements for the degree of Doctor of Philosophy

by

Katharina L. Star

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A dissertation written by

Katharina L. Star

B.A., Kent State University, 2002

MA Ed., The University of Akron, 2006

Ph.D., Kent State University, 2013

Approved by

__________________________________. Co-director, Doctoral Dissertation Committee
Jane A. Cox

__________________________________. Co-director, Doctoral Dissertation Committee
Steve Rainey

__________________________________. Member, Doctoral Dissertation Committee
Kelly Cichy

Accepted by

__________________________________. Director School of Lifespan Development
Mary Dellmann-Jenkins and Educational Sciences

__________________________________. Dean, College of Education, Health
Daniel F. Mahony and Human Services

iii
The present study examined the relationship between compassion fatigue, burnout, compassion satisfaction, and self-care among counselors and counselors-in-training. Additionally, the current study investigated if recent life changes, age, sex, race, years of experience, education level, and work/internship setting impacted counselors’ and counselors’-in-training self-reports of compassion fatigue, burnout, compassion satisfaction, and self-care.

A total of 253 counselors and counselors-in-training were surveyed through a professional conference, internship classes, and email listservs. Variables were measured through the use of a demographic questionnaire, the Professional Quality of Life Scale (ProQOL 5), the Self-Care Assessment Worksheet (SCAW), and the Recent Life Changes Questionnaire (RLCQ). Pearson-product moment correlations, analysis of variances (ANOVAs), and t-tests were utilized to determine potential relationships between variables.

Results indicated that recent life changes impact both burnout and compassion fatigue. Compassion satisfaction appeared to influence burnout, but not compassion fatigue. Results also determined that burnout and compassion fatigue are positively correlated with each other.
When examining the demographic variables, results revealed that women experience higher levels of compassion fatigue than men. Burnout was found to be higher for participants who are working or interning in agency and school settings than those in private practices or hospitals. Participants in agency and school settings were also found to be associated with lower amounts of self-care than those in private practices. Nonstudent agency workers were determined to have higher amounts of compassion satisfaction with age and increased engagement in psychological self-care activities. However, self-care was negatively correlated with compassion satisfaction for participants in school settings.
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This dissertation is dedicated to Grandma Betts, a woman who always believed in the value of education and who spent her life caring for others with compassion. We
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CHAPTER I

INTRODUCTION TO THE STUDY AND REVIEW OF THE LITERATURE

The Nature of the Helping Profession

Whether it is for assistance with managing a physical illness, support for a struggle with addiction, or aid in learning new skills, at times, people rely on others for help. The qualified providers of such services are described as helping professionals, in that their occupation revolves around assisting others in some way. Generally, helping professions refer to the fields of mental health providers, medical professionals, and educators. The nature of these occupations have the distinction of being “high-touch” vocations, an expression used to illustrate how such careers require a lot of face-to-face contact with people who are in need of support (Maslach & Leiter, 1997, p. 20).

The field of professional counseling is considered one of these high-touch helping professions that require many direct hours in the service of others (Stebnicki, 2007). Counselors provide personal assistance to others in a variety of settings, including schools, mental health agencies, and hospitals and in a variety of roles, such as supervisors and educators. Counselors and other helping professionals are considered to be uniquely empathetic individuals who often derive a sense of meaning and fulfillment from a career that is focused on assisting others (Skovholt, 2001). However, despite the rewards of knowing that one is helping others, counselors are also faced with probable stressors that are inherent in the field. Counselors must often cope with job stressors, such as assisting clients who are experiencing elevated amounts of distress, lack of resources, high work performance demands, and minimal outlets to release work stress
These innate work-related difficulties can lead to both personal and professional issues, diminishing counselor wellness, and may in turn negatively impact client care (Lawson, Venart, Hazler, & Kottler, 2007).

**Statement of the Problem**

These stressors and strains of the counseling profession can lead to a continuum of issues, including compassion fatigue and burnout (Stebnicki, 2007). In general, compassion fatigue is defined as a quick-developing condition that afflicts a counselor with PTSD-like symptoms initiated by hearing the traumatic events experienced by their clients (Figley, 1995). Burnout refers to a slow-onset syndrome caused by excessive work-related demands such as extended work hours, difficult and demanding clients, overloaded with paperwork, and high productivity loads that do not allow much time off (Cherniss, 1980; Maslach & Jackson, 1984). Compassion fatigue contributes to a sense of helplessness in the counselor, whereas burnout contributes to lack of interest in one’s career (Figley, 2002b; Maslach & Leiter, 1997). It is believed that effects of both compassion fatigue and burnout can be experienced on a physical, cognitive, and emotional level (Figley, 1995; Maslach, 1982).

Radey and Figley (2007) suggested that one way to combat such issues is to foster a strong sense of compassion satisfaction, a term used to describe a change in perception from centering on the stress to focusing on the positive impacts of one’s work as a helping professional. For example, a professional counselor who is continually thinking about the negative aspects of the occupation may shift thoughts to considering some of
the fulfilling sides of their work. This modified outlook can include reflecting on why one picked the helping profession, success one has had with clients, and other more gratifying parts of the field (Linley & Joseph, 2007; Radey & Figley, 2007; Stamm, 2005).

Another way to maintain a sense of job fulfillment is for counselors to preserve a feeling of wellness across their personal and professional lives (Myers & Sweeney, 2005). Throughout the literature, it has been recommended that counselors and other helping professionals maintain a positive stance through self-care strategies (Becvar, 2003; Kottler, 1993; Norcross & Guy, 2007; Pearlman, 1999; Skovholt, 2001; Stebnicki, 2008). Self-care is considered activities in which one engages in order to achieve a productive sense of balance and wellness (Myers & Sweeney, 2005; Riordan & Saltzer, 1992; Yassen, 1995). For example, a counselor who spends a lot of time seated and thinking about client issues may find some relief in more physical activities or humor. Myers and Sweeney (2005) advocated for a holistic approach to wellness, incorporating various aspects of the self, such as creativity and spirituality.

Participating in such self-care practices can be difficult for counselors, who often put the needs of others before their own, perceiving themselves as helpers who could never be in need of any support themselves (Lawson et al., 2007). Self-care is rarely emphasized in counselors’ training courses, supervision, and work place environments (Pines & Aronson, 1988; Yager & Tovar-Blank, 2007; Young & Lambie, 2007). Due to fear of rejection or repercussions, concerns about compassion fatigue and burnout can be difficult to talk about with peers and supervisors (Maslach, 1993). However, counselors
have an ethical responsibility to take care of themselves to avoid any potential for impairment (American Counseling Association [ACA], 2005; T. M. O’Halloran & Linton, 2000).

Despite being advocated as an ethical responsibility throughout the literature, self-care practices for counselors in relation to compassion fatigue, burnout, and compassion satisfaction has received little research attention. Understanding the possible benefits of self-care may help increase its value in the counseling community, and provide counselor educators and supervisors with a better understanding of how self-care can impact them and those they assist. Such information can also be advantageous to the agencies, schools, and other locations that employ counselors. Determining if self-care practices can improve compassion satisfaction and decrease the chances of acquiring burnout and compassion fatigue can be valuable to counselors at any point across career development.

**Purpose of the Study**

The purpose of this study is to determine the possible relationships between self-care practices and compassion fatigue, burnout, and compassion satisfaction for professional counselors and counselors-in-training. Despite the expressed need throughout the literature for self-care, no research studies have been conducted to examine the role of self-care with compassion fatigue, compassion satisfaction, and burnout in counselors along a continuum from students training to be counselors to those counselors who are licensed and employed in a variety of settings.
Research Questions

The present study seeks to answer the following research questions: Is there a relationship between compassion fatigue, burnout, compassion satisfaction, self-care, and recent life changes among professional counselors and counselors-in-training? Does years of experience, age, sex, race, level of education, and/or work/internship setting relate to counselors’ and counselors’-in-training self-reports of compassion fatigue? Does years of experience, age, sex, race, level of education, and/or work/internship setting relate to counselors’ and counselors’-in-training self-reports of burnout? Does years of experience, age, sex, race, level of education, and/or work/internship setting relate to counselors’ and counselors’-in-training self-reports of compassion satisfaction? Does years of experience, age, sex, race, level of education, and/or work/internship setting relate to counselors’ and counselors’-in-training self-reports of self-care?

Definitions of Terms

Burnout. Maslach and Jackson (1984) characterized burnout as “emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur in professionals who do people work of some kind” (p. 1). Burnout develops gradually, causing cognitive, affective, and behavioral changes and symptoms experienced by the helping professionals (Maslach, 1982; Pines, Aronson, & Kafry, 1981).

Compassion fatigue. Compassion fatigue is the term used to describe the experience of distress due to continual exposure to the stories of trauma presented by clientele. For example, counselors provide empathetic listening and understanding to clients who may describe in detail their experiences with painful events. Such stories
may illicit sudden PTSD-like symptoms in the helping professional, including hypervigilence, avoidance behaviors, and sleeplessness. Helping professionals experiencing compassion fatigue feel extreme sympathy and want to remove the sufferer’s pain, but ultimately are overwhelmed with a sense of hopelessness (Figley, 1995, 2002a, 2002b).

*Compassion satisfaction.* The phrase compassion satisfaction is used to describe the feeling of fulfillment that results from the process of helping others, which reminds the helping professional about the altruistic reasons they had picked the profession in the first place (Radey & Figley, 2007; Stamm, 1999b, 2002).

*Counselor impairment.* The American Counseling Association Taskforce on Counselor Wellness and Impairment has defined impairment as:

Therapeutic impairment occurs when there is a significant negative impact on a counselor’s professional functioning which compromises client care or poses the potential for harm to the client. Impairment may be due to:

- Substance abuse or chemical dependency
- Mental illness
- Personal crisis (traumatic events or vicarious trauma, burnout, life crisis)
- Physical illness or debilitation

Impairment in and of itself does not imply unethical behavior. Such behavior may occur as a symptom of impairment, or may occur in counselors who are not impaired.
Counselors who are impaired are distinguished from stressed or distressed counselors who are experiencing significant stressors, but whose work is not significantly impacted. Similarly, it is assumed that an impaired counselor has at some point had a sufficient level of clinical competence, which has become diminished as described above. (Lawson & Venart, 2005, p. 243)

**Self-care.** Self-care refers to activities, which lead towards a sense of living a balanced life. These strategies are holistic in nature, focusing on the various aspects of wellness, including the physical, spiritual, emotional factors (T. M. O’Halloran & Linton, 2000).

**Wellness.**
Wellness is a way of life oriented toward optimal health and well-being, in which body, mind, and spirit are integrated by the individual to live life more fully within the human and natural community. Ideally, it is the optimum state of health and well-being that each individual is capable of achieving. (Myers, Sweeney, & Witmer, 2000, p. 252)

**Review of the Literature**
The purpose of this study is to determine potential relationships between self-care, compassion fatigue, compassion satisfaction, and burnout. Additionally, this study seeks to determine possible relationships between these four variables and recent life changes, age, sex, race, education level, work/internship setting, and years of experience. The review of the literature examines the concepts of self-care, compassion fatigue,
compassion satisfaction, and burnout, including past research examining relationships among all of the research variables.

The review of the literature begins by examining the concept of compassion fatigue, including past research, related concepts, and current models. Next, a brief review of compassion satisfaction defines this concept and examines past research studies. The section on compassion fatigue is followed by a review of burnout, including past research, differing definitions, and potential causes. Last, counselor wellness and self-care are reviewed, including past research findings, models of wellness, and possible ways of improving counselor wellness.

**Compassion Fatigue**

Compassion fatigue is often referred to as “the cost to caring” and results when counselors are continually exposed to the traumatic stories of clients which are frequently revisited in therapy (Figley, 1995, 2002a, 2002b). The helping profession is unique in that it advises that counselors maintain professionalism and remove personal concerns and judgments, while sustaining present focus and continued compassion and empathy for the client. Many counselors were drawn to the field due to their ability to readily empathize with others (Figley, 1995). However, when this ability is compromised, counselor impairment may result in counselors losing their sense of meaning and the ability to provide compassionate care for clients (Stebnicki, 2007). Paradoxically, the more a counselor is able to compassionately relate to traumatized clients, the further a counselor is at risk for developing compassion fatigue (Figley, 1999).
Compassion fatigue develops from observing the pain of others and wanting to somehow help, but feeling overwhelmed and haunted by the clients’ traumatic stories (Figley, 1995, 2002a, 2002b; Pearlman & Mac Ian, 1995; Radey & Figley, 2007; Stamm, 1999b). Through being present with numerous stories of suffering, across long work days, the counselor begins to feel fatigued, meaning that the counselor’s ability to feel and show continued concern is weakened (Figley, 1995, 2002a; Radey & Figley, 2007). The symptoms that develop vary widely and include intrusive imagery in relation to clients’ trauma experiences, variable mood, avoidance behaviors, nervousness, and sleeplessness (Figley, 1995, 2002a; Neumann & Gamble, 1995; Pearlman & Mac Ian, 1995). Given that compassion fatigue does not have a set criterion of symptoms it can easily go unnoticed by the counselor, co-workers, and supervisors (Stebnicki, 2007).

**Research on compassion fatigue.** In a self-report study of counselors, Lawson (2007) found that over 10% of the 501 counselors surveyed were experiencing compassion fatigue. As noted, compassion fatigue is caused by exposure to traumatized clients. This study also revealed that the majority of counselors surveyed felt that the largest part of their clientele had experienced significant trauma. This suggests that compassion fatigue may be a common threat for the counseling professional.

The occurrence and effects of compassion fatigue are not only prevalent among counselors. Its incidence has also been explored across various helping professions and specialties. Compassion fatigue has been recognized as a hazard for nurses (Bush, 2009), hospice care workers (Alkema, Linton, & Davies, 2008), child protection workers (Conrad & Keller-Guenther, 2006), urban disaster relief providers (R. E. Adams, Figley,
& Boscarino, 2008), residential childcare workers (Eastwood & Ecklund, 2008), clinicians working with sexual violence survivors (Schauben & Frazier, 1995), employee assistance professionals providing workplace crisis intervention (Jacobson, 2006), clinicians working with sexually abused clients (Cunningham, 2003), oncology social workers (Simon, Pryce, Roff, & Klemmack, 2005), crisis line counselors (Dunkley & Whelan, 2006), and those helping professionals working with trauma survivors (Killian, 2008). Personal accounts of compassion fatigue have also been examined in clinicians working with specific populations, including counselors working with persons with HIV/AIDS (Smith, 2007), substance abuse counselors (Fahy, 2007), and family therapists (Becvar, 2003).

Compassion fatigue can have many detrimental effects on these various types of helping professionals. More than half of helpers working with traumatized clients have reported a change to a more negative view of the world, including an increased sense of unfairness and feelings of fear (Tehrani, 2007). In a qualitative analysis, therapists working with family violence compared to therapists working outside that specialty were found to have negatively changed perspectives in their world views which was off-putting in their personal relationships (Ben-Porat & Itzhaky, 2009). Farrenkopf (1992) indicated that a majority of the 24 therapists working with sex offenders surveyed similarly experienced a change in perception, possibly due to compassion fatigue. Many reported feelings of hopelessness regarding client growth and change. This is consistent with the findings of Moulden and Firestone (2007), who found that clinicians working
with sexual offenders became more suspicious of others and had developed symptoms of PTSD, both indications of compassion fatigue.

Other significant PTSD symptoms have been reported by helping professionals. Wee and Myers (2002) reported that over half of the 34 mental health workers surveyed who provided crisis services in Oklahoma City after the 1995 bombing were experiencing significant distress similar to PTSD symptoms. Similar findings were also found with mental health trauma workers in New York City following the events of September 11th (Creamer & Liddle, 2005). The development of compassion fatigue seems obvious in such extreme examples. However, studies have also shown that particular demographic characteristics make helping professionals more susceptible.

Research suggests that the threat of developing compassion fatigue may be influenced by various demographic factors. Sex appears to affect levels of compassion fatigue, as studies have shown that females tend to experience greater amounts and severity of symptoms (Kassam-Adams, 1999; Killian, 2008; Meyers & Cornille, 2002; Sprang, Clark, & Whitt-Woosley, 2007; Van Hook & Rothenberg, 2009). The amount of time exposed to traumatized clients has been determined to increase risk of developing compassion fatigue (Brady, Guy, Poelstra, & Brokaw, 1999; Creamer & Liddle, 2005; Wee & Myers, 2002). The clinician’s age has been found to impact chances of symptoms, as younger clinicians have shown higher levels of compassion fatigue (Creamer & Liddle, 2005; Ghahramanlou & Brodbeck, 2000; Sprang et al., 2007). The clinician’s personal history of trauma has also been correlated with increased risk for compassion fatigue (Baird & Kracen, 2006; Dunkley & Whelan, 2006; Pearlman & Mac
Ian, 1995; Trippany, Wilcoxon, & Satcher, 2003). This is especially concerning given that studies have indicated that a substantial number of clinicians have a personal trauma history (Elliot & Guy, 1993; Pearlman & Mac Ian, 1995; Pope & Feldman-Summers, 1992).

Lastly, fewer years of experience has also been determined to increase vulnerability to compassion fatigue (Creamer & Liddle, 2005; Sprang et al., 2007). Novice counselors and trainees are especially prone to compassion fatigue due to a lack of experience and unrealistic expectations. As M. S. Corey and Corey (2007) pointed out, beginner counselors are often faced with increased feelings of nervousness and stress due to initial job placements, and with disappointment when the positions do not meet their perceived notions of what they thought their career would be like. Many new counselors must deal with the uncertainty of starting their careers and become aware of the organizational constraints set forth by their employers (Killian, 2008).

Regardless of years of experience, counselors are increasingly faced with working with large caseloads of traumatized clients (Lawson, 2007; Trippany, Kress, & Wilcoxon, 2004). It can be argued that the majority of clients have been traumatized in one way or another, which can become a hazard for the majority of counselors at some point in their career (Gentry, Baranowsky, & Dunning, 2002). It is suspected that the prevalence of compassion fatigue is much higher than what has been reported (Stamm, 1999b). Since this phenomenon does not have a set criterion of symptoms, it can easily go unnoticed by the counselor, co-workers, and supervisors (Stebnicki, 2007). Counselors may also be afraid to discuss their symptoms with others, fearing that they will lose their credibility.
and possibly even their careers. Also adding to the confusion are all of the similar and often interchangeable terms that are used to describe concepts comparable to compassion fatigue, such as vicarious traumatization and Secondary Traumatic Stress Disorder.

**Related concepts.** The concept of compassion fatigue originated from Joinson’s (1992) literature in the field of nursing to describe the feelings of exhaustion that accompanied caring for those with illness. Figley (1995) began to explore this phenomenon in relation to mental health workers, particularly the secondary stress reactions that many counselors experience when working with clients with a history of trauma. As a result, Figley (1995, 2002a) introduced the term Secondary Traumatic Stress Disorder (STSD) to describe the notion that through reliving traumatic occurrences with a client, a counselor may develop symptoms that are similar to Post-Traumatic Stress Disorder (PTSD). Vicarious traumatization, a term developed by McCann and Pearlman (1990), is also used throughout the literature to explain how disturbing it can be for counselors to work with clients who have experienced distressing events. Last, the phrase “empathy fatigue” was expressed by Stebnicki (2000, p. 23) instead of compassion fatigue, emphasizing the ability of counselors to empathize with clientele.

As Craig and Sprang (2010) noted, these various constructs are employed throughout the literature, oftentimes with compatible definitions to describe the same phenomenon. To date, none of these terms have been empirically tested to examine possible differences and much of the literature uses them interchangeably (Craig & Sprang, 2010; Figley, 1999). As Stebnicki (2007) concluded, the term used to describe exhaustion issues of counselors will differ in regards to the author and area of study.
This study used the phrase compassion fatigue to illustrate the complex condition that can negatively affect counselors due to the often stressful nature of the counseling profession.

**Compassion fatigue compared to post traumatic stress disorder.** As mentioned, Secondary Traumatic Stress (STS) was the phrase created by Figley (1995) to emphasize the notion that therapists can experience PTSD-like symptoms, simply by hearing and empathizing with the trauma told by clients. Even though compassion fatigue is now considered the more suitable phrase, the construct continues to relate to the clinician’s experience of symptoms that are remarkably similar to PTSD (Baranowsky, 2002; Stamm, 1999b). The *Diagnostic Statistical Manual (DSM-IV-TR)* described symptom criteria for PTSD to include intrusive thoughts and images, avoidance behaviors, increased startle response, and sleep disturbances, following the experience of a traumatic event (American Psychiatric Association, 2000). Those who develop compassion fatigue will often develop symptoms similar to PTSD which can contribute to the development of parallel feelings of fear, defenselessness, and detachment (Figley, 1995; Stebnicki, 2007).

One may not necessarily need to directly experience the trauma in order to develop symptoms similar to those described. As Cunningham (2003) pointed out, the *DSM-IV-TR* diagnosis of PTSD includes the indirect experience of trauma, such that one can be diagnosed with the disorder by learning of another’s trauma details. Despite the inclusion of the secondary trauma experience of others, PTSD literature and research has not concentrated on the indirect encounter of trauma (Figley, 1995). According to the APA (2000), compassion fatigue is not currently considered a diagnosable condition.
Some researchers contend that compassion fatigue is a pathological disorder that deserves recognition as a diagnosis (Figley, 1995; Stamm, 1999b), while other researchers have emphasized the inevitability of the condition due to the expectations and stressors of being a helping professional (McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995).

It is possible that compassion fatigue will gain more recognition in time. Given that PTSD is a relatively new DSM-IV-TR diagnosis, only recognized since 1980, and the phenomenon of compassion fatigue has only been examined since the 1990s, it appears that there is much more knowledge to be gained concerning trauma and its effects on those who treat it (APA, 2000; Figley, 1995). One step towards understanding compassion fatigue would be to distinguish it from other similar concepts. Compassion fatigue is not only frequently compared to PTSD, but is also frequently associated with the separate constructs of countertransference and burnout.

**Compassion fatigue compared to countertransference.** Countertransference has been defined as the therapist’s instinctive and often unaware feelings toward a client (G. Corey, 2008). Figley (2002a) explained that compassion fatigue differs from countertransference in that it is an issue that involves the counselor’s care and concern for clientele, whereas countertransference involves the counselor’s personal issues and associations that can affect the therapeutic relationship. It has been found that therapists are more prone to compassion fatigue when the client’s trauma relates to a personally distressing event experienced by the counselor. However, compassion fatigue specifically occurs through the transmission of painful stories that negatively affect a
counselor both personally and professionally (Figley, 2002b; McCann & Pearlman, 1990).

**Compassion fatigue compared to burnout.** Compassion fatigue is also a separate phenomenon than the construct of burnout, a concept that is examined in greater depth in this review. In contrast to compassion fatigue, burnout is the counselor’s response to working in a challenging environment in which the pressures of clientele, rigorous documentation, and administration-imposed constraints cause the counselor to feel depleted (Maslach & Jackson, 1986; Wegela, 1999). Oftentimes clinicians are unaware that burnout is developing as they begin to have a negative outlook on the value of their work and their clients (Maslach, 1982). Burnout typically develops gradually over time whereas compassion fatigue can surface abruptly without the exhaustion that usually accompanies burnout (Stamm, 2005). Burnout can also be experienced through any stressful work environment, whereas compassion fatigue is unique to the helping profession as it is experienced through second-hand accounts of traumatic experiences (Figley, 2002a; Maslach, 1982; Stamm, 1999b). Both of these conditions commonly affect counselors, but each have unique implications on the worker’s sense of health and comfort.

To demonstrate differences between compassion fatigue and burnout, R. E. Adams et al. (2008) surveyed those in the helping profession living in New York City not long after the events of September 11th. Results indicated that those working with traumatized clients were experiencing higher levels of compassion fatigue, but not burnout. Compassion fatigue is caused by strong feelings of empathy, followed by
hopelessness and feeling unable to help, instead of overwhelming workload characteristic of burnout or over-identifying with a client that is present in countertransference. Compassion fatigue comes from a place of wanting to help and a perceived inability to do so, instead of feeling burdened by one’s job or disdain for clientele. It is thought to have better treatment outcomes than both countertransference and burnout (Figley, 2002b).

**Compassion fatigue compared to vicarious traumatization.** This concept of helpers wanting to assist survivors, but becoming distressed themselves through hearing about trauma is also the cornerstone for the construct of vicarious traumatization (McCann & Pearlman, 1990). Much like compassion fatigue, vicarious traumatization is thought to affect counselors through symptoms which are relatively similar to PTSD, including hyperarousal, avoidance behaviors, and continually recalling the event (Baird & Kracen, 2006; Lerias & Byrne, 2003; McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995). Vicarious traumatization was developed out of psychoanalytic and cognitive theories which contend that the counselor’s personal schemas are permanently changed through hearing clients’ trauma stories (Jenkins & Baird, 2002; McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995). This contrasts with the symptom-based construct of compassion fatigue which emphasizes warning signs and treatment instead of inevitable altered cognitive perceptions (Figley, 2002b; McCann & Pearlman, 1990; Sprang et al., 2007).

Despite these apparent differences there is much confusion throughout the literature in distinguishing between these two terms, as some authors have determined that compassion fatigue is a separate entity, whereas others use it interchangeably with
vicarious traumatization. The lack of standardized terms has contributed to misrepresentations in research findings and in clear understandings regarding the impact of working with traumatized clients (Chouliara, Hutchison, & Karatzias, 2009; Dunkley & Whelan, 2006). Pearlman and Mac Ian (1995) have advocated for more precise working classification of terms used in research, including the separation of vicarious traumatization as a distinct construct. However, there is little support in the literature that vicarious traumatization is a unique and measurable concept (Sabin-Farrell & Turpin, 2003).

It appears that all of these terms would benefit from further clarification and consistency. Until this is achieved, it is important to focus on developing ways to assist helping professionals manage the difficulties associated with the profession. As Stebnicki (2007) concluded, terms related to the exhaustion of counselors will differ according to the one researching and the helping field being studied. Despite the discrepancies in theoretical backgrounds and focus of symptoms, all of these terms explain how distressing it can be for a counselor to witness the painful memories of clients (Bride, Radey, & Figley, 2007; Craig & Sprang, 2010; Pearlman & Saakvitne, 1995). Throughout this study, the term compassion fatigue is used to describe this phenomenon.

