An Exploratory Study of the Relationship between Compassion Fatigue and Empathy in Professional Counselors

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This dissertation titled
An Exploratory Study of the Relationship between Compassion
Fatigue and Empathy in Professional Counselors

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ABSTRACT

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An Exploratory Study of the Relationship between Compassion Fatigue and Empathy in Professional Counselors (176 pp.)

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The purpose of this quantitative study was to explore the relationship between compassion fatigue and empathy in professional counselors. The sample of 371 participants was surveyed using the Basic Empathy Scale (Jolliffe & Farrington, 2005), the Professional Quality of Life Scale (Stamm, 1995) and the Impact of Events Scale (Horowitz, Wilner, & Alvarez, 1979). A demographics questionnaire was utilized to gather data on race, gender, age, type of licensure, number of years licensed, clients information, work settings, and personal and professional experience with Posttraumatic Stress Disorder.

The data was analyzed using descriptive statistics, regression analysis, MANOVA procedures, and supplemental analyses. The results of the regression analysis found that compassion fatigue accounts for 4.8% of the variance in empathy scores as measured by their designated surveys. The results of the MANOVA found that the research participants’
compassion fatigue and empathy scores were not different based on years of experience as a professional counselor.

The supplemental analyses included further regression and MANOVA analyses. The supplemental regression analysis found that it is possible to construct a prediction model using a regression analysis that explains 6.6% of the variance in empathy scores. The supplemental MANOVA constructed percentile rankings based on years of experience in order to further investigate the role of experience in the variance of compassion fatigue and empathy scores. The results found the counselors' compassion fatigue and empathy scores were not significantly different based on experience as grouped by the percentile rankings. Discussions of the research instruments, data analysis procedures, recommendations, study implications, and directions for future research are presented.

Approved: ______________________________________________________

Mona Robinson
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I dedicate this work to my husband and to the memory of my grandmother. I would like to thank my husband who is my port in any storm. Your tireless faith in me, and in my ability to accomplish anything I dream has made me believe in myself. I owe my dreams to my late grandmother who still inspires me, and who taught me to always continue the fight no matter how dark the night may become.

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CHAPTER ONE: INTRODUCTION

Purpose of the Study

Compassion fatigue is a phenomenon that affects counselors as a result of being in the helping profession (Bride, Radey, & Figley, 2007; Gentry, Baranowsky, & Dunning, 2002; Pearlman & Mac Ian, 1995; Stamm, 1999; Vrklevski & Franklin, 2008). The compassion fatigue phenomenon may have a negative and harmful impact on counselors, but what risk is there to clients? Is it possible that compassion fatigue affects the counselor’s ability to work with clients and changes the counselor’s ability to empathize and understand clients? This research study explores the relationship between compassion fatigue and the capacity for empathy in counselors.

Background of the Study

The National Institute of General Medical Sciences (2008) defines psychological trauma as an emotional or psychological injury, usually resulting from an extremely stressful or life-threatening situation. A general definition of trauma has proven difficult to create due to the rather subjective nature of differentiating ordinary life stressors from traumatic stressors (Weathers & Keane, 2007).
Horowitz (1997) explains that some life experiences are expected (e.g., car accident without injury) but the events that are not expected (e.g., death in a car accident) are the events that may develop into pathological states and possibly Posttraumatic Stress Disorder (PTSD). The way the body reacts to trauma, specifically the brain, may induce disorders simply due to the stress reactions. A person may experience: depression from their chronic state of fear arousal, malnutrition from the constant state of arousal that burns the body’s nutrients and sugars rapidly, fear of sleep (or sleep disruption) caused by intrusive images upon trying to sleep or disturbing reoccurring dreams. These reactions to trauma may lead to physical ailments such as weightloss, fatigue, or brain fog (Horowitz, 1997).

Vanderkolk (1994) posited that the responses to traumatic stimuli are both physiological and psychological. A trauma survivor’s body may react to reminders of the trauma such as images, smells, sounds, or some other stimuli. The body may respond to the stimuli with such manifestations as sweating, rapid heartbeat, or other physical display. The survivor of the trauma may experience
many psychological symptoms such as intrusive images or avoidance along with the physical symptoms.

Separating ordinary stressors from traumatic stressors is necessary when using the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Text Revision’s (DSM-IV-TR; American Psychiatric Association [APA], 2001) to diagnose posttraumatic stress disorder (PTSD), which originates from trauma (See Appendix A). The DSM-IV-TR emphasizes the need for the stressor that caused the trauma to be “extreme” in order to be considered for a PTSD diagnosis.

The definition of posttraumatic stress disorder in the DSM-IV-TR has served as a unifying construct in the field of trauma by allowing commonalities to be seen in “core aspects of psychological trauma and its devastating aftermath” (Weathers & Keane, 2007, p.107). Researchers are able to see that trauma symptoms may be similar regardless of the type of triggering traumatic event. However, there has been much debate resulting from the DSM-IV-TR criteria for PTSD (Weathers & Keane, 2007). The debate has revolved around the PTSD “Criteria A” text in the DSM-IV-TR. It has been argued that the “Criteria A” text creates an overly broad definition that may lead to inappropriate
applications (Weathers & Keane, 2007). The nature of the stressor and what qualifies as “extreme” continues to be a topic of debate.

There is also debate as to which term is appropriate to describe the trauma symptoms counselors may experience due to close relationships with trauma clients. Secondary traumatic stress, compassion fatigue (Figley, 1995), and vicarious traumatization (McCann & Pearlman, 1990) are a few terms used to refer to helpers experiencing trauma symptoms in connection to their clients trauma experiences.

Compassion fatigue refers to the experiencing of trauma symptoms by a person who has been exposed to another person’s trauma. Some trauma symptoms may include posttraumatic stress disorder (PTSD) symptoms such as intrusive thoughts and images (Figley, 1995; Figley & Stamm, 1996) depression symptoms (Figley & Stamm, 1996; Horowitz, 1997; Stamm, 1999), and physical symptoms such as feeling emotionally drained, physically exhausted, headaches, body tension, and illnesses (Horowitz, 1997; Iliffe & Steed, 2000; Vanderkolk, 1994), sleeplessness, weight loss, fatigue (Horowitz, 1997).

Figley and Stamm now refer to secondary traumatic stress (STS) as compassion fatigue, which they argue is a
more user friendly, less stigmatizing term (Baranowsky, 2002; Figley, 2002; Stamm, 1999). Stamm believed that STS may be construed as something negative and compassion fatigue was a more acceptable term (Stamm, 1999). Researchers use the terms STS and compassion fatigue interchangeably according to their own preference. Throughout this research the terms STS and compassion fatigue will be viewed as the same phenomenon. Compassion fatigue will be used in place of STS.

Compassion fatigue is not included in the Statistical Manual of Mental Disorders Fourth Edition Text-Revision (DSM-IV-TR; APA, 2001), and to date is not a diagnosable disorder. Regardless of whether the compassion fatigue phenomenon is diagnosable as a disorder, counselors and helpers are experiencing disturbances and troubling symptoms due to the nature of their work. Some researchers contend that compassion fatigue should be categorized as pathological (Figley, 1995; Stamm, 1999). Other researchers have contended that disturbances due to the nature of the helping profession are not pathological, but are natural and inevitable (McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995; Rosenbloom, Pratt, & Pearlman, 1999).
Figley (1995) and Stamm (1999) have suggested that compassion fatigue is indeed a disorder and should be categorized as such. Stamm (1999) argued that compassion fatigue should be measured under the posttraumatic stress disorder (PTSD) rubric when appropriate. There is debate as to whether hearing about trauma qualifies as “an extreme stressor” that the DSM-IV-TR calls for in order to use the PTSD diagnosis. Stamm did not argue for each therapist experiencing trauma to be viewed as pathological. His argument contended that reactions following exposure to a trauma survivor do not necessarily have to be categorized as a disorder. However, should pathology develop a diagnosis of PTSD should be applied and used when necessary.

The term compassion fatigue was first used in connection to nurses who were worn down by their jobs (Joinson, 1992). Figley (1995) began using the term compassion fatigue in place of his coined term secondary traumatic stress disorder. Figley (2002) explained the difference between PTSD and compassion fatigue as being that compassion fatigue is a result of deep involvement with a traumatized person and not the original event (Baranowsky, 2002; Figley, 2002).
Figley (1995) and Bride, Radey, and Figley (2007) theorized that the diagnostic criteria for PTSD could also be used to diagnose compassion fatigue. Counselors and other helping professionals may experience compassion fatigue when working with or as a result of working with trauma survivors (Gentry, Baranowsky, & Dunning, 2002).

Figley (1995) and Stamm (1999) are operating from a standpoint that compassion fatigue may be pathological and should be seen as a form of PTSD. This perspective is not the only one in the field of trauma and secondary trauma. Some researchers believe that therapists naturally have reactions to clients’ stress, and this natural reaction is inevitable (McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995; Rosenbloom, Pratt, & Pearlman, 1999).

There is no general consensus in the literature on compassion fatigue as to whether the disturbances and trauma symptoms therapists experience should be considered a diagnosable disorder. Furthermore, not all researchers agree trauma experienced by therapists is a pathological phenomenon that compares to PTSD and should be viewed as such. Vicarious traumatization is another aspect of trauma work that needs to be considered in the debate.
McCann and Pearlman (1990) defined vicarious trauma as changes that occur in a helper’s cognitive schemas, beliefs, and expectations and assumptions about self and others. These changes are due to the helper’s work with trauma survivors and may be permanent. Pearlman and Mac Ian (1995) suggested the changes that occur in a helper due to vicarious traumatization are the result of an empathic engagement with trauma survivors.

McCann and Pearlman (1990) argued that vicarious traumatization is inevitable, cumulative, and lasting in helpers who work with trauma survivors. They believed that the alterations to the helper’s cognitive schemas due to working with trauma survivors will significantly impact the helper’s feelings, life, and relationships (McCann & Pearlman, 1990). It is important to note that vicarious traumatization does not reflect pathology in the helper, but is seen as a normal and natural response to working with trauma survivors (Pearlman & Mac Ian, 1995; Rosenbloom, Pratt, & Pearlman, 1999).

Though helpers are experiencing PTSD-like symptoms, among other disturbances such as physical ailments, they are not being diagnosed with PTSD. Compassion fatigue has been hypothesized to be equivalent to PTSD (Bride, Radey, &
Figley, 2007; Figley, 1995), but it must be stated that the two are not the same. Helpers experience compassion fatigue from listening to trauma material and not experiencing actual trauma events. Compassion fatigue is not PTSD, but a unique experience stemming from the act of helping.

There are many terms that may be used when referring to trauma experienced by helpers in connection to their client’s trauma material. Secondary traumatic stress, compassion fatigue, secondary victimization, secondary traumatic stress disorder, vicarious traumatization, and secondary survivor are used to describe disturbances and trauma experienced by helpers. Though these terms may have some distinct differences in theoretical origin or symptom foci, they describe the same phenomenon, the helper becoming distressed by the act of helping trauma survivors (Bride, Radey, & Figley, 2007; Vrklevski & Franklin, 2008). Throughout this research different terms including compassion fatigue, secondary victimization, secondary stress disorder, vicarious traumatization, and secondary survivor, will be drawn from and explored.

Individuals at risk for compassion fatigue are not limited to therapists or other helping professionals, family and friends are also vulnerable (Figley, 1995;
McCann & Pearlman, 1990). Counselors are experiencing compassion fatigue due to the close contact and therapeutic nature of their relationships with clients who have experienced trauma. The counselors hear the survivor’s experience, witness the emotions and memories the survivor has in connection to the trauma, and empathize with that person.

An integral part of the relationship between a helper and the client is empathy. Empathy is the ability for a person to understand the feelings and situation of another person (Rothschild, 2006). Rothschild (2006) wrote a working definition of empathy as it applies to helping professionals;

As psychotherapists, empathy is our major, greatest, and most reliable tool. Often it is our capacity for empathy that brings us to the helping profession in the first place. Empathy allows us to relate to those in our care, to have a sense of what they are feeling. It also helps us put their experiences into perspective, understanding how they are being affected by the incidents that we are trying to mediate. When we have an insight, an accurate hunch, or seem to read the client’s mind, that may also be a result of
empathy. Without it, we could not be the effective therapists that we are. Empathy is an integral, necessary tool of our work (p. 10).

**Relevance of Empathy**

According to Rothschild (2006) there are two types of empathy; conscious and unconscious. Conscious empathy makes it possible for therapists to relate to clients and understand their situation, actually being able to understand what it may be like to be the client. Unconscious empathy is outside the therapists’ awareness and control. An example may be taking on the mood of a client, an unconscious reaction to another person (Rothschild, 2006, p. 29).

Rothschild (2006) hypothesized that therapists may be suffering in their work due to unconscious empathy. Rothschild posited that empathy acts as a therapist’s greatest tool for working with and understanding clients; however, empathy may also be a factor that may threaten the therapist’s own well-being. Compassion fatigue may be a result of empathy (Figley, 2002).

It has been suggested that counselors may experience a lack of empathy due to compassion fatigue (Hesse, 2002; Valent, 2002). As counselors work in emotionally charged
situations their ability to empathize may become overtaxed and exhausted (Gentry, Baranowsky, & Dunning, 2002). Since empathy is a core component in the counseling relationship, a counselor with a lack of empathy may not have the capacity to help their clients and essentially is an impaired professional. Empathy is an important component for therapy and counselors experiencing a lack of empathy may not be able to maintain a healthy counseling relationship. It is important that counselors understand the effect their work and passion may produce (compassion fatigue) so that they will seek the help needed to stay healthy and protect their clients from harm. Counselors need to be aware of the possibility that compassion fatigue could hinder their ability to work with clients.

If compassion fatigue originates from empathy, as suggested by Figley (2002) and as a result of compassion fatigue empathy may be affected (Hesse, 2002; Valent, 2002) there is a possible circular pattern between compassion fatigue and empathy. Clearly there is a relationship between compassion fatigue and empathy that demands examination.

There has been no research with the specific intent of studying the relationship between compassion fatigue and
empathy in professional counselors. Prior research has investigated the impact of trauma material and compassion fatigue on helpers (any person working within the helping professions, not necessarily a professional counselor). This research study explored the relationship between compassion fatigue and empathy in professional counselors. The study examined the possibility of predicting empathy levels from compassion fatigue in professional counselors and investigated possible differences between counselors new to the field and experienced counselors.

**Statement of the Problem**

Compassion fatigue may have many effects on a counselor, such as PTSD symptoms, physical symptoms, and interference with empathic abilities. Researchers have theorized that empathy is what causes a helper to be vulnerable to compassion fatigue (Canfield, 2005; Conrad & Kellar-Guenther, 2006; Figley, 1995, 2002; Hesse, 2002; Rothschild, 2006; Valent, 2002). Empathy allows counselors to understand a client’s reactions, thoughts, and feelings, and truly connect with the client. This deep understanding and connection opens the counselor up to experience the client’s trauma as the counselor’s own. When counselors experience trauma symptoms due to working with trauma
survivors it is known as compassion fatigue. The counselors may be reminded of their own past trauma, or the counselor may experience trauma symptoms connected with the client’s trauma experience. There is no existing research specifically on the nature of the relationship between compassion fatigue and empathy in professional counselors. Existing research suggests that compassion fatigue and traumatized helpers is an important issue. Studies have shown that helpers may experience negative effects (nightmares, intrusive thoughts, avoidant behavior, numbing, etc.) of their professions. Though no research has specifically researched professional counselors, closely related professionals such as psychologists, social workers, domestic violence helpers, and sexual abuse survivor helpers have been examined in interdisciplinary studies discussed in chapter two.

Researchers have theorized that the counselors’ capacity for empathy also puts them at risk for compassion fatigue (Figley, 1995, 2002; Hesse, 2002; Rothschild, 2006; Valent, 2002). Thus far the relationship between empathy and compassion fatigue has been thought to be unidirectional in that empathy may lead to compassion
fatigue, but the possible looping effect of compassion fatigue interfering with empathy has not been explored.

In order to understand the connection between compassion fatigue and empathy the two must be studied together with the specific intent of examining the relationship. Though it may be possible to link compassion fatigue and empathy from the current literature and past studies, it is not possible to know the relationship between the two with the existing research. This study further explored compassion fatigue, empathy, and their connection.

**Research Questions**

The following primary research question will be addressed;

1. Is it possible to predict the level of empathy from compassion fatigue in professional counselors as measured by the Basic Empathy Scale (BES; Jolliffe & Farrington, 2005) and The Professional Quality of Life Scale (ProQOL; Stamm, 2005)?

The following secondary research questions will be addressed;
2. What is the prevalence of compassion fatigue in Ohio licensed counselors?

3. Is there a significant difference between counselors new to the field and experienced counselors on the combination of empathy and compassion fatigue scores as measured by the BES and ProQOL?

**Introduction to Research Tools**

The Basic Empathy Scale (BES; Jolliffe & Farrington, 2005) was used to measure empathy in participants. The BES measures affective empathy (the capacity to experience the emotions of another) and cognitive empathy (the capacity to comprehend the emotions of another. The presence of empathy facilitates pro-social behavior and inhibits antisocial behavior (Jolliffe & Farrington, 2006). People with high empathy have a heightened ability to experience and understand others' emotions (Jolliffe & Farrington, 2006). People with low empathy fail to recognize and comprehend the emotional state of others and the possible effect that their behavior may have on others (Jolliffe & Farrington, 2006). Those with high empathy levels will respond to distress and discomfort in others by trying to alleviate the problems unlike people with low empathy. Throughout
this research the above defined terms of high empathy and low empathy will be referred to and used.

