Common Characteristics of Compassionate Mental Health Counselors:

A Qualitative Study

Dissertation

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Abstract

This qualitative study was conducted to identify perceptions and emerging concepts related to compassion in mental health counseling. In addition, this study examines diverse counselor perceptions and attitudes toward compassion and the impact of “being” a compassionate counselor. The construct of compassion has been empirically studied in many helping professions; however, most research has focused on counselors working with trauma victims in medical settings and large scale disasters. The sample comprised 16 mental health counselors (i.e., 13 females and 3 males). These counselors are licensed professionals working in the state of Ohio. Three major categories were identified and ten subthemes emerged from the analysis of the data: (a) client population, (b) work environment, and (c) coping mechanisms. Based on the findings practical recommendations are offered to mental health counselors, supervisors, as well as counselor educators.
DEDICATION

Dedicated to Emmitt and Dallas, my two young sons that have helped me truly understand compassion within motherhood.
The value of compassion and a belief in the power it has to unite people was instilled in me from a very young age. Both of my parents dedicated their lives to showing compassion to the world through their professional and personal endeavors. Prior to her death, my mother worked for over 30 years as a nurse for the Cincinnati Board of Health. In this role she served many individuals who could not afford medical care. She also trained new nurses and advocated for access to services for the underprivileged as the Assistant Director of Nursing. My father was also a civil servant, in the state of Ohio. He advocated for the public by serving as a state senator for over 28 years and president of the Cincinnati NAACP. In his professional work, he showed compassion for and encouraged others to show compassion for people of diverse backgrounds and those who are or have been incarcerated. I learned to show compassion toward my parents, by embracing the experience of growing up in a home that was commonly visited by those reaching out to my parents for support and guidance. In addition, spending time in the statehouse watching lobbyist and politicians trying to make sense of data to engage in policy reform definitely left an impression on me related to the disconnect between research and lived experiences. Although my parents are currently deceased, the compassion they instilled in me lives on I share their “spirit” with all whom I encounter. Today, as a mental health counselor and advocate for mental health policy reform I continue the tradition of my family and embrace their legacy.
In addition to my parents there are many people who have similar spirits who have served as my angels and guided me to this place in my life. First and far most I would like to acknowledge my advisor, Dr. James Moore III, along with Dr. Michael Casto and Dr. Kenneth Yeager who have been guided me to this point. Together they have had a synergistic impact on my life. Through the years these individuals and many others have shown compassion towards me and given me opportunities when others did not believe in me. For this I am forever grateful.

Since returning to school in 2002 to complete my undergraduate degree, there have been moments when I struggled to believe in my abilities. However, these individuals taught me that “It is not the strongest of the species that survive, nor the most intelligent, but the one most responsive to change.” The previous quote by Charles Darwin has shaped how I view the world and all of the nightmares that I have encountered while pursing my dreams. I will never forget all of those who have helped shape me, my dreams, and my world. Overall, their ability to simultaneously tolerate the changing me and advocate for my needs has been beautiful to witness and encounter. Thank you.
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Presentations


Fields of Study

Major Field: Education and Human Ecology
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CHAPTER 1
INTRODUCTION

Statement of the Problem

The construct of compassion has been empirically studied in many helping professions; however, most research has focused primarily on counselors working with trauma victims in medical settings and large scale disasters (Adams, Figley & Boscarino, 2008; Alkema, Linton, & Davies, 2008; Boscarino, Figley, & Adams, 2004; Carmel & Friedlander, 2009; Roberts, Flannelly, Weaver, & Figley, 2003; Smith, 2007; Wee & Myers, 2002). Many of these studies do not include professional counselors or distinguish the type of licensure held by the counseling professionals. In fact, most of these studies fail to include mental health professionals from diverse populations (e.g., Black/African American, Latino/a, GLBT, and disabled; Bride, Radey, & Figley, 2007; Bruhn, 2001; Follette, Polusny, & Milbeck, 1994; Smith, 2007).