A model of compassion fatigue. To further clarify and explain the construct of compassion fatigue, Figley (2002a) developed a model consisting of 11 components which bring about its onset (see Figure 1). The variables not only outline the predictive
The Compassion Fatigue Process (Figley, 2001)

*Figure 1.* The Compassion Fatigue Process

and progressive nature of compassion fatigue, but also can assist clinicians in recognizing its development.

As the model demonstrates, in order to experience both compassion and compassion fatigue, the clinician must first possess the capacity for empathetic understanding. This is shown as one initial part of the process, labeled “Empathetic Ability,” which is considered ineffective unless the added incentive for “Concern” is present. This depiction of concern represents the counselor’s call to use developed skills and techniques to help those who need such services (Figley, 2002a). Through empathy, the counselor is able to see the situation through the client’s perspective, which can make the counselor also feel the client’s emotions (Rothschild & Rand, 2006). It has been argued that many counselors chose their occupation due to an innate ability to empathize with and care for others (Stebnicki, 2007). Figley (1995) speculated that a clinician’s
increased capacity for empathy subjects them to a higher likelihood of developing compassion fatigue since empathetic understanding can connect the clinician more fully to the client and subject the clinician to feeling more of the pain.

Naturally, in order for the counselor to directly hear the clients’ stories and experience the sensitivity of the trauma, the counselor must have direct exposure to the client and the client’s suffering (Figley 2002a). This is seen on the model as “Exposure to Suffering.” As helpers begin to develop compassion fatigue, they find themselves withdrawing from clients and their stories (Stamm, 1999b). Danieli (1984, 1985, 1988) suggested that when clinicians become overwhelmed by clients’ recollections of trauma, the clinician will begin to ignore and even deny the trauma events. Danieli (1984, p. 23) determined that this “conspiracy of silence” serves to protect the therapist from distress at the expense of the client.

Similarly, Baranowsky (2002, p. 155) referred to the therapist’s inability to listen and redirect the client as the “silencing response.” Such a way of reacting can have detrimental effects on the client’s ability to work through trauma-related issues. Through redirection, downplaying the trauma, or inappropriately using humor, counselors are silencing the trauma and conveying to clients that they are not open to fully engaging in these distressing stories (Gentry et al., 2002).

In contrast, when clinicians are actively engaged in listening to a client discuss past trauma events, the clinician is displaying the next part of the model, an “Empathetic Response” to the client. This occurs when the counselor utilizes the skills of active listening and understanding to the point at which the counselor can deeply relate to the
client’s experience (Figley, 2002a). This response does not only include the ability of the counselor to relate to the client, but also represents how this empathy is internalized by the counselor. Empathy is a crucial aspect in facilitating client growth, but may also lead to a strong, internal reaction by the counselor and quite possibly trigger the beginning development of compassion fatigue (Gentry et al., 2002; Rothschild & Rand, 2006; Stebnicki, 2007).

Along with empathy, compassion is another valuable tool utilized by counselors to help clients through the healing process. Compassion is defined by one’s ability to sympathize with another and care enough to want to help alleviate his or her suffering (Gilbert, 2005; Lewin, 1996). Compassion is considered a separate entity than empathy because compassion not only includes understanding, but also engenders one’s desire to help the individual who is experiencing distress (Gilbert, 2005). The area of the compassion fatigue process model labeled “Residual Compassion Stress” refers to the strain that the counselor encounters due to continually responding with concern to the client along with a drive to alleviate the client’s suffering, often leading to compassion fatigue (Figley, 2002a). Figley (1995) hypothesized that the more compassionate helping professionals are, the more they are at risk for developing compassion fatigue. It has been hypothesized that if this stress continues to build, the counselor’s ability to feel both empathy and compassion for clientele is degraded which can lead to possible counselor impairment and ethical violations (Gentry et al., 2002; Neumann & Gamble, 1995; Valent, 2002).
The compassion fatigue process model does display several ways in which the counselor can manage this stress before it develops into such possible impairment or fatigue. The first coping skill pictured is “Sense of Satisfaction,” which is the amount of fulfillment the counselor senses towards assisting the client to achieve therapeutic gains. This variable also allows the counselor to feel content in the limited capacity of the role of a helper, while giving the client some accountability towards the change process (Figley, 1995, 2002a; Radey & Figley, 2007; Stamm, 2002). Another coping mechanism presented in the model to reduce compassion stress is the feeling of “Detachment,” or degree to which the counselor can separate from clients and their traumatic stories in order to take time for self-care and a sense of personal space (Figley, 2002a). The need for personal time away from the role of helper and participation in self-care activities has been suggested throughout the literature (Baker, 2003; Becvar, 2003; T. M. O’Halloran & Linton, 2000; Radey & Figley, 2007; Stebnicki, 2007). The ability to separate work from home life has been shown to be related to a reduction of emotional involvement with clients (Simon et al., 2005). However, if the counselor does not take time away to disengage from work, fatigue is likely to occur.

It is recommended that counselors are tasked with manageable case loads and take advantage of time off and allow for time away from being in compassionate service to others (Eastwood & Ecklund, 2008; Van Hook & Rothenberg, 2009). This is partly due to what is shown in the model as “Prolonged Exposure to Suffering” or the extended time period through which the counselor is exposed to client pain and distress. Numerous studies have determined that extended periods of working with traumatized clients
increases self-reports of compassion fatigue (Brady et al., 1999; Craig & Sprang, 2010; Creamer & Liddle, 2005; Sprang et al., 2007).

Another concern addressed in this model is the experience of “Traumatic Memories” in which the counselor is faced with disturbing recollections of clients’ stories that elicit PTSD-like symptoms. Symptoms of compassion fatigue can include sleep disturbances, overwhelming thoughts and memories concerning the clients’ experiences of trauma, becoming easily frightened by noises or change in environment, and despondent or nervous mood (Figley, 1995, 2002a; Wee & Myers, 2002). Somatic symptoms, such as headaches and muscle pain, can also be present (Bush, 2009). Traumatic recollections and PTSD-like symptoms can be caused by client stories that bring about a memory of the counselor’s own personal trauma, the anxiety that occurs when working with a particularly intimidating client, or from counseling a client who has gone through exceptionally distressing trauma (Figley, 2002a; Pearlman & Saakvitne, 1995). Research has determined that counselors who have experienced past trauma themselves are at greater risk of developing compassion fatigue (Baird & Kracen, 2006; Pearlman & Mac Ian, 1995).

Finally, the last piece of the Compassion Fatigue Process model illustrates “Other Life Demands” or a dramatic shift in the counselor’s life that can contribute to the development of compassion fatigue. For example, the counselor unexpectedly needs to alter a work schedule due to a change in family role, personal health concerns, or receiving new professional demands. These types of changes would be felt as stressful for most professionals, but are exceptionally salient when combined with the other
factors in this model leading up to compassion fatigue (Figley, 2002a). Once compassion fatigue develops, the clinician’s roles outside of the professional realm may be negatively impacted. The therapist’s personal life may suffer, resulting in strained relationships and further isolation (Chrestman, 1999; Collins & Long, 2003). However, there are steps that helping professionals can take to avoid or defeat compassion fatigue.

**Compassion Satisfaction**

It has been suggested that in order for clinicians to overcome compassion fatigue, they need to stop focusing on the stressful aspects of being a helper and begin to consider ways in which their work brings a sense of fulfillment (Radey & Figley, 2007; Stamm, 2002). The phrase compassion satisfaction is used to describe this feeling of accomplishment that results from the process of helping others and brings counselors back to the altruistic reasons they had picked the profession in the first place (Stamm, 1999b). Radey and Figley (2007) argued that the perception of work-related stress can be reframed as a source of strength instead of fatigue, bringing the impression of success and enjoyment in one’s role as a counselor. Through the development of compassion satisfaction, counselors will begin to notice how their roles have helped clients work through personal suffering and into a place of personal growth and responsibility (Stamm, 2005).

The concept of compassion satisfaction was derived from positive psychology in which the clinician reworks thoughts and feelings from centering on the negative aspects of working with difficult and traumatized clientele, to considering the human potential for positive progress and development (Radey & Figley, 2007). Negative thinking limits
one’s potential by causing constricted thinking and limited creativity, whereas positivity contributes to a broadening of ideas and behaviors (Radey & Figley, 2007). This expanded view can enhance the counselor’s problem-solving capabilities, which can ultimately assist the client in generating new outcomes (Radey & Figley, 2007). The more frequently that the counselor focuses on the positive aspects of client-related work, the more satisfaction and value one will find in the profession (Linley & Joseph, 2007). This experience of compassion satisfaction will not only bolster the counselor’s feelings of worth, but will also improve the treatment that the client receives (Linley & Joseph, 2007; Radey & Figley, 2007).

There are several ways in which counselors can achieve this knowledge and understanding of compassion satisfaction. First, counselors need to maintain a more affirmative affect, which can be accomplished through maintaining an optimistic outlook on clients, developing a more supportive work environment, limiting trauma cases and seeing a wider range of clientele, and taking vacation from work and thoughts about stress-evoking cases (Eastwood & Ecklund, 2008; Killian, 2008; Radey & Figley, 2007). Second, counselors should obtain more practical resources and applications on decreasing stress. Such resources can begin during the clinician’s training, in which educators can begin to emphasize compassion satisfaction. Learning about stress reduction can begin through education provided in courses and lectures and continue throughout the counselor’s career through agency meetings and continuing education opportunities (Baker, 2003; Killian, 2008; Radey & Figley, 2007). Lastly, counselors also must develop self-care practices (T. M. O’Halloran & Linton, 2000; Stebnicki, 2007).
Although frequently mentioned in the ethical codes and courses of the helping professions, courses on self-care are rarely provided (ACA, 2005; Killian, 2008).

Other variables have also been found to influence the development of compassion satisfaction. Years of experience working with traumatized clients is one such variable that research has shown to be positively correlated with compassion satisfaction (Craig & Sprang, 2010). Craig and Sprang determined that clinicians with more years of experience reported higher levels of fulfillment and satisfaction. This may be due to the clinicians’ better understanding of how to treat this population and witnessing the long-term positive changes that occurred in these clients (Craig & Sprang, 2010). Higher levels of compassion satisfaction may also be a common experience for clinicians working with traumatized clients. Such increased satisfaction was evidenced by a survey conducted by Tehrani (2007) who determined that the majority of those working with traumatized clients self-reported feeling fulfilled through their role as a helper.

Sex has also been linked to differences in levels of satisfaction as a clinician. Women report higher levels of growth and positive changes than men (Linley & Joseph, 2007). A qualitative exploration of compassion satisfaction determined that higher amounts of social support was the ultimate determining factor of compassion satisfaction (Killian, 2008). Clinicians have also reported that this sense of satisfaction is often derived from witnessing client growth and recovery and being a part of a supportive team of healers (Collins & Long, 2003; Schauben & Frazier, 1995). By understanding which factors assist in compassion satisfaction, ways in which compassion fatigue can be decreased may be discovered.
Developing compassion satisfaction not only increases a sense of fulfillment, but it can also prevent counselor stress and impairment. Studies have shown that the development of compassion satisfaction can effectively decrease the occurrences of compassion fatigue and burnout (Collins & Long, 2003). Eastwood and Ecklund (2008) found that compassion satisfaction was negatively correlated with burnout among residential treatment childcare workers. Melamed, Szor, and Bernstein (2001) determined that compassion satisfaction for mental health professionals at outpatient facilities was not only inversely correlated with burnout, but also to feelings of loneliness. Compassion satisfaction was similarly found to decrease the effects of burnout for clinicians working with adolescent sex-offenders (Kraus, 2005). Another study, which examined child welfare workers, showed that compassion satisfaction was correlated with lower reports of burnout and compassion fatigue (Van Hook & Rothenberg, 2009). Overall, compassion satisfaction is a promising idea for counselors to strive for in order to protect against compassion fatigue and burnout.

**Conclusions on compassion fatigue and compassion satisfaction.** It is a commonly held belief that the majority of helpers entered the profession with a strong desire to assist others through the healing process (Baker, 2003; Figley, 1995; Stebnicki, 2008). This drive for caring and empathetic understanding can lead professionals towards deep hurt and despair as they are continually exposed to clients’ stories of trauma and misery. The stress and strain of being in such a position can lead to compassion fatigue. This condition is marked with PTSD-like symptoms, such as hypervigilance and sleeplessness, and can develop into feelings of hopelessness and fear.
Compassion fatigue is a risk that is particularly unique to the helping profession (Figley, 1995; Stamm, 1999b). It can come on suddenly and can rapidly prompt changes in both the personal and professional life of the counselor (Figley, 1995, 2002b). The term burnout describes a similar, yet separate concept that is also a common occurrence for helping professionals (Maslach, 1982). The next section includes detailed definitions, symptoms, models of, and research on burnout. This is followed by a review on self-care and an examination of the literature on ways in which counselors can increase compassion satisfaction and overall wellness.

**Burnout**

Originally used to describe those who habitually abuse substances, the term burnout is now used to describe the shift in the helping professional from feelings of energy and empathy to depletion and indifference (Grosch & Olsen, 1994). The notion of burnout experienced by helping professionals was initially established by Freudenberger (1974) to describe the emerging feelings of exhaustion that develop due to increased stress on the job and dissatisfaction with one’s occupation. The first article ever written on burnout was based on an examination of volunteers employed in a community social service agency (Freudenberger, 1974). This study examined the workers’ change in attitudes and behaviors, finding that there was a noticeable shift from enthusiasm to exhaustion in the outlook of the volunteers (Freudenberger, 1974).

Such writing, research, and exploration on burnout and helping professionals continued throughout the 1980s when many authors examined the topic and developed similar definitions. Maslach (1982) has written extensively on burnout and has defined
the concept in terms of one’s loss of emotional and physical energy, resulting in lack of concern and interest in one’s occupation. Cherniss (1980) conceptualized burnout to include a process of steps, starting with stress, leading to strain, and ending with defensive coping mechanisms. Despite minor variations in definitions, the phenomenon of burnout in this study considers several models of conceptualization, focusing on the exhaustion experienced by those working in the helping profession.

**Research on burnout.** It has been estimated that approximately 10-15% of mental health clinicians will develop burnout some time during their career (Kahill, 1986). Various demographic factors, including location, have been found to influence the chances of developing burnout. Sprang et al. (2007) utilized a version of the Professional Quality of Life Scale (ProQOL) to examine the influence of location on 1,121 mental health providers. The ProQOL is a self-reporting instrument that measures a helping professional’s experience with compassion fatigue, compassion satisfaction, and burnout. These researchers determined that those clinicians located in rural locations experienced higher levels of burnout. This may be due to the shortage of mental health providers in rural locations, which translates into larger case loads, less social support, and fewer resources for these clinicians (Sprang et al., 2007). In a survey of practicing counselors and ACA members, Lawson (2007) found that those working in community agencies self-reported higher levels of burnout on the ProQOL-III-R than those employed in private practice. Dupree and Day’s (1995) examination of 86 psychotherapists also found that work setting influenced burnout, determining that psychotherapists working in agencies experienced more burnout than those in private practice setting (Dupree & Day,
This may be a result of organizational constraints, productivity demands, and lack of control that is often more prominent in agency work (Kottler, 1993; Raquepaw & Miller, 1989). Community agencies also tend to be the only option for low socioeconomic clients who are often experiencing multiple stressors, comorbid disorders, and trauma (Sprang et al., 2007).

The study by Dupree and Day (1995) also concluded that men self-reported more burnout symptoms than women. Utilizing a sample of 521 APA members, Vredenburgh, Carlozzi, and Stein (1999) similarly found that men are more prone to higher levels of burnout, especially on intensity of depersonalization. These findings coincided with Van Morkhoven’s (1998) study that inspected burnout in relation to 358 surveyed psychologists located in Texas. Using a demographic questionnaire and the MBI, it was found that males were more prone to advanced degrees of burnout (Van Morkhoven, 1998).

Van Morkhoven (1998) also determined that younger mental health clinicians had higher incidents of burnout. Likewise, another survey of practicing psychologists found that younger clinicians were experiencing higher levels of burnout (Ackerley, Burnell, Holder, & Kurdek, 1988). Based on self-reports of APA members, Vredenburgh et al. (1999) concluded that younger and less experienced clinicians were more prone to burnout. In a similar examination of burnout and counseling psychologists, less experienced and younger counseling psychologists reported higher amounts of burnout (Jiang, Yan, & Shuyue, 2004). In particular, younger age was associated with experiencing increased emotional exhaustion and less experience was linked to an
inferior sense of personal accomplishment (Jiang et al., 2004). Gillespie and Numerof (1991) conducted a study of demographic variables in relation to levels of burnout in health service professionals, in which younger age and limited experience were also positively correlated with heightened burnout. It may be presumed that older and more experienced counselors know how to cope more than those who are new to the field and have had less life experiences (Cranswick, 1997).

These studies have shown that burnout is associated with several demographic variables. However, some researchers still disagree about how burnout develops. Cherniss (1980) viewed burnout as a developmental process, during which helping professionals pass through specific stages. Maslach (1982) described burnout as a syndrome that results in a loss of meaning in one’s occupation. Cherniss’ (1980) position of burnout as a process is examined first.

**Burnout as a process.** Cherniss (1980) described burnout as a process in which the helping professional first experiences stress, followed by strain, and finally cumulating in defensive coping. Stress is the beginning of this progression and develops as helping professionals begin to feel that their jobs are not meeting the expectations they had originally set for them. Such an initial let down leads to a succession of changes in attitudes and behaviors. This stress piece of the process will continue to expand as the professional finds it demanding to manage work-related hurdles. The pressure of helping professions are commonly associated with poor work relationships, organizational demands and limitations, long work hours, concerns about liability, and difficult clientele (Cherniss, 1980; Maslach, 1982; Pines & Aronson, 1988). The development of an altered
perspective caused by stress is especially the case for novice counselors, who most likely had created highly unrealistic expectations (Grosch & Olsen, 1994).

Whether a novice or seasoned clinician, the initial experience of stress can progress into a sense of strain in which the helping professional begins to feel a loss in ability to manage job pressures and struggles to cope with performance demands (Maslach, 1982). Once feelings of strain have developed, lowered motivation and diminished sense of self-efficacy begin to invade the clinician’s professional work. The helping professional who once valued their career can no longer find meaning in the work that they do (Kottler, 1993; Pines & Aronson, 1988). Encountering this decline in meaning and spiritual values, the helping professional may find it difficult to continue in the profession, believing that efforts to help others are not effective (Skovholt, 2001; Stamm, 2002). The helping professional begins to face feelings of failure and continues to deteriorate in amount of energy and motivation devoted to the field (Maslach & Goldberg, 1998; Potter, 1980).

In order to manage these feelings of exhaustion and ineffectiveness, the helping professional will develop defensive coping skills (Cherniss, 1980). A counselor will start to develop a negative view of clients, blaming them for their problems and using derogatory language to describe their conditions (Cherniss, 1980; Kottler, 1993; Pines & Aronson, 1988). For example, a counselor may feel frustrated with a client who is struggling with substance abuse and frequently no shows for appointments. The counselor may refer to the client as an “alcoholic,” blaming the client for not showing through accusations that the client was too intoxicated to remember or drive to the
appointment. Such defensive coping can lead to counselor impairment, as the counselor may begin to lack respect and empathy for clients (Cherniss, 1980). Overall, the process of burnout has taken its complete course when the counselor has developed a cynical view of clients and of the helping profession in general. When a clinician has reached this level of burnout, they no longer take pride in their work, have little interest in their job, and can lack empathy towards clients.

Based on this progression, burnout increases the chances that the helping professional may violate ethical standards and guidelines (Cherniss, 1980; T. M. O’Halloran & Linton, 2000). It is important to note that the early indicators of burnout often go unnoticed by the counselors and clients until they have reached the point of the counselor leaving the profession or becoming detrimental to clients (Pines & Aronson, 1988). A closer examination of the array of symptoms is needed to fully comprehend early warning signs and later harmful effects.

**Burnout as a syndrome.** Burnout often affects the person on a physical, emotional, and spiritual level and manifests with a wide-range of symptoms (Maslach & Jackson, 1984; Savicki & Cooley, 1982). The person experiencing burnout may notice an array of symptoms, such as increased irritability and absenteeism, but typically will not attribute it to a personal development of this disorder. Maslach and Jackson (1984) characterized burnout as “emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur in professionals who do people work of some kind” (p. 1.). This definition is currently the most widely used, as it emphasizes the cognitive, affective, and behavioral changes and symptoms experienced by helping professionals.
Emotional changes are common with burnout, as the professional begins to feel frustrated, powerless, and apathetic (Maslach & Goldberg, 1998; Valent, 2002). This experience of emotional depletion may vacillate between frustration, irritability, and anxiety to feelings of hopelessness, helplessness, depression, and an overall sense of feeling numb. The helping professional will begin to lose energy and enthusiasm causing feelings of boredom, such as daydreaming about life outside of work while on the job or with clients (Meldrum, King, & Spooner, 2002; Pines & Aronson, 1988; Raquepaw & Miller, 1989; Valent, 2002). These shifts in affect caused by burnout are usually rooted in the person’s sense of being emotionally overextended and feeling overwhelmed by constant demands and increased responsibilities (Maslach & Leiter, 1997).

As this emotional stress and mental strain continue, somatic issues may also begin to surface. These physical symptoms can include headaches, muscular pain, stomach issues, and hypertension (Farber, 1990; Maslach & Leiter, 1997; Paine, 1984; Pines & Maslach, 1978; Valent, 2002). Those experiencing burnout may feel fatigued, develop sleep issues, unintentionally lose weight, and have difficulty concentrating (Farber, 1990; Freudenberg & Richelson, 1980; Paine, 1984; Valent, 2002). Given that burnout causes exhaustion of both the mind and body, eventually changes in personal perceptions and behaviors occur (Pines & Maslach, 1978). As emotional and physical changes occur, more profound symptoms characterized by cognitive modifications also arise. These changes in thoughts and values are represented as a loss of interest, enthusiasm, and meaning in both one’s occupation and life in general (Maslach & Jackson, 1984; Pines et al., 1981).
The occurrence of this transformation in beliefs is considered the most salient aspect of burnout development. Depersonalization refers to this negative shift in how one views their clients and overall occupation (Maslach & Jackson, 1984). With depersonalization, a helping professional who is caring and concerned has the potential to become cynical, judgmental, and unfeeling (Maslach, 1986; Valent, 2002). This can cause feelings of anger and frustration at an organization for its heavy demands and the clinician may start to blame clients for their own problems. The clinician is disinclined to go to work, and appreciates cancellations and no-shows (Kottler, 1993). Skovholt (2001) described these shifts in meaning and perception as an erosion of spiritual values. The clinician with burnout portrayed impatience, irritability, and apathy with a rigid viewpoint and an increasing sense of cynicism concerning both their personal and professional lives (Freudenberger & Richelson, 1980; Maslach, 1982; Pines & Aronson, 1988).

As this negative outlook continues, behavioral changes start to manifest. The helping professional will present with a lack of interest and concern for one’s work. Such a decline in work performance is evidenced by behaviors such as checking and responding to email and voicemail less frequently, attending fewer work meetings, falling behind in paperwork, and recurrent tardiness and absenteeism (Maslach & Jackson, 1984; Maslach & Leiter, 1997).

The helping professional not only withdraws from the occupation, but isolating behaviors outside of work are also present. They may refuse to discuss their job with family and friends or avoid social situations altogether. Many clinicians already have a
limited social life, but this becomes more prominent if burnout develops, as the professional begins to prefer being alone and engaging in more passive activities, such as watching television (Kottler, 1993; Maslach & Leiter, 1997). Such avoidant behaviors and loss of enthusiasm causes the professional to withdraw from both personal and professional relationships (Kahill, 1988; Maslach & Jackson, 1984; Paine, 1984). The depletion caused by burnout can additionally lead to risky behaviors, including excessive drug and alcohol use (Freudenberg & Richelson, 1980; Pines & Aronson, 1988) or use of other substances, including caffeine and tobacco (Grosch & Olsen, 1994).

All of these changes that culminate into isolation and pessimistic scrutiny of others eventually give way to feelings of guilt. The clinician may begin to feel remorse and turn blame inward which can lead to feelings of reduced accomplishment and self-esteem. Personal beliefs are often affected, as the clinician becomes less enthusiastic about career aspirations and feels ineffective and inadequate in their work (Maslach & Leiter, 1997). The sense of reduced personal accomplishment includes negative self-evaluations, and feelings of both inadequacy and outright failure (Maslach, 1986; Maslach & Goldberg, 1998). An outlook that entails a personal viewpoint of lack of achievement and low self-efficacy, can ultimately lead to the helper’s deliberate decision to leave the field or to unconsciously harming clients due to impairment (Maslach & Jackson, 1986). Examination into the sources of burnout development can clarify how a helping professional can change from enthusiastic to apathetic.

**Causes of burnout.** Helping professionals are faced with multiple pressures and demands (Maslach, 1986). Maslach and Goldberg (1998) determined that burnout is
caused by multidimensional problems common in the helping field, such as challenging clientele, difficult work relationships, and overwhelming amounts of work (Maslach, 2003). Pines and Aronson (1988) emphasized the external contributors to burnout, describing it as “a state of physical, mental, and emotional exhaustion caused by long-term involvement in situations that are emotionally demanding” (p. 9). The numerous causes of burnout include the work environment, interpersonal relationships, and intrapersonal traits (Maslach & Goldberg, 1998). Issues within organizations are examined first, as they are continually referred to in the literature as the most salient culprit of stress and burnout.

**Organizational issues.** Problems within the clinician’s place of employment include a host of issues that are particularly compounded for mental health professionals (Lloyd, King, & Chenoweth, 2002). Maslach and Leiter (1997) have identified six organizational factors that can lead to burnout: work overload, insufficient reward, unfairness, lack of control, little sense of community, and value conflicts. Helping professionals perform a complex job filled with time constraints and client concerns that involve long and often intense hours of work (Lloyd et al., 2002; Maslach & Leiter, 1997). The professionals are strained with concern for lawsuits, minimal resources and support, and pressures of productivity (Edelwich & Brodsky, 1980; Maslach & Leiter, 1997). Clinicians are rewarded for the number of clients they see and paperwork they complete, instead of the quality of care they provide (Maslach & Leiter, 1997). Over time, a clinician may begin to feel powerless to protect against organizational issues, giving up impressions of choice and control (Edelwich & Brodsky, 1980).
negative experiences with the organization can progress into feelings of anger, distrust, and diminished respect (Maslach & Leiter, 1997). Even when the organization is aware of employee unhappiness or high turnover rates, mental health facilities often must comply with the restrictions set by managed care and other 3rd party payers which translates into large caseloads and weighty documentation (Lloyd et al., 2002; Maslach & Leiter, 1997).