The second tool that was administered to participants was The Professional Quality of Life Scale (ProQOL; Stamm, 2005). The ProQOL measures Compassion Satisfaction (the pleasure the helper derives from being able to do their work well), Burnout (feelings of hopelessness and difficulties in dealing with work or in doing a job effectively), and Compassion Fatigue (work-related secondary exposure to extremely stressful events).

The third scale that was sent to participants was the Impact of Events Scale (IES; Horowitz, Wilner, & Alvarez, 1979), which measures current intrusive and avoidance symptoms. Intrusion symptoms were characterized by unbidden thoughts and images, troubled dreams, strong pangs or waves of feelings, and repetitive behavior. Avoidance symptoms were characterized by ideational constriction, denial of the event, blunted sensation, behavioral inhibition or counterphobic activity, and awareness of emotional numbness.

The brief descriptions of the test measures BES, The ProQOL and the IES are meant as an introduction to the scales. This introduction familiarizes the reader with the
terms, and constructs measured by the research tools. The measures will be explored further in Chapter Three.

**Research Alternatives**

The prior research on compassion fatigue and empathy has not clearly defined the nature of the relationship between these two variables. The first possible research outcome could have shown that high scores on the BES are correlated with high scores on the ProQOL. Counselors’ empathy exposes them to compassion fatigue (Figley 1995, 2002). It is possible that counselors with higher levels of empathy may experience compassion fatigue more frequently. Counselors who scored higher on the BES may experience more compassion fatigue, which could be indicated with higher scores on the compassion fatigue scale of the ProQOL.

The second possible research outcome could have shown an inverse relationship between empathy and compassion fatigue. Counselors’ empathy, or ability to empathize with a client, may rise and fall in connection to compassion fatigue. The higher a counselor’s compassion fatigue (higher ProQOL scores) the greater likelihood that empathy will be affected. It may be possible to measure empathy and obtain results showing that counselors with high levels of compassion fatigue have lower levels of empathy than other
clinicians. The BES was used to measure empathy in participants.

**Counseling Experience**

Research has shown that professional counselors with less experience in the field (fewer years of experience as a counselor) have a greater chance of developing compassion fatigue (VanDeusen & Way, 2006; Way, VanDeusen, Martin, Applegate, & Jandle, 2004). It is likely that counselors with less experience will show more disruptions and signs of compassion fatigue than counselors with more years of experience in the field. The more years of experience counselors have in the field the less likely they will experience compassion fatigue. The current study categorized new counselors as counselors who have held a counseling license for under four years and experienced counselors were categorized as counselors who have held a counseling license four years or more.

To date there have been no studies which specified or suggested the number of years of experience counselors must have before their chances of experiencing compassion fatigue lessen. For this reason The Ohio Counselor, Social Worker, and Marriage and Family Therapist Board’s Supervisor Designation guidelines will be utilized. The
board deems counselors with over three years of experience as experienced enough to apply for supervisory designation. Though this study will not be gathering information based on the supervisory designation, the counselors with enough years of experience to be able to provide supervision will be recognized as experienced counselors. This research will refer to counselors who have held their license for four years or more as “experienced counselors” and counselors who have held their license for under four years as “counselors new to the field”.

**Significance**

The relationship between helper and client may be affected by compassion fatigue (Valent, 2002). It is possible for the counselor to experience a lack of empathy, deny client traumas, have fragmented attention, dehumanize the client or survivors and view them as nothing more than cases or research subjects, and in some instances the counselor may have an overenthusiastic involvement with the client (Valent, 2002). No matter how the counselor is experiencing compassion fatigue, whether they have PTSD symptoms or the counseling relationship altering symptoms described by Valent (2002), it is detrimental to the relationship.
Delimitations

This research study was conducted by examining counselors, and examining counselors with varying amounts of experience in the field; new counselors and experienced counselors. The participants were divided into two groups based on counseling experience. Group one is counselors new to the field (which is specified as counselors who have been licensed for less than four years), and group two is comprised of experienced counselors in the field (which is specified as counselors who have been licensed for four years or more).

The population selected for this research was counselors. In order to guarantee a sample of licensed counselors this research utilized services from The Ohio Data Network, which only provides information on Ohio licenses. The sample was selected from a comprehensive list of Licensed Professional Counselors and Licensed Professional Clinical Counselors. The Ohio Data Network serves entities such as The State of Ohio Counselor, Social Worker, and Marriage and Family Therapist Board. The Ohio Data Network receives information for distribution directly from The State of Ohio Counselor, Social Worker, and Marriage and Family Therapist Board.
Limitations

The sample was derived from Ohio counselors, excluding counselors from all other states.

The research study was not a longitudinal study. The research measured counselors new to the field versus counselors with experience.

Definition of Terms

Compassion Fatigue - the natural behaviors and emotions that arise from knowing about a traumatizing event experienced by a significant other - the stress resulting from helping or wanting to help a traumatized person (Figley, 1995, p xiv).

Burnout - a result of emotional stress from the workplace and a failure to cope with the stress leads to emotional exhaustion characterized by professionals losing all positive feeling, sympathy, and respect for clients (Maslach, 1978). This may lead to cynical or dehumanizing perceptions of client (Maslach, 1978). Professionals may also have physical exhaustion, illnesses, and psychosomatic symptoms (Maslach, 1978).

Empathy - ability to relate to others, to have a sense of what they are feeling. It helps us to understand others’
perspectives and how their situations are affecting their lives.

*Helper* - will be used throughout this proposal to refer to individuals who are in the mental health field working with clients. These individuals may not necessarily be professional counselors; they may be social workers, psychologists, chemical dependency professionals, child protection workers, etc.

*Posttraumatic Stress Disorder (PTSD)* - occurs as a result of exposure to or witnessing of an extreme traumatic stressor or event. The event involves actual or threatened death, serious injury, or another threat to the person’s physical well-being. The person may also have witnessed an event involving death, the threat of death or serious injury, or other threat to the person’s physical well-being. The person may also have learned about an unexpected or violent death, the serious injury of, or threat of injury or death to a family member or other close associate (DSM-IV-TR, 2001, p. 463).

*Secondary Traumatic Stress* - trauma experienced by an individual that has been in close contact with a trauma survivor. The person has not experienced the trauma firsthand but has learned about the trauma of the survivor.
Secondary Traumatic Stress Disorder – Figley (2002) coined and defined this term as the identical symptoms as Posttraumatic Stress Disorder but in a person who has been exposed to the trauma survivor and not the trauma event itself and the intrusion and avoidance symptoms are related to the survivor’s experience. Figley (2002) meant for this term to be a harsher form of secondary traumatic stress much like the relationship between adjustment disorder (posttraumatic stress disorder criteria has not been met) and posttraumatic stress disorder.

Vicarious Trauma - Therapists’ reactions to their trauma clients’ trauma material, which may be graphic and painful, and as a result the therapist may experience painful images and emotions associated with their clients’ trauma memories, and may over time incorporate these memories into their own memory systems resulting in the therapist experience PTSD symptoms (McCann & Pearlman, 1990).

Summary

Despite much theory, the connection between compassion fatigue and empathy has not been founded in research. Scholars have suggested and postulated about the relationship in an attempt to understand how compassion
fatigue and empathy interact. This study specifically explores the relationship between compassion fatigue and empathy, and helps to further the knowledge based on research.

This research utilized a sample of licensed counselors to establish compassion fatigue prevalence in the population. Existing research has not shown compassion fatigue rates in counselors and has primarily been interdisciplinary studies. In order to establish prevalence and be able to generalize the findings this research examined only counselors. The following chapter will provide a review of relevant literature.
CHAPTER TWO: LITERATURE REVIEW

Introduction

The review of the literature will provide an overview of important elements of the research study such as secondary traumatic stress (STS), compassion fatigue, burnout, empathy, and vicarious traumatization. This chapter will also provide a basis and rationale for the study.

State of Current Research

The current literature on compassion fatigue is relatively uniform in findings and implications. Findings indicate that helpers are experiencing PTSD like symptoms due to the relationship with clients’ trauma material. The term counselor has been used throughout literature and research to refer to many disciplines other than professional counselors. No studies have been found that specifically examined counselors.

The majority of studies dealing with compassion fatigue, vicarious trauma, or other related terms, have a mixture of helpers from various backgrounds such as social work, psychology, health sciences and with various levels of degrees and training. For example Way, VanDeusen, Martin, Applegate, and Jandle (2004) posit that the
existing studies on sexual abuse counselors have many differences in the study samples, variables measured, and methodologies that result in a need for caution when interpreting the findings, and an inability to generalize the results.

Research on sexual abuse counselors is not the only area of research that is difficult to generalize to a specific population. There have been no studies that investigate professional counselors and the effects of trauma material. One specific problem with all inclusive studies, or studies that mix many disciplines, is that the findings are not applicable to one profession specifically, so it is not known if the variances can be attributed to training, education, profession, etc.

Research has focused heavily on helpers that work with a specific population rather than within a specific discipline making it impossible to generalize by discipline. Secondary trauma research has focused primarily on helpers that provide long-term services to sexual abuse survivors (Bell, 2003). A second area of research has been focused on clinicians who work with domestic violence abusers and survivors. Though, to some extent, the findings in these research areas may be applicable to all those that
work with trauma survivors. There is still a need to examine the impact of compassion fatigue by discipline. It is important to know if some professionals are at a higher risk simply due to profession and if so what may be the underlying reasons.

Another issue with current literature is the homogeneity of research samples. The vast majority of studies have a high representation of women, and in some cases no male participants were included at all. Possible reasons for this gender difference in the literature include low male response rates (Schauben & Frazier, 1995), a small number of males in the particular area of study (Illiffe & Steed, 2000), or a research focus only on female helpers (Brady, Guy, Poelstra, & Brokaw, 1999; Trippany, Wilcoxon, & Satcher, 2003). Not all researchers address the issue of gender balance in their studies nor give reasons for unbalanced samples.

**History of Terms**

There has been, and still is, a great deal of overlap, confusion, and theoretical reworking by researchers regarding burnout, compassion fatigue, secondary traumatic stress, secondary traumatic stress disorders, and vicarious trauma. A large part of the confusion manifests in the
debate as to how and to what degree these terms are similar. These terms are often confusing and used interchangeably in literature and conversation (Rothschild, 2006).

Though there may be specific details that make each term unique, the underlying PTSD symptoms are dominant in secondary traumatic stress, compassion fatigue, secondary traumatic stress disorder, and vicarious trauma. It is the similarities that link these terms and allow them to be used interchangeably. The research in each of these areas will be discussed and used in this literature review due to the natural overlap between these terms. Each of these terms refers to the phenomena that arise from helpers' connection to trauma and trauma clients. The differences reside in the focus of symptoms.

The following section will explain the roots of these important concepts and how each evolved over time. This section is included to further clarify and solidify the similarities and differences between each concept. Concept development and their usage in the current study will be presented.
**Burnout**

Out of the four concepts that describe negative risks associated with the helping profession (burnout, vicarious trauma, secondary traumatic stress, compassion fatigue) burnout is the oldest (Rothschild, 2006). Burnout is associated with workplace overload, stress, and exhaustion. Lack of achieving work goals, frustration, and feelings of helplessness also all contribute to burnout (Canfield, 2005; Figley, 1995; Maslach, 1978). The progression of burnout is gradual and cumulative resulting from emotional exhaustion (Canfield, 2005; Trippany, Kress, & Wilcoxon, 2004).

**Differentiating Burnout from Compassion Fatigue**

Before compassion fatigue was introduced to the helping profession there was burnout, a reaction to the stress and overload of work. The main distinction between compassion fatigue and burnout is that burnout occurs due to the nature and overload of work while compassion fatigue comes from working with specific types of clients, namely trauma survivors. Burnout is a condition that occurs as a result of a prolonged period of time exposed to stress, overload, exhaustion, etc., whereas compassion fatigue
“may occur as a result of a single exposure to a traumatic incident” (Conrad & Kellar-Guenther, 2006).

Though researchers link compassion fatigue and burnout it must be stated that the two are not the same. Though burnout and compassion fatigue are theoretically different it is possible that they contribute to each other. Burnout negatively affects helper’s resiliency making them more susceptible to compassion fatigue (Gentry, Baranowsky, & Dunning, 2002). Helpers that lack stress related coping skills may be more susceptible to burnout and this lack of coping skills may affect a counselor’s ability to protect themselves from compassion fatigue.

Vicarious Trauma and Secondary Traumatic Stress

After the introduction of burnout in the 1970’s, vicarious trauma and STS were introduced in the mid 1980’s. Vicarious trauma was introduced as a term applied to children affected by the trauma of others, later the term was applied to psychotherapists’ reactions to clients (Rothschild, 2006). More specifically vicarious trauma is a therapist’s reaction to trauma clients (Baranowsky, 2002; McCann & Pearlman, 1990). Vicarious trauma is a result of empathic engagement with clients’ trauma material, which
transforms the helper’s inner experience (Pearlman & Saakvitne, 1995).

The term secondary traumatization was first used to describe how trauma symptoms may be contagious among family members (Rothschild, 2006). The term later evolved into secondary traumatic stress (STS) and was then applied similarly to vicarious trauma (Rothschild, 2006). Though vicarious trauma and STS are similar in that the phenomena are connected to exposure to trauma there are key differences that should be noted.

The distinguishing difference between vicarious trauma and STS is that with vicarious trauma the therapist’s view of the world is altered and the survivor’s memories may be incorporated into the therapists own memories and used as frame of reference when viewing the world. Pearlman and Mac Ian (1995) define vicarious trauma as “the transformation that occurs within the therapist as a result of empathic engagement with clients’ trauma experiences and their sequelae…and vicarious trauma implies changes in the therapist’s enduring ways of experiencing self, other, and the world” (p. 558).

Vicarious trauma is not a sudden occurrence. It is a result of multiple exposures and incorporation of the
clients’ trauma overtime (McCann & Pearlman, 1990). The effects of vicarious trauma are cumulative, permanent, and are evident in the helper’s professional and personal life (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995).

STS may appear suddenly and the PTSD-like symptoms are the defining characteristics (Figley, 1995). Vicarious trauma is defined using the therapist’s changes in cognitions. Vicarious trauma includes the symptoms of STS along with changes in the helper’s sense of meaning, identify, world view, and beliefs about self and others (Pearlman & Saakvitne, 1995).

STS and Figley’s (1995) term secondary traumatic stress disorder are closely related. Figley (1995) used STS as a lesser version of secondary traumatic stress disorder. Figley (2002) has defined the difference between the terms as being the amount of time the symptoms have been experienced. According to Figley (2002) the helper with secondary traumatic stress has been exposed to trauma material and has been affected by the traumatizing events but this has not reached secondary traumatic stress disorder proportions.

The term secondary traumatic stress disorder is not recognized or used by all researchers. Figley (1995) coined
the term and uses it throughout his research and publishing. The distinction between STS and secondary traumatic stress disorder is also not recognized or used by all researchers. However, some researchers do use and refer to Figley’s terms thus making it necessary to understand their definitions and how to apply and use each term.

The Connection between Secondary Traumatic Stress Disorder and Posttraumatic Stress Disorder

Secondary traumatic stress disorder symptoms, according to Figley (1995), are “identical” to Posttraumatic Stress Disorder (PTSD). The defining difference between secondary traumatic stress disorder and PTSD is that persons who experiences secondary traumatic stress disorder did not experience the event that is causing the symptoms, but have been closely associated with the trauma survivor who experienced the traumatic incident. The person with secondary traumatic stress disorder is having symptoms in connection with the trauma survivor’s trauma material and not their own trauma. The therapist with secondary traumatic stress disorder is experiencing trauma as a “secondary source” not as a primary witness to the incident.
Though therapists are experiencing PTSD symptoms, among other physical ailments (Horowitz, 1997), they are not being diagnosed with PTSD. Therapists that experience disturbances, PTSD symptoms, and physical ailments in connection with their client’s trauma are experiencing compassion fatigue. Compassion fatigue is a unique phenomenon that helpers experience by listening and not experiencing. Though it has been argued to be “nearly identical to PTSD” (Bride, Radey, & Figley, 2007) it is not the same.

**The History of Posttraumatic Stress Disorder in the DSM**

Posttraumatic Stress Disorder (PTSD) was recognized and added to the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1980. Since its inclusion in the DSM the definition of PTSD has changed several times. When PTSD was first explained and defined in the DSM-III the triggering event for the symptoms would “evoke significant symptoms of distress in most people, and is generally outside the range of common experiences as simple bereavement, chronic illness, business losses, or marital conflict” (APA, 1980, p. 236).

The rather broad definition in the DSM-III was further refined and the present definition of PTSD requires the
person’s response to the triggering event must have involved “intense fear, helplessness, and horror” (APA, 2001, p. 467). The traumatic event itself must be “an extreme stressor”, which the DSM-IV-TR gives an example of such a stressor as being life-threatening, to be considered for the PTSD diagnosis. If the event does not meet the requirement of having been an extreme stressor then the differential diagnosis of “Adjustment Disorder” must be assigned.