The ability to display compassion is essential to mental health counseling and requires the counselor to empathize with the client (Carroll, 2001; Figley, 2002a; Rogers, 1980). According to Bruhn (2001), forming a relationship with a helper is an emotional experience that requires “a supportive affirmative working alliance between the helper and the [client] (p. 54). Mental health counselors and other helping professionals are expected to deploy a level of emotional energy that often creates a therapeutic alliance
and includes empathetic response to client stories (Corey, 1991). In 1995, members of the American Counseling Association (ACA) were surveyed, and it was found that “holistic-humanistic empowerment for personal development and interpersonal concern” was the predominant value system (Kelly, 1995, p. 652). Therefore, mental health counselors, who ascribe to these values, should not avoid experiencing compassion and empathy as they enter the client’s worldview to better understand how he/she experiences the world (Figley, 2002b; May, Angel, & Ellenberger, 1958; Myers & Sweeney, 2004; Rogers, 1980; Sweeney, 2001).

Although the term compassion is infrequently used within the counseling literature, it is critical to incorporate this term into the lexicon of counseling to enhance the understanding of the counselor-client dyad and the personal and professional impact of “being” a counselor (Ben-Porat & Itzhaky, 2009; Carroll, 2001). Aligned with this notion, Carroll stated:

When human beings [counselors] work they use themselves as the main focus of their work, they infuse themselves into it, they become it; it is them at work, not just work done by them. Their work changes from being a job, or indeed even a career, to becoming an extension of themselves, of who they are. (p. 77)

Mental health counselors who utilize a humanistic or existential approach may be more susceptible to this phenomenon because of their willingness to be vulnerable with clients (Dollarhide, 2010; May et al., 1958; Moodley, 2010; Sterling, 2001; Yalom, 1980).
The willingness to be vulnerable with clients can cause negative (e.g., compassion fatigue) or positive (e.g., compassion satisfaction) effect on the personal and professional functioning of the counselor (Ben-Porat & Itzhaky, 2009; Moodley, 2010; Stamm, 2002, Figley 2002a). However, according to Trippany, Kress, and Wilcoxon (2004), counselors in all settings, in spite of their theoretical orientation, work with clients who are survivors of trauma; therefore, all counselors are exposed to material that may be traumatizing and heighten the counselors vulnerability to compassion fatigue. This naturalistic study utilizes grounded theory to explore the concept of compassion, its historical foundation, and implications for mental health counselors from diverse backgrounds.

**Purpose of the Study**

The concept of compassion is holistic; it is a biological, psychological, and social response as an attempt to survive (Valent, 2002). Due to the detrimental effects of unrecognized and unmanaged compassion fatigue and the benefits of compassion satisfaction, further investigation of the phenomenon among mental health counselors is needed. According to Figley (2002a), “compassion fatigue, like any other kind of fatigue, reduces our capacity or our interest in bearing the suffering of others” (p. 1434), and understanding the impact of this phenomenon on counselors is crucial to responsible mental health care.
Between one-fourth and one-half of counselors are at moderate risk for compassion fatigue, as a result of working with victims of trauma (Boscarino et al., 2004; Figley, 2002a, 2002b). In addition, job victimization (e.g., sexual harassment, discrimination, assault) by a client, supervisor, or peer was also mentioned as contributing factors to compassion fatigue (Balfour & Neff, 1993; Figley, 2002a, 2002b). These studies included psychiatrists, social workers, nurses, doctors, psychologists, genetic counselors, disaster mental health workers, case managers, and clergy working in rural and urban environments and within many different organizations and institutions. However, most studies have not included licensed counselors or adequate representation from practitioners from diverse social and ethnic backgrounds (i.e., Black, Latino/a, Asian, Gay Lesbian Bisexual and Transgendered, disabled).