Since the advent of managed care, productivity has continued to take center stage (Maslach & Leiter, 1997). Therapists have experienced diminished control, multiple restraints on their creativity, and limitations on how they can conduct treatment (Edelwich & Brodsky, 1980; Lloyd et al., 2002; Maslach & Leiter, 1997). The helping professional is faced with trying to balance necessary work demands versus occupational goals and desires. Counselors tend to feel more distressed when they believe that their caseload is unreasonably large (Walsh & Walsh, 2002). Despite an increase in workload and required investment into higher education, helping professionals are not seeing an increase in salary (Jenaro, Flores, & Arias, 2007). Most clinicians enter the field with the objective to help others, figuring that they will be able to at least make a living on their earned salary (Edelwich & Brodsky, 1980). However, resentments may grow as helping professionals compare their field to other professions and determine that they have much higher workloads and professional educational requirements for much less recognition (Edelwich & Brodsky, 1980; Jenaro et al., 2007). In order for a clinician to achieve any upward mobility, they will need to exit a position that involves all client contact and
move into administration within the organization (Edelwich & Brodsky, 1980; Jenaro et al., 2007; Maslach & Leiter, 1997).

**Interpersonal issues.** Deciding to no longer work with clients and move into a more administrative role may not be too difficult for clinicians, as clients also contribute to burnout (Jenaro et al., 2007; Pines & Aronson, 1988). Constantly being attentive to other people’s problems can be depleting, leading counselors to seek solace in work that doesn’t involve the same degree of self-sacrifice (Maslach & Leiter, 1997). The therapist-client relationship requires that the therapist remain selfless and acknowledge the one-way giving and receiving of the relationship (Pines & Aronson, 1988).

Remaining selfless often comes easily to helping professionals, as those who enter such fields tend to be overly dedicated and caring, with a desire to assist others (Figley, 1995). Helpers may be overly sensitive to those they serve, finding the clients’ issues to be emotionally draining (Pines & Aronson, 1988). Clinicians must also manage their feelings of loss through the process of building rapport with clients which is followed by a sense of great separation when the client ends services (Skovholt, Grier, & Hanson, 2001; Stebnicki, 2007). In other words, the therapist comes to know and care about a client and then must learn to disengage and let go of personal investment as the client begins to terminate, only to have to go through the process again with a new client (Skovholt et al., 2001; Stebnicki, 2007). This cycle of caring for and then releasing clients can weigh heavily on the therapist’s spirit (Skovholt et al., 2001).

Counselors are also faced with difficult client-related circumstances, such as confrontation by difficult and unfriendly clients, threats of violence, and fear that a client
will harm themselves or others (Jenaro et al., 2007). Maslach (1982) concluded that due to client stressors, more face-to-face direct hours with clientele lead to enhanced feelings of burnout. Besides direct hours, the amount of complex and taxing cases can also contribute to the progression of burnout (Maslach, 1986). Helping professionals witness a lot of unhappiness and human suffering. However, they are expected to present with high energy and personality despite being continually exposed to negative sides of people (Freudenberger & Richelson, 1980).

Aside from stress through encounters with clients, other interpersonal relationships can contribute to the helping professional’s potential burnout. Frequent conflicts arise when working with equally stressed-out coworkers and supervisors (Cherniss, 1980; Maslach & Goldberg, 1998). Many helping professionals experience unsupportive staff and lack of positive feedback from supervisors, which can lead to further personal distress and burnout (Maslach, 1986).

Several studies have illustrated how supervision can impact the development of burnout. Davis, Savicki, Cooley, and Firth (1989) surveyed 120 mental health and school counselor members of the Oregon Personnel Guidance Association to examine the relationship between counselor burnout and supervision experiences. Utilizing the Maslach Burnout Inventory (MBI) and the Counselor Supervision Inventory, it was determined that a counselor’s discontent with supervision was considerably linked to all three variables of burnout incorporated on the MBI, including emotional exhaustion, depersonalization, and personal accomplishment (Davis et al., 1989).
The MBI was also used to measure burnout in a study by Leiter and Maslach (1988) that examined the experiences of burnout and supervision in nurses and other support staff of a Californian hospital. Along with the MBI, participants were also asked to describe their relationships with various coworkers as pleasant, neutral, or unpleasant (Leiter & Maslach, 1988). This study concluded that a poor supervisory relationship, particularly viewing one’s supervision as unconstructive, increased self-reported burnout, significantly raising the emotional exhaustion piece of burnout (Leiter & Maslach, 1988).

**Intrapersonal issues.** Much like interpersonal relationships, intrapersonal dynamics may also contribute to burnout. A small number of studies have examined how mental health professionals’ personality traits may affect the development of burnout. In one such study, Capner and Caltabiano (1993) investigated both volunteer and professional counselors’ burnout levels in relation to Type A personality. This personality type was examined based on the hypothesis that those with Type A personality are more prone to burnout as they tend to be extremely ambitious and competitive, lack patience, and practice little social support seeking. Using the MBI to assess burnout and Baron’s (1985) shortened scale to determine Type A personality traits, it was shown that those self-reporting characteristics of Type A personality were more likely to encounter burnout (Capner & Caltabiano, 1993).

Similarly, Naisberg-Fennig, Fennig, Keinan, and Elizur (1991) utilized a self-report burnout inventory to study 49 psychiatrists employed in mental health hospitals located in Israel. Levels of burnout were compared to personality scales, including anxiety and repression-sensitization scales. Naisberg-Fennig et al. found that
high anxiety state scores were associated with higher burnout while resourcefulness was connected to lower levels of burnout. Mills and Huebner (1998) also examined personality qualities in relation to burnout. The researchers investigated the personality traits of school psychologists that specifically correlated with Maslach and Jackson’s (1984) three dimensions of burnout. It was found that extraversion was negatively correlated with feelings of emotional exhaustion and diminished personal accomplishment, whereas the personality characteristic of agreeableness had an inverse relationship with depersonalization (Mills & Huebner, 1998).

**Conclusions on burnout.** Burnout is a phenomenon used to describe the emotional, cognitive, affective, and behavioral changes that helping professionals experience due to occupational stressors (Freudenberger, 1974; Maslach, 1982). Burnout typically leads to feelings of negativity concerning oneself and occupation, which can result in apathy in all work-related areas (Maslach & Leiter, 1997). Such an outlook can be particularly devastating in the helping profession, as clinicians’ lack of caring can have adverse effects on clients (Kottler, 1993; Maslach & Jackson, 1984).

Burnout is particularly widespread in the helping professions because such occupations are considered “high touch” in that a substantial amount of time is spent exposed to people seeking assistance (Maslach & Leiter, 1997). Counselors and other helping professionals are also faced with high performance pressures, numerous demands on time, and little support (Edelwich & Brodsky, 1980). High stress work factors, along with a lack of appreciation and resources, accumulate over time in a process of stress, strain, and defensive coping mechanisms (Cherniss, 1980).
This phenomenon is popularly described as a syndrome throughout the literature, which includes emotional exhaustion, depersonalization, and reduced personal accomplishment (Maslach & Jackson, 1984). A small amount of literature has considered demographic and personality factors that may contribute to burnout. However, many authors expressed that there are multidimensional factors that appear to influence the counselor’s experience of burnout (Maslach & Goldberg, 1998). These variables include demanding and complex clients, low wages, difficulty managing work hours, little agency resources, and lack of acknowledgement and appreciation (Jenaro et al., 2007).

**Counselor Wellness and Self-Care**

In recent years there has been growing concern about burnout and compassion fatigue in the counseling profession. As Stebnicki (2007) pointed out, the American Counseling Association (ACA) initiated a task force in 2004 to establish educational perspectives and prevention tactics that address these rising concerns. The ACA Taskforce on Counselor Wellness and Impairment brings attention to these issues by providing practical information, valuable resources, and self-directed assessment tools to bring awareness of the potential risks for professional burnout and fatigue while promoting self-care and counselor wellness (Lawson & Venart, 2005).

Achieving personal and professional balance is a prominent theme throughout ACA’s campaign (Lawson & Venart, 2005). As mentioned in the review of burnout and compassion fatigue, helping professionals often experience an intense sense of imbalance due to issues that are common in the field. For example, high work demands and long
hours leave little time for external personal interests (Maslach & Goldberg, 1998). Having few pursuits beyond work contributes to the helping professional’s typical self-sacrificing behaviors without allowing for time to decompress and let go of built up stress (Lawson et al., 2007). The nature of the therapeutic process particularly lends itself to a one-sided relationship in which the counselor assumes a role of constantly giving to others without receiving the same interest, empathy, and concern in return (Kottler, 1993).

Many authors have encouraged a proactive approach to counselor wellness in an attempt to impede this inclination of counselors to overwork, lack personal nurturance, and be overall imbalanced (Lawson et al., 2007). This focus accentuates holistic self-care, in which the counselor can closely examine numerous parts of one’s life, consider areas that are being neglected, and formulate prospective adjustments (Myers & Sweeney, 2008). These themes of self-care and counselor wellness have become increasingly examined in the literature as a way to not only achieve greater balance, but to also prevent the debilitating phenomena of burnout and compassion fatigue (Bride et al., 2007; T. M. O’Halloran & Linton, 2000). A closer examination of self-care and wellness follows to clearly characterize these terms and identify relevant models.

**Self-care.** Self-care refers to activities in which one proactively engages for personal wellness, growth-promoting habits, and prevention (Myers & Sweeney, 2005). These pursuits are meant to assist the helping professional in relieving stress and achieving an overall sense of a more balanced lifestyle (Riordan & Saltzer, 1992; Yassen, 1995). Self-care strategies address various personal needs to achieve a sense of holism
and wellness, such as spirituality and creativity (Myers & Sweeney, 2005). Becvar (2003) referred to such activities as practicing “healthy selfishness” (p. 475), emphasizing the necessity for helping professionals to tend to self-care needs.

When a helping professional begins to consider adopting these self-care initiatives, it is important to consider which activities suite them best (Pearlman, 1999). For instance, some may find that reading helps one unwind while another may prefer a martial art. Preferences in personalized self-care plans often relate to one’s unique personal history, sex, personality, and needs of one’s developmental stage (Venart, Vassos, & Pitcher-Heft, 2007). Regardless of preferred self-care strategies, counselors are encouraged to think holistically by attempting to engage in interests that address many aspects of the self and that include both rest and play (Pearlman & Saakvitne, 1995). Given that the symptoms of both compassion fatigue and burnout negatively affect the entirety of one’s being, self-care practices should encompass physical, emotional, social, and spiritual aspects of the counselor (Becvar, 2003; T. M. O’Halloran & Linton, 2000; Stebnicki, 2007; Yassen, 1995). Several wellness models have been developed to address the numerous parts of self-identity that form the framework for one’s entire personal wellness.

Models of counselor wellness and self-care. As a profession, counseling is based on the concepts of personal development, prevention, and wellness. These values have formed the foundation for the development of wellness models. The Wheel of Wellness Model was the first model of wellness created from the principles of the counseling profession (Myers & Sweeney, 2005). The Wheel of Wellness Model
eventually progressed into the Indivisible Self Wellness Model, an empirically validated model that includes influences from other fields (Myers & Sweeney, 2005). The following illustrates each of these models and more in-depth look at the most current model is examined.

**The wheel of wellness model.** Myers and Sweeney (2005) described and made various observations concerning this initial model of wellness. First, the Wheel of Wellness Model (see Figure 2) was created by Sweeney and Witmer in 1991 as a way to address each of the distinct elements which come together to affect one’s capacity for wellness. Maintaining an Adlerian perspective, the model depicts spirituality and the self as central to achieving wellness. The internal and external forces extend out from the core, influencing one’s ability to gain and maintain wellness. Last, wellness is illustrated as a circle to metaphorically represent the inability to roll smoothly if one piece of the wheel is inadequate or missing (Myers & Sweeney, 2005).

**The indivisible self wellness model.** The Wheel of Wellness Model has since evolved into the Indivisible Self Wellness Model, a strength-based model of wellness (see Figure 3). This model is still based in Adlerian Individual Psychology and now additionally includes validation of research that spans across numerous disciplines (Myers & Sweeney, 2005). This evidence based model is holistic, growth-oriented, and considers the many parts that make up wellness across the lifespan (Myers & Sweeney, 2005, 2008). Given that this model is both comprehensive and empirically validated, it is not surprising that the ACA task force for counselor wellness and impairment has utilized it for prevention and awareness (Lawson & Venart, 2005).
Figure 2. The Wheel of Wellness Model

The Indivisible Self Wellness Model demonstrates a thorough depiction of wellness, with the self at a higher order of wellness at the center surrounded by five second-order factors. These five factors consist of the physical self, creative self, social self, essential self, and coping self. These factors are composed of 17 separate dimensions of wellness (Myers & Sweeney, 2005, 2008). The model also consists of four contexts or systems which can influence one’s ability to achieve wellness. These
systems include local, institutional, global, and chronometrical contexts (Myers & Sweeney, 2005). To further understand counselor wellness and self-care, each of the five second-order factors in relation to the four contexts are examined.

*Physical self.* The physical self includes those activities that involve the body and includes the components of exercise and nutrition (Myers & Sweeney, 2005). The physical self can be threatened by various issues characteristic of the work of helping professionals. For instance, the sedentary nature of counseling poses unique issues to the
body, such as backaches, neck pain, and stiffness (Venart et al., 2007). Due to the stress of the job, many helping professionals find themselves drained after work and unable to engage in active pursuits, preferring to take a passive role, such as watching television, that may further diminish one’s physical health (Venart et al., 2007). As mentioned, both burnout and compassion fatigue can be experienced through somatic issues. These physical experiences may include muscle pain and tension, headaches, sleep issues, and nervousness (Farber, 1990; Figley, 1995; Maslach & Leiter, 1997; Paine, 1984; Pines et al., 1981; Valent, 2002).

A qualitative analysis conducted by Killian (2008) demonstrated this somatic impact that counselors may encounter. This study found that the majority of the 20 clinicians interviewed reported that feelings of stress could be sensed throughout the body in such capacity as pain and tension. Additionally, most clinicians in this study self-reported that work demands negatively impacted sleep. Stress that is stored in the body may be alleviated by physical exercise. For example, a survey of trauma workers revealed that about half of these workers utilized exercise and some other outside hobby as a way to manage feelings of fatigue associated with their work (Tehrani, 2007).

Besides exercise, activities for the physical self also encompass relaxation, sleep hygiene, movement, and nutrition. For example, relaxation practices such as massage or yoga can be helpful stress relievers for clinicians (Venart et al., 2007). One’s physical surroundings are also included in this factor and include visual and olfactory stimuli, which can also be enhanced to relieve stress. It has also been suggested that helping professionals take care in how they decorate their office and consider aromatherapy
options for a more relaxing experience (Venart et al., 2007). By attending to the various aspects of the physical self, counselors can alleviate some stress and achieve more balance.

*Creative self.* Each aspect of the creative self influences the others and can ultimately decrease stress for the helping professional; thinking, emotions, control, work, and positive humor are all considered part of the creative self and can affect each other in various ways (Myers & Sweeney, 2005). For instance, the way in which one is feeling on an emotional level can affect one’s work in that having a more optimistic mood can make one think about work more favorably. The converse can also be true, in that having a positive work life can engender a sentiment of satisfaction throughout one’s entire life (Myers & Sweeney, 2005).

Another example of how the factors of the creative self influence each other can be understood when considering control and work. Having a sense of control over work responsibilities can change one’s emotion. For instance, counselors often lack control over their work tasks, such as how they can diversify their time and amount of paperwork (Young & Lambie, 2007). Given that both burnout and compassion fatigue often arise out of feelings of hopelessness and powerlessness, regaining feelings of control can greatly lessen the occurrence of impairment (Maslach & Goldberg, 1998). A study conducted by Ackerley et al. (1988) confirmed this concern, finding that clinicians who self-reported experiencing the most burnout typically felt that they were afforded little power at work.
Humor is another example of the creative self that can be developed to improve a sense of personal power and overall wellness (Myers & Sweeney, 2005). Humor has been found to enhance critical thinking, increase one’s sense of general satisfaction, and boost one’s immune system (Myers & Sweeney, 2005, 2008). Humor can be especially helpful for counselors by aiding in work-related optimism, satisfaction, and stress management (Gladding, 2005, 2007). Additionally, humor has been found to help alleviate feelings of exhaustion while enhancing mood (Gladding, 1995). For example, keeping a sense of humor about work can help deter potential tension caused by coworkers or difficult clients. Humor can also increase flexibility by helping counselors think more creatively in how to deal with both personal and professional issues (Gladding, 2005, 2007).

Increased creativity is believed to be a way to avoid feeling uninspired and bored (Gladding, 2005). Creativity assists counselors in generating more functional solutions, developing healthier ways of relating with others, and improving motivation (Gladding, 1995, 2005). Utilizing creativity helps counselors manage work demands, develop new solutions to work issues, and maintain a productive level of energy (Gladding, 1995, 2005). By developing the creative self, helping professionals better their lives and deter stress through enhanced curiosity, problem-solving skills, and self-expression (Myers & Sweeney, 2005, 2008).

Social self. The social self incorporates the factors of friendship and love (Myers & Sweeney, 2005). This part of the wellness model addresses the part of the self that yearns for support from others and is fulfilled by mutual give-and-take relationships.
(Myers & Sweeney, 2005, 2008). Emphasis on the need for social support to protect against impairment has been echoed throughout the literature (Becvar, 2003; Figley, 1995, 2002b; Lawson, 2007; Pearlman & Saakvitne, 1995). As high work demands with little social support have become customary for helping professionals, the social self is considered especially salient to counselor wellness (Melamed et al., 2001; Radey & Figley, 2007). For instance, counselors are skilled at providing social services to clientele. However, between long hours face-to-face with clients and solitary time completing paperwork, counselors rarely have the time and resources to receive their own personal support from others (Skovholt, 2001).

In addition to this one-way relationship of assistance to clients, counselors are also mandated to keep client information confidential (ACA, 2005). This can lead to feelings of isolation, as the counselor is unable to discuss thoughts and concerns regarding cases with others (Becvar, 2003; Catheral, 1999; Maslach, 1982). Instead, the counselor will physically leave work, only to bring thoughts and empathetic concerns about clients’ problems home. Knowing that it would be unethical to discuss cases with friends and family, counselors are forced to internalize their worries (Becvar, 2003). Additionally, many helping professionals shy away from openly discussing such concerns with peers and supervisors out of fear of being viewed as incompetent and unprofessional (Maslach, 1993). Counselors may feel alone in this struggle and further withdraw from others (Pearlman, 1999).

Research has confirmed that peer support can help with this battle of isolation. In one study examining this sense of seclusion, Melamed et al. (2001) demonstrated that
loneliness was inversely correlated with job satisfaction for mental health professionals at outpatient clinics. Melamed et al. (2001) distributed questionnaires on loneliness, burnout, and job satisfaction, to which a total of 31 therapists responded. Results through a Pearson correlation analysis indicated that lack of loneliness was significantly connected to feelings of job satisfaction and the number of staff meetings (Melamed et al., 2001).

Similarly, Coster and Schwebel (1997) found that the majority of the interviewed psychologists participating in their study ranked peer support as their number one contributor to job performance and personal wellness. Six psychologists were selected for this study based on criteria established by faculty members in a graduate school psychology program. The participating faculty members were required to be licensed as a psychologist, participating in the field for a minimum of 10 years, and considered to be well-functioning by their peers. Interviews of these six selected psychologists revealed that all but one considered peer support to be the most important factor contributing towards their personal wellness and superior job performance (Coster & Schwebel, 1997).

Research has also demonstrated that peer support can decrease experiences of burnout. In an examination of surveyed social workers, it was discovered that the social support of coworkers provided a significant barrier to the effects of burnout (Koeske & Koeske, 1989). Likewise, Ross, Altmaier, and Russell’s (1989) survey of doctoral students working at a college counseling center found that receiving support from supervisors and coworkers was connected to fewer experiences of burnout. A total of
169 doctoral students completed questionnaires based on job-related stress, social support, and burnout. The data were analyzed using multiple regressions and indicated that minimal supervisor support was associated with increased levels of burnout. However, social support from supervisors and peers was significantly related to lower reported levels of burnout (Ross et al., 1989).

In order to endorse social support for helping professionals, organizations are encouraged to institute peer support groups (Melamed et al., 2001; Pearlman, 1999). These groups are best utilized as a means to counterbalance one’s professional role through discussions with coworkers that acknowledge the stress and emotions of the job (Pearlman, 1999). Peer groups also serve as a way to assist helping professionals to increase social awareness and improve the social self, normalize experiences and concerns, brainstorm ideas for difficult client cases, and learn new self-care strategies to use on a regular basis (Clemans, 2004; Pearlman & Saakvitne, 1995; Raingruber & Kent, 2003).

Recognizing the effectiveness of such peer support, several state counseling associations currently offer counseling services to fellow counselors who are experiencing fatigue or burnout (Stebnicki, 2008). Several authors have also considered outside sources that may offer peer support. Notably, Baker (2003) suggested that therapists have listservs or other on-line resources available as a way to increase social support. Such extended communication can provide an outlet for counselors to share valuable information and resources, including ideas for self-care plans and impairment prevention (Baker, 2003). Similarly, Stamm (1999a) discussed the possibility of virtual
connection to community, in which clinicians around the world can associate with each other online as a way to eliminate isolation, manage work stress, and defend against impairment through on-line peer support groups.

Regardless if peers unite online or in-person, there is a strong need for clinicians to find social support as part of self-care (Stamm, 1999a). Such connection is especially desirable for those newest to the field to help cope with emotional strains and possible feelings of disappointment (Maslach, 1982; Steed & Bicknell, 2001). Supervisors and those more experienced in the field can provide necessary help to more novice counselors, while enhancing their own community (Steed & Bicknell, 2001). To gain a wider perspective, support can also be extended to include others in different fields, such as social workers and psychiatrists (Stamm, 1999a). Finding such support will be beneficial in advancing the social self by fostering feelings of belonging, identity, and encouragement (Myers & Sweeney, 2005).

Essential self. The essential self contains the aspects of spirituality, self-care, sex identity, and cultural identity (Myers & Sweeney, 2005). This piece of overall wellness supplies one with purpose, meaning, hope, confidence in self-identity, and interest in personal wellbeing (Myers & Sweeney, 2005, 2008). A strong essential self is crucial for helping professionals to remain objective, balanced, and motivated (Venart et al., 2007). If this piece of wellness is weakened for the counselor, issues such as helplessness, vulnerability, and dependency may transpire (Pearlman & Saakvitne, 1995).

The essential self tends to erode quickly if the helping professional becomes afflicted with burnout and/or compassion fatigue. Before the onset of such issues, the
counselor typically neglects self-care needs, loses touch with both personal and professional identities, and experiences a weakened sense of personal meaning (Pearlman & Saakvitne, 1996). A loss of hope sets in as counselors fail to find meaning in their career, a sure sign of burnout and/or compassion fatigue (Figley, 1995; Kottler, 1993; Pines & Aronson, 1988; Stebnicki, 2008). This erosion of meaning is typically exhibited in relation to others, such as shifting personal beliefs and becoming judgmental towards clients or disapproving of coworkers (Cherniss, 1980; Kottler, 1993; Myers & Sweeney, 2005; Pines & Aronson, 1989). However, the essential self can be nurtured and developed long before impairment ensues.

One way to enhance the essential self would be to spend time cultivating one’s spirituality. Cashwell, Bentley, and Bigbee (2007) reported that spirituality can have a profound effect on counselor wellness, explaining that it helps to replenish the stressed-out counselor and advances the typically depleted traits of attentiveness, acceptance, compassion, and meaning. A qualitative analysis of psychotherapists conducted by Dlugos and Friedlander (2001) demonstrated that spirituality can contribute to career satisfaction. The participants in this study were selected due to being perceived by their peers as possessing a strong devotion to and satisfaction with their clinical work. When asked what factors contributed to their career motivation and fulfillment, the majority interviewed cited that solid spirituality was the most significant factor of inspiration and contentment (Dlugos & Friedlander, 2001).

Aside from spirituality, the self-identity aspects of the essential self can contribute to counselor wellness. For instance, professional identity in particular has been a struggle
for many counselors (Young & Lambie, 2007). The term counselor can conjure up many different descriptions, such as guidance counselor, mental health counselor, camp counselor, or school counselor. This can be frustrating to counselors in the field who find it challenging to explain what their position is in the helping community. It can also be confusing for those counselors who themselves have become unclear about their professional functions and responsibilities (Young & Lambie, 2007). In order to thrive as a counselor, clear role identity and satisfaction is necessary (Young & Lambie, 2007). Achieving a greater sense of professional identity, along with adequate focus on self-care and spirituality can significantly improve the essential self and protect against impairment (Myers & Sweeney, 2005, 2008).

*Coping self.* The coping self involves factors of leisure, stress management, self-worth, and realistic beliefs (Myers & Sweeney, 2005). This piece of the self is accountable for managing the ways in which one overcomes difficult situations and how one responds to various life circumstances (Myers & Sweeney, 2005, 2008). The coping self is developed through one’s ability to have enjoyable free time, cope with and relieve tension, value the self, and have reasonable expectations (Myers & Sweeney, 2008).

Out of all of these aspects of the coping self, leisure and stress management were most often discussed in the literature. Notably, Maslach (1982) recommended that helping professionals decompress and unwind from professional stress by taking short breaks throughout the work day, making time for non-professional activities, and breaking away from work all together through time-off or vacationing. Kottler (1993) agreed with this idea, suggesting that therapists create work breaks throughout the day
instead of continually seeing clients back-to-back. Kottler similarly suggested the
development of personal leisure pursuits, emphasizing that the helping professional seek
out hobbies that renew aspects of the body and mind that often go unused during a typical
work day.