According to the DSM-IV-TR learning about an extreme stressor that was experienced by a person who is a family member or other close association is enough to trigger PTSD (APA, 2001, p. 463). The closeness a counselor and client share while in therapy exposes the counselor to situations leading to PTSD symptoms and may be referred to as compassion fatigue in helpers. As mentioned in chapter one, there is debate over the PTSD criteria. It has been suggested that “Criteria A” is too broad and may be overused and unnecessarily applied (Weather & Keane, 2007).

Counselor’s Exposure to Trauma

According to the DSM-IV-TR individuals at risk for PTSD may have experienced, but are not limited to, military combat, violent personal assault, such as sexual assault,
physical attack, robbery, mugging, being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war or in a concentration camp, natural or manmade disasters, severe automobile accidents, or being diagnosed with a life-threatening illness. The most at risk individuals for Posttraumatic Stress Disorder are “survivors of rape, military combat and captivity, and ethnically or politically motivated internment and genocide” (APA, p.466).

Counselors work with a large population of clients that have experienced some sort of trauma. These trauma clients include domestic violence survivors, sexual assault, abuse, and molestation survivors, war veterans, and survivors of all other types of trauma. As stated in chapter one roughly two-thirds of the American population, will experience a traumatic event that could possibly lead to PTSD (Marotta, 2000). Within this large percentage some populations are at a higher risk due to the sheer amount of people within that population that will be exposed to a traumatic event. For instance one in six women will experience an attempted or completed rape in her lifetime as opposed to one in thirty-three men (Hensley, 2002).
Existing Studies on Helpers

Meldrum, King, and Spooner (2002) studied 300 mental health professional case managers across Australia. The case managers were a mixture of psychologists, medical personnel, occupational therapists, social workers, psychiatric nurses, clinical personnel, and other workers such as welfare workers. The participants were involved with psychiatric inpatient or outpatient mental health services. The researchers reported prevalence rates using three categories; clinical secondary traumatic stress, subclinical secondary traumatic stress, and low or asymptomatic. The findings indicated that 35.7% of the sample experienced either clinical or subclinical secondary traumatic stress. When the sample was broken down by location rural workers (45.5%) were at far greater risk than urban workers (31.16%) to experience clinical or subclinical secondary traumatic stress due to larger caseloads.

Conrad and Kellar-Guenther (2006) studied child protection workers in Colorado. The participants’ jobs included caseworkers, supervisors, and a category marked as other employees. The 363 workers were given surveys to measure compassion fatigue, burnout, and compassion
satisfaction (satisfaction helping professionals find in their jobs and performance). The participants were placed in the categories of “extremely low risk” (scores of 0-26), “low risk” (scores of 27-30), “moderate risk” (scores of 31-35), “high risk” (scores of 36-40), and “extremely high risk” (scores of 41-115) based on scores of a self-test that measures risk for compassion fatigue and risk for burnout. Nearly half (49.9%) of all participants had “high” or extremely high” risk for compassion fatigue, while only 7.7% had “high” or “extremely high” risk for burnout.

Rudolph, Stamm, and Stamm (1997) found that 37% of the 179 mental health care providers sampled reported a high risk of compassion fatigue. Bachelor, master, and doctoral level providers comprised the sample, with 113 of the participants being female. Master level providers had the highest risk of developing compassion fatigue, followed by doctoral level providers, and finally bachelor level providers having the lowest risk of developing compassion fatigue. The authors did not provide a rationale for the findings. The small number of male participants is a limitation of this study and caution should be taken when generalizing these results.
Conrad and Kellar-Guenther (2006) and Rudolph, Stamm, and Stamm (1997) have shown that 35%-50% of helpers are being negatively affected by their work in the helping professions. Though the results are not able to be generalized due to the mixture of disciplines comprising each sample, the results are no less alarming. A large amount of helpers are experiencing compassion fatigue or symptoms of compassion fatigue, it is likely that a sample of professional counselors will result in similarly affected numbers.

An underlying issue with studies on STS/compassion fatigue is the fact that the participants were a mixture of helper from many disciplines. Though it may be possible to make broad hypotheses based on interdisciplinary studies it is not possible to use the results to generalize to a specific discipline. In order to be able to specifically speak to one profession the study must include only participants from the given profession. This proposed research will focus specifically on professional counselors.

Compassion Fatigue and Empathy

Secondary traumatic stress/compassion fatigue may be experienced due to the empathic connection between
therapists and trauma survivors. Therapists may experience PTSD symptoms after hearing about their client’s trauma material and experiences. Empathy is the key element in transference of trauma from the trauma survivor to the therapist (Canfield, 2005; Conrad & Kellar-Guenther, 2006; Figley, 1995).

Empathic engagement with trauma survivors is an important component in psychotherapeutic intervention (Canfield, 2005). It is the therapist’s capacity for empathy that exposes them to compassion fatigue and the possibility of becoming traumatized due to the act of helping trauma survivors. The more empathic helpers are toward the trauma survivors they serve the more likely they will experience compassion fatigue (Conrad & Kellar-Guenther, 2006).

Compassion fatigue may negatively affect empathy in counselors exposed to trauma material. Walker (2004) acknowledges that “empathy can be destroyed and this in turn can lead to inappropriate responses such as emotional unavailability that can be very damaging to a client” (p.180). But, it is the counselor’s feelings of hopelessness and uselessness due compassion fatigue that
open them up to what Walker (2004) refers to as negative transferences from the client.

**Changes in Empathy**

Empathy is a key element of a counseling relationship. It may be possible for empathy to change over time and with experience in the counseling profession. The following studies show that empathy levels are indeed able to be changed, and therefore empathy is not a stable trait.

Pecukonis (1990) researched the effects of an affective/cognitive empathy training program on 24 aggressive adolescent females in a residential treatment center. Pretests were given to all participants. The pretest package included the Hogan Empathy Test (1969), an emotional empathy scale developed by Mehrabian and Epstein (1972), and finally an ego development measure developed by Loevinger and Wessler (1970). The participants were randomly assigned to control and test groups based on their ego scale score. The researchers contended that there is a positive relationship between high ego and high empathy scores and thus divided the high and low empathy scorers evenly ensuring equal numbers in the control and test groups. The test groups were given four one and a half hour training sessions designed to increase levels of affective
and cognitive empathy. The training took place over two weeks. After the four training sessions the same versions of the Hogan Empathy Test (1969) and the emotional empathy scale developed by Mehrabian and Epstein (1972) were administered as posttest measures. The results revealed significant increases in affective empathy after training, while cognitive empathy increases were not significant. The participants in the control groups decreased on posttest measures. The participants with high ego scores did not increase empathy levels to the extent of those who had lower ego pretest scores.

Lovell (1999) conducted a study of student American Counseling Association members. The aim was to explore the connection between empathy and cognitive development on what the author called “a large scale”. The study had 340 usable surveys returned. The results showed a positive correlation between cognitive development and empathy. The participants with higher levels of thinking had higher levels of empathy. Lovell concluded that a deeper understanding of self and higher cognitive functioning will yield higher levels of empathy, and suggested that it be taken into consideration by counselor educators that by
moving students into higher levels of thinking they would in turn be increasing the empathy levels of their students.

In a more recent study, Lyons and Hazler (2002) found that second year counseling master students had higher levels of affective/trait based empathy and cognitive/skill based empathy than first year counseling master students. The authors concluded that the counseling students are learning or developing empathy through the counseling programs. Second year students have had more time in the counseling program therefore their empathy levels are higher than first year student levels. The researchers note that this is a substantial finding due to the fact that affective/trait based empathy had generally been thought to be a stable trait. The results show that both types of empathy (affective and cognitive) may indeed be learned or developed and that neither type of empathy is a stable trait.

The research shows that empathy is not a stable trait and is able to change. If a counselor’s empathy may rise due to training and cognitive development it may be possible for empathy to be lowered due to high stress and compassion fatigue. There has been no research to confirm or reject the notion that empathy is indeed impacted by
compassion fatigue or any other circumstance. However, it may be possible to interfere with empathy through compassion fatigue. Empathy may change with clinicians as levels of compassion fatigue heighten or lessen.

**Risk Factors for Compassion Fatigue**

Every counselor has the potential for developing compassion fatigue. The act of engaging in a therapeutic relationship with a person who has experienced trauma opens the door to possible counselor traumatization. But, embedded in the literature one may recognize several factors that have been shown to raise a clinician’s chances of developing compassion fatigue. These factors are trauma client case load (Schauben & Frazier, 1995; Sprang, Clark, & Whitt-Woosley, 2007), field experience (VanDeusen & Way, 2006; Way, VanDeusen, Martin, Applegate, & Jandle, 2004), clinician’s history of abuse (Kassam-Adams, 1999; Pearlman & Mac Ian, 1995; VanDeusen & Way, 2006), specific type of client (Iliffe & Steed, 2000), and possible gender differences (Iliffe & Steed, 2000; Meyers & Cornille, 2002; Sprang, Clark, & Whitt-Woosley, 2007).

The higher the caseload of trauma survivors a clinician carries the greater likelihood of compassion fatigue. Schauben and Frazier (1995) studied the effects of
working with sexual violence survivors on female counselors. They analyzed 148 questionnaires (118 psychologists and 30 sexual violence counselors), males were excluded due to the small male response. The researchers concluded that counselors who work with a higher number of survivors experienced more disrupted beliefs and more PTSD symptoms (compassion fatigue symptoms) and vicarious trauma than those with fewer survivor clients.

Sprang, Clark, and Whitt-Woosley (2007) surveyed 1,121 mental health providers in a rural southern state. The participants were a mixture of disciplines such as physicians, psychiatrists, licensed clinical counselors, social workers, marriage and family therapists, and psychologists. The researchers found that helpers’ caseloads of clients with PTSD “predicted their levels of compassion fatigue and burnout”. The helpers who worked with higher numbers of clients with PTSD experienced compassion fatigue and burnout at a higher rate than helpers with lower numbers of PTSD clients.

Way, VanDeusen, Martin, Applegate, and Jandle (2004) compared clinicians who treat survivors of sexual abuse and sexual offenders. The researchers found that the shorter
the time the clinician had been in the field the greater the intrusive trauma. VanDeusen and Way (2006) conducted a study that researched vicarious trauma along with the trust and intimacy of clinicians providing sexual abuse treatment. The study found that clinicians newer in the field experienced greater disruptions in cognitions and trust and intimacy than did others with more experience.

Researches have speculated that clinicians new to the field experience more disturbances and trauma symptoms due to inexperience, and as experience and competency increase symptoms subside (Pearlman & Mac Ian, 1995). Counselors with less experience may need more specialized training, supervision, support from co-workers, and continuing education to adapt (VanDeusen & Way, 2006; Way, et al., 2004) It is also possible that more distressed clinicians leave the field and only therapists that experience small amounts of trauma symptoms continue (Pearlman & Mac Ian, 1995; Way, et al., 2004). Clinicians with fewer survivor clients may be experiencing fewer trauma symptoms because they are not taking in the amount of trauma material as counselors with higher numbers of survivor clients. Clinicians with higher numbers of trauma survivor clients may be experiencing trauma symptoms at a higher rate due to
the sheer amount of trauma material they are exposed to and process.

If clinicians have a past history of being abused they are more vulnerable to the development of compassion fatigue and PTSD symptoms. However it is not know if the clinician is experiencing symptoms due to their own past history of abuse, empathy for the client’s abuse due to their own personal trauma, a combination of both, or some other combination of factors. Regardless of the reasons, a clinician’s history of abuse impacts their experiences as a counselor.

Pearlman and Mac Ian (1995) studied clinicians who were also survivors of abuse. The clinicians who were survivors of abuse reported significantly more disruptions and distress than those who had no abuse history. But, even within the clinicians who were survivors there were significant differences. The clinician survivors who were newer to the field of trauma treatment (less than two years of experience) reported more distress and disruptions than clinician survivors who had more trauma treatment experience. Pearlman and Mac Ian (1995) hypothesized that the longer the clinician survivors are in the field the greater likelihood that they will overcome their own
personal issue and have less distress and disruptions. But, the authors pointed out that it is possible that the survivor clinicians who had high amounts of distress and disruptions due to their own personal history left the field and as a result only those who overcame their past experiences continued in the field. A limitation of this study is the fact that the researchers only reported how long the participants had been providing trauma treatment and not how long the participants had been practicing in their fields. It is possible that clinicians’ interests change or jobs change over time and they have been in the field for many years but have just started providing trauma treatment. This would be an important factor to note.

VanDeusen and Way (2006) conducted a study that researched vicarious trauma along with the trust and intimacy of clinicians providing sexual abuse treatment. Clinicians with less severe maltreatment history reported fewer disruptions than those with more severe abuse history. Clinicians who experienced more abuse throughout their lives had greater disruptions when working with survivors of sexual abuse than those clinicians who did not. A clinician’s own history will also contribute to negative effects of being a helper.
Kassam-Adams (1999) studied psychotherapist in outpatient agencies in Virginia and Maryland. The researcher distributed 273 surveys with 100 being completed and returned. The participants were master or doctoral level helpers with a variety of disciplines such as social work, counseling, clinical psychology, counseling psychology, nursing, or categorized as other. Seventy-five percent of the sample was female. The results revealed that helpers with a history of childhood trauma were more likely to experience PTSD symptoms when working with survivors of trauma. The researcher acknowledged the lack of generalizability due to the small number of men in the sample.

Clinicians who work with survivors of abuse have a higher chance of compassion fatigue that those who work with perpetrators. Iliffe and Steed (2000) conducted a qualitative research study with counselors working with perpetrators and survivors of domestic violence. Those helpers working with survivors (women clients in this study) reported feeling emotionally drained, physically exhausted, more headaches, body tension, and illnesses than prior to this work. The male and female helpers that facilitated groups with perpetrators of domestic violence
(groups of male perpetrators in this study) reported feeling energized by their work. The authors found that changes to cognitive schemas and changes of worldview were also reported by participants regardless of the type of client served.

**Possible Gender Differences**

It has been suggested that gender may be a high-risk factor for compassion fatigue based on prior research. The research in this area has show conflicting results. Meyers and Cornille (2002) conducted a study of child protection service (CPS) professionals with the aim to assess the prevalence of secondary traumatic stress symptoms in CPS worker. Eighty-four percent of the sample was female and 16% was male. The gender distribution should be noted as a limitation in this study. According to the results female workers reported more trauma symptoms than male workers. Female workers reported more symptoms such as anger, irritability, jumpiness, exaggerated startle response, trouble concentration, hypervigilance, nightmares, intrusive thoughts and images, and numbing of responses. The female workers also experienced more physical symptoms such as cardiovascular problems, gastrointestinal problems, respiratory problems, and muscular pains and discomfort.
The results of this study should be used cautiously due to the relatively small number of male participants that may have led to skewed findings.

In Sprang et al.’s (2007) research of 1,121 mental health providers the genders representation was vastly female at 69.9% leaving 30.4% male. The researches acknowledged a “reasonable gender distribution”, but noted that overrepresentation of female respondents has limited the research in this area. The authors found that female gender enhanced the risk of experiencing compassion fatigue and burnout.

In the research conducted by Iliffe and Steed (2000), the authors found that men and women helpers experienced similarly evoked distressing feeling by listening to domestic violence experiences. However it was noted that women helpers had a higher rate of clients and thus had more intense and more frequent distressing feelings. The researchers concluded that it was not the gender of the counselor that led to the differences but the amount of clients and the type of client. The majority of women helpers worked with survivors of violence (which in this study were women). The counselors, men and women, working with the perpetrators reported feeling energized after
group sessions. The women working with the perpetrators did not report more intense and more frequent distressing feelings than their male counterparts thus leaving the researcher to conclude the type of client is the underlying factor and not the helpers’ gender.

The research in this area is unclear as to how gender impacts the effects of compassion fatigue and trauma symptoms. Meyers’ and Cornille’s (2002) sample, along with Sprang, Clark, and Whitt-Woosley’s (2007) sample was a vast majority of women at 69.9%. The gender distribution, high representation of female participants, in these studies could have led to the implied gender differences found. On a different note Iliffe and Steed (2000) found no real gender differences in their study with equal gender representation. The only differences were found to have occurred as a result of client gender, which was connected to the type of trauma experienced. This area of study requires more research to understand the connection between gender and compassion fatigue.

**Spirituality and Coping Strategies**

One part of the compassion fatigue research has been conducted on the possibility of strategies that may counteract or balance compassion fatigue symptoms. The
research has not shown when or why the strategies are utilized: before the symptoms manifest, due to the onset of symptom manifestation, or after the symptoms have been present. The reasons for using coping strategies may or may not be due to compassion fatigue. It is possible that some helpers practice coping strategies as part of their normal lifestyle and not specifically for dealing with compassion fatigue and the accompanying symptoms. Though it has been suggested that utilizing positive coping strategies may help alleviate or counteract compassion fatigue or trauma symptoms (Brady, Guy, Poelstra, & Brokaw, 1999; Horowitz, 1997; Pearlman, 1999; Pearlman & Mac Ian, 1995; Rosenbloom, Pratt, & Pearlman, 1999; Schauben & Frazier, 1995).

There has been research in the area of compassion fatigue that connects recovery and spirituality. Pearlman (1999) defines spirituality as “meaning and hope, sense of connection with something beyond oneself, awareness of all aspects of life, and sense of the non-material” (p. 54). Helpers’ spiritual beliefs, including sense of meaning and purpose in life, may be shifted due to STS (Rosenbloom, Pratt, & Pearlman, 1999). When faced with client trauma and stories of human cruelty a therapist’s basic beliefs may be challenged (Brady, Guy, Poelstra, & Brokaw, 1999).
Researchers have suggested spirituality and coping strategies may be an effective way of dealing with compassion fatigue or vicarious traumatization (Brady et al. 1999; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995). Pearlman and Mac Ian (1995) suggested that some therapist characteristics and work characteristics may influence vicarious traumatization. The research has shown a mixture of results.