**Significance of the Study**

The goal of this study was to identify perceptions and emerging concepts related to “being’ a compassionate counselor. The conceptual framework of compassion on a continuum creates a state of being that may be mediated by effective intervention that does not require the professional to leave the profession (e.g., typical response to burnout) or disconnect from clients (e.g., avoidance of discussing issues related to countertransference in a therapeutic manner). Understanding compassion as a way to process client stories creates an opportunity to advocate for counselor well-being without sacrificing the empathetic relationship of the counseling-dyad. As a result of these findings, the researcher plans to inform and educate counselors and counselor educators on the multiple realities of “being” a compassionate counselor, from diverse perspectives.
Thus, gaining an understanding of how counselors can be more intentional in their work and how counselor educators can be more intentional in their explanation of the hazards and benefits of “being” a compassionate mental health counselor. As Figley (2002a) noted, “it is, therefore, up to all of us to elevate these issues to a greater level of awareness in the helping professions. Otherwise, we will lose clients and compassionate [counselors]” (p. 1440).

Figley (1995) proposed a model to help practitioners and researchers understand the relationship between the role of empathy and previous traumatic experiences and offered suggestions for the prevention and treatment of compassion fatigue. Counselors and other helping professionals are expected to deploy a level of emotional energy that creates a therapeutic alliance and includes empathetic response to client stories (Corey, 1991). The model developed by Figley works around the assumption that there are costs associated with this level of emotional disclosure and the transfer of this type of energy between the client and the helper. The model consists of 8 variables that have been found to cause compassion fatigue: (a) empathetic ability – aptitude for noticing pain in others; (b) empathetic concern – motivation to respond to people in need; (c) exposure to the client – experiencing the emotional energy of the suffering client through direct exposure; (d) empathetic response – the extent to which the helper makes an effort to reduce the suffering of the sufferer through empathetic understanding; (e) compassion stress – the residue of emotional energy from the empathetic response to the client and is the ongoing demand for action to relieve the suffering of a client; (f) prolonged engagement – ongoing sense of responsibility for the care of the suffering over a protracted period of
time; (g) traumatic recollections – memories that trigger symptoms of PTSD and associated reactions such as depression and anxiety; (h) life disruptions – unexpected changes in professional and/or personal responsibilities, more problematic when coupled with the factors mentioned above. This model also includes two factors that can mediate experiences with compassion fatigue and may represent compassion satisfaction: (a) sense of achievement – lowers or prevents compassion stress and is the extent to which the helper is satisfied with his or her efforts to help the client; and (b) disengagement – lowers or prevents compassion stress, and represents the extent to which the helper can distance her/himself from the client’s suffering. Figley’s model continues to be used in research to predict the onset of compassion fatigue, mitigate experiences with fatigue, and help prevent fatigue from occurring (Adams et al., 2008).

According to Stamm (2002), fifty percent of the U.S. population has been exposed to at least one event that would qualify as a precursor to posttraumatic stress disorder (PTSD), yet only about 8% develop the disorder. Due to the low prevalence rates of PTSD in mental health professionals, researchers have explored protective factors to compassion fatigue (e.g., compassion satisfaction); these factors may be derived from positive experiences with clients or personal relationships. Stamm developed a compassion satisfaction scale to understand the positive and negative aspects of compassion. As a result of the work of Stamm, the Accelerated Recovery Program (ARP) for Compassion fatigue developed (Gentry, Baranowsky, & Dunning, 2002). Outcome research associated with this program provided support to their theory that work satisfaction is the antidote to both burnout and compassion fatigue.
Counselors are typically required to engage in supervision throughout training and during the first two years as a licensed professional (Association for Counselor Education and Supervision, 2005; Bernard & Goodyear, 2004; Counselor, Social Worker, and Marriage and Family Therapist Board of Ohio, 2009). In addition, counselors are encouraged to engage in peer supervision throughout their professional career. However, the counselor’s willingness to engage in conversations about compassion fatigue may be limited. Many counselors believe that they are unable to access mental health care and are hesitant to disclose the impact their clients have on their personal lives (Henderson, 2001; Kottler & Hazler, 2001). Figley (2002) refers to this phenomenon as the “conspiracy of silence” and compares it to the silence of family violence, racism, and sexual harassment. In 1989, Figley demonstrated his frustration with highly qualified professionals abandoning clinical work and research with traumatized people because of their inability to deal with the pain of others. Further, according to Figley, counseling professionals who “begin to view themselves as saviors or at least as rescuers” are most vulnerable for compassion fatigue (pp. 144-145). However, researchers studying compassion, too often, rely on quantitative studies that control for demographic variables, despite large population samples, and omissions or exclusions of outliers may contribute to the silencing and marginalization of experiences with compassion for helpers from diverse backgrounds (Adams et al., 2008; Follette, Polusny & Milbeck, 1994).
Definition of Terms