Self-worth can improve by working towards developing a healthier belief system.
Specifically, augmenting one’s realistic beliefs can enhance the coping self and have a
positive impact on helping professionals (Young & Lambie, 2007). For counselors,
having realistic beliefs about one’s career involves being practical about the rate at which
to expect client change, being realistic about one’s responsibility for client growth, and
preserving a reasonable work load (Young & Lambie, 2007). Establishing such realistic
beliefs is especially crucial for novice helping professionals who are often hindered by
their own idealistic views of the field (Savicki & Cooley, 1982). Counselors of any level
of experience are encouraged to frequently self-assess for realistic beliefs with the
intention of boosting the coping self to manage stress at work and throughout life (Myers

**Contexts.** Aside from the five second-order factors, the indivisible self model also
includes contextual variables which encompass all of the influential systems to which one
belongs. These four contexts include local, institutional, global, and chronometrical
systems (Myers & Sweeney, 2005, 2008). First, local contexts are comprised of safety
and the systems of family, neighborhood, and community. Second, institutional contexts
focus on policy and laws concerning education, religion, government, or business and
industry. Third, global contexts concentrate on world events and include politics, culture,
global events, environment, media, and community. Last, chronometrical contexts center on the perpetual, positive, and purposeful aspects across the lifespan.

Each one of these contexts can be altered to enhance self-care for the helping professional (Myers & Sweeney, 2005). For example, contextual modifications can occur in agencies, schools, or other clinical settings, that have the potential to bolster job satisfaction self-care activities for counselors (Young & Lambie, 2007). The literature on counselor wellness and contexts has focused on the need for improvements to occur on a local level, specifically with the organizations that employ counselors (Myers & Sweeney, 2005, 2008). These possible organizational transformations are outlined below and incorporate flexibility, training and educational opportunities, and peer support for counselor wellness.

Organizational changes for counselor wellness. Professional and personal obligations pose time constraints that can make it difficult to attend to individual self-care needs. This is especially true for helping professionals who are faced with increased expectations for productivity of direct client contact hours (Maslach & Leiter, 1997). Such high demands create extended work-related time commitments for tasks such as completing paperwork, following up on phone calls, and after hour crisis care coverage (Young & Lambie, 2007). Finding time for personal self-care can then become another burden for the already tapped out counselor, who may even blame themselves for not being able to achieve a more balanced life on their own (Killian, 2008). It is often overlooked that self-care can be fostered in the work environment through organizational
adjustments to provide wellness-related assistance to employees (Norcross & Guy, 2007; Young & Lambie, 2007).

The possibility of implementing self-care strategies into the work day may at first appear to be counterproductive to organizations (Young & Lambie, 2007). After all, it has been suggested that to improve wellness, clinicians should have smaller case loads, extended time off, and time away for trainings, all of which would seem to take away from productivity (Kottler, 1993; Maslach, 1982; Maslach & Leiter, 1997; Pearlman & Saakvitne, 1995). On the contrary, promoting self-care in the workplace can help employees become more efficient at and satisfied with their jobs (T. M. O’Halloran & Linton, 2000). As high turnover due to discontentment has become the norm at many agencies, organizations are continually conducting new hiring and training that contributes to a loss in productivity and efficiency (Figley, 2002a).

If organizations do not make changes, it will not only injure their efficiency, but will also have the potential to compromise client care (Figley, 1995). As Lawson (2007) pointed out, when a helping professional is not well, then he or she is not able to offer quality and effective services to those seeking help. There is also potential for organizations to face ethical charges if client care and employee wellness are not addressed. The ACA Code of Ethics (2005) directed counselors to take necessary steps if organizational policies are causing detrimental client care, such as overloading clinicians’ caseloads and providing insufficient training (Sommer, 2008). Such ethical violations can be prevented if organizations take steps to assist in employee wellness.
**Flexibility.** One way in which organizations can prevent clinician impairment and maintain productivity is to allow for some flexibility in clinicians’ schedules (Pines & Aronson, 1988). This variability can allow the clinician a sense of control over time and resources (Inbar & Ganor, 2003). Cooper (1982) advised that control over one’s schedule is a vital way to prevent burnout. It is important that helping professionals are given more manageable workloads, frequent breaks away from phone calls and paperwork, and time off or vacation (Eastwood & Ecklund, 2008; Maslach, 1982, 1986; Van Hook & Rothenberg, 2009). As seen in the Indivisible Self Model, such flexibility and leisure time assists in coping with work demands and managing stress (Myers & Sweeney, 2005).

Flexibility can also materialize through variability. Particularly, it is has been recommended that organizations reduce staff-client ratios, and limit stressful and trauma cases to a more balanced caseload (Killian, 2008; Pearlman 1999; Pines & Aronson, 1988; Stebnicki, 2000). Organizations can limit client contact by diversifying employee tasks, allowing for a variety of responsibilities that is not solely focused on face-to-face time with clients (Maslach, 1982; Norcross & Guy, 2007). Pearlman and Saakvitne (1995) suggested that clinicians should be afforded the ability to set limits with clients, such as only being available at specified times and setting up boundaries with phone contact.

**Training and education.** Flexibility at work can also consist of time allocated for training and education to broaden the work day of clinicians while providing skill-building opportunities (Pines & Aronson, 1988). Clinicians can learn about a
variety of topics that can assist in their job tasks and client care, such as proper
documentation, diagnosis, and treatment planning. Offering in-service trainings is
beneficial to the organization, clinicians, and those they serve, as it is often convenient
for clinicians, cost-effective for employers, and can add to clinical competency (Young &
Lambie, 2007).

Educational opportunities can also prevent counselor impairment and enhance
compassion satisfaction (Stebnicki, 2000). By providing in-service trainings and outside
workshops, an organization can help revive interest and passion in clinical work (Bride et
al., 2007; Inbar & Ganor, 2003). Stebnicki (2000) noted that sometimes time away
learning new techniques and information can enhance the clinician’s sense of enthusiasm
and meaning in the profession, which are depleted in cases of burnout and compassion
fatigue. These offered trainings can also be wellness-based and educate clinicians on the
hazards of the helping profession, and the signs and symptoms of burnout and
compassion fatigue, along with proactive strategies towards prevention (Craig & Sprang,
2010; Riordan & Saltzer, 1992; Stebnicki, 2008; Watson & Gauthier, 2003; Young &
Lambie, 2007).

Peer support. Aside from the aforementioned benefits, trainings can also serve
the purpose of promoting social support within the field (Norcross & Guy, 2007;
Pearlman, 1999; Skovholt, 2001). As mentioned previously, being a helping professional
can be surprisingly solitary, with little connection to peers due to the limited amount of
time between clients, phone calls, and documentation (Norcross & Guy, 2007). Peer
support within organizations can alleviate this loneliness, normalize counselor
experiences, aid in case conceptualization, and promote wellness (Pearlman, 1999; Skovholt, 2001; Spicuzza & De Voe, 1982)

For an organization to begin facilitating this level of support, it is recommended that recurring staff meetings are scheduled (Catheral, 1999; Maslach, 1982; Norcross & Guy, 2007; Pines & Aronson, 1988). In support of the need for ongoing staff meetings, Melamed et al. (2001) found that more frequent staff meetings were inversely related to accounts of self-reported loneliness. They surveyed 31 therapists about satisfaction with their jobs, experiences of loneliness, and levels of burnout. Pearson correlation analysis results determined that staff meetings were significantly associated with less loneliness (Melamed et al., 2001).

As a way to build this type of continual support at work, Spicuzza and De Voe (1982) recommended that organizations create “mutual aid groups” that would consist of meetings for counselors to assist each other in skill development and alleviation of stress. Similarly, Yassen (1995) proposed the development of peer support groups within organizations as a way to share resources, ideas, and techniques. Such groups of peers would aid in self-care by providing clinicians with a social outlet in which it is safe to explore set-backs and share in accomplishments (Yassen, 1995).

Even though peer support can be advantageous in advancing counselor self-care and wellness, there can be some problems associated with such groups. Catheral (1999) warned that such support groups can become counterproductive if it turns into a meeting full of complaining and negativity in which counselors leave feeling more agitated and drained than before. To decrease such risk for further burnout, Catheral suggested that
such peer meetings center on providing support, focusing on client strengths, and generating fresh perspectives for clinical practice. These meetings would then be a beneficial way for counselors to discuss cases in order to gain a richer perspective, while feeling safe to express personal concerns (Catheral, 1999).

**Implications for counselors-in-training.** Consistent peer support has the potential to diminish quickly, as does supervisory guidance and professor instruction, once the student becomes an employed counselor in the field (Norcross & Guy, 2007). Lack of support and experience can generate stress for any professional new to their field. However, the helping profession is unique in that the inexperienced are more vulnerable to developing burnout or compassion fatigue (Cranswick, 1997; Creamer & Liddle, 2005; Gillespie & Numerof, 1991; Sprang et al., 2007; Vredenburgh et al., 1999).

Maslach (1982) surmised that such risk is significant because beginner helping professionals are unprepared for the emotional strain of such work and unaware of potential stressors common to the field. M. S. Corey and Corey (2007) concurred that novice counselors often become frustrated with new job-demands, disappointed due to the job not living up to personal expectations, disgruntled by organizational issues, and stressed due to the demands apparent to the field. Helping professionals new to the field are often too overly self-focused and will commonly measure professional success only in the realm of client change (Skovholt, 2001). Common work-related issues may be surprising to the novice counselor who was not expecting to feel overworked and underappreciated (Kottler, 1993). However, education and supervision can better prepare
counselors-in-training for what to expect and how to prevent burnout and compassion fatigue once out in the field.

**Education.** Figley (2002b) expressed that education is a fundamental way to prevent compassion fatigue and Maslach (1982) held academic programs accountable for leaving out discussion of possible burnout issues. Much of the literature advocates for self-care practices to be learned early on while in training to be a helping professional (Baker, 2003; Coster & Schwebel, 1997; Cunningham, 2004; Savicki & Cooley, 1982; Yager & Tovar-Blank, 2007). Despite this suggestion to learn prevention, clinicians have reported that self-care strategies are seldom discussed in either graduate school or continuing education programs (Killian, 2008). In a study of students attending graduate psychology programs, over 80% reported that the program did not provide self-care practices in writing (Munsey, 2006).

Putting self-care intentions in writing can have a positive effect on actualizing such efforts (Baker, 2003). Yager and Tovar-Blank (2007) recommended that counselor education programs require graduate students to sign an informed consent outlining the need for students to maintain an openness and commitment to their personal growth and exploration. Likewise, Radey and Figley (2007) suggested that instructors develop contracts with students that outline the self-care strategies they plan on implementing during internship. M. S. O’Halloran and O’Halloran (2001) advocated for information on self-care to be included in all courses, with proof of such advocacy written in the syllabus.
Stebnicki (2008) argued that graduate programs are performing a disservice if they ignore the need for wellness and focus only on counselor skills, theory, and training. Maslach (1982) assumed that training programs fail to mention self-care and open communication about the stress of the profession out of concern for student retention. Such apprehension may be based on the worry that if students knew the potential pitfalls of becoming a helping professional, they may decide that it is not the right career choice and drop out of the graduate program (Maslach, 1982). To the contrary, Maslach believed it is better to make a decision to discontinue with education than decide to leave the profession after putting time and energy into training for it.

Norcross and Guy (2007) concurred with this idea, emphasizing the importance of educators informing students of the potential strain of the profession and ways to overcome some of the difficulties. Students should be reminded that becoming a counselor is a process that will be met with many rewards and obstacles (Yager & Tovar-Blank, 2007). Discussing self-care and prevention may become standard in graduate school, as the Council for Accreditation of Counseling and Related Educational Programs (CACREP) has addressed its necessity (CACREP, 2009). In the Professional Identity section of the CACREP standards, Standard II.G.1.d., lists “self-care strategies appropriate to the counselor role” (p. 10) to be included in the “core curriculum” (p. 10). Instead of remaining silent about this issue, counselor educators should create a safe environment to discuss impairment issues, monitor students for potential development of them, and assist students in need of help in this area (Myers & Sweeney, 2005).
To further support students’ understanding of self-care and the possible pitfalls of the profession, graduate counseling programs should develop a course that solely focuses on self-care and prevention (Stebnicki, 2008; Witmer & Granello, 2005). Such education has the potential to benefit graduate students with self-care plans and impairment prevention, with the added benefit of interpersonal support and recreation (Stebnicki, 2008). By making such a course a requirement, it can potentially counteract the common complaint that many students report of simply not having the time between jobs, classes, and home to learn about self-care practices (Yager & Tovar-Blank, 2007). Through a survey of master’s level counseling students, Riley (2005) found that those students who were assigned a wellness course self-reported higher levels of wellness than those who did not participate in such a course.

Given that there are many course requirements that fill students’ schedules, it may seem daunting for graduate programs to add an additional course focused on self-care (Newsome, Christopher, Dahlen, & Christopher, 2006). However, information on self-care, wellness, and impairment can be added as a part of current offerings to supplement this need (Sommer, 2008; Yager & Tovar-Blank, 2007). For example, these topics can be added to course reading assignments or students can be required to conduct class presentations on wellness issues in relevant courses such as practicum and internship (Sommer, 2008; Yager & Tovar-Blank, 2007). Self-care concepts and impairment issues can also be included as topics in student counseling groups, such as the Chi Sigma Iota campus chapter (Yager & Tovar-Blank, 2007).
Besides promoting self-care in writing and courses, Maslach (1982) encouraged faculty to demonstrate self-care behaviors in their own lives. Students may perceive an increased value in self-care when faculty members model such behaviors (Yager & Tovar-Blank, 2007). Even though faculty advise for self-care, they may not be participating in it themselves (Bober & Regehr, 2006). If wellness is not practiced or is completely overlooked by faculty, students may get the impression that self-care is insignificant (Yager & Tovar-Blank, 2007).

**Supervision.** Aside from teaching self-care in graduate school courses, supervision can be another way that graduate counseling programs educate students about counselor wellness and prevent counselor impairment (Stebnicki, 2007). Practicum, internship, and postgraduate supervision are prime times to teach self-care skills among information on counseling techniques and theory (Salston & Figley, 2003; Stebnicki, 2007). As Smith (2007) explained, supervisors can assist trainees in developing healthy self-care habits early on so that students will have a greater understanding of wellness as they advance in their careers.

There are numerous ways in which supervisors can introduce the significance of wellness to trainees. One way would be to review the code of ethics with the trainee, focusing on wellness concepts (Young & Lambie, 2007). For example, the ACA Code of Ethics (2005) points to the requirement that all counselors maintain personal awareness of possible impairment and engage in self-care practices to achieve balance and meet work demands. Similarly, the American School Counselor Association (ASCA)
mandated that school counselors continually assess for personal impairment that can ultimately affect client care (ASCA, 2004).

Another way to address wellness and impairment issues would be to provide sufficient training in treating traumatized clientele (Pearlman, 1999). Such supervisory training should include preparation on how to handle one’s emotional context while protecting client welfare (Pearlman, 1999). Supervisors must also address any signs of impairment and observe wellness during training, using such instances as educational opportunities (Pearlman, 1999; Witmer & Granello, 2005). However, in order to bring self-awareness to trainee wellness, supervisors need to be willing to discuss self-care and impairment issues with trainees and be willing to address these issues in themselves (Yager & Tovar-Blank, 2007).

Supervisors should provide an environment that allows the trainee to disclose feelings and comfortably assess for personal self-care habits (Cummins, Massey, & Jones, 2007). Utilizing self-care contracts and assessment instruments can help normalize the trainees’ experience with counseling related stress (Myers & Sweeney, 2005; Simon et al., 2005). By sending the message that it is safe to discuss and explore wellness issues, trainees will be equipped to consider the topics of self-care and wellness throughout their careers (Cummins et al., 2007).

**Research on self-care, burnout, compassion fatigue, and compassion satisfaction.** Even though the literature emphasizes the need for counselor wellness and self-care for both counselors-in-training and professional counselors, little research has been conducted to examine self-care practices of counselors and trainees in relation to
burnout, compassion fatigue, and compassion satisfaction. However, studies of other helping professionals have shown evidence of self-care protecting against these issues.

One such study, exploring residential treatment childcare workers, found that consistent application of self-care practices protected against burnout and compassion fatigue (Eastwood & Ecklund, 2008). Compassion fatigue, burnout, and compassion satisfaction were measured using the Professional Quality of Life Survey (ProQOL-RIII) and self-care was measured utilizing the Self-Care Practices Questionnaire. Results from 57 residential childcare workers indicated that self-care strategies, including social support and personal hobbies, were correlated with lower levels of both burnout and compassion fatigue.

Similarly, an investigation of hospice care professionals also employed the ProQOL-RIII to determine levels of compassion fatigue, burnout, and compassion satisfaction (Alkema et al., 2008). Self-care strategies were revealed using the Self-Care Assessment Worksheet (SCAW). Survey results found that a commitment to self-care activities was related to lower levels of compassion fatigue and burnout, along with elevated amounts of compassion satisfaction or fulfillment with one’s occupation (Alkema et al., 2008).

Likewise, Kraus (2005) concluded that clinicians’ self-reported compassion satisfaction was elevated through higher reports of self-care practices. This was determined through a survey of 90 mental health professionals working with adolescent sex offenders. The Compassion Satisfaction and Fatigue test was utilized to measure compassion fatigue, burnout, and compassion satisfaction. Self-care practices were
measured by asking participants to rate how helpful they had found various self-care activities to be over the past six months. The results did not show a significant connection between self-care practices and compassion fatigue or burnout. However, self-care was found to be associated with higher levels of compassion satisfaction (Kraus, 2005).

In a qualitative study of counselors and psychologists, self-care practices were similarly found to enhance the quality of life by lowering perceived stress and enhancing personal sense of balance (Grafanaki et al., 2005). In this study, a total of 10 clinicians participated in semi-structured interviews. The clinicians’ responses to interview questions were captured in narratives. These interviews resulted in a collection of narratives that revealed how leisure activities enhanced coping, contributed to stress management, and created a sense of balance for counselors and psychologists (Grafanaki et al., 2005).

**Conclusions on counselor wellness and self-care.** Self-care is characterized by a proactive approach to prevention and improvement of personal wellness (Myers & Sweeney, 2005). Self-care practices should address cognitive, emotional, behavioral, spiritual, interpersonal, and physical aspects of the self (Yassen, 1995). Such a holistic approach is more likely to efficiently help clinicians manage feelings of fatigue and burnout (Stebnicki, 2007). To further assist in decreasing the prevalence of impairment, a systemic approach to wellness should also include support from peer groups, organizations, and graduate school programs (Norcross & Guy, 2007).
Due to the potential risk of counselor impairment, it has become an ethical obligation to develop prevention strategies in order to protect both helping professionals and the clientele they serve (Stebnicki, 2007). According to the ACA’s Taskforce on Counselor Wellness and Impairment, compassion fatigue brings about impairment in counselors which in turn is a threat to the safety of clients (Lawson & Venart, 2005). By practicing self-care, the clinician is modeling growth-oriented practices to clients (Myers & Sweeney, 2008).

Taking care of oneself also sends the message that the counselor is participating in life skills that are recommended to clients (Kottler, 1993). As Skovholt (2001) argued, it is hypocritical to expect others to follow suggestions if one is unable to do it oneself. This can be especially true for faculty members in graduate school programs, who may value self-care, but are not outwardly engaged in such strategies (Bober & Regehr, 2006). Learning self-care skills early on in one’s career as a counselor enhances the helping professional’s potential for further growth throughout one’s career and possibly transforms them into a better clinician (Stebnicki, 2008). More experienced counselors can utilize self-care to maintain job satisfaction, improve motivation, and strengthen personal balance (Radey & Figley, 2007).

**Summary of Chapter I**

Compassion fatigue and burnout can lead to issues that affect the counselor on a physical, cognitive, spiritual, and behavioral level (Bush, 2009; Figley, 1995, 2002a; Maslach, 1982). Severe symptoms can be a result of developing compassion fatigue or burnout, such as somatic complaints and irritability (Figley, 1995; Maslach & Jackson,
1984). Numerous authors have advocated for self-care activities as the way to prevent these issues and enhance counselor wellness. Self-care strategies may also have the potential of improving compassion satisfaction, or sense of fulfillment one derives out of the rewards of being a helping professional (Radey & Figley, 2007; Stamm, 1999b).

Without the development of self-care techniques to ameliorate the symptoms of compassion fatigue, the helping profession runs the risk of losing valuable and empathetic clinicians (Figley, 1995; Raquepaw & Miller, 1989). However, little research has been conducted which examines the influence of self-care practices on helping professionals’ wellness, particularly how self-care effects experience of compassion fatigue, burnout, and compassion satisfaction (Radey & Figley, 2007). This study seeks to examine the relationship between self-care activities and compassion fatigue, burnout, and compassion satisfaction for professional counselors and counselors-in-training.
CHAPTER II

METHODOLOGY

The purpose of this study is to determine the possible relationships between self-care practices and compassion fatigue, burnout, and compassion satisfaction for professional counselors and counselors-in-training. Additionally, this study is intended to uncover potential relationships between self-reported data on self-care practices and compassion fatigue, burnout, and compassion satisfaction and demographic information, including sex, age, years of experience, education level, and work setting.

In determining this information, the following research questions were addressed:

1. Is there a relationship between compassion fatigue, burnout, compassion satisfaction, self-care, and recent life changes among professional counselors and counselors-in-training?

2. Does years of experience, age, sex, race, level of education, and/or work/internship setting relate to counselors’ and counselors’-in-training self-reports of compassion fatigue?

3. Does years of experience, age, sex, race, level of education, and/or work/internship setting relate to counselors’ and counselors’-in-training self-reports of burnout?

4. Does years of experience, age, sex, race, level of education, and/or work/internship setting relate to counselors’ and counselors’-in-training self-reports of compassion satisfaction?
5. Does years of experience, age, sex, race, level of education, and/or work/internship setting relate to counselors’ and counselors’-in-training self-reports of self-care?

The remainder of this chapter is divided into several sections: participants, instrumentation, procedures, and data analysis. The participants section outlines inclusion criteria for those surveyed and rationale for determining the number of participants. The instrumentation section describes each instrument used in the study, including justification for its use. The procedures section explains data collection and the questionnaire packet. Last, the data analysis procedures are described.

**Participants**

As mentioned in chapter 1, compassion fatigue and burnout can impact counselors at any point in their career (Figley, 1995; Maslach, 1982). To examine counselor responses that account for different levels of experience, the current study participant criteria included counselors-in-training and licensed professional counselors. The counselors-in-training were master’s and doctoral degree level students attending either a clinical mental health, school counseling, or counselor education and supervision program accredited by the Council for the Accreditation of Counseling and Related Educational Programs (CACREP). These trainees were completing their first semester or more of internship and had found placement at diverse sites (e.g., community agencies, public schools, hospitals). The licensed professional counselor participants also were employed in a variety of settings (e.g., private practices, schools, agencies) and were identified as mental health counselors, school counselors, and/or counselor educators.
A convenience sample was used, as these professional counselors and counselors-in-training were surveyed from a conference for counselors, students in internship classes in graduate school programs, and online listservs. Participants were sampled at the 2011 All Ohio Counselors Conference, an annual conference held in central Ohio that attracts counselors and trainees from across the state. The participating graduate students in counseling were solicited through their graduate program internship class. The researcher also requested participation from subscribers to online listservs sponsored by counseling organizations and intended for professional counselors, trainees, and counselor educators.

All participants were surveyed in regards to their experiences with self-care, compassion fatigue, burnout, and compassion satisfaction. Demographic information was also collected, as the literature has pointed out how such variables may contribute to varying amounts of compassion fatigue and burnout. Demographic information collected included age (Ackerley et al., 1988; Creamer & Liddle, 2005; Ghahramanlou & Brodbeck, 2000; Gillespie & Numerof, 1991; Jiang et al., 2004; Sprang et al., 2007; Vredenburgh et al., 1999), sex (Kassam-Adams, 1999; Killian, 2008; Meyers & Cornille, 2002; Sprang et al., 2007; Van Hook & Rothenberg, 2009; Vredenburgh et al., 1999), years of experience (Creamer & Liddle, 2005; Gillespie & Numerof, 1991; Jiang et al., 2004; Vredenburgh et al., 1999), work or internship setting (Dupree & Day, 1995; Kottler, 1993; Lawson, 2007; Raquepaw & Miller, 1989; Sprang et al., 2007), and level of education (Gillespie & Numerof, 1991).
In total, nine variables were examined in this study: self-care, compassion fatigue, burnout, compassion satisfaction, sex, age, education, experience level, and job/internship setting. These variables were used to determine the total number of participants needed. Stevens (2007) advised that the sample size for this type of study should be at least 15 to 20 participants for every predictor variable. Cohen (1988) similarly suggested including 20 or more participants per variable when utilizing analysis of variables (ANOVAs). Using Stevens’ (2007) equation, the current study would require approximately 165 to 220. This current study aimed to survey approximately 220 participants.

**Instrumentation**

Instrumentation was chosen to determine potential relationships between self-care, compassion fatigue, burnout, compassion satisfaction, and the aforementioned demographic variables. The instruments used in this study included the: demographic questionnaire, the Recent Life Changes Questionnaire (RLCQ; Miller & Rahe, 1997), the Professional Quality of Life Scale (ProQOL 5; Stamm, 2010), and the Self-Care Assessment Worksheet (SCAW; Saakvitne & Pearlman, 1996). These instruments were selected due to reliability and validity, reasonable completion time for participants, and ability to examine the variables required of this study. Following is a description and further justification of each of these instruments.

**Demographic Questionnaire**

A demographic questionnaire (see Appendix A) was administered to participants to collect relevant information. The questionnaire requested information needed to
understand the nature of counselors-in-training and professional counselors’ experiences with self-care, compassion fatigue, burnout, and compassion satisfaction in relation to job or internship setting (school, agency, private practice, hospital, etc.), experience level (i.e., intern, less than 5 years, etc.), sex, age, and level of education (student, Master’s degree, etc.).

**Recent Life Changes Questionnaire (RLCQ)**

The Recent Life Changes Questionnaire (RLCQ) was used to obtain information regarding participants’ experiences with current life stressors (see Appendix B). The RLCQ is derived from the Social Readjustment Rating Scale (SRRS), originally created by Holmes and Rahe in 1967 as a checklist to rate life stressors as a predictor to possible risk of illness (Miller & Rahe, 1997). In 1997, Miller and Rahe created the RLCQ, an updated version of the SRRS that included additional life events, more relevant language, and further precise questions. For instance, “major change in finances” was updated to include the options of: “increased income,” “decreased income,” or “investment and/or credit difficulties.” The RLCQ maintained 30 of the original items and includes an additional 44 life events that are more detailed than the original scale (Miller & Rahe, 1997).