Way et al., (2004) compared clinicians treating sexual abuse survivors and clinicians treating sexual offenders. Gender distribution in the sample was 39.48% male and 60.52%. The ethnicity of the sample was vastly overwhelmed with Caucasians making up 94% of the 347 participants. Minorities represented only six percent of the sample, or 20 participants, this should be noted as a limitation. The researchers found that clinicians who worked with survivors more likely to seek professional support and to use positive coping strategies such as spiritual practices, physical exercise, seek own therapy, and seek support from family and friends. The results showed that greater trauma effects were positively associated with greater use of positive personal strategies and negative personal
strategies. Greater use of professional support was not associated with lower trauma effects.

Trippany, Wilcoxon, and Satcher (2003) studied 114 female therapists that treated sexual trauma survivors. The researchers aimed to examine selected personal (spirituality, personal trauma history, etc.) and practice variables (caseload, supervision, etc.) that may contribute to vicarious traumatization in therapists serving child survivors of sexual victimization versus therapists serving adults survivors of sexual victimization. The researchers did not find a relationship between effective coping mechanisms and spirituality in the participants, nor did the researchers find predictors of vicarious trauma in either therapists of children survivors or therapists of adult survivors. The researchers suggested that the findings may have been influenced due to the homogeneity of the participants. This should be noted as a limitation of this study.

Brady, Guy, Poelstra, and Brokaw (1999) surveyed 1,000 women psychotherapists. The studies purpose was to survey the therapists on vicarious trauma. Therapists with higher levels of exposure to sexual abuse material reported more trauma symptoms, but no significant disruptions of
cognitive schemas. The researchers found that the more exposure to trauma material the higher the participants spiritual well-being. The authors noted that “many therapists” in their study stressed the importance of pursuing physical and spiritual well-being activities, thus engaging in positive coping strategies. This study supported the theory that spirituality may in fact counteract vicarious trauma. However, as with Trippany, Wilcoxon, and Satcher’s (2003) study, a limitation of this study is the fact that only women therapists were surveyed. This study is unable to be generalized to all therapists.

Schauben and Frazier (1995) conducted a study with women psychologists and sexual violence counselors. The authors noted that male counselors were excluded because of few male responses. The sample was comprised of 148 women, and 98% of the participants were Caucasian. The researchers found that participants who utilized more coping strategies reported fewer disrupted beliefs, fewer PTSD symptoms, less vicarious trauma, less negative affect, and less burnout. As with previously mentioned studies, this study is not able to be generalized because of the homogenous sample. It is unknown how the male respondents (which were excluded) were similar or different from their female counterparts.
Rationale for Instrumentation

This research utilized the Basic Empathy Scale (BES) developed by Jolliffe and Farrington (2005), The Professional Quality of Life Scale (ProQOL) developed by Stamm (2005) and the Impact of Event Scale (IES) developed by Horowitz, Wilner, and Alvarez (1979).

The BES was chosen for this research study due to the scale’s ability to provide several different empathy scores. The BES provides an overall score of empathy as well as separate scores for cognitive and affective empathy and is comprised of 20 questions. There are several empathy measures for specific populations such as The Child Molester Empathy Measure (CMEM; Fernandez, Marshall, Lightbody, & Sullivan, 1999), or The Jefferson Scale of Physician Empathy (Hojat, Mangione, Nasca, Cohen, Gonnella, Erdmann, Veloski, & Magee, 2001) but there is not a scale to use for professional counselor. Since there is no scale designed to use specifically for professional counselors, this study will utilize a scale suitable for many populations. The Hogan’s Empathy Scale (Hogan, 1969) provides only a general empathy score and is comprised of 64 questions, which is much longer than the BES. Mehrabian and Epstein’s Questionnaire Measure of Emotional Empathy
Scale (QMEE; Mehrabian & Epstein, 1972), like Hogan’s Empathy Scale, only provides a general score for empathy. The BES was chosen due to its short length and ability to provide three different empathy scores.

The ProQOL was chosen for this research study due to the versatility of the scale and its length. The tool provides three separate self-contained scales, and is comprised of 30 questions. A researcher may gather data on compassion fatigue, burnout, and compassion satisfaction with one tool. The compassion fatigue scale was used for the primary research analysis in this study, and the burnout scale and compassion satisfaction scale were used in subsequent analyses. The Compassion Satisfaction and Fatigue Test (Figley & Stamm, 1996) contains the same scales as the ProQOL but has 66 items. The Compassion Fatigue Self Test (Figley, 1995), which has been developed into the ProQOL, has many versions. The original scale measured compassion fatigue and burnout with 40 items. However, no past version has the combination of all three measurement scales with the desired short length the ProQOL offers.

The IES was chosen for this research due to the scales short length (20 items) and ability to provide an overall
score of trauma symptoms as well as separate scores for intrusive symptoms and avoidance symptoms. The IES-R (Weiss, 2004) will not be utilized due to the longer length and the revised scale being less established than the original version. Other trauma and PTSD symptom gathering scales such as the Clinician-Administered PTSD Scale (CAPS; Blake, Weathers, Nagy, Kaloupek, Charney, & Keane, 1998), the PTSD Checklist (PCL; Weathers, Litz, Huska, & Keane, 1994) and the Trauma and Attachment Belief Scale (TABS; Pearlman, 2003) were not utilized for distinct reasons.

The CAPS is a clinician administered questionnaire and is not suitable for this study since participants will need to self-report. The PCL has three versions that are designed for specific populations. There is a military version, a specific event version, and the civilian version. The only version that possibly could have been utilized in this study was the civilian version. The civilian version was not suitable for this study for two reasons; the civilian version does not have as much research to recommend usage as the other two versions, and the PCL was developed using samples with high prevalence rates of PTSD so it may not be suitable for use with lower rate samples (Norris & Hamblen, 2003). The TABS was
specifically designed to identify changes in cognitive schemas and has been used to assess vicarious trauma, which this study is not assessing.

**Summary**

The review of the literature has shown common themes and gaps in the research of compassion fatigue and related phenomena. No research has examined a specific discipline; helpers from any field have been included in studies, preventing the findings from being generalized. To address this issue the proposed research study examined licensed counselors and licensed clinical counselors in hopes of generalizing the results. The research has found that helpers new to the field have a greater likelihood of experiencing compassion fatigue. This study examined counselors’ experience in the field along with compassion fatigue scores as measured by the ProQOL. Research has also suggested that counselors with higher numbers of trauma survivor clients experience more trauma symptoms and compassion fatigue. The proposed research will gather information on participants’ current and past clients.

Chapter three will provide a detailed description of the research design including research questions and hypotheses, identification of the research population,
description of the research tools, sampling plan, data collection procedures, and data analysis procedures.
CHAPTER THREE: METHODOLOGY

Introduction

This study utilized a quantitative analysis approach to explore the relationship between compassion fatigue and empathy in professional counselors. This chapter describes the research design for the research study, which includes the identification of the population, the sampling plan, instrumentation, and the plan for collecting data. The data analysis procedures will be discussed as well.

Research Design

The research design for this study utilized descriptive statistics, regression analysis, and MANOVA. Descriptive statistics are procedures used to classify, summarize, and describe data (Hinkle, Wiersma, & Jurs, 2003). Regression analysis is a procedure used to analyze the relationship between two variables. MANOVA (multivariate analysis of variance) evaluates whether the population means of a set of dependent variables vary across levels of a factor or factors (Green & Salkind, 2005, p. 218). Reliability and validity is reported in chapter four. The purpose of this study was to explore the relationship between compassion fatigue and empathy in
professional counselors and establish a prevalence of compassion fatigue among professional counselors.

The following primary research question was addressed:

1. Is it possible to predict the level of empathy from compassion fatigue in professional counselors as measured by the Basic Empathy Scale (BES; Jolliffe & Farrington, 2005) and The Professional Quality of Life Scale (ProQOL; Stamm, 2005)?

Research question one will be addressed using the following research hypothesis:

Null Hypothesis One;

It is not possible to predict empathy levels from compassion fatigue scores as measured by the BES and ProQOL.

Alternative Hypothesis One;

It is possible to predict empathy levels from compassion fatigue scores as measured by the BES and ProQOL.

The following secondary research questions were addressed:

2. What is the prevalence of compassion fatigue in Ohio licensed counselors?
This research question will be answered by using descriptive statistics. No research hypothesis will be utilized.

3. Is there a difference between counselors new to the field and experienced counselors on the combination of empathy and compassion fatigue scores as measured by the BES and ProQOL?

Research question three will be addressed using the following research hypothesis:

**Null Hypothesis Two:**

There is no significant difference between counselors new to the field and experienced counselors on the combination of empathy and compassion fatigue scores as measured by the BES and ProQOL.

**Alternative Research Hypothesis Two:**

There is a significant difference between counselors new to the field and experienced counselors on the combination of empathy and compassion fatigue scores as measured by the BES and ProQOL.

The researcher mailed survey packets to randomly selected Licensed Professional Counselors (LPCs) and Licensed Professional Clinical Counselors (LPCCs) in the
state of Ohio using the United States Postal Service. The survey packet included a cover letter explaining the research and asking for participation, a brief demographics questionnaire, three surveys (BES, The ProQOL, IES) for completion, a self-addressed stamped envelope in which the participants returned the completed packet, and a self-addressed, stamped post card returned separate from the survey packet. The post cards were utilized to maintain a record of participants requiring follow-up contact encouraging participation while keeping the completed survey packets anonymous. The researcher utilized and conducted appropriate statistical analysis on the data collected.

**Identification of the Population**

The population selected for study in this research was counselors in the state of Ohio. This population was utilized due to the relatively small amount of research on counselors in connection to compassion fatigue and empathy. The results of this study are able to be generalized to Ohio counselors, and to establish a prevalence of compassion fatigue in Ohio counselors. Inclusion of other disciplines in this research would have hindered the ability of the researcher to generalize the results to
counselors, nor could prevalence of compassion fatigue in counselors have been established.

**Sampling Plan**

Participants for this study were randomly selected from a list of Licensed Professional Counselors (LPCs) and Licensed Professional Clinical Counselors (LPCCs) obtained from The Ohio Data Network. According to The Ohio Data Network there are 3,368 Licensed Professional Counselors (LPCs) in the state of Ohio and 3,968 Licensed Professional Clinical Counselors (LPCCs) in the state of Ohio.

The researcher randomly selected 1,000 counselors (500 LPCs and 500 LPCCs) to participate in the study. A lottery style drawing was conducted for each licensure. All prospective participants were added to the lottery for each licensure designation. Five hundred names were drawn from each licensure (500 LPCs and 500 LPCCs). This process guaranteed a true random sample. A combined total of 1,000 survey packets were mailed, 500 to selected LPCs and 500 to selected LPCCs.

After data collection the participants were also assigned one of two designations (new to the field or experienced) based on years of experience as a professional counselor. Counselors who had held a counseling license for
less than four years were categorized as counselors new to the field. Counselors who had held a counseling license for four years or more were categorized as experienced counselors.

In order for counselors to obtain a LPCC license they must have at least two years of full-time counseling experience with supervision as a LPC. A total of 3,000 supervised hours over two years, 1,500 each year counting toward the total. Counselors are not mandated to upgrade their license from LPC to LPCC. There are counselors who choose to maintain a LPC license even if they qualify for a LPCC license. For these reasons it was expected that there would be a mixture of new and experienced counselors within each licensure designation (LPC and LPCC). The researcher utilized both licensure designations when randomly choosing participants.

**Instrumentation**

Three surveys along with a demographics questionnaire were utilized in this study. The included instruments were the Basic Empathy Scale (BES) developed by Jolliffe and Farrington (2005), The Professional Quality of Life Scale (ProQOL) developed by Stamm (2005), and the Impact of Event Scale (IES; Horowitz, Wilner, & Alvarez, 1979).
The Basic Empathy Scale

The Basic Empathy Scale (BES; Jolliffe & Farrington, 2005) was developed by Jolliffe and Farrington in 2005. The BES is used to measure affective (the capacity to experience the emotions of another) and cognitive empathy (the capacity to comprehend the emotions of another) in individuals (Jolliffe & Farrington, 2005). The participants were asked to respond to the 20 items on the survey using a five-point Likert Scale with designations “Strongly Disagree”, “Disagree”, “Neither Agree nor Disagree”, “Agree”, and “Strongly Agree”. The items were scored according to the provided score sheet and the sum of the item answers corresponds to the empathy of the participant. A separate score for affective and cognitive empathy may be attained, or a combination of both empathy types will give the researcher a total empathy score.

Permission from the author D. Jolliffe (personal communication, February 2, 2009) was granted to alter language due to cultural differences. Two questions on the scale were altered; question 10 was changed from “I can usually work out when my friends are scared” to “I can usually figure out when my friends are scared”, question 14 was changed from “I can usually work out when people are
cheerful” to “I can usually figure out when people are cheerful”. No other alterations were made.

The higher a participant scores on the BES the greater their capacity for empathy. People with high empathy have a heightened ability to experience and understand others’ emotions (Jolliffe & Farrington, 2006). People with low empathy fail to recognize and comprehend the emotional state of others and the possible effect that their behavior may have on others (Jolliffe & Farrington, 2006). The alpha reliability for the BES was reported as follows: Overall BES = .87, Affective Empathy Scale = .85, and the Cognitive Empathy Scale = .79. The overall BES will be used for the primary research question. The Affective Empathy Scale and the Cognitive Empathy Scale will be analyzed in subsequent analyses.

The author did not provide score interpretation guidelines, however, journal articles where provided that showed average scores with specific populations. The BES was used with young adults, with an average age of 15 years old who had witnessed bullying in school. The scores were divided into categories such as those who helped the person being bullied and those who did not help because they did not feel it was their business. The average score on the
Overall BES for those who helped was 77.1 for females and 65.5 for males, and the average score for those who did not feel it was their business was 73.6 for females and 61.5 for males. When this researcher averaged both genders scores the average Overall Score for those who helped was 71.25 and for those who did not help the average Overall Score was 67.55. Though, this is not an ideal rubric it does provide a basis for what scores look like on the scale.

The Professional Quality of Life Scale

The Professional Quality of Life Scale (ProQOL; Stamm, 2005) is the most recent version of the Compassion Fatigue Self-Test (Figley, 1995). The ProQOL is comprised of three self-contained scales that measure Compassion Satisfaction (the pleasure the helper derives from being able to do their work well), Burnout (feelings of hopelessness and difficulties in dealing with work or in doing a job effectively), and Compassion Fatigue (work-related secondary exposure to extremely stressful events). The ProQOL contains 30 items (phrases) that are scored on a five-point Likert Scale with the designations “0=Never”, “1=Rarely”, “2=A Few Times”, “3=Somewhat Often”, “4=Often”, “5=Very Often”. The participant responds to phrases such as
“I feel connected to others” using the Likert Scale provided.

The ProQOL’s 30 survey items are divided into the three scales (Compassion Satisfaction, Burnout, and Compassion Fatigue) and scored accordingly. Higher scores on the Compassion Satisfaction scale represent a greater satisfaction related to the ability to be an effective caregiver and lower scores may indicate a problem with the participants job. Higher scores on the Burnout scale indicate that the participant is at higher risk for experiencing burnout and lower scores represent positive feelings about the participant’s ability to be effective in their job. Higher scores on the Compassion Fatigue scale represent a need to evaluate the fears of the workplace, how the participant feels about their work and work environment, and a possible need to speak with a supervisor, healthcare professional, or colleague about the issue. The higher the score on this scale the more secondary trauma that is being experienced, while low scores indicate less secondary trauma experiences.

The current version of the ProQOL (Stamm, 2005) is the newest scale revision. The scale has been shortened from 66 items to 30 items, which has made the current version more
reliable than the longer form and has reduced colinearity (Stamm, 2005). The three subscales’ alpha reliability was reported as Compassion Satisfaction Scale = .87, Burnout = .72, and Compassion Fatigue = .80. The Compassion Fatigue scale will be used in the primary research question. The Burnout scale and Compassion Satisfaction scale will also be reported.

The ProQOL scales each have their own scoring guidelines provided by the author. The Compassion Satisfaction Scale has an author provided average score of 37, with a quarter of people scoring above 42 and a quarter of people scoring below 33. The authors suggest that higher range scores suggest the person derives a good deal of professional satisfaction from their jobs, and that lower range scores, below 33, suggests that the person either has problems with their job or derives satisfaction from activities other than his/her profession.

The Burnout Scale has an author provided average score of 22, with a quarter of people scoring above a 27, and a quarter of people scoring below 18. The authors suggest that individuals with scores lower than 18 reflect positive feelings about their efficiency in their work, and individuals with scores above 27 may wish to evaluate what
about their work makes them feel ineffective in their position. But, the authors caution that individual with high scores may have been having a “bad day” and this score is only cause for concern if it persists.

The Compassion Fatigue Scale has an author provided average score of 13, with a quarter of individuals scoring below 8, and a quarter of individuals scoring above 17. The authors suggest that individuals scoring above 17 may need to evaluate what about their work may frighten them or if there is another reason for the elevated score. The author cautions that the elevated score does not necessarily indicate problems, it does, however, indicate a need to evaluate the situation and possibly discuss it with a supervisor, colleague, or health care professional.