Professional Counselor /Professional Clinical Counselor (PC/PCC/LPC/LPCC)

According to the Ohio Counselor, Social Work, and Marriage and Family Therapist Board (2009):

A "graduate degree in counseling" is required to obtain a license as a PC/PCC and degrees in other disciplines (i.e. Psychology, Social Work and Marriage and Family Therapy) are not considered counseling degrees. Ohio revised Code Chapter 4757 states "Practice of professional counseling" means rendering or offering to render to individuals, groups, organizations or the general public a counseling service involving the application of clinical counseling principles, methods or procedures to assist individuals in achieving more effective personal, social, educational or career development and adjustment, including the diagnosis and treatment of mental and emotional disorders. "Clinical counseling principles, methods, or procedures" means an approach to counseling that emphasizes the counselor's role in systematically assisting clients through all of the following: assessing and analyzing background and current information, diagnosing mental and emotional disorders, exploring possible solutions and developing and providing a treatment plan for mental and emotional adjustment or development. "Clinical counseling principles, methods or procedures" includes at least counseling, appraisal, consulting and referral.
Professional Counselor/Clinical Counselor- Supervisor (PC-S/PCC-S/LPC-S/LPCC-S)

In order to become a supervising counselor, one who is able to provide training supervision for those working toward licensure, the counselor must hold a PC for three years or a PCC for at least one year.

Burnout

Burnout consists of physical, emotional, and mental exhaustion stemming from long-term involvement in situations that are emotionally demanding (Pines & Aronson, 1988).

Compassion Fatigue

In the current study compassion fatigue is defined as a state of exhaustion and dysfunction, and is the result of prolonged exposure to compassion stress (Figley, 1995, p. 253)

Secondary Traumatic Stress

In the current study, secondary traumatic stress is synonymous with compassion fatigue (Figley, 2002a).

Vicarious Traumatization

In the current study, vicarious traumatization is defined as disturbances in the counselors’ view of the world; and is the result of long-term exposure to the traumatic experiences of clients (Figley, 2002a).
CHAPTER 2

REVIEW OF THE LITERATURE

This literature review is situated within an existential and phenomenological ontology and is guided by humanistic theory. The combination of an existential and phenomenological world-view creates “space” for the conscious and unconscious, known and unknown, rational and intuitive, as well as causal and inferential features of “being” a compassionate counselor to emerge. Historically, compassion has been studied from a Eurocentric positivist stance; composed of a plethora of survey research that minimizes the affective reality of the counselor-client dyad. Therefore, this literature review (a) explores the phenomenon of compassion in the helping professions (b) exposes the gaps of knowledge pertaining to compassionate experiences of mental health counselors [e.g., Professional Counselor (PC) or Professional Clinical Counselor (PCC)], and (c) emphasizes the lack of research on perceptions attitudes, and experiences of counselors representative of diverse cultural and ethnic groups. Additionally, studies related to the history of the profession of counseling provide a context for understanding the process of “becoming” a professional counselor and explore theories related to counselor well-being and job satisfaction.
Compassion