A total of 74 life stressors are listed on the RLCQ under the left-hand column labeled “Life Change Events,” representing life changes in family, work, personal, and financial domains (Miller & Rahe, 1997). Next to each event in the right-hand column is a corresponding value called “Life Change Units (LCUs),” which signify the magnitude of each life event (Miller & Rahe, 1997). For example, “death of a spouse” has the LCU
of 119, whereas “vacation” has the value of 24. To measure recent life stressors, the individual is directed to determine which life change events have occurred within the last year. The corresponding LCUs for each event are added up for a total score. A score of 300 or higher indicates a higher risk of illness, scores 150 through 299 have a moderate risk, and a score of 150 or below is linked to only a slight risk for illness (Holmes & Rahe, 1967; Miller & Rahe, 1997).

For the purpose of the current study, the RLCQ was not used to determine risk of illness. Rather, it was utilized to account for possible current life stressors that may affect a participant’s responses on the other assessments. For example, one may score high on compassion fatigue if the individual has had a recent life-changing event, such as the loss of a loved one. A study by Sherman and Thelen (1998) confirmed this possibility through a survey of over 500 therapists regarding self-reported personal issues and distress. Survey results indicated a significant relationship between work-related stress and lowered job satisfaction with the more stressful life events a therapist experienced in a given year (Sherman & Thelen, 1998).

Validity and reliability have not been established for the RLCQ. A study conducted by Pearson and Long (1985) utilized this questionnaire with US Army active military reserves, determining that the RLCQ has adequate test-retest reliability. Permission to use the RLCQ was granted by Dr. Richard Rahe (see Appendix C).

**The Professional Quality of Life Scale (ProQOL 5)**

The Professional Quality of Life Scale (ProQOL) originated from the Compassion Fatigue Self Test, initially created by Figley in the 1980s as a way to understand the
negative impact that working with traumatized individuals had on helping professionals (Stamm, 2005). By the late 1980s Figley began to work with Stamm, who by 1993 added the construct of compassion satisfaction to the scale (Stamm, 2010). The scale became known as the Compassion Satisfaction and Fatigue Test, evolving into a scale that examined both the difficult and fulfilling aspects of work as a helping professional (Stamm, 2005, 2010). In the late 1990s, Stamm and Figley decided jointly to end their collaboration, at which point the measurement was completely allocated to Stamm who changed the name to the Professional Quality of Life Scale (ProQOL). Since it has been renamed, the ProQOL has been updated in five versions and translated into almost 10 languages (Stamm, 2010).

The current fifth version of the ProQOL (see Appendix D) now provides standardized scoring, in which 50 is the mean and 10 is the standard deviation (Stamm, 2005). Originally a 66-item survey, the ProQOL has also been modified to contain 30 items, allowing for greater ease of completion while retaining the most pertinent items (Stamm, 2005). This revised version also separates compassion fatigue, compassion satisfaction, and burnout into distinct scales with independent results (Stamm, 2005, 2010). That is, after completing the survey, the helping professional will receive a separate score for compassion fatigue, burnout, and compassion satisfaction.

Another change made to the newest version is that the Likert Scale has been adjusted from a 0 to 5 value scale to a scale ranging from 1 to 5. This change was made to clarify reverse scoring and further standardize the test by using a more common Likert Scale of 1 to 5. For each item, the participant is asked to rate the extent to which each of
the statements relate to their own experience. The scale is valued at: 1 = *Never*, 2 = *Rarely*, 3 = *Sometimes*, 4 = *Often*, and 5 = *Very often*. There are a total of 30 statements to rate, 10 relating to symptoms of each of the three measured constructs of burnout, compassion fatigue, and compassion satisfaction.

Statements on burnout relate to gradual forming symptoms, dissatisfaction in one’s occupation, and concerns about being unsuccessful in one’s role as a helper. For example, the item “I feel worn out because of my work as a [helper]” would be an item that addresses a symptom of burnout. According to the test manual, the average score for burnout is 50 with a standard deviation of 10 (Stamm, 2010). The alpha scale reliability for the burnout scale is 0.75 (Stamm, 2010). Approximately 25% score above 57 and another 25% score below 43 (Stamm, 2010). A score below 18 indicates little concern for burnout and overall satisfaction with one’s role as a helper (Stamm, 2010). However, a score above 57 would indicate feelings of discontent and ineffectiveness (Stamm, 2010). Stamm (2005, 2010) explained that a score indicating high dissatisfaction could possibly occur if the person was unhappy at the time of the test, but not a reflection of that person’s typical feelings about work.

Next, statements such as, “I am proud of what I can do to [help]” correlate with compassion satisfaction, or the sense of fulfillment one finds as a helping professional. The average score on this scale is 50, with a standard deviation of 10, and alpha scale reliability of 0.88 (Stamm, 2010). Stamm reported that around 25% score higher than 57 and just about 25% will score below 43. Higher scores signify that the person is interested in their field, relates to clients and coworkers, and feels fulfilled in knowing
one is making a difference in the world (Stamm, 2010). A lower score, on the other hand, denotes less satisfaction in one’s position as a helping professional (Stamm, 2010).

Last, the compassion fatigue scale measures items that address the more sudden PTSD-like symptoms of this issue, such as the sample item “As a result of my [helping], I have intrusive, frightening thoughts.” This scale is also standardized with an average score of 50, standard deviation of 10, and an alpha reliability of 0.81 (Stamm, 2010). Roughly 25% of those surveyed score below 43 and around the same percentage of people score above 57 (Stamm, 2010). Stamm advised that a score above 57 may be associated with issues at work and should be discussed with a professional, trusted coworker, or immediate supervisor. It is important to note that scores do not correlate with a specific problem and cannot be used for diagnostic purposes (Stamm, 2010). The scoring for each of these three separate scales is summarized in Table 1.

Table 1

*Scoring Information for the ProQOL 5*

<table>
<thead>
<tr>
<th>Sums of Scores</th>
<th>Standardized Scores</th>
<th>Amount of Variable</th>
</tr>
</thead>
<tbody>
<tr>
<td>22 or less</td>
<td>43 or less</td>
<td>Low</td>
</tr>
<tr>
<td>23-41</td>
<td>About 50</td>
<td>Average</td>
</tr>
<tr>
<td>42 or more</td>
<td>57 or more</td>
<td>High</td>
</tr>
</tbody>
</table>

A limitation of the ProQOL 5 is that there has not been any published reports or information verifying the instrument’s validity (Bride et al., 2007). Stamm (2005)
reported that this instrument’s construct validity has been confirmed considering that more than several hundred publications have utilized the ProQOL. As Stamm (2010) indicated in the ProQOL 5 Manual:

The three scales measure separate constructs. The Compassion Fatigue scale is distinct. The inter-scale correlations show 2% shared variance ($r=-.23; \text{co-}\sigma = 5\%; n=1187$) with Secondary Traumatic Stress and 5% shared variance ($r=-.14; \text{co-}\sigma = 2\%; n=1187$) with Burnout. While there is shared variance between Burnout (BO) and Secondary Traumatic Stress (STS) the two scales measure different constructs with the shared variance likely reflecting the distress that is common to both conditions. The shared variance between these two scales is 34% ($r=.58; \text{co-}\sigma = 34\%; n=1187$). The scales both measure negative affect but are clearly different; the BO scale does not address fear while the STS scale does. (Stamm, 2010, pp. 13-14)

The ProQOL is the most popular instrument used to measure the experience of compassion fatigue, burnout, and compassion satisfaction among helping professionals (Stamm, 2010). The Maslach Burnout Inventory (MBI) is another widely used instrument to assess for burnout in helping professionals (Maslach, Leiter, & Schaufeli, 2009). However, the ProQOL was chosen for the current study because it seeks to collect data on burnout, along with compassion satisfaction and compassion fatigue. The ProQOL is beneficial as it adequately addresses the current research questions, is simple for participants to take, and addresses the positive experiences of being a helping
professional. Permission to use the ProQOL for the current study was granted by Dr. Beth Hudnall Stamm (see Appendix E).

The Self-Care Assessment Worksheet (SCAW)

Created by Saakvitne and Pearlman (1996), the Self-Care Assessment Worksheet (SCAW) is a self-report questionnaire that measures the degree to which one engages in a spectrum of self-care activities (see Appendix F). The SCAW encompasses a holistic view of self-care similar to the Indivisible Self Model by Myers and Sweeney (2005), in which separate parts make up wellness as a whole. On the SCAW, self-care is divided into six main categories: physical, psychological, emotional, spiritual, work, and balance (Saakvitne & Pearlman, 1996).

The “Physical Self-Care” category addresses exercise and nutrition. The “Psychological Self-Care” category lists activities that enhance mental wellbeing. “Emotional Self-Care” demonstrates activities that involve expression, self-understanding, and connection with others. The “Spiritual Self-Care” category consists of activities involving personal meaning and beliefs. “Work or Professional Self-Care” consists of activities that contribute to job satisfaction. Last, the “Balance” category considers the sense of stability throughout one’s personal and professional roles.

Each of these six categories on the SCAW contains corresponding self-care activities. The participant responds to items by rating frequency of engagement for each activity (Saakvitne & Pearlman, 1996). For example, under the physical self-care category, one of the items reads “Get enough sleep.” The participant then rates the item from 1 to 5 to determine regularity of participation for this activity. Answering with a
“1” would indicate that it never occurs, while a “5” would suggest that the activity is
frequently engaged in. Each of the six categories consist of a different number of
self-care activities which are added to determine total self-care engagement in each
category (Saakvitne & Pearlman, 1996). Thus, each grouping of self-care activities has
the potential for a different range of scores. For instance, there are 15 items listed under
“Physical” with a possible score of 15 to 75 and 11 items for “Emotional” with a score
range of 11 to 55. Additionally, the categories of physical, psychological, emotional,
spiritual, and work/professional self-care all include an item marked other, which allows
the participant to add in an activity in which they partake. Table 2 illustrates each of the
self-care categories on the SCAW, the corresponding number of questionnaire items that
fall under each category, and the potential score range for each of the categories.

Even though scores are totaled for each category, the SCAW is primarily used to
determine overall involvement in self-care activities and does not provide psychometric
indicators or determination of one’s level of wellness (Saakvitne & Pearlman, 1996). For
the purpose of the current study, the SCAW was used to examine the participants’ level
of engagement in various self-care activities.

Due to higher relevancy to the research question, the SCAW was preferred over
the Perceived Wellness Survey (PWS). Similar to the SCAW, the PWS is used to
measure wellness both in subcategories and an overall score. As mentioned, the SCAW
categorizes wellness into the subsections of physical, psychological, emotional, spiritual,
workplace, and balance. The PWS utilizes the same categories with workplace and
balance being replaced by intellectual and social (T. Adams, Bezner, & Steinhardt, 1997).
Table 2

*Self-Care Categories, Number of Items, and Score Range for the SCAW*

<table>
<thead>
<tr>
<th>Self-Care Category</th>
<th>Number of Items</th>
<th>Score Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>15</td>
<td>15-75</td>
</tr>
<tr>
<td>Psychological</td>
<td>13</td>
<td>13-65</td>
</tr>
<tr>
<td>Emotional</td>
<td>11</td>
<td>11-55</td>
</tr>
<tr>
<td>Spiritual</td>
<td>17</td>
<td>17-85</td>
</tr>
<tr>
<td>Workplace or Professional</td>
<td>12</td>
<td>12-60</td>
</tr>
<tr>
<td>Balance</td>
<td>2</td>
<td>2-10</td>
</tr>
</tbody>
</table>

Unlike the SCAW, the PWS rates aspects of wellness according to personal attitudes, such as one item that reads “I feel a sense of mission about my future.” The SCAW addresses particular self-care strategies, such as “Spend time with nature.”

Specifically examining self-care practices and their possible relationship to compassion fatigue, burnout, and compassion satisfaction is the focus of this present study. Personal attitudes regarding self-care and wellness are not addressed in the current study. Therefore, the SCAW was chosen to assess self-care practices of the participants. A copy of the SCAW can be obtained on the American Counseling Association (ACA) Taskforce for Counselor Wellness and Impairment website at [http://www.counseling.org/wellness_taskforce/tf_wellness_strategies.htm](http://www.counseling.org/wellness_taskforce/tf_wellness_strategies.htm). Permission to use the SCAW was granted by W.W. Norton & Company (see Appendix G).
Procedures

Permission to use the aforementioned survey instruments was granted through the appropriate copyright owners (see Appendices C, E, and G). Research approval was obtained through the Institutional Review Board (IRB) of Kent State University (see Appendix H). Participants were recruited from the 2011 All Ohio Counselors Conference, graduate level counseling internship classes, and through listservs intended for counseling professionals and students. This section describes the steps taken by the researcher to recruit participants, including how permission was granted and how surveys were administered.

The 2011 All Ohio Counselors Conference

Permission to recruit participants from the 2011 All Ohio Counselors Conference (AOCC) was granted by Tim Luckhaupt, Executive Director of the Ohio Counselor Association and AOCC Coordinator (see Appendix I). The conference took place from Wednesday, November 2nd, through Friday, November 4th, 2011. The researcher set up a table at the conference, advertising a request for research participation. The researcher passed out fliers at the conference that indicated an invitation to participate in the study (see Appendix J).

Participants recruited from the 2011 All Ohio Counselors Conference received participant research packets. Each packet included a copy of the informed consent (see Appendix K) for participants to keep for personal records. Packets also contained instructions on how to complete the entire study materials, the demographic questionnaire, and the three instruments: (a) Recent Life Changes Questionnaire (RLCQ;
Miller & Rahe, 1997); (b) the Professional Quality of Life Scale (ProQOL 5; Stamm, 2010); and (c) the Self-Care Assessment Worksheet (SCAW; Saakvitne & Pearlman, 1996). Participants were asked to complete the packet at the table or to take it with them and return their completed information by 4:00 pm on the last day of the conference, Friday, November 4th, 2011.

**Graduate School Students**

Students recruited from graduate counseling internship classes were also administered the same participant research packets. In order to administer the research study to graduate level counseling internship students, the researcher requested permission by their course instructors (see sample script, Appendix L). The instructors and researcher agreed upon a time and day for the researcher to come into the classroom and administer the surveys. Students were provided with class time to complete the packets, which was estimated to take between 15 to 20 minutes.

The researcher sought participation from graduate school students attending internship courses in three CACREP-accredited graduate programs in Ohio. The master’s degree level students were selected based on enrollment in their first semester or more of internship class in clinical mental health or school counseling graduate programs. The recruited doctoral students were required to be attending an internship course through CACREP-accredited programs in counselor education and supervision.

The researcher came to these internship classes to personally proctor and administer the study. Students were provided with a copy of the informed consent (see Appendix K), which included an explanation that study participation was not mandated,
nor would taking it provide any extra credit for class. Students were provided enough class time to complete their research packets.

**Listserv Participants**

Along with students and conference attendees, participants were also recruited from counseling listservs, including COUNSGRADS and the Ohio Counseling Association listserv (OCA-L), which are intended for both counseling professionals and students. These participants included licensed counselors, Master’s and Doctoral level students, and counselor educators. If required by the listserv administration, permission was obtained before an email was sent out on the listserv requesting participation (see sample script, Appendix M). Once permission was granted from the listservs’ moderator, an email was sent out through the listserv, requesting participation in the study. The email contained a link to the website hosting the survey.

Online participants were provided with the same informed consent (see Appendix K) and assessments, which were administered through a secure website. However, the informed consent was electronically verified and participants were asked to print a copy for their own personal records. Participants were only able to advance to the survey once they had acknowledged that they have received the informed consent. Confidentiality, including participants’ email addresses, was maintained throughout the online survey process.

**Monetary Incentive Procedures**

All participants were offered to enter a raffle for a $75.00 gift certificate to the Self-Esteem Shop, an online provider of books and other resources for mental health
professionals. Given that several methods were used to collect participant data, different methods were also required in collecting information to be entered into the raffle. Conference and graduate student participants were able to enter the raffle upon completing and returning their research packets. To enter the raffle, participants were asked to fill out an index cards with their name, address, phone number, and email address. These index cards were then placed into a lock box and kept separate from participant survey responses.

Upon completing the study, online participants were able to advance to a secure website where they could enter their information to be entered into the raffle. The researcher then transferred all of this information onto 3 x 5 index cards. These index cards were then combined with the cards from the conference and graduate student participants. A winner was chosen at random once all of the research packets were returned within the allotted time and the online survey was closed. The winner was informed via email. The researcher both mailed and emailed a copy of the gift certificate to the winner.

Data Analysis

Once data collection was completed, all of the data were coded and analyzed using the Statistical Package for the Social Sciences (SPSS). The significance criterion (α) for all statistical analyses was set to .05 (Stevens, 2007). First, the researcher utilized descriptive statistics to summarize the demographics of the participants. These results illustrated mean scores, standard deviations, and frequency distributions for the demographic, criterion, and predictor variables (Hinkle, Wiersma, & Jurs, 1998). Next,
correlation coefficient analysis was conducted to test for relationships between the variables (Field, 2009). These variables included all of the demographic information and the results of the instrumentation on self-care, compassion fatigue, burnout, and compassion satisfaction. Last, analysis of variances (ANOVAs) and t-tests were performed to examine potential differences between these variables (Field, 2009).

**Summary of Chapter 2**

The purpose of this study was twofold. First, it was to determine potential relationships between compassion fatigue, burnout, compassion satisfaction, self-care, and recent life changes. The second purpose was to examine possible relationships among demographic characteristics of counselors and counselors-in-training and compassion fatigue, burnout, compassion satisfaction, and self-care practices. The voluntary participants in this study consisted of counselors and counselors-in-training recruited from a professional conference, graduate level internship classes, and online listservs. All participants were requested to complete an informed consent approved by the Kent State University IRB, a demographic questionnaire, the Recent Life Changes Questionnaire (RLCQ; Miller & Rahe, 1997), the Professional Quality of Life Scale (ProQOL 5; Stamm, 2010), and the Self-Care Assessment Worksheet (SCAW; Saakvitne and Pearlman, 1996).

Once all of the data were collected, descriptive statistics, correlations, ANOVAs, and t-tests were conducted. First, the descriptive statistics illustrated a quantitative summary of the data. Next, correlation coefficient analysis was processed to look for potential relationships between the predictor variables that can affect research outcomes.
Last, ANOVAs and t-tests were performed to evaluate possible differences between the variables. Chapter 3 provides the results of these analyses.
CHAPTER III

RESULTS

The purpose of this study was to determine the possible relationships between compassion fatigue, burnout, compassion satisfaction, and self-care practices for professional counselors and counselors-in-training. Additionally, this study aimed to examine the potential relationships among recent life changes, age, years of experience, sex, race, education level, work/internship setting, and counselors’ and counselors’-in-training self-reports of compassion fatigue, burnout, compassion satisfaction, and self-care.

This chapter consists of a summary of the statistical analyses and results of this study. Results of descriptive statistics are first presented, which describe the main characteristics of all of the variables. Descriptive statistics are followed by results of each of the four research questions. Correlational results are reported to describe the relationships between the variables. Analysis of variances (ANOVAs) and t-tests are also utilized to depict the differences between variables.

Descriptive Results

A total of 253 counselors and counselors-in-training were sampled in this present study. This section illustrates the descriptive statistics of those sampled, summarizing the data set for all of the variables. These statistics include the means, standard deviations, minimums, and maximums for all of the primary variables. The presented primary variables include compassion fatigue, burnout, compassion satisfaction, self-care, and
recent life changes. Additionally, this section illustrates the descriptive statistics for the subscales of the self-care assessment.

**Primary Variables**

Descriptive statistics are presented for the primary variables of compassion fatigue, burnout, compassion satisfaction, self-care, and recent life changes. A summary of the means, standard deviations, minimums, and maximums are shown in Table 3.

Table 3

*Descriptive Statistics of the Primary Variables for All N*

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compassion Fatigue</td>
<td>247</td>
<td>18.95</td>
<td>4.60</td>
<td>11</td>
<td>36</td>
</tr>
<tr>
<td>Burnout</td>
<td>247</td>
<td>20.90</td>
<td>4.84</td>
<td>10</td>
<td>34</td>
</tr>
<tr>
<td>Compassion Satisfaction</td>
<td>247</td>
<td>40.13</td>
<td>5.66</td>
<td>19</td>
<td>50</td>
</tr>
<tr>
<td>Self-Care</td>
<td>246</td>
<td>166.73</td>
<td>39.65</td>
<td>75</td>
<td>246</td>
</tr>
<tr>
<td>Recent Life Changes</td>
<td>250</td>
<td>10.34</td>
<td>6.51</td>
<td>1</td>
<td>62</td>
</tr>
</tbody>
</table>

The ProQOL 5 was used to determine the counselors’ and counselors’-in-training self-reports of compassion fatigue, burnout, and compassion satisfaction. Scores of 22 or less may indicate little or no issues with compassion fatigue, whereas scores higher than 42 are associated with increased level of compassion fatigue. In this present study, participants’ scores for compassion fatigue ranged from 11 to 36 with a mean of 18.95 and standard deviation of 4.60, indicating a lower risk of compassion fatigue.
Next, results of the burnout scale determined that participants’ scores ranged from 10 to 34 with a mean of 20.90 and standard deviation of 4.84. These results imply little risk for burnout, as scores lower than 23 are reported to be of minimal concern for burnout. Scores above 41 on the burnout scale are of concern, indicating potential for burnout, job dissatisfaction, and feelings of ineffectiveness.

Last, study participant scores on compassion satisfaction ranged from 19 to 50 with a mean of 40.13 and a standard deviation of 5.66. These results indicated moderate to high levels of compassion satisfaction. Higher scores or those above 41 are correlated to job satisfaction and effectiveness. However, lower scores or those under 23 relate to dissatisfaction as a helping professional and lack of interest in the counseling field.

Self-care was examined utilizing Self-Care Assessment Worksheet (SCAW), whose primary purpose is to determine overall engagement on self-care activities. The SCAW does not indicate psychometric determinants of one’s level of wellness. Scores on the SCAW can range from 70 to 350. In the present study, participants’ total scores for the SCAW ranged between 75 and 246 with a mean of 166.73 and a standard deviation of 39.65 (Table 3).

As mentioned in chapter 2, scores on the SCAW are divided into the subgroups of physical, psychological, emotional, spiritual, work, and balance. Table 4 illustrates the descriptive statistics of each of these subscales for all of the participants. These scores represent the amount of self-care participants reported engaging in for each type of self-care category. Each of the six subscales contains a different number of items and score range.
Higher scores indicate greater engagement of self-care practices that correspond with each particular subcategory. First, the physical self-care subscale has a total of 15 items and scores can range from 15 to 75. In the current study, participants’ scores ranged between 18 and 56, with a mean of 37.42 and a standard deviation of 9.33. Second, the psychological scale has 13 items with a range from 13 to 65. Participants scored between 16 and 48 with a mean of 31.81 and a standard deviation of 7.05. Third, the emotional subscale contains 11 items and scores can range from 11 to 55. Participants’ scores ranged from 10 to 39 with a mean of 23.98 and a standard deviation of 6.28. Scores of 10 indicate that at least one item was not answered in this section.

The fourth subscale of spiritual self-care has 17 items with possible range of 17 to 85. Participants in the present study scored between 17 and 66 with a mean of 42.55 and

<table>
<thead>
<tr>
<th>Subscale</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>246</td>
<td>37.42</td>
<td>9.33</td>
<td>18</td>
<td>56</td>
</tr>
<tr>
<td>Psychological</td>
<td>246</td>
<td>31.81</td>
<td>7.05</td>
<td>16</td>
<td>48</td>
</tr>
<tr>
<td>Emotional</td>
<td>246</td>
<td>23.98</td>
<td>6.28</td>
<td>11</td>
<td>39</td>
</tr>
<tr>
<td>Spiritual</td>
<td>243</td>
<td>42.55</td>
<td>11.98</td>
<td>17</td>
<td>66</td>
</tr>
<tr>
<td>Work</td>
<td>243</td>
<td>26.53</td>
<td>6.73</td>
<td>12</td>
<td>42</td>
</tr>
<tr>
<td>Balance</td>
<td>243</td>
<td>5.34</td>
<td>1.99</td>
<td>0</td>
<td>9</td>
</tr>
</tbody>
</table>
a standard deviation of 11.98. Fifth, the work subscale has 12 possible items and scores can range from 12 to 60. Participants’ scores ranged from 12 to 60 with a mean of 26.53 and a standard deviation of 6.73. Last, the balance subscale contained 2 items and a score range between 2 and 10. Participants scored between 0 and 9 with a mean of 5.34 and a standard deviation of 1.99. Scores of 0 indicate that no answers were given in balance section.

The last analyzed primary variable examined recent life adjustments and stressors. The Recent Life Changes Questionnaire (RLCQ) was used to determine self-reports of stressful life events that the participants may have experienced over the past year. As discussed in chapter 2, the RLCQ consists of a total of 74 possible recent life changes. Participants’ scores ranged between 1 and 62 with a mean of 10.34 and standard deviation of 6.51. These scores strictly represent the amount of life stressors participants self-reported and do not involve any further interpretation.

The most frequently reported responses to the RLCQ were examined for all participants. Nonstudent participant responses were also separately determined to indicate any possible differences for these participants. Results were similar between the two groups. Majority of the most frequently indicated life changes belonged in the “Work” category of the RLCQ. These responses included, “Change in your work hours or conditions” (62.1% for all n; 55.5% for nonstudents only), “Change in your responsibilities at work: More responsibilities” (51% for all n; 52% for nonstudents only), and “Change to a new type of work” (44.3% for all n; 40.5% for nonstudents only).
Additionally, “Major decision regarding your immediate future” (47.4% for all $n$; 41.6% for nonstudents only) was also another frequently reported life change and belonged to in the “Personal and Social” category of the RLCQ.

**Demographic Variables**

The present study included a total of 253 participants. Of these participants, 157 were surveyed through online listservs, 69 were surveyed at a professional conference, and 27 were surveyed through graduate counseling internship classes. The demographic variables for this study include age, years of experience, sex, race, education level, and work/internship setting. A summary of the demographic variables for all of the participants is presented in Table 5.

**Research Questions Results**

The following describes the correlations, ANOVAs, and t-tests results. Tables are also provided to display some of these results. Results are divided into five main sections to address each of the research questions.