The Impact of Event Scale

The Impact of Event Scale (IES; Horowitz, Wilner, & Alvarez, 1979) was used to measure current (past seven days) intrusive and avoidance symptoms. The authors characterized intrusive symptoms as unwanted thoughts and images, troubled dreams, strong pangs or waves of feelings, and repetitive behavior. Avoidance symptoms were characterized as ideational constriction, denial of the meanings and consequences of the event, blunted sensation,
behavioral inhibition or counterphobic activity, and awareness of emotional numbness symptoms. The IES is comprised of 20 items (phrases) that are rated on a Likert scale. A full-scale score may be obtained or separate scores for intrusive symptoms and avoidance symptoms may be obtained. The participants rate phrases such as “I had trouble falling asleep or staying asleep” using Likert scale designations “Not at all=0, “Rarely=1”, “Sometimes=3” and “Often=5”. The higher the scores the more often the participant is experiencing the symptoms. The split half reliability of the total scale was reported as .86. The alpha reliabilities for the IES are reported as follows; Intrusive Scale = .78, Avoidance Scale = .82. The between scale correlation of the Intrusive Scale and the Avoidance Scale was reported as .42 indicating an association but measurement of different dimensions (Horowitz et al., 1979).

The original authors of the IES suggest that three levels of score evaluation be implemented: low (0-8.5), medium (8.6-19.0), and high (over 19.0). The low level scores do not require evaluation, the medium level scores require possible evaluation, and high level scores may require intervention.
Data Collection Procedures

Appropriate measures to ensure safety and confidentiality of research participants were taken throughout this research. The participants were informed of the purpose of the research, their rights as participants, and that their participation in the research was voluntary. Participants were randomly selected from a list of LPCs and LPCCs obtained from the Ohio Data Network.

The selected participants were mailed an introductory post card via the United States Postal Service one week before the survey packet was mailed to all participants. The introductory post card not only served as preliminary contact with participants but also helped the researcher identify address errors. The survey packet was mailed via the United States Postal Service one week after the introductory post card.

The survey packets were completely anonymous. A self-addressed, stamped post card with the participants name and address was provided. The return post card was return mailed separate from the completed survey packet. The post card was utilized to maintain a record of participants requiring follow-up contact encouraging participation. Returned survey packets, post cards, and any information
gathered and data collected from participants was kept in a confidential locked location.

The survey packet and follow-up communication originated from Ohio University and was printed on Ohio University letterhead. This procedure was followed to assure the participants of a legitimized research project. Contact information of the researcher and supervising faculty member was provided for participants who wished to have further contact before agreeing to participate.

Completing and returning the survey packet in the self-addressed stamped, envelope served as the participants’ consent to participate as was indicated by the cover letter. Approximately one week after the initial survey packet was mailed a follow-up post card was sent via the United States Postal Service encouraging participation in the research. The post card included the researchers contact information in order to request a replacement survey packet if needed. The participants were mailed weekly post card reminders for three weeks following the initial survey packet mailing (total of three post card reminders).

The data collection procedure ended one week after the final contact with participants. When the data collection
procedure ended a follow-up post card was mailed to individuals who did not respond to the request to participate in the research study. The post card was comprised of three short questions aimed to clarify any differences between individuals who chose to participate in the research and individual who elected not to participate. The questions asked how long the individual has been a licensed counselor, if he or she served PTSD diagnosed trauma survivors, and how many current clients have a PTSD diagnosis. These specific questions were asked to gather detailed information that compared to the information gathered from the actual participants.

Data Analysis Procedures

Upon completion of the data collection process the researcher entered all data into the Statistical Package for the Social Sciences (SPSS) to begin data analysis. Descriptive statistics and scatterplot graphs were utilized to determine linearity of the data, identify missing data, and identify possible outliers. Histograms were constructed and used to examine skewness and establish that the data was normally distributed.

1. Research Question Two was addressed first, using descriptive statistics. Since descriptive
statistics was utilized in the data cleaning process, which took place before analysis could begin, the information to address Research Question Two was available first. Scatterplot graphs were utilized to determine linearity of the data. Box plots were utilized to illustrate central tendency and dispersion of the data. Possible outliers were identified at this point. A histogram was constructed to depict skewness and normality (uniform or nonuniform) of the data. Tests of reliability and validity were conducted.

2. Research Question One was addressed with a regression analysis after linearity had been established. Data must be assumed to be linear for correlations and Pearson r correlation coefficient to be utilized to examine the correlation. If data is nonlinear the Pearson r correlation coefficient will under estimate the correlation of the data.

3. Research Question Three was addressed utilizing MANOVA. (The BES, ProQOL, and IES were analyzed at this time, including full-scale and subscales of each instrument.) Special attention was paid to the homogeneity of covariance matrices assumptions
because there is a possibility that the relationship may change over time.

**Summary**

This chapter has provided details regarding the methodology of the research study. The primary and secondary research questions and hypotheses were provided, as well as the identification of the population, sampling plan, detailed descriptions of the research tools, data collection procedures, and planned data analysis procedures.
CHAPTER FOUR: RESULTS

Introduction

This chapter will present the analysis of the data collected for this research. The descriptive data for the research participants is provided first. Secondly, performance reliability and validity of the research instruments used for this research is reported. Next, research questions and analysis used for the hypothesis testing is presented. Finally, the supplemental analyses will be reported.

Mailing Response

Participants for this study were randomly selected from a list of Licensed Professional Counselors (LPCs) and a list of Licensed Professional Clinical Counselors (LPCCs) obtained from The Ohio Data Network. The Ohio Data Network imports data directly from the Ohio Counselor, Social Worker, Marriage and Family Therapist Board. According to The Ohio Data Network there are 3,368 Licensed Professional Counselors (LPCs), and 3,968 Licensed Professional Clinical Counselors (LPCCs) in the state of Ohio.

A lottery style drawing was conducted for each licensure. All prospective participants were added to the lottery for each licensure designation. Five hundred names
were drawn from each licensure (500 LPCs and 500 LPCCs). This process guaranteed a true random sample. A combined total of 1,000 survey packets were mailed, 500 to selected LPCs and 500 to selected LPCCs. A total of 371 survey packets were returned with all research instruments completed, and 30 partially completed survey packets were returned. A total of 21 prospective participants declined to participate without reason while 2 prospective participants noted experiencing significant losses that led to their decline to participate. A letter notifying the researcher of the death of one prospective participant was received. A total of 70 survey packets were returned to the research as undeliverable, and 29 survey packets were received at least three weeks after the return deadline.

Demographic Information

A total of 371 survey packets were returned with all research instruments completed and were used for demographic information and analysis. The survey packets that were returned partially completed could not be used in all statistical tests and were excluded. Partially completed survey packets and late survey packets will be discussed later in this chapter.
The survey packets mailed to participants included a demographics questionnaire. The questionnaire gathered information including whether counselors had been diagnosed with PTSD, current counseling licensure held, years of experience as a counselor, gender, age, race, work setting, current and past number of clients with PTSD, and what types of traumas their clients have experienced. There were 366 (98.7%) valid responses, and 5 (1.3%) missing responses to the question asking if the counselor had ever been diagnosed with PTSD. A total of 55 (14.8%) counselors reported that they had received a PTSD diagnosis at some point in their lives, and 311 (83.8%) reported that they had not been diagnosed with PTSD. All 371 participants reported which licensure they held, 172 (46.4%) reported being Licensed Professional Counselors (LPCs) and 199 (53.6%) reported being Licensed Professional Clinical Counselors (LPCCs).

The participants were divided into two groups based on counseling experience. A total of 362 (97.6%) participants reported their experience, while 9 (2.4%) had missing responses. Seventy-eight (21.0%) participants identified as counselors new to the field (under four years of counseling experience), and 284 (76.5%) participants identified as
experienced counselors (counselors with four years of experience or more).

All 371 research participants reported their biological gender. A total of 285 (76.8%) research participants identified as female, and 86 (23.2%) research participants identified as male. All 371 research participants also reported age. The median age of the participants was 50 years old, and the mean age was 48 years old, with a standard deviation of 11.76.

One (0.3%) of the 371 research participants did not respond to the question gathering information about race, leaving 370 (99.7%) valid responses. A total of 346 (93.3%) identified as “Caucasian/White”, 14 (3.8%) identified as “Black/African American”, 3 (0.8%) identified as “Hispanic/Latino”, 3 (0.8%) identified as “Other”, 2 (0.5%) identified as “Asian/Pacific Islander”, 2 (0.5%) identified as “Native American/Alaska Native”, and 1 (0.3%) did not respond to the question. These percentages are consistent with other research studies in the field of helpers.
Table 1

Demographics of Research Participants

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biological Sex/Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>285</td>
<td>76.8%</td>
</tr>
<tr>
<td>Male</td>
<td>86</td>
<td>23.2%</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian/White</td>
<td>346</td>
<td>93.3%</td>
</tr>
<tr>
<td>Black/African American</td>
<td>14</td>
<td>3.8%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>3</td>
<td>0.8%</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>0.8%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>2</td>
<td>0.5%</td>
</tr>
<tr>
<td>Native American/Alaskan Native</td>
<td>2</td>
<td>0.5%</td>
</tr>
<tr>
<td>Non-reported</td>
<td>1</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

A total of 367 (98.9%) of the research participants reported their current work setting and 4 (1.1%) participants did not respond to the question. Based on their current work settings practicing counselors totaled 313 (85.4%) of the research participants, and a total of 54 (14.7%) of the participants were not currently practicing, leaving the remaining 4 (1.1%) that did not respond.
The participants were asked to report what work setting in which they were currently practicing, and were given four work settings to choose from: “community mental health”, “residential”, “private practice”, and “not currently practicing”. Some participants chose more than one category or did not feel their current work setting fit within the given choices and wrote in a different work setting. In order to be true to the data all reported work settings were included and the following categories were formed; “Community Mental Health” included 142 (38.3%) participants, “Private Practice” included 110 (29.6%) participants, “Not Currently Practicing” included 54 (14.6%) participants, “School/University” included 19 (5.1%) participants, “Residential” included 17 (4.6%) participants, “Other” included 9 (2.4%) participants, “Community Mental Health and Private Practice” included 8 (2.2%) participants, “Residential and Private Practice” included 5 (1.3%) participants, “Community Mental Health, Residential, and Private Practice” included 1 (0.3%) participant, “Physical Rehabilitation” included 1 (0.3%) participant, and “Hospital Based Outpatient” included 1 (0.3%) participant. Due to slight rounding variations in
the SPSS software the percentage total for these work settings is 100.1%.

Table 2

Work Settings of Research Participants

<table>
<thead>
<tr>
<th>Settings</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Mental Health</td>
<td>142</td>
<td>38.3%</td>
</tr>
<tr>
<td>Private Practice</td>
<td>110</td>
<td>29.6%</td>
</tr>
<tr>
<td>Not Currently Practicing</td>
<td>54</td>
<td>14.6%</td>
</tr>
<tr>
<td>School/University</td>
<td>19</td>
<td>5.1%</td>
</tr>
<tr>
<td>Residential</td>
<td>17</td>
<td>4.6%</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>2.4%</td>
</tr>
<tr>
<td>Community Mental Health and Private Practice</td>
<td>8</td>
<td>2.2%</td>
</tr>
<tr>
<td>Residential and Private Practice</td>
<td>5</td>
<td>1.3%</td>
</tr>
<tr>
<td>Community Mental Health, Residential, and Private Practice</td>
<td>1</td>
<td>0.3%</td>
</tr>
<tr>
<td>Physical Rehabilitation</td>
<td>1</td>
<td>0.3%</td>
</tr>
<tr>
<td>Hospital Based Outpatient</td>
<td>1</td>
<td>0.3%</td>
</tr>
<tr>
<td>Non-reported</td>
<td>4</td>
<td>1.1%</td>
</tr>
</tbody>
</table>

Note. Due to slight rounding variations in the SPSS software the percentage total is 100.1%.

The participants were asked if they currently treat adult clients with a PTSD diagnosis and a total of 196
(52.83%) research participants reported that they currently treat adult clients with PTSD, 81 (21.83%) reported that they do not currently treat adult clients with PTSD, and 94 (25.34%) did not respond to the question. The participants were also asked if they currently treat children with a PTSD diagnosis, 120 (32.3%) research participants reported currently treating children clients with PTSD, 118 (31.8%) reported that they did not currently treat children clients with PTSD and 133 (35.9%) did not respond to the question.

The research participants were asked if they had treated clients with a PTSD diagnosis in the past, 230 (62.0%) had treated past adult clients with PTSD, 30 (8.0%) reported not to have treated adult clients with PTSD in the past, and 111 (30.0%) did not respond to the question. The participants were also asked if they had treated child clients with a PTSD diagnosis in the past, 146 (39.35%) had treated children clients with PTSD, 71 (19.14%) reported not to have treated children with PTSD and 154 (41.51%) did not respond to the question.

The research participants were given a list of possible traumas their clients (current or past) may have experienced and asked to indicate all that applied. A total of 321 (86.5%) participants reported their clients have experienced “Sexual Abuse”, 285 (76.8%) reported their
clients have experienced “Physical Abuse”, 283 (76.3%) reported their clients have experienced “Domestic Violence”, 277 (74.7%) reported their clients have experienced “Rape”, 263 (70.9%) reported their clients have experienced “Molestation”, 250 (67.4%) reported their clients have experienced “Death of a Loved One”, 180 (48.5%) reported their clients have experienced “Major Illness”, 180 (48.5%) reported their clients have experienced “Violent Physical Attack”, 146 (39.4%) reported their clients have experienced “Traffic Collision”, 115 (31.0%) participants reported their clients have experienced “Military Combat”, 88 (23.75%) reported their clients have experienced “Robbery”, 78 (21.0%) reported their clients have experienced “Home Invasion”, 62 (16.7%) reported their clients have experienced “Mugging”, 56 (15.1%) reported their clients have experienced “Other” traumas, 55 (14.8%) reported their clients have experienced “Natural Disaster”, 40 (10.8%) reported their clients have experienced “Being Kidnapped”, 29 (7.8%) reported their clients have experienced “Manmade Disaster”, and 23 (6.2%) reported their clients have experienced “Being Taken Hostage”. 
Table 3

**Traumas Experienced by Clients**

<table>
<thead>
<tr>
<th>Trauma Experienced</th>
<th>Client Number (Percent of Sample)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Abuse</td>
<td>321 (86.5%)</td>
</tr>
<tr>
<td>Physical Abuse</td>
<td>285 (76.8%)</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>283 (76.3%)</td>
</tr>
<tr>
<td>Rape</td>
<td>277 (74.7%)</td>
</tr>
<tr>
<td>Molestation</td>
<td>263 (70.9%)</td>
</tr>
<tr>
<td>Death of a Loved One</td>
<td>250 (67.4%)</td>
</tr>
<tr>
<td>Major Illness</td>
<td>180 (48.5%)</td>
</tr>
<tr>
<td>Violent Physical Attack</td>
<td>180 (48.5%)</td>
</tr>
<tr>
<td>Traffic Collision</td>
<td>146 (39.4%)</td>
</tr>
<tr>
<td>Military Combat</td>
<td>115 (31.0%)</td>
</tr>
<tr>
<td>Robbery</td>
<td>88 (23.7%)</td>
</tr>
<tr>
<td>Home Invasion</td>
<td>78 (21.0%)</td>
</tr>
<tr>
<td>Mugging</td>
<td>62 (16.7%)</td>
</tr>
<tr>
<td>Other</td>
<td>56 (15.1%)</td>
</tr>
<tr>
<td>Natural Disaster</td>
<td>55 (14.8%)</td>
</tr>
<tr>
<td>Being Kidnapped</td>
<td>40 (10.8%)</td>
</tr>
<tr>
<td>Manmade Disaster</td>
<td>29 (7.8%)</td>
</tr>
<tr>
<td>Being Taken Hostage</td>
<td>23 (6.2%)</td>
</tr>
</tbody>
</table>

*Note. Percentage based on 371 research participants.*
The research participants were given three instruments to complete; the Basic Empathy Scale (BES; Jolliffe & Farrington, 2005), the Professional Quality of Life Scale (ProQOL; Stamm, 1995), and the Impact of Events Scale (IES; Horowitz, Wilner, & Alvarez, 1979). The mean scores along with the minimum and maximum scores are provided for each scale and subscale.

The BES Full Scale had a mean score of 74.47, a minimum score of 52, a maximum score of 96, and a standard deviation of 6.91. The BES Cognitive Subscale had a mean score of 36.94, a minimum score of 27.0, a maximum score of 45.0, and a standard deviation of 3.27. The BES Affective Subscale had a mean score of 37.51, a minimum score of 23.0, a maximum score of 52.0, and a standard deviation of 5.20.