Compassion is defined as a feeling of deep sympathy and sorrow for another who is stricken by misfortune, accompanied by a strong desire to alleviate the suffering of the individual or community (Merriam-Webster, 2002, 2010). This term differs from empathy or sympathy because compassion requires concern, understanding, and an active desire to impact the life of another (Figley, 2002a). It has also been described as a “sympathetic consciousness of others” or “an association or relationship between persons or things where whatever affects one similarly affects the other” (Merriam-Webster, 2010). This definition of compassion illuminates the interpersonal emphasis of counseling and the uncertainty of interconnectedness; and requires a sense of being cared about, of nurturing, and of caring (Gelatt, 1995). During counseling, there are moments when the counselor and client work through their experiences of oppression in symbolic and real ways. Therefore, the counselor should attend to his or her own countertransferential efforts to control or submit and strive for egalitarian moments in the counseling dyad. These moments are representative of a compassionate connection between the counselor and client. Although the goal of the therapeutic relationship is the client’s liberation, the process of the relationship enables the continuing liberation [personal development] of the [mental health] counselor as well (Ivey, 1995; Madison-Colmore, & Moore, 2002). In addition, counselors who ascribe to an existential or humanistic approach are more likely to process experiences with countertransference, due to their transpersonal beliefs about the counseling dyad.
On another note, existential counselors see the counseling process as a journey that involves transference and countertransference, which permits counselors to be vulnerable and share their reactions to clients with compassion (Lambie, 2006; May, 1958). According to Stamm (2002), the construct of compassion occurs on a continuum with fatigue at one end of the continuum and satisfaction at the other end. Therefore, by definition all counselors are on the spectrum at any point in time (Lambie, 2006; Lawson & Venart, 2006).

The study of compassion fatigue evolved from studies related Secondary Traumatic Stress Disorder (STSD), which evolved from the study of Post Traumatic Stress Disorder (PTSD) [American Psychiatric Association, 2000; Figley, 1995]. Both of these disorders are recognized in the Diagnostic and Statistical Manual of Mental Disorders (2000) and are a result of being in harms way and/or by bearing the distress of others who are. PTSD was included in the DSM-III in the early 1980s and the International Society for Traumatic Stress Studies developed treatment guidelines for PTSD in 1997 (Foa, Keane, & Friedman, 2000; Goodman, Thompson, Weinfurt, Cori, Acker, Mueser, & Rosenberg, 1999). These guidelines were developed to inform mental health professionals of the best practices in the treatment of individuals with a diagnosis of PTSD.

The symptoms that characterize PTSD are reliving the trauma, avoidance of thoughts, memories, people and places associated with the event, emotional numbing, and elevated arousal. PTSD can cause significant disability and impairment of daily functioning (American Psychiatric Association, 2000; Groth-Marnat, 2003).
There is a growing body of literature acknowledging that PTSD is a universal response to traumatic events and the symptom patterns are found in many different cultures (Groth-Marnat, 2003; Meldrum, King, & Spooner, 2002). Therefore, compassion fatigue is a reaction to secondary traumatic stress and is represented by behaviors and emotions that are caused by helping or wanting to help a traumatized or suffering person (Valent, 2002). Valent found 18% of mental health case managers experienced compassion fatigue at levels equivalent to those experienced by people who met criteria for a diagnosis of PTSD. The authors concluded that their data suggest significant occupational and health safety risks associated with the mental health case manager role and that there is a clear public interest and duty to help these workers through various prevention and treatment programs.