**Research Question One Results**

The first research question asks, “Is there a relationship between compassion fatigue, burnout, compassion satisfaction, self-care, and recent life changes among professional counselors and counselors-in-training?” A Pearson product-moment correlation was utilized to examine the relationships between these variables. Table 6 depicts a summary of these results.
Table 5

Demographic Variables for All N

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>251</td>
<td>37.75</td>
<td>11.88</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-29</td>
<td>84</td>
<td>33.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-39</td>
<td>73</td>
<td>29.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40-49</td>
<td>43</td>
<td>17.2%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50-59</td>
<td>37</td>
<td>14.7%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60-69</td>
<td>14</td>
<td>5.6%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years Experience</td>
<td>241</td>
<td>5.55</td>
<td>8.03</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-9</td>
<td>184</td>
<td>76.3%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10-19</td>
<td>38</td>
<td>15.8%</td>
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</tr>
<tr>
<td>20-29</td>
<td>1</td>
<td>5.4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-39</td>
<td>5</td>
<td>2.1%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40-49</td>
<td>1</td>
<td>0.4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td>253</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td>40</td>
<td>15.9%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Females</td>
<td>213</td>
<td>84.1%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current Internship</td>
<td>252</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Masters Level</td>
<td>69</td>
<td>27.4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctoral Level</td>
<td>10</td>
<td>4.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Applicable</td>
<td>173</td>
<td>68.7%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>251</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White/Cauc</td>
<td>219</td>
<td>87.3%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blk/Af Amer</td>
<td>23</td>
<td>9.2%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Am Indian, Alaskan</td>
<td>2</td>
<td>0.8%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>3</td>
<td>1.2%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>1.6%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education Level</td>
<td>246</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Masters Student</td>
<td>80</td>
<td>32.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Masters Degree</td>
<td>146</td>
<td>59.3%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctoral Degree</td>
<td>14</td>
<td>5.7%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>2.4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work/Internship Setting</td>
<td>252</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agency</td>
<td>96</td>
<td>37.9%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>School</td>
<td>75</td>
<td>29.6%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private Practice</td>
<td>38</td>
<td>15.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>University</td>
<td>17</td>
<td>6.7%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>7</td>
<td>2.8%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counselor Ed</td>
<td>19</td>
<td>7.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 6

*Summary of Correlations Between Primary Variables for All N*

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>CF (1)</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Burnout (2)</td>
<td>.527**</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>CS (3)</td>
<td>-.115</td>
<td>-.556**</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>RLC (4)</td>
<td>.216**</td>
<td>.170**</td>
<td>-.026</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Self-Care (5)</td>
<td>.021</td>
<td>-.081</td>
<td>.039</td>
<td>-.097</td>
<td>–</td>
</tr>
</tbody>
</table>

*Note.* CF = compassion fatigue, CS = compassion satisfaction, and RLC = recent life changes.  
** *p < .01*

The results of this Pearson product-moment correlation found some significant correlations between the variables of the first research question (Table 6). First, compassion fatigue and burnout were positively correlated ($r = .527, p < .01$), showing that as burnout increases, compassion fatigue also increases. Second, burnout was negatively correlated with compassion satisfaction ($r = -.556, p < .01$). This indicates that as a person’s level of burnout rises, their experience with compassion satisfaction decreases. Third, the amount of recent life changes was positively correlated with both burnout ($r = .170, p < .01$) and compassion fatigue ($r = .216, p < .01$), meaning that burnout and compassion fatigue increase with the amount of recent life stressors. No correlations were found between self-care and the other primary variables. However,
some correlations were found between self-care and compassion satisfaction when only examining the results for participants in a school and agency settings.

Significant correlations were found between compassion satisfaction and other variables, depending on participants’ work/internship setting.

**Agency setting.** Correlations revealed one significant finding between compassion satisfaction and self-care for nonstudent participants working in an agency setting. Table 7 depicts the correlations between compassion satisfaction and self-care for nonstudent participants working in an agency setting. Compassion satisfaction was found to be correlated with the subscale of “Psychological” self-care ($r = .296, p < .05$), suggesting that compassion satisfaction increased with higher self-reports of psychological self-care for nonstudent participants working in an agency setting.

**School setting.** Participants in a school setting showed significant correlations between compassion satisfaction and variables related to self-care. Depicted in Table 8, results determined negative correlations between the overall total of self-care and compassion satisfaction ($r = .216, p < .05$) for all participants working or interning in a school setting. This implies that counselors and counselors-in-training in a school setting experience decreased amount of compassion satisfaction when engaging in greater amounts of self-care.

Additionally, Table 8 shows that the self-care subscales of physical, psychological, emotional, spiritual, and balance were found to be negatively correlated with compassion satisfaction for those working or interning in a school setting. This suggests that counselors and counselors-in-training in a school setting reported higher
Table 7

Correlations Between Compassion Satisfaction and Self-Care for Nonstudent Participants Working in an Agency Setting

<table>
<thead>
<tr>
<th>Variables</th>
<th>Compassion Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Self-Care</td>
<td>.182</td>
</tr>
<tr>
<td>Self-Care Subscales:</td>
<td></td>
</tr>
<tr>
<td>Physical</td>
<td>.163</td>
</tr>
<tr>
<td>Psychological</td>
<td>.296*</td>
</tr>
<tr>
<td>Emotional</td>
<td>.101</td>
</tr>
<tr>
<td>Spiritual</td>
<td>.156</td>
</tr>
<tr>
<td>Work</td>
<td>.128</td>
</tr>
<tr>
<td>Balance</td>
<td>.114</td>
</tr>
</tbody>
</table>

Note. * p < .05

Table 8

Correlations Between Compassion Satisfaction and Self-Care for All N Working/Interning in a School Setting

<table>
<thead>
<tr>
<th>Variables</th>
<th>Compassion Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Self-Care</td>
<td>-.321*</td>
</tr>
<tr>
<td>Self-Care Subscales:</td>
<td></td>
</tr>
<tr>
<td>Physical</td>
<td>-.264**</td>
</tr>
<tr>
<td>Psychological</td>
<td>-.303*</td>
</tr>
<tr>
<td>Emotional</td>
<td>-.323*</td>
</tr>
<tr>
<td>Spiritual</td>
<td>-.326*</td>
</tr>
<tr>
<td>Work</td>
<td>-.230</td>
</tr>
<tr>
<td>Balance</td>
<td>-.266**</td>
</tr>
</tbody>
</table>

Note. * p < .05  ** p < .01
levels of compassion satisfaction when participating in less amounts of physical, psychological, emotional, spiritual, and balance self-care.

Similar correlations were found when only examining the results for nonstudent participants working in a school setting. However, no correlational relationship was found between compassion satisfaction and the balance self-care subscale for nonstudent participants employed in a school setting. These results suggest that compassion satisfaction is higher with less amounts of overall self-care and physical, psychological, emotional, and spiritual self-care for nonstudent counselors employed in a school setting. Correlational results between compassion satisfaction and self-care for nonstudent participants employed in a school setting are presented in Table 9.

Table 9

*Correlations Between Compassion Satisfaction and Self-Care for Nonstudents Working in a School Setting*

<table>
<thead>
<tr>
<th>Variables</th>
<th>Correlated With Compassion Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Self-Care</td>
<td>-.362**</td>
</tr>
<tr>
<td>Self-Care Subscales:</td>
<td></td>
</tr>
<tr>
<td>Physical</td>
<td>-.286**</td>
</tr>
<tr>
<td>Psychological</td>
<td>-.399*</td>
</tr>
<tr>
<td>Emotional</td>
<td>-.388*</td>
</tr>
<tr>
<td>Spiritual</td>
<td>-.373*</td>
</tr>
<tr>
<td>Work</td>
<td>-.245</td>
</tr>
<tr>
<td>Balance</td>
<td>-.252</td>
</tr>
</tbody>
</table>

*Note. *p < .05  **p < .01*
Research Question Two Results

The second research question was, “Does age, years of experience, sex, race, education level, and/or work/internship setting relate to counselors’ and counselors’-in-training self-reports of compassion fatigue?” Results of the Pearson product-moment correlations did not reveal significant correlations between compassion fatigue and age or years of experience. Correlations between compassion fatigue and age and years of experience are illustrated in Table 10.

Table 10

Correlations for Primary Variables and Age and Years of Experience for All N

<table>
<thead>
<tr>
<th>Variables</th>
<th>Age</th>
<th>Years Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compassion Fatigue</td>
<td>.043</td>
<td>.081</td>
</tr>
<tr>
<td>Burnout</td>
<td>-.038</td>
<td>.004</td>
</tr>
<tr>
<td>Compassion Satisfaction</td>
<td>.119</td>
<td>.066</td>
</tr>
<tr>
<td>Self-Care</td>
<td>.097</td>
<td>.033</td>
</tr>
</tbody>
</table>

A t-test was performed to examine the differences between the means of compassion fatigue between male and female participants. Males were found to have a mean of 17.39 on the compassion fatigue scale, whereas the mean for females was 19.25. A t-test determined that the females scored higher than males and that the difference is statistically significant. This indicates that female participants self-reported greater levels of compassion fatigue than male participants.
An ANOVA was performed to find potential differences in compassion fatigue between separate racial groups. Participants had the option to self-report their race as White/Caucasian, Black/African American, American Indian/Alaskan Native, Asian, Native Hawaiian/Pacific Islander, Hispanic/Latino, or other. As seen in Table 11, no significant differences were found between racial groups in regards to self-reports of compassion fatigue.

Table 11

Summary of ANOVA Results for Compassion Fatigue and Race

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between</td>
<td>56.583</td>
<td>4</td>
<td>14.146</td>
<td>.682</td>
<td>.605</td>
</tr>
<tr>
<td>Within</td>
<td>4978.258</td>
<td>240</td>
<td>20.743</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>5034.841</td>
<td>244</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: *p < .05

Participants self-reported their education level as being either a master’s degree level student, completed master’s degree, doctoral degree, or other. ANOVA results did not find any significant differences between these groups in regards to their self-reports of compassion fatigue (Table 12).
Table 12

*Summary of ANOVA Results for Compassion Fatigue and Education Level*

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between</td>
<td>22.053</td>
<td>2</td>
<td>11.026</td>
<td>.527</td>
<td>.591</td>
</tr>
<tr>
<td>Within</td>
<td>4831.110</td>
<td>231</td>
<td>20.914</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>4853.162</td>
<td>233</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note. *p < .05

Participants were given the option to indicate that their work or internship setting was in a community agency, school, private practice, counseling center at a college/university, hospital, as a counselor educator, or other. No significant differences were found between self-reports of compassion fatigue and participants’ work or internship setting.

**Research Question Three Results**

The third research question asked, “Does age, years of experience, sex, race, education level, and/or work/internship setting relate to counselors’ and counselors’-in-training self-reports of burnout?” As illustrated in Table 10, no significant correlations were found between burnout and age or years of experience. T-tests did not find significant differences in burnout between males and females. Additionally, ANOVA results did not reveal any significant differences of burnout between the separate racial groups (Table 13) or education levels (Table 14).
Table 13

*Summary of ANOVA Results for Burnout and Race*

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between</td>
<td>92.517</td>
<td>4</td>
<td>23.129</td>
<td>.999</td>
<td>.409</td>
</tr>
<tr>
<td>Within</td>
<td>5558.039</td>
<td>240</td>
<td>23.158</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>5650.555</td>
<td>244</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note. *p < .05*

Table 14

*Summary of ANOVA Results for Burnout and Education Level*

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between</td>
<td>71.453</td>
<td>2</td>
<td>35.726</td>
<td>1.545</td>
<td>.215</td>
</tr>
<tr>
<td>Within</td>
<td>5341.287</td>
<td>231</td>
<td>23.122</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>5412.739</td>
<td>233</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note. *p < .05*

T-tests were conducted to determine potential differences between participants depending upon their work/internship setting. Counselors and counselors-in-training employed or interning in a community agency ($\bar{x} = 21.75$) or school setting ($\bar{x} = 21.94$) were found to have significantly greater self-reports of burnout than those in private
practice ($X = 18.45$) or hospital setting ($X = 18.33$). Significant differences were not found between any other work or internship settings.

**Research Question Four Results**

The fourth research question was, “Does age, years of experience, sex, race, education level, and/or work/internship setting relate to counselors’ and counselors’-in-training self-reports of compassion satisfaction?” Results of the Pearson product-moment correlations did not show significant correlations between compassion satisfaction and age and years experience (Table 8). T-tests did not reveal significant differences in compassion satisfaction between males and females. Additionally, ANOVA results did not find any significant differences in compassion satisfaction between different racial groups (Table 15), work/internship setting, or education levels (Table 16).

Table 15

*Summary of ANOVA Results for Compassion Satisfaction and Race*

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between</td>
<td>255.492</td>
<td>4</td>
<td>63.873</td>
<td>2.021</td>
<td>.092</td>
</tr>
<tr>
<td>Within</td>
<td>7585.063</td>
<td>240</td>
<td>31.604</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>7840.555</td>
<td>244</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note.* *p* < .05
Table 16

Summary of ANOVA Results for Compassion Satisfaction and Education Level

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between</td>
<td>66.712</td>
<td>2</td>
<td>33.356</td>
<td>1.114</td>
<td>.330</td>
</tr>
<tr>
<td>Within</td>
<td>6915.634</td>
<td>231</td>
<td>29.938</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>6982.346</td>
<td>233</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. *p < .05

As shown in Table 17, compassion satisfaction was found to be correlated with age ($r = .292, p < .05$) for nonstudent counselors employed in an agency setting. This implies that compassion satisfaction increases with age for agency-employed counselors. No significant correlation was found between compassion satisfaction and years of experience for nonstudent, agency-employed counselors.

Table 17

Correlations Between Compassion Satisfaction and Age and Years of Experience for Nonstudent Participants Working in an Agency Setting

<table>
<thead>
<tr>
<th>Variables</th>
<th>Age</th>
<th>Years Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compassion Satisfaction</td>
<td>.292*</td>
<td>-.041</td>
</tr>
</tbody>
</table>

Note. *p < .05
Research Question Five Results

The last research question is, “Does age, years of experience, sex, race, education level, and/or work/internship setting relate to counselors’ and counselors’-in-training self-reports of self-care?” Results of the correlations did not show any significance between self-care and age or years of experience (Table 10). T-tests did not find significant differences in self-care depending on sex. Additionally, ANOVA results did not find significant differences in self-care between racial groups (Table 18) and different education levels (Table 19).

T-tests determined significant differences in self-reports of self-care depending on participants’ work or internship setting. Counselors and counselors-in-training employed or interning in a community agency ($\bar{X} = 166.47$) or school setting ($\bar{X} = 149.41$) were found to have significantly lower self-reports of self-care than those in private practice ($\bar{X} = 190.55$). Significant differences were not found between any of the other work or internship settings.

Table 18

Summary of ANOVA Results for Self-Care and Race

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between</td>
<td>4965.945</td>
<td>4</td>
<td>1241.486</td>
<td>.781</td>
<td>.539</td>
</tr>
<tr>
<td>Within</td>
<td>380146.396</td>
<td>239</td>
<td>1590.571</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>385112.340</td>
<td>243</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. *p < .05
Table 19

*Summary of ANOVA Results for Self-Care and Education Level*

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between</td>
<td>8851.435</td>
<td>2</td>
<td>44425.717</td>
<td>2.831</td>
<td>.061</td>
</tr>
<tr>
<td>Within</td>
<td>359521.870</td>
<td>230</td>
<td>1563.139</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>368373.305</td>
<td>232</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note.* *p < .05

**Summary of Chapter 3**

Results of the five research questions are presented in this chapter. Descriptive statistics were used to describe the main characteristics of all of the variables. The descriptive statistics were followed by results of each of the five separate research questions. Correlations, t-tests, and ANOVAs were performed to examine relationships between different variables.
CHAPTER IV
DISCUSSION

The purpose of this study was to examine potential connections between compassion fatigue, burnout, compassion satisfaction, self-care, and recent life changes among professional counselors and counselors-in-training. Additionally, the intention of this study was also to determine possible relationships between counselors’ and counselors’-in-training demographic characteristics of years of experience, age, gender, race, education level, work/internship setting and self-reports of compassion fatigue, burnout, compassion satisfaction, and self-care practices.

This chapter provides a discussion of the study results. First, the findings of each of the five research questions are examined, comparing these results to existing literature. Next, strengths and limitations are presented, followed by recommendations for future research. Last, a summary of this research study is provided.

Research Question One

The first research question sought to determine potential relationships between compassion fatigue, burnout, compassion satisfaction, self-care, and recent life changes. The field of professional counseling is considered a high-touch profession, meaning that counselors are required to spend considerable face-to-face time with clients who need their support (Maslach & Leiter, 1997; Stebnicki, 2007). The counseling profession presents many unique stressors, including exposure to countless traumatic stories, limited resources, large caseloads, and minimal support. The demands of a counseling position can contribute to personal and professional problems, reduce counselor wellness, and
potentially negatively affect client care (Edelwich & Brodsky, 1980; Maslach & Goldberg, 1998; Maslach & Leiter, 1997; Stebnicki, 2007; Young & Lambie, 2007).

A review of the literature presented in chapter 1 revealed that the challenges of the field lead counselors to be more susceptible to developing compassion fatigue and/or burnout. Compassion fatigue often develops in a short period of time, presenting as PTSD-like symptoms in counselors due to continual contact with clients and hearing stories about their traumatic experiences (Figley, 1995, 2002a, 2002b). Burnout, on the other hand, normally develops gradually over time and is caused by the work demands of the counseling profession, such as excessive paperwork, long work hours, low salary, difficult clients, and disagreements with coworkers (Maslach, 1982; Maslach & Jackson, 1986).

In the present study, compassion fatigue and burnout were measured and results were examined to determine possible relationships between the two variables. A correlation was found between burnout and compassion fatigue, indicating that these variables increase together. Past research has not determined such a correlation, but this may be due to a lack of specifically examining the relationships between burnout and compassion fatigue. Previous research studies have mainly reported on the relationship between burnout or compassion fatigue and compassion satisfaction or demographic variables.

As discussed, burnout and compassion fatigue are related, but separate concepts. However, it is reasonable to consider that these issues can influence each other. Compassion fatigue is the result of feeling helpless in the face of others’ issues and
trauma, whereas burnout involves a sense of resentment and disdain due to difficult job
tasks and challenging clientele. For instance, since burnout tends to develop gradually
while compassion fatigue typically has a much quicker onset, it is possible that over time,
the experience of compassion fatigue can be a contributing factor to the later
development of burnout. Additionally, a counselor who is experiencing burnout may
begin to feel guilty about their feelings for their clients, especially when met with a
traumatic story, thus impacting the counselor’s development of compassion fatigue.

It has been theorized in past literature that both of these issues can be prevented
through the development of compassion satisfaction (Radey & Figley, 2007; Stamm,
2002, 2005). Compassion satisfaction involves feelings of fulfillment derived from one’s
role as a helper. Past research studies have determined that burnout has an inverse
relationship with compassion satisfaction (Eastwood & Ecklund, 2008; Kraus, 2005;
Melamed et al., 2001). Findings of this study similarly found that burnout is negatively
correlated with compassion satisfaction, suggesting that the development of compassion
satisfaction may be a factor that can help to prevent burnout for counselors and
counselors-in-training.

Past studies have also indicated a similar inverse relationship between compassion
fatigue and compassion satisfaction for helping professionals (Alkema et al., 2008;
Collins & Long, 2003; Van Hook & Rothenberg, 2009). In the current study, data
analysis did show that the relationship between compassion fatigue and compassion
satisfaction was moving towards an inverse correlation. However, this negative
relationship between these two variables was not found to be significant.
Similar to compassion satisfaction, past research has determined that actively engaging in self-care activities was found to decrease incidents of burnout and compassion fatigue (Alkema et al., 2008; Eastwood & Ecklund, 2008). However, a separate study by Kraus (2005) did not find a correlation between self-care and self-reports of burnout and compassion fatigue. Consistent with Kraus, this study also did not establish a significant relationship between self-care and compassion fatigue or burnout. Additionally, the current study did not ascertain a relationship between self-care and compassion satisfaction.

These results are unlike past studies that indicated increased self-care was associated with higher levels of compassion satisfaction (Alkema et al., 2008; Kraus, 2005). This may be due to the nature of the participants in the current study. Majority of the participants sampled were students in the internship portion of their education or had less than 10 years of experience as a counselor. Novice counselors and counselors-in-training may have increased feelings of compassion satisfaction that are not influenced by practicing self-care. Being new to the field, these participants may feel greatly enthusiastic and have high hopes and expectations about their new role as a counselor. Unlike more experienced counselors, they may not have yet experienced the factors that can contribute to compassion fatigue and burnout, such as heavy caseloads, numerous traumatized clients, and lack of support.

Other factors that may have influenced self-care practices of these participants may include outside influences, such as home life and career aspirations. For example, most participants were under the age of 40 and may be influenced by transitions and
other variables that are often prevalent for those in that age group, such as finding a partner, raising children, or building a career.

Many participants were also sampled from a conference for counselors. These participants may have different qualities than counselors who do not attend conferences, such as greater interest and passion in their field and/or more time and dedication to advancing their careers. Such participants may have high levels of compassion satisfaction with a desire to build their counseling skills. These participants’ self-care practices may involve a high degree of activity in developing their techniques as a counselor. Additionally, they may have been feeling refreshed from attending the conference, which could potentially influence their responses to the surveys.

Although past research has examined the relationships between compassion fatigue, burnout, compassion satisfaction, and self-care, no studies have looked at how recent life changes may relate to these variables. The current study found that burnout and compassion fatigue increased with the amount of recent life stressors. This finding suggests that stressful changes contribute to the development of burnout and compassion fatigue. It is possible that the more recent life changes a counselor or counselor-in-training experiences, the more susceptible they become to developing these issues.

Interestingly, the participants’ highest ranked recent life changes belonged to the “Work” category of the RLCQ. The most frequently indicated recent life changes included “Change in your work hours or conditions,” “Change in your responsibilities at work: More responsibilities,” and “Change to a new type of work.” These results imply
that majority of the participants’ recent stressors were work-related. It makes theoretical sense that changes and stressors at work would impact participants’ risk of developing compassion fatigue and burnout.

More than half of all participants (55.5%) reported experiencing a recent change in their work hours and conditions. When examining only the nonstudent participants, an even higher percentage (62.1%) reported a change in work hours and conditions. These results may potentially be an indicator of the changing demands occurring in the counseling field, such as higher caseloads, company downsizing, or increases in required documentation. Over half of the participants also self-reported a change to more work responsibilities (51% for all participants and 52% for nonstudents), which is similarly a sign of raised responsibilities for counselors. Lastly, 44.3% of all participants and 40.5% of nonstudent participants indicated a change to a new type of work. This suggests that majority of the participants are new to the counseling field, which is consistent with the demographic findings that determined 76.3% of participants had less than 10 years of experience in the field. It is also possible that these results reflect the ever-changing roles and responsibilities of counselors.

Research Question Two

The second research question looked to determine a relationship between demographic variables and compassion fatigue. Although not examined in past research, this study did not find any significant relationship between compassion fatigue and race, education level, or work/internship setting. Inconsistent with past research, this study also did not determine a relationship between compassion fatigue and age or years of
experience. Past research proposed that younger and less experienced counselors are more prone to developing compassion fatigue (Creamer & Liddle, 2005; Ghahramanlou & Brodbeck, 2000; Sprang et al., 2007). The present results may have been influenced by the fact that majority of the participants were under the age of 40 with less than 10 years of experience in the field. As mentioned in chapter 1, counselors who experience compassion fatigue and burnout typically do not stay in the field (Figley, 1995; Maslach & Jackson, 1986; Raquepaw & Miller, 1989). It is possible that the participants who have stayed in the field have not experienced these issues or have developed ways to overcome them.

Aside from establishing a relationship between compassion fatigue and age and years of experience, past research has also revealed a relationship between compassion fatigue and gender. Reports have indicated that compassion fatigue is more prevalent among female helping professionals (Kassam-Adams, 1999; Killian, 2008; Meyers & Cornille, 2002; Sprang et al., 2007; Van Hook & Rothenberg, 2009). Lending support to these findings, results of the present study also suggest that females are more prone to compassion fatigue. Females were found to self-report significantly higher amounts of compassion fatigue symptoms than the male participants.

These results are concerning given that women make up the majority of those already in or entering the counseling profession (Willyard, 2011). The current study reflected this, as the majority of the study participants were women. Compassion fatigue involves more of a turning inward, feeling upset that one cannot do enough as a helper
(Figley, 1995). Whereas with burnout, feelings are directed outwards, expressing displeasure in coworkers, clients, and the counseling field as a whole (Maslach, 1982).

The socialization of women to be giving and nurturing, even if it means sacrificing personal needs, may also influence the way in which they react to the stressors of the profession (Willyard, 2011). These types of responses would appear to fit more accurately with the symptoms of compassion fatigue. Additionally, many of the roles women play outside of their careers, such as mother, daughter, or partner, often require a great deal of care and compassion. It is possible that these additional roles, relationships, and responsibilities contribute to compassion fatigue among women.

**Research Question Three**

The third research question inquired about potential relationships between demographic variables and burnout. A number of past research studies determined that younger and less experienced counselors and similar helping professionals report higher levels of burnout (Ackerley et al., 1988; Gillespie & Numerof, 1991; Jiang et al., 2004; Van Morkhoven, 1998; Vredenburgh et al., 1999). Knowledge, skills, and preparedness are often developed through practice as a helping professional. It is possible that older and more experienced counselors are better equipped to handle stressors of the job (Cranswick, 1997). Past research has also determined that compassion satisfaction increases with age and years of experience (Craig & Sprang, 2010). Compassion satisfaction can be a mitigating factor in decreasing the occurrence of burnout for older and more experienced counselors (Collins & Long, 2003; Eastwood & Ecklund, 2008; Kraus, 2005; Melamed et al., 2001; Van Hook & Rothenberg, 2009).
Despite past research indicating such a link, the current study did not support the connection between burnout and age or years of experience. Again, this may be due to the participants’ demographics, with majority being under the age of 40 with less than 10 years of experience in the field. It is also plausible that those who did develop burnout either left the field or developed ways to manage it.

This study also did not reveal any relationships between burnout and gender. This finding does not resonate with past studies that have found a higher incidence of burnout between males than females (Dupree & Day, 1995; Van Morkhoven, 1998; Vredenburgh et al., 1999). The present study consisted of 40 males and 213 females, which could have affected theses results. Additionally, this study did not find a significant connection between burnout and race or education level, factors that have not been examined in previous research studies.