The ProQOL’s Compassion Fatigue Scale had a mean score of 10.27, a minimum score of 0.0, a maximum score of 32.0, and a standard deviation of 5.91. The ProQOL’s Burnout Scale had a mean score of 18.71, a minimum score of 7.0, a maximum score of 37.0, and a standard deviation of 5.72. The ProQOL’s Compassion Satisfaction Scale had a mean score of 38.38, a minimum score of 15.0, a maximum score of 50.0, and a standard deviation of 6.65.
The IES Full Scale had a mean of 17.39, a minimum score of 0.0, a maximum score of 73.0, and a standard deviation of 17.61. The IES Avoidance Subscale had a mean of 8.69, a minimum score of 0.0, a maximum score of 40.0, and a standard deviation of 9.54. The IES Intrusion Subscale had a mean score of 8.8, a minimum score of 0.0, a maximum score of 35.0, and a standard deviation of 8.83. There were 140 (37.76%) individuals who scored over 19 on the IES Full Scale; it is author suggested that individuals scoring 19 or over may require intervention.
Table 4

Participant Scores on Research Instruments

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Mean</th>
<th>Range</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Empathy Scale</td>
<td>74.47</td>
<td>52-96</td>
<td>6.91</td>
</tr>
<tr>
<td>Affective Subscale</td>
<td>37.51</td>
<td>23-52</td>
<td>5.20</td>
</tr>
<tr>
<td>Cognitive Subscale</td>
<td>36.94</td>
<td>27-45</td>
<td>3.27</td>
</tr>
<tr>
<td>Professional Quality of Life Scale</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compassion Fatigue Scale</td>
<td>10.27</td>
<td>0-32</td>
<td>5.91</td>
</tr>
<tr>
<td>Compassion Satisfaction Scale</td>
<td>38.38</td>
<td>15-50</td>
<td>6.65</td>
</tr>
<tr>
<td>Burnout Scale</td>
<td>18.71</td>
<td>7-37</td>
<td>5.72</td>
</tr>
<tr>
<td>Impact of Event Scale</td>
<td>17.39</td>
<td>0-73</td>
<td>17.61</td>
</tr>
<tr>
<td>Avoidance Subscale</td>
<td>8.69</td>
<td>0-40</td>
<td>9.54</td>
</tr>
<tr>
<td>Intrusion Subscale</td>
<td>8.8</td>
<td>0-35</td>
<td>8.83</td>
</tr>
</tbody>
</table>

**Reliability Analysis on Instrumentation**

**Basic Empathy Scale**

The Basic Empathy Scale (BES; Jolliffe & Farrington, 2005) demonstrated adequate reliability in this research study. These scores were based on the responses of 360
research participants. Coefficient alpha was $\alpha = .80$ for the overall scales. The scale’s authors reported reliability of .87. The subscales also demonstrated adequate reliability. The Affective Empathy Scale’s coefficient alpha was $\alpha = .77$, and the Cognitive Empathy Scale’s coefficient alpha was $\alpha = .75$. The authors reported reliability of .85 for the Affective Empathy Scale, and an alpha reliability of .79 for the Cognitive Empathy Scale. Principal component analysis for the BES revealed two subscales within the full scale. The findings suggested that the scale performed as the author described, measuring both affective and cognitive empathy.

**Professional Quality of Life Scale**

The Professional Quality of Life Scale (ProQOL; Stamm, 1995) demonstrated adequate reliability in this research study. The ProQOL is comprised of three self-contained scales, a Compassion Fatigue Scale, a Burnout Scale, and a Compassion Satisfaction Scale. The reliability scores were bases on 363 participants for the Compassion Fatigue Scale, 366 participants for the Burnout Scale, and 371 participants for the Compassion Satisfaction Scale. Participants with missing data on an individual scale were not included in that particular analysis.
The current study found coefficient alpha for the Compassion Fatigue Scale was $\alpha = .80$, for the Burnout Scale it was $\alpha = .73$, and for the Compassion Satisfaction Scale it was $\alpha = .90$. The authors reported a reliability of .80 for the Compassion Fatigue Scale, .72 for the Burnout Scale, and .87 for the Compassion Satisfaction Scale. Principal component analysis revealed that the ProQOL had groupings for three scales, as these scales are individual scales and not components of a full scale. The findings suggested the ProQOL did have three self-contained scales and performed as the author described measuring compassion fatigue, compassion satisfaction, and burnout.

**Impact of Events Scale**

The Impact of Events Scale (IES; Horowitz, Wilner, & Alvarez, 1979) demonstrated adequate reliability in this research study. The reliability was based on 365 research participants. The number of participants used in this analysis differs from other analyses due to the fact that participants could be utilized in the subscale reliability that could not be used in the full scale analysis. Participants may have answered all questions on one subscale while leaving others blank thus preventing their usage in full scale analysis. The coefficient alpha for the
IES Full Scale was $\alpha = .94$. The authors reported the split half reliability of .86 for the IES Full Scale. The IES may be divided into subscales to obtain scores for intrusive symptoms and avoidance symptoms. The coefficient alpha was $\alpha = .91$ for the Intrusive Scale, and $\alpha = .90$ for the Avoidance Scale. The author reported an alpha reliability of .78 for the Intrusion Scale, and .82 for the Avoidance Scale. Principal component analysis revealed that the IES had groupings for two subscales within the full scale. This finding suggested that the scale performed as the author described, measuring both intrusion and avoidance symptoms.
Table 5

Research Instruments Reliability Analysis

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Current Study Reliability α</th>
<th>Author Reported Reliability α</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Empathy Scale</td>
<td>.80</td>
<td>.87</td>
</tr>
<tr>
<td>Affective Subscale</td>
<td>.77</td>
<td>.85</td>
</tr>
<tr>
<td>Cognitive Subscale</td>
<td>.75</td>
<td>.79</td>
</tr>
<tr>
<td>Professional Quality of Life Scale</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compassion Fatigue Scale</td>
<td>.80</td>
<td>.80</td>
</tr>
<tr>
<td>Compassion Satisfaction Scale</td>
<td>.90</td>
<td>.87</td>
</tr>
<tr>
<td>Burnout Scale</td>
<td>.73</td>
<td>.72</td>
</tr>
<tr>
<td>Impact of Event Scale</td>
<td>.94</td>
<td>.86</td>
</tr>
<tr>
<td>Avoidance Subscale</td>
<td>.90</td>
<td>.82</td>
</tr>
<tr>
<td>Intrusion Subscale</td>
<td>.91</td>
<td>.78</td>
</tr>
</tbody>
</table>

Outliers and Extreme Values

The data was analyzed for extreme values and outliers at this point. The standardized scores were within tolerable ranges of ±4 as suggested by Stevens (2007) for sample sizes over 100. The Box Plots, Normal Q-Q Plots, and
Histograms did not reveal any outliers or extreme values. Histograms of each research instrument were examined at this time. The BES had a normal distribution, the Compassion Fatigue Scale had a negative skew, the Burnout Scale had a slight negative skew, the Compassion Satisfaction Scale had a positive skew, and the IES had no bell curve with a majority of the scores falling at or near zero.
Figure 1a: Histograms of Compassion Fatigue and Burnout Scales
Figure 1b: Histograms of Compassion Satisfaction Scale and IES Full Scale
The Research Questions

The following primary research question was addressed:

1. Is it possible to predict the level of empathy from compassion fatigue in professional counselors as measured by the Basic Empathy Scale (BES; Jolliffe & Farrington, 2005) and The Professional Quality of Life Scale (ProQOL; Stamm, 2005)?

The following secondary research questions were addressed:

2. What is the prevalence of compassion fatigue in Ohio licensed counselors?
   This research question will be answered by using descriptive statistics. No research hypothesis will be utilized.

3. Is there a difference between counselors new to the field and experienced counselors on the combination of empathy and compassion fatigue scores as measured by the BES and ProQOL?

The Primary Research Question

A regression analysis was conducted to answer the first research question. The following null hypothesis was tested for this question:
It is not possible to predict empathy levels from compassion fatigue scores as measured by the BES and ProQOL?

Since this research study is non-experimental the assumptions for the random-effects model were utilized (Green & Salkind, 2005). In order for the regression analysis to have been conducted two assumptions were met. The two assumptions are as follows:

Assumption 1: The X and Y variables are bivariately normally distributed in the population.

Assumption 2: The cases represent a random sample from the population, and the scores on each variable are independent of other scores on the same variable.

The regression analysis was conducted to see how well the ProQOL’s Compassion Fatigue Scale predicted empathy scores as measured by the BES. To meet the assumptions, and establish that the variable distributions were normal, an ANOVA was conducted only to analyze Leven’s Test of Homogeneity of Variance as suggested by Meyers, Gamst, and Guarino (2006). Levene's test was not violated and the variances are assumed to be equally distributed. In order to establish linearity of the data the residuals plots were examined and revealed the data to be linear. A scatterplot
of empathy and compassion fatigue scores was also examined and revealed a positive linear relationship. The regression was then conducted.

Figure 2: Scatterplot of Empathy and Compassion Fatigue Scores

The results of the regression analysis suggested a rejection of the null hypothesis. The results found a significant relationship $F(1, 350) = 17.62, p = .000$ ($p < .05$)
between the BES and the Compassion Fatigue Scale. The \( R^2 = .048 \), showing that compassion fatigue accounts for 4.8% of the variance in empathy scores on the BES. Adjusted \( R^2 = .045 \) revealing a small shrinkage. The beta weight for the Compassion Fatigue Scale was \( \beta = .219 \), which in simple linear regression is also Pearson \( r \). The t statistic found the regression coefficient to be statistically significant \( (p < .001) \) showing that the Compassion Fatigue Scale is a significant predictor of the BES and a rejection of the null hypothesis.

Table 6

Results of Coefficients with the Compassion Fatigue Scale

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
<th>t</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (Constant)</td>
<td>71.91</td>
<td>.721</td>
<td>99.70</td>
<td>.000</td>
</tr>
<tr>
<td>Compassion Fatigue Scale</td>
<td>.26</td>
<td>.061</td>
<td>.219</td>
<td>4.20</td>
</tr>
</tbody>
</table>

a. Dependent Variable: BES Total Scale

Secondary Research Questions

Research question two was addressed utilizing descriptive statistics. No research hypothesis was utilized for the question. In order to answer the research question
the participants were given the ProQOL, which included a subscale that measures compassion fatigue. The Compassion Fatigue Scale had a mean score of 10.27, a median score of 9, and a standard deviation of 5.91. The scores ranged from 0 to 32. These scores are below the scale’s author provided average score of 13. The author suggests that the individuals scoring above a 17 need to evaluate their situations and discuss it with a supervisor, colleague, or health care professional. A total of 42 (11.32%) participants scored above a 17 on the Compassion Fatigue Scale.

A MANOVA test was utilized to answer research question three. The following null hypothesis was tested for this question:

There is no significant difference between counselors new to the field and experienced counselors on the combination of empathy and compassion fatigue scores as measured by the BES and ProQOL.

In order to utilize a MANOVA test for this research three assumptions had to be met. The assumptions are as follows:
Assumption 1: The dependent variables are multivariately normally distributed for each population, with the different populations being defined by the levels of the factor.

Assumption 2: The population variances and covariances among the dependent variables are the same across all levels of the factor.

Assumption 3: The participants are randomly sampled, and the scores on a variable for any one participant is independent from the scores on this variable for all other participants.

A MANOVA test was conducted to see if the participants had different scores on the BES and the ProQOL’s Compassion Fatigue Scale due to their experience as a counselor. Since there is a moderate correlation (.219) between the two dependent variables, the BES and the Compassion Fatigue Scale, it is possible to use MANOVA (Meyers, Gamst, & Guarino, 2006) (see Appendix D for Correlation Matrix). A high correlation between the two dependent variables would have run the risk of multicollinearity, and the two variables could have been testing the same construct. The mean score for “counselors new to the field” on the Compassion Fatigue Scale was 10.82 and for the BES was
75.56. The mean score for “experienced counselors” on the Compassion Fatigue Scale was 10.20 and for the BES was 74.36.

The results of the Box’s Test of Equality of Covariance Matrices was nonsignificant, $F(8.94, 272467.03) = .031$, and did not reject the null hypothesis ($p > .01$) meaning that the observed covariances of the dependent variables do not differ significantly across groups. Levene’s Test of Equality of Error Variances was also nonsignificant ($p > .01$) for each dependent variable, the BES $F = .01$ and $p = .92$, and the Compassion Fatigue Scale $F = 4.84$ and $p = .03$, each with 342 degrees of freedom. This failure to reject the null hypothesis means that the error variances of the dependent variables do not differ significantly across groups. Since Box’s Test and Levene’s Test were both nonsignificant, the MANOVA results were analyzed further.

The Wilks’s Lambda value of .994 was nonsignificant, $F(2, 341) = 1.04$, $p = .356$, partial $\eta^2 = .006$. The nonsignificant result indicated that the group means on the BES and the Compassion Fatigue Scale are not different based on counselors’ years of experience. The MANOVA test resulted in a failure to reject the null hypothesis.
Table 7

MANOVA Results

<table>
<thead>
<tr>
<th>Multivariate Test</th>
<th>Value</th>
<th>F</th>
<th>Hypothesis df</th>
<th>Error df</th>
<th>Sig.</th>
<th>Partial Eta Squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wilks’s Lambda</td>
<td>.994</td>
<td>1.04</td>
<td>2</td>
<td>341</td>
<td>.356</td>
<td>.006</td>
</tr>
</tbody>
</table>

**Supplemental Analyses**

A second Regression Analysis was conducted in order to construct a better prediction model for scores on the BES (empathy). The predictors (Compassion Fatigue Scale, Burnout Scale, Compassion Satisfaction Scale, IES Full Scale, and “Years of Practice”) were added to the regression model with the Hierarchical Method. The three subscales of the ProQOL (Compassion Fatigue Scale, Burnout Scale, and Compassion Satisfaction Scale) were added to the model, in that particular order, since the Compassion Fatigue Scale had already been established as a significant predictor of the BES (empathy). The IES Full Scale was added after the ProQOL scales and “Years of Practice” was added last because it is not a scale. This method created five models.
The third model with the Compassion Fatigue Scale, the Burnout Scale, and the Compassion Satisfaction Scale as predictors was selected as the best prediction model for the BES (empathy). Though the Burnout Scale did not add anything significant to the model, Compassion Satisfaction, which was entered after the Burnout Scale, did add significant change, thus the Burnout Scale was included in the final model. The IES Full Scale and “Years of Practice” did not add anything statistically significant to the models that included them as predictors. Due to their nonsignificant change results the models that included the IES Full Scale and “Years of Practice” were not selected.

Model three had an $R^2 = .066$ and the adjusted $R^2 = .058$. The model explained 6.6% of the variance in the BES scores with a small amount of shrinkage.
Table 8

Supplemental Regression Model Summary

<table>
<thead>
<tr>
<th>Model</th>
<th>R²</th>
<th>Adjusted R²</th>
<th>R² Change</th>
<th>F Change</th>
<th>Sig. F Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>.047</td>
<td>.045</td>
<td>.047</td>
<td>16.298</td>
<td>.000*</td>
</tr>
<tr>
<td>2</td>
<td>.054</td>
<td>.049</td>
<td>.007</td>
<td>2.377</td>
<td>.124</td>
</tr>
<tr>
<td>3</td>
<td>.066</td>
<td>.058</td>
<td>.012</td>
<td>4.152</td>
<td>.042*</td>
</tr>
<tr>
<td>4</td>
<td>.066</td>
<td>.055</td>
<td>.000</td>
<td>.066</td>
<td>.797</td>
</tr>
<tr>
<td>5</td>
<td>.069</td>
<td>.055</td>
<td>.003</td>
<td>.878</td>
<td>.350</td>
</tr>
</tbody>
</table>

*Significant at .05

a. Predictors: (Constant) Compassion Fatigue
b. Predictors: (Constant) Compassion Fatigue, Burnout
c. Predictors: (Constant) Compassion Fatigue, Burnout, Compassion Satisfaction
d. Predictors: (Constant) Compassion Fatigue, Burnout, Compassion Satisfaction, IES Full Scale
e. Predictors: (Constant) Compassion Fatigue, Burnout, Compassion Satisfaction, IES Full Scale, Years of Practice
f. Dependent Variable: BES
Table 9

Results of Supplemental Regression Analysis Coefficients for Model Three

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 (Constant)</td>
<td>65.97 3.950</td>
<td>16.7 .000</td>
</tr>
<tr>
<td>Compassion Fatigue Scale</td>
<td>.294 .081</td>
<td>.254 3.636 .000</td>
</tr>
<tr>
<td>Burnout Scale</td>
<td>.001 .104</td>
<td>.001 .007 .994</td>
</tr>
<tr>
<td>Compass Satisfaction Scale</td>
<td>.145 .071</td>
<td>.142 2.038 .042</td>
</tr>
</tbody>
</table>

a. Dependent Variable: BES Total Scale
Since the literature held theory that experience was a determining factor in compassion fatigue and empathy the researcher decided to divide the research participants into four groups based on their years of experience using the “ranking” function in SPSS and dividing the participants into four percentiles. Each counselor was assigned a ranking based on experience. The newest quarter of the counselors were assigned into the first percentile and ending with the most experienced quarter being assigned to the fourth and final percentile.

The mean score on the Compassion Fatigue Scale for each percentile was; percentile one, 11.13, percentile two, 10.27, percentile three, 9.67, and percentile four, 10.34. The mean score on the BES for each percentile was; percentile one, 75.51, percentile two, 73.94, percentile three, 74.34, percentile four, 74.72.

The MANOVA was conducted a second time with these groupings used as the independent variable and the BES and Compassion Fatigue Scale were again used as the dependent variables.

The result of Box’s Test, $F(10.83, 1305918.51) = 1.19$, $p = .3$, was nonsignificant. Levene’s Test was also nonsignificant for each dependent variable, BES $F = .94$, $p = $
.42, and the Compassion Fatigue Scale \( F = 1.86, p = .14 \), each with 340 degrees of freedom. After evaluating Box’s Test and Levene’s Test and the nonsignificant results were confirmed, the MANOVA results were further analyzed. Wilks’s Lambda was nonsignificant with a value of .987, \( F(6, 678) = .721, p = .633 \), and partial \( \eta^2 = .006 \).