The prevalence of STSD in helping professionals has been studied throughout the world and in most studies between one-fourth and one-half of the participants was found to have STSD or PTSD or to be at moderate risk for compassion fatigue. These studies included psychiatrists, social workers, nurses, doctors, psychologists, genetic counselors, disaster mental health workers, case managers, and clergy, working in rural and urban environments, within many different organizations and institutions. On the job, victimization (e.g., sexual harassment, discrimination, assault) by a client, supervisor, or peer may also occur and contribute to compassion fatigue (Balfour & Neff, 1993). However, most studies did not include licensed counselors or adequate representation from practitioners from diverse backgrounds (i.e., Black, Latino, Asian, and GLBT; Follette et al., 1994).
Diversity and Compassion

The future of counseling will require compassionate counselors who are able to see the potentials and possibilities in everyone, offer mutual support, extend equality to all people, bring about circumstances in which everyone can win, recognize that whatever you focus on expands, eliminate judgments, and trust and love one another (Gelatt, 1995; Zalaquett, Fuerth, Stein, Ivey, & Ivey, 2008). Researchers studying multicultural issues within mental health counseling have attributed the increased need of these skills to increasing chaos in today’s society as a result of rapid change, diversity, and mass dissemination and access to information. Over a decade after recommendations by Gelatt (1995), Zalaquett et al (2008) refer to this phenomenon as a “cultural transformation of the citizenry of the United States”, and continue to articulate the need to transform how mental health professionals engage with clients and suggest an egalitarian [compassionate] approach to mental health care. (p. 364)

In 1977, Association of Counselor Education and Supervision (ACES) stated that a training program should “reflect the needs [of] society that are represented by different ethnic and cultural groups served by counselors” to produce counselors and supervisors who are competent working in cross-cultural dyads (p. 597). As a result of efforts by ACES and the Association for Multicultural Counseling and Development (AMCD), ACA developed the Multicultural Counseling Competencies to mandate/guide counselors, supervisors, and counselor educators to attend to issues related to culture, race, and ethnicity when working with or advocating for clients, trainees and students. Despite this mandate and call to action, McNeill, Hom, and Perez (1995) stated: “there is
a dearth of information available on the unique training needs of racial and ethnic minorities.” Further, their sentiments mirror the amount of information available on minority perspectives on “being” a professional counselor and perceptions and beliefs about compassion. These authors also articulated the barriers to compassionate cross-cultural counseling dyads and supervision. It is quite possible that the lack of diversity within counselor educators and supervisors may contribute to the lack of interest in gaining insight into this phenomenon from a cross-cultural perspective; reiterating the need for qualitative research on personal and professional development issues of ethnic minority counselors and supervisors (Holcomb-McCoy & Bradley, 2003; McNeill, et al., 1995; Zalaquett et al., 2008).

Researchers studying compassion, too often, neglect to include the multicultural requirements in their studies, despite large population samples. This may be due to the lack of access to diverse mental health practitioners; however, it may also be due to a lack of effort on the part of the researcher to actively recruit or request demographics of participants to increase the generalizability and utility of research findings (Follette, et al., 1994). For example, Follette, Polusny, and Milbeck, 1994 surveyed 225 mental health professionals working with trauma victims and did not fully attend to the demographics of the sample. These researchers did focus on the gender, professional identity, degree attainment, and aspects of the counselors case load and work environment but neglected to capture race/ethnicity or other multicultural constructs. However, most of the studies analyzed in this literature review acknowledge the limitations of researchers’ participant pool and generalizability of findings.
While many of the findings and recommendations related to compassion and mental health counseling are insightful, counselors, counselor educators, and supervisors from diverse backgrounds may be hesitant to utilize the theories and techniques out of resistance and/or feeling marginalized by the ontological, positivist approach to the research (King & Otis, 1993; Lather, 2002; McCarthy, 2005). For example, Bride, Radey, & Figley (2007) conducted a review of scales used to measure compassion and related constructs but failed to discuss the implications or limitations when using the scales with mental health care providers from racially or ethnically diverse groups. These omissions or methodological approaches continue even today.