The present study failed to determine a connection between burnout and most of the demographic factors. However, this study did find a relationship between work/internship setting and burnout levels. Results showed that participants working or interning in agency or school settings showed significantly higher amounts of burnout than those in a private practice or hospital setting. These results reinforced previous research studies that indicated burnout was more prevalent among mental health professionals employed in community agencies than those working in a private practice (Dupree & Day, 1995; Lawson, 2007).

Community agencies are thought to have greater constraints and productivity demands, along with more challenging clientele than found in private practice and
hospital settings (Kottler, 1993; Raquepaw & Miller, 1989; Sprang et al., 2007). Results of this study suggest that these obstacles may also be present in school settings, leading to higher rates of burnout for school-based counselors. Private practices and hospitals may have factors that contribute to lower incidents of burnout, such as greater flexibility, more manageable caseloads, increased support and communication among coworkers, and further resources.

**Research Question Four**

The fourth research question asked about potential relationships between demographic variables and compassion satisfaction. Results of this study did not replicate past studies which determined that clinicians with more years of experience and female clinicians experience greater amounts of compassion satisfaction (Craig & Sprang, 2010; Linley & Joseph, 2007; Tehrani, 2007). When examining results for all of the participants, no relationships between compassion satisfaction and demographic variables were found. However, the current study did reveal evidence of substantial relationships between compassion satisfaction and other variables depending on education level and work setting.

First, results indicated that compassion satisfaction increased with age for nonstudent participants employed in an agency setting. It is possible that with age comes more experience and skill development, which helps clinicians better cope with job stressors. Other factors that may be impacted by age and experience, such as getting to see clients improve over time, becoming more capable at handling client crisis and trauma, and networking and developing relationships with other clinicians may help
generate feelings of fulfillment as a helper. More seasoned clinicians may have greater awareness of the stress and strain of the field, are better prepared to handle their job, and have more realistic expectations about their occupation (Maslach, 1982). They may also have found that the development of compassion satisfaction keeps them fulfilled and satisfied in their role as a helper. Compassion satisfaction may be a factor that contributes to prolonging one’s career as a counselor.

Next, research has examined the relationship of self-care practices and compassion satisfaction, concluding that a commitment to self-care was related to elevated amounts of compassion satisfaction (Alkema et al., 2008; Kraus, 2005). This study found that psychological self-care was correlated with increased levels of compassion satisfaction for nonstudent participants employed in agency settings. Psychological self-care involves activities that enhance mental wellbeing, including practicing stress reduction techniques, attending personal psychotherapy, self-reflecting, trying new experiences, approaching life with curiosity, and occasionally turning down extra responsibilities. Results suggest that working towards psychological wellness may be a factor in the longevity of being an agency-based counselor.

Last, results of the relationship between compassion satisfaction and self-care for school-based counselors and counselors-in-training was in contradiction to previous research findings and expectations. This study found that compassion satisfaction was negatively correlated with overall self-care practices for nonstudent counselors in a school setting. Nonstudent school-based counselors were also found to have a negative relationship between compassion satisfaction and the physical, psychological, emotional,
spiritual, and balance subcategories of self-care. With the exception of the balance subcategory, the same negative correlations were found for the student participants interning in a school setting.

Numerous hypotheses can be made to explain for these unanticipated results. Compassion satisfaction involves feeling satisfied as a helping professional, whereas self-care practices are activities one engages in for personal wellbeing (Myers & Sweeney, 2005; Radey & Figley, 2007). It is plausible that participating in self-care activities takes away from one’s focus on job fulfillment and satisfaction. Self-care can become another task or burden that actually reduces gratification one has as a helping professional. Perhaps school-based counselors with higher levels of compassion satisfaction are more actively involved in their occupation than personal wellbeing. Their role as a counselor may bring more fulfillment than participating in additional activities outside their occupation.

**Research Question Five**

The fifth and final research question sought to determine potential relationships between demographic variables and self-care practices. Overall, there has been very little research examining the influence of self-care practices on helping professionals. There is currently no past research studies that examine possible connections between demographic variables and self-care activities.

The present study did not find relationships between the amount of self-care activities one participates and one’s age, gender, race, years of experience, or level of education. However, a connection was found between amounts of self-care and work or
internship setting. Those working or interning in an agency or school setting were found to be engaging in less self-care activities than those counselors or counselors-in-training in a private practice setting. This finding was somewhat reflected in past literature that has concluded that counselors working in agency settings are faced with higher stress and demands than those employed in a private practice (Dupree & Day, 1995; Lawson, 2007). Agency work often involves a high degree of productivity and organizational constraints along with minimal control over job tasks and responsibilities (Kottler, 1993; Raquepaw & Miller, 1989). Additionally, agencies are typically the only option for low socioeconomic clients who are often faced with difficult stressors, co-occurring mental health disorders, and past trauma (Sprang et al., 2007).

**Clinical Implications**

This study has uncovered findings that can begin to look at factors contributing to burnout and compassion fatigue. Results concluded that higher amounts of recent life changes were associated with greater levels of burnout and compassion fatigue. These findings may help counselors, counselors-in-training, and supervisors to recognize how recent life changes, especially work-related stressors, can contribute to counselor burnout and compassion fatigue. These results can be used to open up more discussions on counselor wellness and self-care through supervision, training, and educational programs.

Education can be the most fundamental and effective way to assist counselors in preventing compassion fatigue and burnout (Figley, 2002b; Maslach, 1982). Graduate schools, continuing education programs, and supervision may include information on the impact of recent work-related and overall life changes, including defining stressors,
discussing how client care may be impacted, and sharing ways to manage personal and professional changes and stress. As determined by this study, being at risk for compassion fatigue also puts a counselor at risk for developing burnout. Educational opportunities can play a key role in avoiding these issues, including prevention strategies and compassion satisfaction development (Craig & Sprang, 2010; Riordan & Saltzer, 1992; Stebnicki, 2008; Watson & Gauthier, 2003; Young & Lambie, 2007).

The impact of the setting in which a counselor is employed is another consideration brought to attention in this study. Counselors and counselors-in-training at agency and school settings were found to have higher levels of burnout than those in private practice and hospitals. Those interning or working at agency and school settings were also determined to engage in less self-care activities than those in private practice.

These results suggest that the stressors of counseling in agency and school setting may set practitioners up for compassion fatigue and burnout. It is possible that private practices and hospital settings offer smaller caseloads, have less severely traumatized clients, afford greater work-life balance, have less organizational constraints, or provide other factors that seem to inhibit the development of compassion fatigue and burnout. Agency and school settings may benefit from investigating what private practices and hospitals are doing to promote self-care and prevent burnout and compassion fatigue.

Limitations

Several limitations are evident in the present study. First, even though there was a relatively large sample of counselors and counselors-in-training, this research study poses limited generalizability due to the uniformity of the study participants. Majority of the
participants were Caucasian, female, under the age of 40, and with less than 10 years of experience in the field. With so few years of experience, it is possible that many of the participants have not been in the field long enough to have signs of compassion fatigue and burnout. In addition, participants were recruited from a professional conference, online listservs, and internship classes. Counselors and counselors-in-training at a conference or participating in a listserv may have more time to take a survey, may have greater passion for the field, and may be practicing more self-care. Those participants in internship class may have been at the height of their enthusiasm, when they are beginning to see clients for the first time. These factors contribute to the concern that perhaps less experienced and more enthusiastic participants were surveyed in the present study, potentially overestimating compassion satisfaction. Counselors and counselors-in-training who were not surveyed may be fundamentally different than those who were. Counselors and counselors-in-training not surveyed may have less time or may be too overwhelmed to participate in conferences, listservs, or complete research surveys.

Second, there is also potential for the need for social desirability to impact survey results. Due to the stigma of professional burnout and compassion fatigue, these issues are thought to be underreported by helping professionals (Stamm, 1999b). Underestimating undesirable variables is always a concern when relying on self-reports. Being at a conference or in an internship class may have also lifted the participants’ interest in the profession and desire to be competent, lowering reports of compassion fatigue and burnout.
Last, additional limitations involve the instrumentation used to measure the variables. The SCAW has not been thoroughly studied for validity and reliability. This measurement determines different types of self-care for the clinician. There may be more effective forms of self-care that are not included on this survey. The RLCQ included a specific list of recent life changes, limiting respondents only to the stressful events listed on the questionnaire. Other stressors not included on this survey, such as loss of a pet or life stressors of loved ones, may also have impacted one’s experience with the primary variables of this study.

**Recommendations for Future Research**

More research is needed to further understand causes and ways to prevent both burnout and compassion fatigue. Additional studies should also focus on how to develop and sustain compassion satisfaction in the challenging field of counseling. Future studies would benefit from having a more diverse sample. Other factors should be included in future studies, such as exposure to traumatized clients, amount of peer and organizational support, personal attitudes, beliefs, and vulnerabilities, education and training, supervision, other variables that may impact a helping professional’s experience with compassion fatigue, burnout, compassion satisfaction, and self-care. Future research can examine the possible influences of other variables that were not included in the present study.

Setting variables were found to be important factors in the present study. It was found that significant differences between those working or interning in an agency versus those in a school setting. Future research may benefit the field by taking a more in-depth...
examination of such differences, perhaps finding factors that help prevent burnout and compassion fatigue in different settings.

The present study relied on self-reports through surveys to determine these experiences with burnout, compassion fatigue, and other variables. Instead of using self-report surveys, future qualitative studies may have the advantage of discovering potential themes in counselor burnout and compassion fatigue. Qualitative research may also be utilized to explore self-care practices that may assist with coping. Such studies may also reveal information on how more seasoned counselors stayed in the field.

Both quantitative and qualitative research would benefit from longitudinal studies. The present study did not address potential changes that can occur over time. Future research may benefit from taking a longitudinal approach to examining the relationships of these variables. In particular, it may be beneficial to study counselors throughout their careers, noting the development of compassion satisfaction, compassion fatigue, or burnout across the career span. Potential relationships may be uncovered that can help in determining what factors, such as self-care or work setting, influence the long-term progression of compassion fatigue, burnout, or compassion satisfaction.

The current study had a high percentage of student participants. In future longitudinal studies, a researcher could assess for compassion fatigue, burnout, compassion satisfaction in a student who has only just begun working with clients and then reassess these variables along the counselor’s career. Participants in such a longitudinal study can be monitored over the course of their careers. For instance, compassion fatigue and burnout issues and wellness can be reassessed when the
counselor becomes licensed and employed, takes on a larger caseload, and is exposed to clients who have experienced traumatic events.

**Summary**

There were two main purposes to this study: to examine possible relationships between compassion fatigue, burnout, compassion satisfaction, and recent life changes and to determine potential relationships between these primary variables and demographic variables. A convenience sample of 253 counselors and counselors-in-training was collected through a professional conference, internship classes, and email listservs. Participants were administered a demographic questionnaire, the Professional Quality of Life Scale (ProQOL 5), the Self-Care Assessment Worksheet (SCAW), and the Recent Life Changes Questionnaire (RLCQ).

Results of this study determined that counselors and counselors-in-training experience higher levels of burnout and compassion fatigue with greater amounts of recent life changes. Burnout and compassion fatigue were also found to be significantly related. Compassion satisfaction was associated with lower amount of burnout, but did not have a relationship with compassion fatigue.

There is still little research that addresses wellness and burnout and compassion fatigue of helping professionals, particularly professional counselors. Future research is needed to determine effective ways to prevent the impact of working in the field, especially the inherent risk of compassion fatigue and burnout. Additionally, further research is needed to determine what strategies assist counselors in upholding their positions in and reducing the negative effects of being a helping professional.
APPENDICES
Appendix A

Demographic Questionnaire

Please read each statement carefully. Please circle the letter next to your choice or fill in the blank. Thank you for your time and participation.

1. Your sex (please circle one):
   a. Male
   b. Female

2. Your Race/Ethnicity (please circle one):
   a. White/Caucasian
   b. Black/African American
   c. American Indian or Alaskan Native
   d. Asian
   e. Native Hawaiian or Pacific Islander
   f. Hispanic or Latino
   g. Other (please explain): ________________________________

3. Your age ________

4. Level of education (please select one):
   a. Master’s level student; please note anticipated degree name
   b. Master’s Degree (including current Doctoral students); please note degree name
   c. Doctoral Degree; please note degree name
   d. Other (please explain) ________________________________

Please read each statement carefully. Please circle the letter next to your choice or fill in the blank.

5. Current employment or internship setting:
   a. Community Agency
   b. School
   c. Private Practice
   d. Counseling Center at a College/University
   e. Hospital
   f. Counselor Educator
   g. Other (please explain) ________________________________
6. Number of years of counseling experience (post-master’s) _______.

7. Are you currently in internship?
   a. Yes, Master’s level internship.
   b. Yes, Doctoral level internship.
   c. No.
APPENDIX B

RECENT LIFE CHANGES QUESTIONNAIRE (RLQC)
Appendix B

Recent Life Changes Questionnaire (RLCQ)

The Recent Life Changes Questionnaire

This assessment tool provides information regarding the recent life changes you have experienced over the past year.

Instructions: Please place a check mark on the line corresponding with all recent life events that you have experienced within the last year.

______________________________________________

Life Change Event

______________________________________________

Health
1. An injury or illness which:
   - Kept you in bed a week or more, or sent you to the hospital ______
   - Was less serious than above ______
2. Major dental work ______
3. Major change in eating habits ______
4. Major change in sleeping habits ______
5. Major change in your usual type and/or amount of recreation ______

Work
6. Change to a new type of work ______
7. Change in your work hours or conditions ______
8. Change in your responsibilities at work:
   - More responsibilities ______
   - Fewer Responsibilities ______
9. Promotion ______
10. Demotion ______
11. Transfer ______
12. Troubles at work:
   With your boss  ______
   With your coworkers  ______
   With persons under your supervision  ______

13. Other work troubles  ______

14. Major business adjustment  ______

15. Retirement  ______

16. Loss of job:
   Laid off from work  ______
   Fired from work  ______

17. Correspondence course to help you in your work  ______

**Home and Family**

18. Major change in living conditions  ______

19. Change in residence:
   Move within the same town or city  ______
   Move to a different town, city, or state  ______

20. Change in family get-togethers  ______

21. Major change in health or behavior of family member  ______

22. Marriage  ______

23. Pregnancy  ______

24. Miscarriage or abortion  ______

25. Gain of a new family member:
   Birth of a child  ______
   Adoption of a child  ______
   A relative moving in with you  ______

26. Spouse beginning or ending work  ______

27. Child leaving home:
To attend college ______
Due to marriage ______
For other reasons ______

28. Change in arguments with spouse ______

29. In-law problems ______

30. Change in the marital status of your parents:
   Divorce ______
   Remarriage ______

31. Separation from spouse:
   Due to work ______
   Due to marital problems ______

32. Divorce ______

33. Birth of grandchild ______

34. Death of spouse ______

35. Death of other family member:
   Child ______
   Brother or sister ______
   Parent ______

**Personal and Social**

36. Change in personal habits ______

37. Beginning or ending school or college ______

38. Change of school or college ______

39. Change in political beliefs ______

40. Change in religious beliefs ______

41. Change in social activities ______

42. Vacation ______

43. New, close, personal relationship ______
44. Engagement to marry ______
45. Girlfriend or boyfriend problems ______
46. Sexual difficulties ______
47. “Falling out” of a close personal relationship ______
48. An accident ______
49. Minor violation of the law ______
50. Being held in jail ______
51. Death of a close friend ______
52. Major decision regarding your immediate future ______
53. Major personal achievement ______

Financial
54. Major change in finances:
   Increased income ______
   Decreased income ______
   Investment and/or credit difficulties ______
55. Loss or damage of personal property ______
56. Moderate purchase ______
57. Major purchase ______
58. Foreclosure on a mortgage or loan ______

APPENDIX C

PERMISSION TO USE THE RLCQ
Appendix C

Permission to Use the RLCQ

On Tue, Jun 7, 2011 at 4:24 PM, Katharina Star <kstar720@yahoo.com> wrote:
Dear Dr. Rahe,

I am a doctoral candidate in the Counseling and Human Development program at Kent State University. I am currently working on my dissertation. I am conducting a study to examine self-care, compassion fatigue, and burnout among professional counselors and counselors-in-training. I am very interested in using the Holmes-Rahe Social Readjustment Rating Scale to account for stressful life events that may influence scores on other measures.

Please inform me of the steps needed to gain permission a) for the use of this scale and b) to make item wording changes to better fit participants.

Thank you for your time and consideration in this matter.

Katharina Star, PC

Dear Katharina,

You certainly have my permission to use the original SRRS in your dissertation. However, the Social Readjustment Rating Scale (SRRS) was developed in the early 1960s. I revised the scale 3 times over the years and the most recent revision is found in the Miller and Rahe article listed on my Publications page on my web site (www.drrahe.com). You really need to read that article as it has the history of the SRRS leading to my Recent Life Changes Questionnaire (RLCQ) that is presented in the Appendix of that article. Also, the points for the life change events in the SRRS, later termed Life Change Units (LCU), are far out of date. The Miller and Rahe article presents the most recent LCU determinations, made in the 1990s. Finally, the RLCQ has more life change events than the SRRS making it a more comprehensive survey for persons’ recent life stress.

Richard H. Rahe, M.D.
Professor of Psychiatry
President, Health Assessment Programs, Inc.
3907 Croisan Mt. Dr. S.
Salem, Oregon 97302
APPENDIX D

THE PROFESSIONAL QUALITY OF LIFE SCALE 5 (PROQOL 5)
Appendix D

The Professional Quality of Life Scale 5 (ProQol 5)

Compassion Satisfaction and Compassion Fatigue (ProQOL) Version 5 (2009)

When you counsel people you have direct contact with their lives. As you may have found, your compassion for those you counsel can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a counselor or counselor-in-training. Consider each of the following questions about you and your current work situation. Circle the response that honestly reflects how frequently you experienced these things in the last 30 days.

1. I am happy.
   - Never
   - Rarely
   - Sometimes
   - Often
   - Very Often

2. I am preoccupied with more than one person I counsel.
   - Never
   - Rarely
   - Sometimes
   - Often
   - Very Often

3. I get satisfaction from being able to counsel people.
   - Never
   - Rarely
   - Sometimes
   - Often
   - Very Often

4. I feel connected to others.
   - Never
   - Rarely
   - Sometimes
   - Often
   - Very Often

5. I jump or am startled by unexpected sounds.
   - Never
   - Rarely
   - Sometimes
   - Often
   - Very Often

6. I feel invigorated after working with those I counsel.
   - Never
   - Rarely
   - Sometimes
   - Often
   - Very Often

7. I find it difficult to separate my personal life from my life as a counselor.
   - Never
   - Rarely
   - Sometimes
   - Often
   - Very Often

8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I counsel.
   - Never
   - Rarely
   - Sometimes
   - Often
   - Very Often

9. I think that I might have been affected by the traumatic stress of those I counsel.
   - Never
   - Rarely
   - Sometimes
   - Often
   - Very Often
10. I feel trapped by my job as a counselor.
   Never Rarely Sometimes Often Very Often

11. Because of my counseling, I have felt “on edge” about various things.
   Never Rarely Sometimes Often Very Often

12. I like my work as a counselor.
   Never Rarely Sometimes Often Very Often

13. I feel depressed because of the traumatic experiences of the people I counsel.
   Never Rarely Sometimes Often Very Often

14. I feel as though I am experiencing the trauma of someone I have counseled.
   Never Rarely Sometimes Often Very Often

15. I have beliefs that sustain me.
   Never Rarely Sometimes Often Very Often

16. I am pleased with how I am able to keep up with counseling techniques and protocols.
   Never Rarely Sometimes Often Very Often

17. I am the person I always wanted to be.
   Never Rarely Sometimes Often Very Often

18. My work makes me feel satisfied.
   Never Rarely Sometimes Often Very Often

19. I feel worn out because of my work as a counselor.
   Never Rarely Sometimes Often Very Often

20. I have happy thoughts and feelings about those I counsel and how I could help them.
   Never Rarely Sometimes Often Very Often

21. I feel overwhelmed because my caseload seems endless.
   Never Rarely Sometimes Often Very Often

22. I believe I can make a difference through my work.
   Never Rarely Sometimes Often Very Often
23. I avoid certain activities or situations because they remind me of frightening experiences of the people I counsel.
   Never  Rarely  Sometimes  Often  Very Often

24. I am proud of what I can do to counsel.
   Never  Rarely  Sometimes  Often  Very Often

25. As a result of my counseling, I have intrusive, frightening thoughts.
   Never  Rarely  Sometimes  Often  Very Often

26. I feel “bogged down” by the system.
   Never  Rarely  Sometimes  Often  Very Often

27. I have thoughts that I am a “success” as a counselor.
   Never  Rarely  Sometimes  Often  Very Often

28. I can’t recall important parts of my work with trauma victims.
   Never  Rarely  Sometimes  Often  Very Often

29. I am a very caring person.
   Never  Rarely  Sometimes  Often  Very Often

30. I am happy that I chose to do this work.
   Never  Rarely  Sometimes  Often  Very Often

© B. Hudnall Stamm. (2009). Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL). /www.isu.edu/~bhstamm or www.proqol.org. This test may be freely copied as long as (a) author is credited, (b) no changes are made, and (c) it is not sold.
APPENDIX E

PERMISSION TO USE THE PROQOL
Appendix E

Permission to Use the ProQOL

Hello,

Thank you for your request for the ProQOL. Please accept my sincere apology for the delay in replying to you. Our usual online support person is in Africa at the moment which caused delays in our responses.

Attached is the document you requested.

I wish you the very best as you use the ProQOL. Please do consider donating a copy of your data if that is possible http://www.proqol.org/About_ProQOL_Data_Bank.html. It is through these donations that we are able to progress the measure.

Beth Hudnall Stamm
Director, ProQOL.org

On 6/7/2011 5:10 PM, wst_formmailer@secureserver.net wrote:
Customized Permission : True
Please tell us briefly about your project (1-3 sentences is fine): I am a doctoral candidate in Counseling at Kent State University. My dissertation study is focused on self-care strategies, compassion fatigue, burnout, and compassion satisfaction among professional counselors and counselors-in-training.
Proposed wording change (if appropriate): A formal permission document to include in my dissertation.
Other Wording Change:
Translation Request: (if appropriate). Please tell us what language and if you want to create a new translation or improve an existing one.
Other:
First or Given Name: Katharina
Family or Last Name: Star
Organization (if appropriate): Kent State University
Address 1: 572 Sandalwood Dr.
Address 2: 
City: Bay Village
Postal Code: 44140
Country: USA
State or Provence: OH
email: kstar720@yahoo.com
APPENDIX F

THE SELF-CARE ASSESSMENT WORKSHEET
Appendix F

The Self-Care Assessment Worksheet

Self-Care Assessment Worksheet

This assessment tool provides an overview of effective strategies to maintain self-care. Rate the following areas of self-care in terms of frequency by circling one response under each item:

Physical Self-Care

Eat regularly (e.g., breakfast, lunch, and dinner)
- Frequently
- Occasionally
- Rarely
- Never
- It never occurred to me

Eat healthy
- Frequently
- Occasionally
- Rarely
- Never
- It never occurred to me

Exercise
- Frequently
- Occasionally
- Rarely
- Never
- It never occurred to me

Get regular medical care for prevention
- Frequently
- Occasionally
- Rarely
- Never
- It never occurred to me

Get medical care when needed
- Frequently
- Occasionally
- Rarely
- Never
- It never occurred to me

Take time off when needed
- Frequently
- Occasionally
- Rarely
- Never
- It never occurred to me

Get massages
- Frequently
- Occasionally
- Rarely
- Never
- It never occurred to me

Dance, swim, walk, run, play sports, sing, or do some other physical activity that is fun
- Frequently
- Occasionally
- Rarely
- Never
- It never occurred to me

Take time to be sexual—with yourself, with a partner
- Frequently
- Occasionally
- Rarely
- Never
- It never occurred to me

Get enough sleep
- Frequently
- Occasionally
- Rarely
- Never
- It never occurred to me
Wear clothes you like
  Frequently Occasionally Rarely Never It never occurred to me

Take vacations
  Frequently Occasionally Rarely Never It never occurred to me

Take day trips or mini-vacations
  Frequently Occasionally Rarely Never It never occurred to me

Make time away from telephones
  Frequently Occasionally Rarely Never It never occurred to me

Other, please describe:
  Frequently Occasionally Rarely Never It never occurred to me

Psychological Self-Care
  Make time for self-reflection
    Frequently Occasionally Rarely Never It never occurred to me

Have your own personal psychotherapy
  Frequently Occasionally Rarely Never It never occurred to me

Write in a journal
  Frequently Occasionally Rarely Never It never occurred to me

Read literature that is unrelated to work
  Frequently Occasionally Rarely Never It never occurred to me

Do something at which you are not expert or in charge
  Frequently Occasionally Rarely Never It never occurred to me

Decrease stress in your life
  Frequently Occasionally Rarely Never It never occurred to me

Let others know different aspects of you
  Frequently Occasionally Rarely Never It never occurred to me

Notice your inner experience—listen to your thoughts, judgments, beliefs, attitudes, and feelings
  Frequently Occasionally Rarely Never It never occurred to me
Engage your intelligence in a new area, e.g., go to an art museum, history exhibit, sports event, auction, theater performance
Frequently  Occasionally  Rarely  Never  It never occurred to me

Practice receiving from others
Frequently  Occasionally  Rarely  Never  It never occurred to me

Be curious
Frequently  Occasionally  Rarely  Never  It never occurred to me

Say “no” to extra responsibilities sometimes
Frequently  Occasionally  Rarely  Never  It never occurred to me

Other, please describe:
Frequently  Occasionally  Rarely  Never  It never occurred to me

**Emotional Self-Care**
Spend time with others whose company you enjoy
Frequently  Occasionally  Rarely  Never  It never occurred to me

Stay in contact with important people in your life
Frequently  Occasionally  Rarely  Never  It never occurred to me

Give yourself affirmations, praise yourself
Frequently  Occasionally  Rarely  Never  It never occurred to me

Love yourself
Frequently  Occasionally  Rarely  Never  It never occurred to me

Re-read favorite books, re-view favorite movies
Frequently  Occasionally  Rarely  Never  It never occurred to me