Table 10

Supplemental MANOVA Results

<table>
<thead>
<tr>
<th>Multivariate Test</th>
<th>Value</th>
<th>F</th>
<th>Hypothesis Df</th>
<th>Error df</th>
<th>Sig.</th>
<th>Partial Eta Squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wilks's Lambda</td>
<td>.987</td>
<td>.721</td>
<td>6</td>
<td>678</td>
<td>.633</td>
<td>.006</td>
</tr>
</tbody>
</table>

The nonsignificant results indicate that even with the newly defined percentiles ranking experience (four percentiles based on the participants experience) the counselors’ scores were not significantly different on the BES and Compassion Fatigue Scale based on experience.

The partial and late returned surveys were analyzed to be sure that these research participants did not differ from the included research participants. These research participants were a majority of experienced counselors with
only three counselors new to the field. The included participants were also a majority of experienced counselors. The demographics and instrument scores did not differ from the included participants.

**Non-participants**

A final post card was mailed to individuals who did not respond to the request to participate in the research study. The post card was comprised of three short questions aimed to clarify any differences between individuals who chose to participate in the research and individual who elected not to participate. The questions asked how long the individual has been a licensed counselor, if he or she served PTSD diagnosed trauma survivors, and how many current clients have a PTSD diagnosis.

The researcher mailed 476 final post cards, which was one post card to each individual that did not participate in the research. A total of 112 usable post cards were returned, 17 post cards were returned as undeliverable, 17 post cards were returned from individuals reporting that they did participate in the research, 14 post cards were returned from self-reported retired individuals or individuals that felt they would not fit the research study, and 3 post cards were returned blank.
Descriptive analyses were utilized on the data. Question one asked how long the individual had been a licensed counselor. A total of 107 of the 112 individuals answered the question. The individuals were divided into groups based on experience, 14 individuals identified as counselors new to the field (under four years of counseling experience), and 93 individuals identified as experienced counselors (counselors with four years of experience or more). The majority of the individuals that responded to the final card were experienced counselors (86.9%), the research participants in this study were also a majority of experienced counselors, 284 (76.5%), while 78 (21.0%) identified as new to the field.

Question two asked if the individual treated PTSD diagnosed clients. A total of 110 individuals answered the question. The number of individuals that reported serving PTSD diagnosed clients was 70 (63.6%), with 40 (36.3%) reporting they do not. The majority of the individuals reported that they do treat PTSD. This question asked if the individual treated PTSD, not if the individual had current clients with PTSD. However the research participants were asked if they currently treat adults with PTSD and then asked in a separate question if they treated
children with PTSD. A total of 196 (52.83%) reported having adult clients with PTSD. Then in the second question a total of 120 (32.3%) reported having children clients with PTSD.

Question three asked how many of the individual’s current clients had a PTSD diagnosis. The individuals were asked to specify if they served none, one, two, three, or more than three. A total of 105 individuals answered the question. The mean score was 1.95 and the median was 2.0. The frequencies were as follows; 44 individuals reported no current PTSD clients, 7 reported one current PTSD client, 6 reported two current PTSD clients, 6 reported three current PTSD clients, and 42 reported having more than three current PTSD clients. This breakdown shows that 61 individuals are currently serving clients with a PTSD diagnosis, while 44 are not. A total of 58% (61 individuals), over half of the individuals who responded to the final post card are currently serving PTSD diagnosed clients. In the research study 52.83% of the participants reported having current adult clients with a PTSD diagnosis.

The individuals that answered the final post card did not show significant differences from the actual research
participants on the three questions asked. Based on the answers provided on the final post card the individuals that elected not participate in the research study do not differ from the actual research participants.

**Summary**

This chapter reported the analyses conducted on the collected research data. The results of a regression analysis and a MANOVA analysis have been reported. A section on supplemental analyses was included, a rationale for each supplemental test was given, and a report of non-participants. In the following chapter these results will be discussed and recommendations for future research will be given.
CHAPTER FIVE: DISCUSSION

Introduction

The purpose of this research study was to explore the relationship between compassion fatigue and empathy in professional counselors, understand rates of compassion fatigue in counselors, and examine if there are differences in compassion fatigue and empathy based on a counselor’s experience. This chapter will provide a discussion of the research results, including discussion of demographic characteristics, results of research analyses, and results of supplemental analyses. Recommendations for future research will also be provided.

Discussion of the Research Study

Compassion fatigue not only affects the counselor but may also affect the counselor’s clients. It is important for counselors to recognize and understand that clients may be harmed when the counselor is experiencing compassion fatigue symptoms. Counselors experiencing compassion fatigue may not convey empathy to clients, dehumanize clients, avoid clients’ traumas or treat clients as research subjects (Valent, 2002).

Compassion fatigue not only affects the counselor but may also affect the counselor’s clients. It is important
for counselors to recognize and understand that clients may be harmed when the counselor is experiencing compassion fatigue symptoms. Counselors experiencing compassion fatigue may dehumanize clients, may avoid clients’ traumas or treat clients as research subjects, or they may not convey empathy to clients (Valent, 2002). The counselor’s ability to help the client through an empathic relationship may be hindered or even impossible due to compassion fatigue. With nearly two-thirds of the American population being exposed to a traumatic event that may lead to PTSD (Marotta, 2000) it is important for counselors to be aware of the possibility of becoming traumatized due to their clients’ trauma material.

The symptoms of compassion fatigue can emerge suddenly (Figley, 1995), unlike symptoms of burnout, which is a progressive condition (Canfield, 2005; Trippany, Kress, & Wilcoxon, 2004). A helper may experience compassion fatigue as a result of contact with a single trauma survivor. Along with the secondary traumatic stress disorder symptoms, which are identical to PTSD symptoms, the counselor experiencing compassion fatigue may feel a sense of helplessness, confusion, and isolation from supporters (Figley, 1995).
Symptoms experienced by traumatized helpers are strikingly similar to symptoms experienced by the trauma survivors (McCann & Pearlman, 1990; Figley, 1995, 2002; Valent, 2002). Both traumatized helpers and trauma survivors experience PTSD symptoms. This similarity in experiences and symptoms can be detrimental to the therapeutic relationship between helper and client.

The relationship between helper and client may be affected by compassion fatigue (Valent, 2002). It is possible for the counselor to experience a lack of empathy, deny client traumas, have fragmented attention, dehumanize the client or survivors and view them as nothing more than cases or research subjects, and in some instances the counselor may have an overenthusiastic involvement with the client (Valent, 2002). No matter how the counselor is experiencing compassion fatigue, whether they have PTSD symptoms or the counseling relationship altering symptoms described by Valent (2002), it is detrimental to the relationship.

Empathy has been identified as an important component in psychotherapeutic intervention (Canfield, 2005). In order to establish a relationship mental health providers use empathy (Gentry, Baranowsky, & Dunning, 2002). Over
time as helpers continue to work in emotionally charged situations empathy may be overtaxed and exhausted even if the professional is taking precautions in self-care (Gentry, Baranowsky, & Dunning, 2002). Since empathy is essential to understand and therapeutically help clients, a counselor with a lack of empathy may not have the capacity to help their clients and essentially is an impaired professional.

It has been suggested that impaired helping professionals, or those with high levels of compassion fatigue or burnout, are at a higher risk of making poor professional decisions such as misdiagnosis, poor treatment planning, or abuse of a client, than those not affected (Munroe, 1999; Rudolph, Stamm, & Stamm, 1997). Scholars theorize that the effects of compassion fatigue hinder the ability to work with clients. Some helpers may avoid clients with trauma, discourage clients from talking about their personal trauma, and unknowingly allow clients to become caretakers in the therapeutic relationship (Munroe, 1999). Along with these risks it is possible that due to compassion fatigue a counselor experiences a lack of empathy (Valent, 2002), along with other symptoms, and the counselor’s ability to understand the client becomes
impaired therefore hindering the therapeutic process and possibly causing harm to the client.

Clients may see helpers who are experiencing these symptoms as naïve, ignorant, limited, patronizing, denigratory, unsympathetic, lacking understanding and compassion (Valent, 2002). In some instances the therapist and counseling relationship may be more traumatic than the client’s own traumatic experience (Valent, 2002). In extreme cases the relationship may become enmeshed, the client may absorb the helper’s problems, and suicidal acts may evolve through the unhealthy relationship (Valent, 2002). These negative aspects emerge through the counselor’s own and traumatic stress thereby affecting the client, the therapeutic process, and the progress in therapy.

Marci, Ham, Moran, and Orr (2007) suggested that the counseling relationship itself is more important than the type of therapy the counselor uses. Several important factors of the counseling relationship are the client being understood, supported, empathized with, and the client believing that the counselor understands and is empathetic. Client perceived empathy has been shown to have a significant impact on the outcome of therapy (Marci et al.,
Marci et al. (2007) studied 20 patient/client dyads engaged in outpatient therapy and found that client perceived therapist empathy was an important component in the therapeutic process.

How the client sees the counselor and the empathy conveyed has a direct impact on the outcome of therapy for that client. A counselor with little to no capability to empathize, due to compassion fatigue, may not be able to convey the empathy necessary for a healthy counseling relationship and positive change in the client. If the counselor’s view of the client is negatively impacted and the client’s view of the counselor is negatively impacted the resulting relationship is harmful, unhealthy, and dangerous for the counselor and the client(s) involved.

The research in the area of trauma that is experienced by helpers is unclear and confusing in terminology. The helping professions have been strewn with many terms that hinge on slight differences such as; secondary traumatic stress, compassion fatigue, secondary victimization, secondary traumatic stress disorder, vicarious traumatization, and secondary survivor. These terms are used to describe disturbances and trauma experienced by helpers. The continued separation of these closely related,
and sometimes synonymous, terms cloud and splinter the research. These slight separations make it difficult to see this area of trauma as one large area of research. A more inclusive and encompassing approach to helper trauma research would benefit the helping professions by eliminating the splintering effect and bridging the gaps made by the varying terms.

Research Sample Characteristics Discussion

Gender and Race

The research sample was comprised of a majority of white females. As discussed in the literature review, previous research in the helping professions has been predominantly with white females. The researcher randomly selected 1,000 individuals, regardless of gender, in an attempt to have a representative sample of the population. One possible explanation for the gender and racial imbalance, in this and other research studies, is the make-up of the counseling population. The samples are quite possibly representative of the population. This is believed to be the case in this research study. The American Counseling Association (ACA), the largest counseling association in the United States, has some demographical information on their members. During a phone interview one
of the ACA representatives cautioned that the stats were only based on the members that reported their gender and race on their applications. A total of 13,543 members reported their gender: 9,650 (71.25%) identified as female and 3,893 (28.75%) identified as male. The ACA does not hold detail breakdowns of membership, so it was not possible to report how many white females comprised the membership. However, the ACA reported that 12,991 members reported race. A total of 11,370 (87.5%) members identified as white, 764 (5.9%) identified as African American, 355 (2.7%) identified as Hispanic or Latino, 191 (1.5%) identified as Other, 180 (1.4%) identified as Asian, 108 (0.8%) identified as Native American, and 23 (0.2%) identified as Multiracial. The gender and racial distribution of this research study are comparable to the membership of the ACA and thus is likely representative of the counseling field.

**Licensure**

The sample was comprised of 172 (46.4%) Licensed Professional Counselors (LPC) and 199 (53.6%) Licensed Professional Clinical Counselors (LPCC). The participants were nearly equally divided between the two licensures. But, by experience there were vastly more experienced
counselors, 284 (76.5%), than counselors new to the field, 78 (21.0%), while 9 (2.4%) did not report their experience. This was an expected finding considering the number of licensed counselors versus the relatively small amount of freshly graduated counselors seeking licensure annually.

**Work Setting**

Community Mental Health was the largest counseling venue for the current research participants, 142 (38.3%). Surprisingly, nearly 30% (110, 29.6%) of the research participants were private practitioners only, which was the second most chosen “work setting”. The “Not Currently Practicing” area was the third highest ranking “work setting” chosen with 54 participants (14.6%). The top three chosen “work areas” combined make-up 82.5% of the sample, not including the individuals that combined areas. Some participants were involved in multiple counseling areas at once, such as Community Mental Health and Private Practice, 8 (2.2%). The large amount of counseling licenses held by non-practicing individuals was a surprising finding. Though some of these licenses may be between renewal years and have not had the opportunity to let the license lapse, it is also possible that some licenses are kept only because
it is easier than going through the licensing process again should a decision be made to reenter the field.

It is important to note that nearly 15% of the research participants are non-practicing counselors and could influence some aspects of counseling research. In the current study when the non-practicing counselors were filtered out of the analyses the statistical results did not change the demographic section or improve the statistical analysis results, therefore they were included in the study. This result was most likely due to the fact that this study was asking about current issues regardless of when the participant had last seen a client. The symptoms could be connected with a current or past client, which is most likely the reason that current practice is not necessary. However, had this study asked specifics or even interview questions about the current clientele or current issues with specific types of clients these individuals would not have fit into the study. It is not unlikely that some participants would have answered the surveys or questions honestly or even in regards to past clients, and perhaps neglected to report their non-practicing status, and skewed the research by reporting no
current problems, or reporting past problems, when in fact they had no clients and therefore no current issues.

The large amount of non-practicing counselors still holding licensure is an issue researchers should be aware of for future research. It is quite possible that some of these non-practicing counselors have been out of the field for many years, and may not be the same population as practicing counselors. By addressing this issue in the research design researchers will be able to decide if the non-practicing counselors fit.

**Client Traumas**

Over half (196, 52.83%) of the research participants reported currently treating adults with PTSD, and in a separate question a total of 120 (32.3%) reported currently treating children with PTSD. In regards to past clients 230 (62.0%) have treated adults with PTSD and 149 (39.35%) have treated children with PTSD. The chances are good that at some point in a counselor’s career a client with PTSD will be part of their clientele.

It is important to note that the counselors were asked to count the number of clients they had with a *diagnosis of PTSD or fit the criteria for diagnosis*. The counselors were not to include clients who may have experienced a trauma
but have not been diagnosed or clients who may be experiencing symptoms but not meet the diagnostic criteria. This distinction is important due to the fact that though clients may not have the diagnosis of PTSD or meet all criteria for diagnosis, they may still be sharing trauma experiences that contribute to disturbing symptoms for their counselor. The total number of trauma survivors treated may actually be higher than reported in this research study because the participants only reported PTSD diagnosed clients or clients with extreme symptoms.

A total of 321 (86.5%) participants reported their clients have experienced “Sexual Abuse”. Over 86% of the research participants are treating or have treated clients who have experienced sexual abuse. Though this does not mean the clients were diagnosed with PTSD, they are still discussing these types of issue in sessions. This example specifically shows that the chances of treating trauma survivors of some type, even without a PTSD diagnosis, are high.

For this reason it is important for counselors, supervisors, and educators to be aware of the possible issues of secondary or vicarious trauma that may be experienced due to these types of clients. Counselors need
to be educated in graduate programs, by supervisors, and by employers of the risks associated with treating trauma survivors. It is important for counselors to know the necessary steps that may protect or counteract the negative aspects associated with treating trauma such as self-care, good supervision, proper client or case load, and warning signs of secondary trauma or vicarious trauma. When counselors are properly informed they will be able to make informed choices and be better prepared to recognize and deal with any negative aspects in an appropriate fashion. These things not only protect the counselors but also the clients from harm.

**Research Instruments Scoring Discussion**

The research instruments each come with scoring interpretation guidelines with the exception of the BES. However, the BES was accompanied by a study that provided average scores for the instrument. Although the scores were based on young adults with an average age of 15 years, it does provide a basic grounding for the scores. The IES and ProQOL do provide scoring guidelines as described in chapter three.
Impact of Events Scale

The IES Full Scale had a mean score of 17.39, the Avoidance Subscale had a mean of 8.69, and an Intrusion Subscale mean of 8.8.

The scores of the IES Full Scale must be interpreted with caution in this study. Interpreting a mean score on this scale deserves more explanation than the other scales. Though 79 (21.3%) participants scored a “0” on the IES Full Scale the other 278 (74.9%) valid scores ranged from 1-73. Even with the high number of “0” scores the mean score was 17.39 which falls into the “medium level” range, as suggested by the scale’s authors. The scale’s authors suggested that medium level scores may require evaluation. However, the 140 (37.76%) individuals who scored over 19 may require intervention. Regardless of the many “0” scores the average score suggests that many counselors are experiencing disturbing symptoms in connection to their work with clients which may require evaluation and even intervention. A total of nearly 40% of the research sample was experiencing possible intervention level symptoms. This result shows that a large amount of the sample could possibly use intervention and support.
The Professional Quality of Life Scale

Each of the three self-contained scales of the ProQOL Scale had their own scores. The Compassion Fatigue Scale had a mean of 10.27, the Burnout Scale had a mean of 18.71, and the Compassion Satisfaction Scale had a mean of 38.38.

The Compassion Fatigue Scores in this study suggest that on average Ohio counselors are below the author provided average of 13. This tells us that on average Ohio counselors are not being affected by compassion fatigue at high rates. However, 42 (11%) research participants scored above a 17 on the scale, which the author suggests is the point when counselors should evaluate their situation.

The Burnout Scale Scores in this study were below the author suggested average score of 22. This suggests that average Ohio counselors have fewer burnout symptoms than the author’s average individual and thus have more positive feelings and more feelings of efficiency in their work.

The Basic Empathy Scale

The Basic Empathy Scale had a mean score of 74.47, a mean of 37.51 on the Affective Scale, and a mean of 36.94 on the Cognitive Scale. Though the author did not provide scoring interpreting guidelines, studies were provided that proved useful when making comparisons. The authors’ young adult
population had lower empathy levels than the current counselor sample in this study. This is an expected finding since counselors may have a natural high empathy level, more so than the average person, which is quite possible the reason counselors enter the helping profession.

**Discussion of Questions’ Statistical Analyses**

Primary Research Question Regression Analysis

The regression analysis resulted in a rejection of the null hypothesis. The compassion fatigue scores were a significant predictor of the empathy scores. This rejection of the null hypothesis showed that it is possible to predict levels of empathy, as measured by the BES, from compassion fatigue scores, as measured by the ProQOL’s Compassion Fatigue Scale. The compassion fatigue explained 4.8% of the variance of the empathy scores.

These findings show that there is a significant relationship between compassion fatigue and empathy in counselors that is worthy of investigation. The importance of understanding how counselors are affected by their clients’ trauma cannot be stressed enough. In order to protect clients from harm the counselors must understand the implications that providing treatment may produce.
Research Question Three MANOVA Analysis

The results of the MANOVA indicated a failure to reject the null hypothesis. This result indicates that there is not a significant difference of empathy and compassion fatigue scores due to a counselor’s experience. The counselors’ scores in this study did not differ significantly in compassion fatigue and empathy scores based on their experience in the field.

Researchers may wish to begin investigating other possible reasons for counselors to experience lower empathy such as clients, personality differences, or area of expertise. It may be the types of clients that counselor serve that may interfere with their empathy levels. It may be possible that in an attempt to self-preserve under stress counselors tend to disconnect from stressful or fear evoking clients. This may not lead to low empathy in the counselor, but the counselor may feel less empathic toward specific clients, such as clients with PTSD. The withdrawal from these clients may be to help protect the counselor from the disturbing images, thoughts, and dreams and may be completely unintentional. But, with less stressful clients the counselors may revert back to natural empathy levels.
Discussion of Supplemental Analyses

A second regression analysis was conducted in an attempt to find a predictor model that surpassed the first model that used Compassion Fatigue as the only predictor. Other predictors were combined with Compassion Fatigue in hopes of boosting the prediction power. The other research instruments were used as predictors along with “Years of Practice”. The results of the regression analysis found that Compassion Fatigue and Compassion Satisfaction were both significant predictors of Empathy. However, since Burnout was entered into the model before Compassion Satisfaction it was included in the chosen model, but for future research Burnout would not be included. The IES Scale and “Years of Practice” did not add anything significant to the model leading to the rejection of models that included them. The chosen model explained 6.6% of the variance in Empathy Scores, which was higher than the 4.8% Compassion Fatigue explained alone in the first regression analysis. Future research may wish to focus on Compassion Fatigue and Compassion Satisfaction as empathy predictors. Researchers may also wish to exclude “Years of Practice” along with Burnout and the IES Scale.
A second MANOVA was conducted using percentiles ranking experience into four newly defined groups, which were used in this second analysis. Since the literature was heavily laden with theory indicating that experience may be a key factor in compassion fatigue and empathy scores an attempt was made to examine experience more thoroughly. However, even with these newly defined groups for experience the results of the MANOVA failed to reject the null hypothesis. Future research may wish to focus more heavily on type of clients and caseload rather than experience of counselors when investigation compassion fatigue and empathy.

**Implications for Practice**

The results of the current study have shown that experience does not make a counselor immune to compassion fatigue or trauma symptoms. Experienced counselors are just as likely as counselors new to the field to experience compassion fatigue or trauma symptoms in regards to work with their clients. These findings show that it is important for all counselors, regardless of licensure or experience, to be aware of the risks of treating trauma survivors. The high amount of counselors reaching intervention level scores on the IES is a sign that this
issue warrants immediate attention. Not only is this an important practice issue but an education issue as well.

Educators should focus on developing counselors with a clear view of self-care techniques, and resource outlets. Counselors that are able to recognize problems when they begin will be quicker to act appropriately and resolve or treat the issues. It is important for educators to teach counselors when to utilize referrals and consultation. The importance of discussing counseling experiences with peers should be stressed in the classroom. An important issue for new counselors to learn is the development and maintenance of proper supervisor and supervisee relationships. A supervisor should be one of the counselor’s greatest assets. Not only should a counseling student learn about the relationship from the supervisee perspective but also it is important for a supervisee to know what is to be expected of a supervisor. This relationship is instrumental in development and protection of new counselors. Not only should the counselors be able to recognizing the symptoms of exhaustion, burnout, compassion fatigue, etc., the supervisors should be aware of these problems and ways to access help.
Supervisors should be aware of the effects of treating trauma survivors and incorporate self-care strategies into the supervisory relationship. Supervisors may also serve as educators to the supervisee by steering them into more support when necessary. Not only is it important for the supervisor to be vigilant for supervisees but also for themselves. Supervisors may also be practicing counselors and may experience trauma symptoms as a result. It may also be possible for the supervisor to experience trauma from their supervisees.

Practitioners should have a strong support network, including supervisors and peers with which to consult. It is important for practitioners to be familiar with other professionals in the area not only for consulting reasons but also for referrals when necessary. Practitioners may wish to stay connected with the field and be familiar with advancements in treatment by attending professional conferences and accessing continuing education seminars. Professionals that treat trauma may find it helpful, if not necessary, to seek out specific courses, conferences, seminars, or training to be better prepared to treat trauma as well as maintain a healthy life.
Limitations of the Study

A limitation of this study is that it was not a longitudinal study. This research sample was divided into counselors new to the field and experienced counselors, and only took measurements one time. A longitudinal study would have followed counselors through their careers taking measurements at designated periods.

A second limitation to this study was the fact that the sample was derived from a complete list of Ohio Licensed Counselors. By obtaining this list the study excluded counselors from all other states as well as all other helping professions.

Implications for Future Research

Future researchers may wish to conduct a national study of counselors to obtain a sample of all counselors in the United States. By conducting a national study the research ensures a sample representative of all counselors.

As discussed earlier, the results of this study suggest future researchers may wish to explore other contributing factors of compassion fatigue besides experience. Research should examine types of clients and
caseload when searching for predictors of compassion fatigue and/or empathy.

Type of client is an important factor to explore in connection with compassion fatigue. Researchers may also wish to explore gender as a contributing factor to compassion fatigue due to the conflicting research thus far. It has been shown that the type of client impacts a counselors experience with compassion fatigue (Iliffe & Steed, 2000). Typically men work with domestic violence perpetrators than women work with domestic violence survivors and women were reporting more compassion fatigue symptoms than men (Iliffe & Steed, 2000). But, this could be explained by the type of client and not the counselor gender.

The data revealed that, by using the chosen research instruments, compassion fatigue is a significant predictor of empathy. Compassion fatigue accounted for 4.8% of the variance in empathy scores. This research has show that compassion fatigue is connected to empathy and deserves further exploration. Future researchers may focus on counselors with high levels of compassion fatigue and how their empathy levels are affected or compare to counselors with little to no compassion fatigue.
Future researchers may want to begin exploring coping strategies or spirituality as possible safeguards against compassion fatigue. By exploring the spiritual practices and coping strategies of counselors with little to no compassion fatigue researchers may find predictors or tools to help identify counselors at risk for compassion fatigue. Moreover, researchers could begin building strategies to help counselors protect themselves from compassion fatigue based on counselors that do not experience compassion fatigue.

It may be of interest for future researchers to explore counselors with a prior PTSD diagnosis and how these counselors compare to counselors without a diagnosis of PTSD. Compassion fatigue may stir past trauma experiences and reawaken trauma symptoms in counselors with past trauma experiences. But, a counselor with a past PTSD diagnosis has already had troubling symptoms on a diagnosable scale and may be at more risk for compassion fatigue than a counselor without a past PTSD diagnosis.

**Conclusion**

This research has found that all counselors are at risk to experience negative effects of the counseling profession. These findings indicate that experienced
counselors cannot ignore the possibility of trauma symptoms and should seek support or intervention if necessary. Counselors should not hesitate to accept help nor should they feel that their experience should have been a safeguard. Trauma symptoms in a helping professional should not be ignored, not only for the professional’s health and safety but also for the safety of clients.

The counseling profession is making great efforts to understand the impact helping has on the helper. The importance of keeping counselors from becoming impaired professionals cannot be overstated. In order to keep our clients safe and continue to serve our communities we must first keep ourselves safe and healthy. Knowing the possible negative effects that counseling may produce in the counselor and how to deal with these issues is an area that deserves and demands attention.
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and social-emotional process during psychotherapy.
Journal of nervous and mental disease, 195(2), 103-111.


International Society for Traumatic Stress Studies, Montreal, PQ, CA.


APPENDIX A: PTSD CRITERIA IN THE DSM

The diagnostic criteria for Posttraumatic Stress Disorder in the *Diagnostic and Statistical Manual of Mental Disorders Fourth Edition Text-Revision* (DSM-IV-TR; APA, 2001, pg. 467-468) are the following:

A. The person has been exposed to a traumatic event in which both of the following were present:

(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death of serious injury, or a threat to the physical integrity of self or others

(2) the person’s response involved intense fear, helplessness, or horror.

B. The traumatic event is Persistently reexperienced in one (or more) of the following ways:

(1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.

(2) recurrent distressing dreams of the event.

(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving
the experienced, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated).

(4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

(5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

(1) efforts to avoid thoughts, feelings, or conversation associated with the trauma

(2) efforts to avoid activities, places, or people that arouse recollections of the trauma

(3) inability to recall an important aspect of the trauma
markedly diminished interest or participation in significant activities

feeling of detachment or estrangement from others

restricted range of affect (e.g., unable to have loving feelings)

sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

- difficulty falling or staying asleep
- irritability or outbursts of anger
- difficulty concentrating
- hypervigilance
- exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
APPENDIX B: IRB APPROVAL

The following research study has been approved by the Institutional Review Board at Ohio University for the period listed below. This review was conducted through an expedited review procedure as defined in the federal regulations as Category(ies): 7

Project Title: An Exploratory Study of the Relationship between Compassion Fatigue and Empathy in Professional Counselors

Researcher(s): Heidi Llewellyn

Faculty Advisor (if applicable): Mona Robinson

Department: Counselor Education

Rebecca Cale
Institutional Review Board

Approval Date 02/27/09

Expiration Date 02/28/10

This approval is valid until expiration date listed above. If you wish to continue beyond expiration date, you must submit a periodic review application and obtain approval prior to continuation.

Adverse events must be reported to the IRB promptly, within 5 working days of the occurrence.

The approval remains in effect provided the study is conducted exactly as described in your application for review. Any additions or modifications to the project must be approved by the IRB (as an amendment) prior to implementation.
APPENDIX C: COVER LETTER AND SURVEY

Dear Clinician,

I am asking for your participation in a research study exploring the relationship between compassion fatigue and empathy in professional counselors. You have been randomly selected from a comprehensive list of Ohio Licensed Professional Counselors and Ohio Licensed Professional Clinical Counselors.

The enclosed questionnaire and surveys will take approximately 15 minutes to complete. The data collection procedure will ensure that you cannot be identified. Please do not write your name on any part of the questionnaire, surveys, or the provided return envelope. All data collected will be completely anonymous and unable to be linked to you.

Participation in this study is entirely voluntary. There is no foreseeable risk to you when completing the questionnaire and surveys. If you agree to participate in this research study, please complete the enclosed questionnaire and surveys and return them in the provided, self-addressed, stamped envelope by MARCH 31, 2009. Return of the completed questionnaire and surveys will serve as your consent to participate.

Verification of your participation in the research study will be made by returning the enclosed, self-addressed, stamped post card. Please mail the post card and completed surveys on separate days as separate pieces of mail. This procedure will ensure your anonymity and that you are not contacted again for participation. I will send you a reminder post card in one week if I have not heard from you.

To thank you for participating in my research, your name will be entered into a drawing to win ONE OF TWO RCA PEARL FLASH MP3 PLAYERS. The approximate odds of winning one of these prizes is 1 in 500.

Thank you in advance for your time and participation in this research. You will help me understand the relationship between compassion fatigue and empathy in counselors. If you have any questions regarding this research please contact me or my advisor, Dr. Mona Robinson using the information below. If you have any questions regarding your rights as a research participant, please contact Dr. Jo Ellen Sherow, Director of Research Compliance, Ohio University, (740)593-0664.

Sincerely,

Heidi Llewellyn, M.Ed., PC
Doctoral Candidate
Ohio University
(740) 541-0201
hl244299@ohio.edu

Mona Robinson, Ph.D., CRC, PC
Assistant Professor
Department of Counseling and Higher Ed.
Ohio University
robinsoh@ohio.edu
Demographic Information

1. Have you ever received a traumatic stress diagnosis or experienced symptoms that would meet the diagnostic criteria for PTSD? _____Yes _____No
   If you answered “yes” how long ago? _____Years _____Months _____Days

2. What is your biological sex? _____Female  _____Male

3. How old are you? _____Years _____Months

4. With which race do you identify?
   _____ Asian or Pacific Islander  _____Black/African American
   _____ Caucasian/White  _____Hispanic/Latino
   _____ Native American/Alaska Native  _____Other

5. How long have you practiced as a licensed counselor? _____Years _____Months

6. Which professional licensure do you currently hold?
   _____Licensed Professional Counselor  _____Licensed Professional Clinical Counselor

7. In which setting do you currently practice?
   _____Community Mental Health  _____Residential
   _____Private Practice  _____Not Currently Practicing

8. How many of your current clients have a PTSD diagnosis or fit the criteria for the diagnosis? _____Adults  _____Children

9. How many of your past clients were diagnosed with PTSD or fit the criteria for the diagnosis? _____Adults  _____Children

10. Which type(s) of trauma(s) have your clients experienced?
    _____Military Combat  _____Rape  _____Natural Disaster
    _____Taken Hostage  _____Violent Physical Attack  _____Manmade Disaster
    _____Being Kidnapped  _____Molestation  _____Death of a loved one
    _____Mugging  _____Sexual Abuse  _____Traffic Collision
    _____Robbery  _____Domestic Violence  _____Major Illness
    _____Home Invasion  _____Physical Abuse  _____Other
Introduction Post Card
Dear Clinician,

I am writing to request your participation in my research. I am focusing on the relationship between compassion fatigue and empathy in professional counselors. This research will help me understand the impact counseling may have on the capacity for empathy.

In a few days you will receive my Research Packet. Please complete it and return it in the self-addressed stamped envelope. To thank you for participating, your name will be entered into a drawing to win ONE OF TWO RCA PEARL FLASH MP3 PLAYERS. Thank you in advance for your participation.

Sincerely,
Heidi Llewellyn, M.Ed., LPC
Doctoral Candidate
Ohio University

Mona Robinson, Ph.D., CRC, PC
Assistant Professor
Department of Counseling and Higher Ed.
Ohio University

Post Card Included In Questionnaire Packet

Name of Participant
Address of Participant

I have completed and returned the “Research Questionnaire Packet” and do not require further follow-up.

Post Card Reminder ONE and TWO

Reminder

Have you completed and returned the “Research Questionnaire Packet” you received about a week ago? If you have not, I would appreciate it if you would please complete it and mail it in the provided self-addressed, stamped envelope. If you need another copy of the “Research Questionnaire Packet” please email me at the provided email address and I will send one to you.

If I do not hear from you in a week, I will mail you another reminder. If you have already completed and returned the packet, I appreciate your time and participation in my research.

Sincerely,
Heidi Llewellyn, M.Ed., LPC
Doctoral Candidate
Ohio University
hl244299@ohio.edu

Mona Robinson, Ph.D., LPC, CRC
Assistant Professor
Department of Counseling and Higher Ed.
Ohio University

Final Post Card Reminder (THREE)
Reminder

Have you completed and returned the “Research Questionnaire Packet” you received a few weeks ago? If you have not, I would appreciate it if you would please complete it and mail it in the provided self-addressed, stamped envelope. If you need another copy of the “Research Questionnaire Packet” please email me at the provided email address and I will send one to you.

If you have already completed and returned the packet, I appreciate your time and participation in my research.

Sincerely,
Heidi Llewellyn, M.Ed., LPC  Mona Robinson, Ph.D., LPC, CRC
Doctoral Candidate   Assistant Professor
Ohio University   Department of Counseling and Higher Ed.
hl244299@ohio.edu   Ohio University

Follow-up Post Card For Non-participants

Hello again! I know you have received a few mailing from me now, and that you have elected not to participate in my study. But, if you could please answer these three questions and return this card it would help us to understand the individuals that did not participate. These answers can not be connected to you in any way. Thank you!
1. How long have you been a licensed counselor? _____Years _____Months
2. I serve PTSD diagnosed trauma survivors. ___Yes ___No
3. The number of PTSD diagnosed trauma survivors that I currently serve is:
   ___None   ___One   ___Two   ___Three   ___More than three

Sincerely,
Heidi Llewellyn, M.Ed., LPC  Mona Robinson, Ph.D., CRC, PC
Doctoral Candidate   Assistant Professor
Ohio University   Department of Counseling and Higher Ed.
Ohio University
**APPENDIX D: CORRELATION MATRIX**

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**. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).