Identify comforting activities, objects, people, relationships, places and seek them out
Frequently  Occasionally  Rarely  Never  It never occurred to me

Allow yourself to cry
Frequently  Occasionally  Rarely  Never  It never occurred to me

Find things that make you laugh
Frequently  Occasionally  Rarely  Never  It never occurred to me

Express your outrage in social action, letters and donations, marches, protests
Frequently  Occasionally  Rarely  Never  It never occurred to me
<table>
<thead>
<tr>
<th>Activity</th>
<th>Frequently</th>
<th>Occasionally</th>
<th>Rarely</th>
<th>Never</th>
<th>It never occurred to me</th>
</tr>
</thead>
<tbody>
<tr>
<td>Play with children</td>
<td>It never occurred to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other, please explain:</td>
<td>It never occurred to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Spiritual Self-Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Make time for reflection</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spend time with nature</td>
<td>It never occurred to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Find a spiritual connection or community</td>
<td>It never occurred to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Be open to inspiration</td>
<td>It never occurred to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cherish your optimism and hope</td>
<td>It never occurred to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Be aware of nonmaterial aspects of life</td>
<td>It never occurred to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Try at times not to be in charge or the expert</td>
<td>It never occurred to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Be open to not knowing</td>
<td>It never occurred to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify what is meaningful to you and notice its place in your life</td>
<td>It never occurred to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meditate</td>
<td>It never occurred to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pray</td>
<td>It never occurred to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sing</td>
<td>It never occurred to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Spend time with children
   Frequently  Occasionally  Rarely  Never  It never occurred to me

Have experiences of awe
   Frequently  Occasionally  Rarely  Never  It never occurred to me

Contribute to causes in which you believe
   Frequently  Occasionally  Rarely  Never  It never occurred to me

Read inspirational literature (talks, music, etc.)
   Frequently  Occasionally  Rarely  Never  It never occurred to me

Other, please explain:
   Frequently  Occasionally  Rarely  Never  It never occurred to me

Workplace or Professional Self-Care
   Take a break during the workday (e.g., lunch)
      Frequently  Occasionally  Rarely  Never  It never occurred to me

   Take time to chat with co-workers
      Frequently  Occasionally  Rarely  Never  It never occurred to me

   Make quiet time to complete tasks
      Frequently  Occasionally  Rarely  Never  It never occurred to me

   Identify projects or tasks that are exciting and rewarding
      Frequently  Occasionally  Rarely  Never  It never occurred to me

   Set limits with your clients and colleagues
      Frequently  Occasionally  Rarely  Never  It never occurred to me

   Balance your caseload so that no one day or part of a day is “too much”
      Frequently  Occasionally  Rarely  Never  It never occurred to me

   Arrange your work space so it is comfortable and comforting
      Frequently  Occasionally  Rarely  Never  It never occurred to me

   Get regular supervision or consultation
      Frequently  Occasionally  Rarely  Never  It never occurred to me

   Negotiate for your needs (benefits, pay raise)
      Frequently  Occasionally  Rarely  Never  It never occurred to me
Have a peer support group
- Frequently  Occasionally  Rarely  Never  It never occurred to me

Other:
- Frequently  Occasionally  Rarely  Never  It never occurred to me

Balance
Strive for balance within your work-life and workday
- Frequently  Occasionally  Rarely  Never  It never occurred to me

Strive for balance among work, family, relationships, play and rest
- Frequently  Occasionally  Rarely  Never  It never occurred to me

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APPENDIX G

PERMISSION TO USE THE SCAW
Appendix G

Permission to Use the SCAW

Dear Katharina Star:

Thank you for your request to use the Self-Care Assessment Worksheet from TRANSFORMING THE PAIN by Karen W. Saakvitne and Laurie Anne Pearlman in your dissertation for Kent State University. This letter will grant you one time, nonexclusive rights to use the material in your dissertation, and in all copies to meet university requirements subject to the following conditions:

1. Such material must either be reproduced exactly as it appears in our publication, or if edited to be shown as adapted from our publication;

2. Full acknowledgment of the title, author, copyright and publisher is given as follows:


3. You must reapply for permission if your dissertation is later published.

Yours,

Elizabeth Clementson

Permissions Manager
W.W. Norton & Company
500 5th Avenue
New York, NY 10110

---

From: ektron@wwnorton.com
Sent: Wednesday, June 22, 2011 2:43 PM
To: Permissions
Subject: WW Norton - Permissions Inquiry

You have received a permissions inquiry from the W.W. Norton WEB site.

Name: Katharina Star
Company:
Addr 1: 572 Sandalwood Dr.
Addr 2:
City: Bay Village
State: OH
Zip: 44140
Phone: 216-924-7946
Fax:
Email: kstar720@yahoo.com

Book Information ...
Publisher: Norton
Author/Editor: Karen W. Saakvitne & Laurie Anne Pearlman
Title: Transforming the Pain: A Workbook on Vicarious Traumatization
Copyright Line: Self-Care Assessment Worksheet
Pages on which excerpt appears: 63-66
Title of Selection: Self-Care Assessment Worksheet
Total no of Pages: 4
Total Words/Lines: 83 lines
Total no of Illus:

Your Publication ...
Title: TBA
Author/Editor: Katharina Star
Publisher: Kent State University
Publication Date: TBA
Publication Format: Other
Number of Pages: TBA
Amount of First Print Run: N/A
Price: N/A
Territory: North American
Comments: I am a doctoral candidate at Kent State University. I am currently working on my dissertation. My study is examining self-care practices, compassion fatigue, burnout, and compassion satisfaction of counselors and counselors-in-training. I would like to use the Self-care Assessment Worksheet from this publication for my study. Thank you for your time and consideration. -Katharina Star
Appendix H

IRB Approval Letter

RE: IRB #11-416 entitled “The Relationship Between Self-Care Practices, Burnout, Compassion Fatigue, and Compassion Satisfaction Among Professional Counselors and Counselors-in-Training”

I am pleased to inform you that the Kent State University Institutional Review Board reviewed and approved your Application for Approval to Use Human Research Participants. Approval is effective for a twelve-month period:

October 18, 2011 through October 17, 2012

Federal regulations and Kent State University IRB policy require that research be reviewed at intervals appropriate to the degree of risk, but not less than once per year. The IRB has determined that this protocol requires an annual review and progress report. The IRB tries to send you annual review reminder notice to by email as a courtesy. However, please note that it is the responsibility of the principal investigator to be aware of the study expiration date and submit the required materials. Please submit review materials (annual review form and copy of current consent form) one month prior to the expiration date.

HHS regulations and Kent State University Institutional Review Board guidelines require that any changes in research methodology, protocol design, or principal investigator have the prior approval of the IRB before implementation and continuation of the protocol. The IRB must also be informed of any adverse events associated with the study. The IRB further requests a final report at the conclusion of the study.

Kent State University has a Federal Wide Assurance on file with the Office for Human Research Protections (OHRP); FWA Number 00001853.

If you have any questions or concerns, please contact me at 330-672-2704 or pwashko@kent.edu.

Respectfully,

Kent State University Office of Research Compliance
224 Cartwright Hall | fax 330.672.2658

Kevin McCreary | Research Compliance Coordinator | 330.672.8058 | kmccrea1@kent.edu
Laurie Kiehl | Administrative Clerk | 330.672.0837 | lkiehl@kent.edu
Paulette Washko | Manager, Research Compliance | 330.672.2704 | Pwashko@kent.edu
APPENDIX I

ALL OHIO COUNSELORS CONFERENCE APPROVAL
--- Forwarded Message
From: Tim Luckhaupt <ocaohio@yahoo.com>
Reply-To: Tim Luckhaupt <ocaohio@yahoo.com>
Date: Tue, 27 Sep 2011 19:45:29 -0400
To: “RAINEY, JOHN” <jrainey@kent.edu>
Cc: “J. David Luckhaupt” <luckyrxosu@msn.com>
Subject: Re: AOCC

Hi Steve,

Please accept this email as permission for your grad student to set-up a table in the registration area to gather research for her project. I’m not exactly sure where we are going to put her yet but she should see our exhibit manager, David Luckhaupt.

Will she be conducting her research all three days of the conference or only on Thursday & Friday?

Tim
APPENDIX J

ALL OHIO COUNSELORS CONFERENCE INVITATION TO PARTICIPATE
Appendix J

All Ohio Counselors Conference Invitation to Participate

Dear Potential Research Participant:
Are you a **licensed counselor** (mental health, school, educator, or supervisor) or **counselor-in-training** (internship level student or pre-licensure counselor)?
If so, I invite you to participate in a study here at the 2011 All Ohio Counselors Conference. My name is Katharina Star and I am a doctoral candidate in the Counseling and Human Development Services Program at Kent State University.

The purpose of this research study is to determine the possible relationship between self-care and compassion fatigue, burnout, recent life changes, and compassion satisfaction among counselors and counselors-in-training.

This study will consist of a demographic questionnaire and three brief inventories, measuring recent life events, self-care, burnout, compassion fatigue and compassion satisfaction. It will take approximately 15-20 minutes to complete this survey. Once you have completed the survey, you will have the opportunity to be entered into a drawing to win a **$75.00 gift card** for the Self-Esteem Shop.

Please consider participating in this study. Your responses are confidential and data related to your responses will remain anonymous. Participation in this survey is voluntary and you may withdraw at any time without penalty. Complete information for informed consent will be provided at my table.

Please find my table located outside the Regent Ballroom 3. Your participation is greatly appreciated. Please feel free to contact me with any additional questions.

Sincerely,
Katharina Star, PC
Doctoral Candidate, Kent State University, Kent, OH
Phone: 216-924-7946
Email: kstar720@yahoo.com

Faculty advisors for this study, Dr. Jane Cox and Dr. Steve Rainey can be reached at 310 White Hall, PO Box 5190, Kent State University, Kent, OH, 44242-0001 or by phone at (330)-672-2662.
APPENDIX K

INFORMED CONSENTS
Appendix K

Informed Consent for All Ohio Counseling Conference Attendees

Informed Consent to Participate in a Research Study

**Study Title:** The Relationship Between Self-Care Practices, Burnout, Compassion Fatigue, and Compassion Satisfaction Among Professional Counselors and Counselors-in-Training

**Principal Investigator:** Katharina L. Star, PC, Doctoral Candidate, Counseling & Human Development Services Program at Kent State University

Hello. You are being invited to participate in my research study. This consent form will provide you with information on the research project, what you will need to do, and the associated risks and benefits of the research. Your participation is voluntary. Please read this form carefully. It is important that you ask questions and fully understand the research in order to make an informed decision. You will receive a copy of this document to take with you.

**Purpose:** I am conducting this research study to examine the possible relationships between self-care, compassion fatigue, compassion satisfaction, recent life events, and burnout among professional counselors and counselors-in-training. I am also examining if demographic factors, such as education level or years of experience, have a significant relationship with counselors’ and trainees’ experiences of self-care, compassion fatigue, compassion satisfaction, and burnout. I want to conduct this study because I believe that more attention is needed in understanding counselor wellness and preventing counselor impairment. The results of this study may guide future training and education for counselors and counselors-in-training. Additionally, results of this study may lead to further research studies aimed at improving counselor wellness and reducing counselor impairment.

**Procedures:** To participate in this study you must be a professional counselor (i.e., mental health counselor, school counselor, counselor educator, etc.) or a counselor-in-training who is currently enrolled in internship class or has completed a graduate-level internship course in counseling. Additionally, in order to be eligible for participation, I ask that you only complete this study up to one time. To take part in my study, please
complete the contents of this research packet. Here you will find an instructions sheet, demographics questionnaire, and three surveys. The demographics questionnaire will ask you questions regarding your sex, age, race, years of experience as a counselor, internship level, and employment type/internship placement. The three questionnaires will ask that you to answer questions about your recent life changes, self-care practices, and personal experiences with compassion fatigue, burnout, and compassion satisfaction.

Please follow the directions on the top of the demographic questionnaire and instruments. This research packet should take approximately 15 to 20 minutes to complete. All responses are treated as confidential, and in no case will responses from individual participants be identified. Rather, all data will be pooled and published in aggregate form only. Please know that your participation is voluntary and that you may stop participating in this study at any time without penalty. Returning this completed research packet to the researcher will indicate your consent.

**Potential Benefits:** This research study will not benefit you directly. However, it has the potential to help benefit the counseling field. Knowing more about the relationship between self-care practices, compassion fatigue, burnout, and compassion satisfaction may help in the development of training and education to improve counselor wellness and prevent counselor impairment.

**Potential Risks:** This research study asks that you self-report on your experiences with self-care, compassion fatigue, compassion satisfaction, burnout, and recent life events. Participation in this study may increase your personal awareness to your own experiences with stress, inadequate self-care, or issues pertaining to burnout and compassion fatigue. If you happen to feel undue stress or discomfort from participating in this study, please contact the Kent State University Counseling and Human Development Center for support at (330) 672-2208.

**Compensation:** Participants will have the opportunity to win a $75.00 gift card for the Self-Esteem Shop, a provider of books and resources for mental health professionals. Participants who complete this study will be entered into a drawing. One participant will be drawn and will receive the gift card. The numerical chance of winning the raffle is approximately one in 125 to 180 participants. Your name and home address will be used to identify you for the drawing. Put your return address on the provided notecard when you return the questionnaire. Your notecard is to be placed in a separate envelope that is with the researcher. If your address is drawn I will mail you the prize. All identifying information will be destroyed after the study.

**Privacy and Confidentiality:** All responses are treated as confidential, and in no case will responses from individual participants be identified. Rather, all data will be pooled and published in aggregate form only. Your study related information will be kept confidential within the limits of the law. Any identifying information will be kept in a secure location and only the researcher will have access to the data.
Research participants will not be identified in any publication or presentation of research results; only aggregate data will be used. Responses to this study will not be linked to you. The completed notecard for raffle participants will be kept separate from your study data. Your anonymity is further protected by not asking you to sign and return the informed consent form.

**Voluntary Participation:** Taking part in this research study is entirely up to you. Please do not complete this study more than one time. You may choose not to participate or you may discontinue your participation at any time without penalty or loss of benefits to which you are otherwise entitled. You will be informed of any new, relevant information that may affect your health, welfare, or willingness to continue your study participation.

**Contact:** If you have any questions, comments, and/or concerns regarding this study, please contact Katharina L. Star at (216) 924-7946. Faculty advisors for this study, Dr. Jane Cox and Dr. Steve Rainey can be reached at 310 White Hall, PO Box 5190, Kent State University, Kent, OH, 44242-0001 or by phone at (330) 672-2662. This project has been approved by the Kent State University Institutional Review Board. If you have any questions about your rights as a research participant or complaints about the research, you may call the IRB at (330)-672-2704.

**Consent Statement:** You have read this consent form and have had the opportunity to have your questions answered to your satisfaction. You voluntarily agree to participate in this study. You understand that a copy of this consent will be provided to you for future reference. Your completion and return of this research packet will be indicative of your consent to participate in this research study. You have been given a copy of this consent form.

I greatly appreciate your time and help with this study.

Sincerely,

Katharina L. Star, PC
Kent State University

Jane Cox, Ph.D.
Kent State University

Steve Rainey, Ph.D.
Kent State University
Informed Consent for Students

KENT STATE UNIVERSITY

Informed Consent to Participate in a Research Study

**Study Title:** The Relationship Between Self-Care Practices, Burnout, Compassion Fatigue, and Compassion Satisfaction Among Professional Counselors and Counselors-in-Training

**Principal Investigator:** Katharina L. Star, PC, Doctoral Candidate, Counseling & Human Development Services Program at Kent State University

Hello. You are being invited to participate in my research study. This consent form will provide you with information on the research project, what you will need to do, and the associated risks and benefits of the research. Your participation is voluntary. Please read this form carefully. It is important that you ask questions and fully understand the research in order to make an informed decision. You will receive a copy of this document to take with you.

**Purpose:** I am conducting this research study to examine the possible relationships between self-care, compassion fatigue, compassion satisfaction, recent life events, and burnout among professional counselors and counselors-in-training. I am also examining if demographic factors, such as education level or years of experience, have a significant relationship with counselors’ and trainees’ experiences of self-care, compassion fatigue, compassion satisfaction, and burnout. I want to conduct this study because I believe that more attention is needed in understanding counselor wellness and preventing counselor impairment. The results of this study may guide future training and education for counselors and counselors-in-training. Additionally, results of this study may lead to further research studies aimed at improving counselor wellness and reducing counselor impairment.

**Procedures:** To participate in this study you must be a professional counselor (i.e. mental health counselor, school counselor, counselor educator, etc.) or a counselor-in-training who is currently enrolled in internship class or has completed a graduate-level internship course in counseling. Additionally, in order to be eligible for participation, I ask that you only complete this study up to one time. To take part in my study, please complete the contents of this research packet. Here you will find an instructions sheet, demographics questionnaire, and three surveys. The demographics questionnaire will ask you questions regarding your sex, age, race, years of experience as a counselor,
internship level, and employment type/internship placement. The three questionnaires will ask that you to answer questions about your recent life changes, self-care practices, and personal experiences with compassion fatigue, burnout, and compassion satisfaction. Please follow the directions on the top of the demographic questionnaire and instruments. This research packet should take approximately 15 to 20 minutes to complete. All responses are treated as confidential, and in no case will responses from individual participants be identified. Rather, all data will be pooled and published in aggregate form only. Please know that your participation is voluntary and that you may stop participating in this study at any time without penalty. Returning this completed research packet to the researcher will indicate your consent.

**Potential Benefits:** This research study will not benefit you directly. However, it has the potential to help benefit the counseling field. Knowing more about the relationship between self-care practices, compassion fatigue, burnout, and compassion satisfaction may help in the development of training and education to improve counselor wellness and prevent counselor impairment.

**Potential Risks:** This research study asks that you self-report on your experiences with self-care, compassion fatigue, compassion satisfaction, burnout, and recent life events. Participation in this study may increase your personal awareness to your own experiences with stress, inadequate self-care, or issues pertaining to burnout and compassion fatigue. If you happen to feel undue stress or discomfort from participating in this study, please contact the Kent State University Counseling and Human Development Center for support at (330) 672-2208.

**Compensation:** Participants will have the opportunity to win a $75.00 gift card for the Self-Esteem Shop, a provider of books and resources for mental health professionals. Participants who complete this study will be entered into a drawing. One participant will be drawn and will receive the gift card. The numerical chance of winning the raffle is approximately one in 125 to 180 participants. Your name and home address will be used to identify you for the drawing. Put your return address on the provided notecard when you return the questionnaire. Your notecard is to be placed in a separate envelope that is with the researcher. If your address is drawn I will mail you the prize. All identifying information will be destroyed after the study.

**Privacy and Confidentiality:** All responses are treated as confidential, and in no case will responses from individual participants be identified. Rather, all data will be pooled and published in aggregate form only. Your study related information will be kept confidential within the limits of the law. Any identifying information will be kept in a secure location and only the researcher will have access to the data.

Research participants will not be identified in any publication or presentation of research results; only aggregate data will be used. Responses to this study will not be linked to you. The completed notecard for raffle participants will be kept separate from your study
data. Your anonymity is further protected by not asking you to sign and return the informed consent form.

**Voluntary Participation:** Participating in this research study is entirely up to you. You may choose to not participate or discontinue participation at any time without penalty. Please know that not participating or discontinuing participation at any time will not affect your course grade.

**Contact:** If you have any questions, comments, and/or concerns regarding this study, please contact Katharina L. Star at (216) 924-7946. Faculty advisors for this study, Dr. Jane Cox and Dr. Steve Rainey can be reached at 310 White Hall, PO Box 5190, Kent State University, Kent, OH, 44242-0001 or by phone at (330) 672-2662. This project has been approved by the Kent State University Institutional Review Board. If you have any questions about your rights as a research participant or complaints about the research, you may call the IRB at (330)-672-2704.

**Consent Statement:** You have read this consent form and have had the opportunity to have your questions answered to your satisfaction. You voluntarily agree to participate in this study. You understand that a copy of this consent will be provided to you for future reference. Your completion and return of this research packet will be indicative of your consent to participate in this research study. You have been given a copy of this consent form.

I greatly appreciate your time and help with this study.

Sincerely,

Katharina L. Star, PC
Kent State University

Jane Cox, Ph.D.
Kent State University

Steve Rainey, Ph.D.
Kent State University
Informed Consent for Listserv Participants

The Relationship Between Self-Care Practices, Burnout, Compassion Fatigue, and Compassion Satisfaction Among Professional Counselors And Counselors-in-Training

Welcome to “The Relationship Between Self-Care Practices, Burnout, Compassion Fatigue, and Compassion Satisfaction Among Professional Counselors And Counselors-in-Training” a web-based research study. Before taking part in this study, please read the consent form below and click on the “I Agree” button at the bottom of the page if you understand the statements and freely consent to participate in the study.

Consent Form

This study involves a web-based survey designed to understand potential relationships between self-care, compassion fatigue, burnout, compassion satisfaction, and recent life changes among counselors and counselors-in-training. This study is being conducted by Katharina L. Star, a doctoral candidate in the Counseling & Human Services Program at Kent State University, and it has been approved by the Kent State University Institutional Review Board. No deception is involved, and the study involves no more than minimal risk to participants (i.e., the level of risk encountered in daily life). Participation in the study typically takes 15 to 20 minutes and is strictly anonymous. Participants begin by answering a demographic questionnaire, followed by surveys about personal experiences with self-care, compassion fatigue, burnout, compassion satisfaction, and recent life changes.

All responses are treated as confidential, and in no case will responses from individual participants be identified. Rather, all data will be pooled and published in aggregate form only. Participants should be aware, however, that the experiment is not being run from a “secure” https server of the kind typically used to handle credit card transactions, so there is a small possibility that responses could be viewed by unauthorized third parties (e.g., computer hackers). Email and IP addresses will not be collected by the researcher.

Participants who complete the entire online study will be afforded the opportunity to win a $75.00 gift certificate to the Self-Esteem Shop, a provider of books and resources for mental health professionals. To be entered into the drawing, you will be asked to provide your name and address. One participant will be drawn and win the prize. If you win, I will mail you the prize. The numerical chance of winning the raffle is approximately one in 125 to 180 participants. Raffle information will be kept separate from survey responses. Participation is voluntary, refusal to take part in the study involves no penalty or loss of benefits to which participants are otherwise entitled, and participants may withdraw from the study at any time without penalty or loss of benefits to which they are otherwise entitled. To be an eligible participant, please only take this study one time.

If participants have further questions about this study or their rights, or if they wish to lodge a complaint or concern, they may contact the principal investigator, Katharina L. Star at (216) 924-7946, Faculty advisors for this study, Dr. Jane Cox and Dr. Steve Rainey at (330)-672-2662, or the Kent State University Institutional Review Board, at (330) 672-2704.

If you are 18 years of age or older, understand the statements above, and freely consent to participate in the study, click on the “I Agree” button to begin the experiment.

[ I Agree ] [ I Do Not Agree ]
APPENDIX L

SAMPLE SCRIPT FOR COURSE INSTRUCTOR
Appendix L

Sample Script for Course Instructors

Dear (NAME),

My name is Katharina Star and I am a doctoral candidate in the Counseling and Human Development Services Program at Kent State University. I am currently conducting a study to learn more about the potential experiences of and relationships between self-care, compassion fatigue, burnout, and compassion satisfaction among counselors and counselors-in-training. It is my hope that this study will contribute towards understanding and improving counselor wellness and reducing counselor impairment.

I am inquiring about the possibility of recruiting participants through the internship courses you instruct at (COLLEGE/UNIVERSITY NAME). If given your permission, I would come to your class at an agreed upon time to administer the research packets. These research packets will contain an informed consent for the participants to keep, instructions, a demographic questionnaire, and three surveys. The entire packet should take approximately 15 to 20 minutes to complete. All participants will have an opportunity to be entered into a raffle for a $75.00 gift certificate to The Self-Esteem Shop, a provider of books and resources for mental health professionals.

This study has been approved by the Kent State University Institutional Review Board. KSU IRB Protocol # 11-416. As a researcher, I will follow any procedures required by other schools’ Institutional Review Board.

Your permission and participation are greatly appreciated. Thank you for your time and consideration in this matter.

Katharina Star, PC
Doctoral Candidate, Kent State University, Kent, OH
Email: kstar720@yahoo.com
Phone: (216) 924-7946

Faculty advisors for this study, Dr. Jane Cox and Dr. Steve Rainey can be reached at 310 White Hall, PO Box 5190, Kent State University, Kent, OH, 44242-0001 or by phone at (330)-672-2662.
APPENDIX M

SAMPLE SCRIPT FOR RECRUITING LISTSERV USERS
Appendix M

Sample Script For Recruiting Listserv Users

Dear Listserv Member:

My name is Katharina Star and I am a doctoral candidate in the Counseling and Human Development Services Program at Kent State University.

I invite you to participate in a study surveying professional counselors (school, mental health, educators, and supervisors) and counselors-in-training (internship level students and pre-licensure counselors).

The purpose of this research study is to determine the possible relationship between self-care and compassion fatigue, burnout, and compassion satisfaction among counselors and counselors-in-training.

Please consider participating in this study. If you complete this survey, you are eligible to be entered into a raffle for a $75.00 gift certificate for the Self-Esteem Shop, a provider of books and resources for mental health professionals. Your responses are confidential, data related to your responses will remain anonymous, and identifying information collected for the raffle will be kept separate for your survey responses. Participation in this survey is voluntary and you may withdraw at any time without penalty. Below is a copy of the informed consent for your review. Please feel free to request a copy to print and/or save.

This study will consist of a demographic questionnaire and three brief inventories, measuring recent life events, self-care, burnout, compassion fatigue and compassion satisfaction. It will take approximately 15-20 minutes to complete this survey.

If you would like to participate, please click on the link below or copy-paste it into the address bar on your browser:

http://www.surveymonkey.com/

Thank you very much for your time and consideration. Your participation is greatly appreciated. Please feel free to contact me should you have any questions. I also encourage you to forward this survey to your students and colleagues for their consideration to complete as well.

Katharina Star, PC
Doctoral Candidate, Kent State University, Kent, OH
Email: kstar720@yahoo.com

Faculty advisors for this study, Dr. Jane Cox and Dr. Steve Rainey can be reached at 310 White Hall, PO Box 5190, Kent State University, Kent, OH, 44242-0001 or by phone at (330)-672-2662.
REFERENCES


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