**multicultural counseling competencies.**

The MCC were originally drafted in the early 1980s (Sue et al., 1982) and were adopted by the AMCD in 1992. The competencies identified the United States as a multicultural society consisting of five major cultural groups: African/Black, Asian, Cuacasian/European, Hispanic/Latino/a, and Native American. The original competencies encouraged counselors to seek knowledge about these cultural groups so that they would have a better understanding of how to best serve these client groups, with the assumption that the counselor was Caucasian and the client was from another cultural group (Arredondo et al., 2005). However, the competencies also recognized that all individuals are ethnic, racial, and cultural beings (Arredondo & Toporek, 2004; Sue, Arrendondo, & McDavis, 1992). In 1996, the competencies were operationalized and the focus shifted from having knowledge about various groups of people to understanding dynamics within the dyad that may be impacted by culture, race, and ethnicity.
To address these issues, the competencies charged the counselor to seek awareness of their own attitudes, understand the worldview of the client, and develop interventions and strategies that are culturally appropriate for their clients. Additionally, key elements were identified for counselors to assess their work on becoming competent in the following areas: (a) exploration of beliefs and attitudes, (b) the process of seeking knowledge, and (c) the implementation of skills (Arredondo et al, 1996; Dollarhide, 2010).

The first competency charges the counselor to gain an awareness of his/her own assumptions, values, and biases. As this process occurs, the counselor seeks formal knowledge and self understanding of his/her own culture and gain an understanding of how it impacts their worldview. This process of self-reflection often enables the counselor to be effective with the client, despite differences between the two. Therefore, it is important that the counselor understands how his or her values related to oppression, racism, discrimination, and stereotyping affect him or her personally and professionally. This process of exploring privilege can inform the counselor of the social impact their values and beliefs may have on others in society, as well as the counseling process (Arredondo et al, 1996; Holcomb-McCoy, 2000; Sue et al., 1992).

The second competency charges the counselor to understand the worldview of clients who are culturally different. This competency also focuses on the counselor’s ability to be aware of negative emotional reactions toward those different from themselves. This is not limited to the client but also refers to how they communicate about other racial and ethnic groups inside and outside of the counseling setting (e.g., work, home, etc.). When seeking understanding of the client’s worldview, it is essential
that the counselor learn about the individual’s life experiences and cultural heritage, while synthesizing the historical knowledge of how the client’s cultural group typically approaches and/or responds to personality formation, career choice, psychological disorders, help seeking, and counseling interventions. As counselors become competent in this area, they often seek research-based knowledge on best practices with various culture groups and become less resistant to interactions with clients from diverse backgrounds inside and outside of the counseling dyad (Arredondo et al., 1996, Arredondo et al., 2005; Holcomb-McCoy, 2000).

The third competency recommends that the counselors develop appropriate intervention strategies and techniques that are beneficial for clients with worldviews different from them (Madison-Colmore & Moore, 2002; Nadal, 2004; Wihak & Merali, 2007). Implementation of this competency is evidenced by the counselor becoming skilled in respecting the client’s religious and spiritual beliefs and values about mental and physical health, gaining an appreciation for who is responsible for providing such services, and understanding how language (i.e., dialect and use of terms) impacts the counseling process (Casto, 1994; Wihak & Merali, 2007). These strategies often consider biological factors, community characteristics, and family dynamics may impact the effectiveness of the approach, when working with clients from diverse backgrounds (Madison-Colmore & Moore, 2002). Additionally, it is important that the counselor is aware of the limitations of treatment guidelines and assessment tools that were developed and normed on primarily Caucasian subjects/clients. Utilizing instruments without adhering to recommendations set forth by the MCC may create biases within the
counseling setting and perpetuate discrimination and stereotyping within the community (Arredondo & Toporek, 2004; Arredondo et al., 1996; Arredondo et al., 1992; Arredondo et al., 2005).

The types of interventions used by counselors who consider themselves culturally competent include attending to verbal and nonverbal messages in a culturally appropriate manner, helping the client explore their experience with racism and oppression to normalize the experience, utilizing religious and spiritual leaders in the consultation and referral process, and interacting with the client with the use of language preferred by the client (Casto, 1994; Hansen, 2010; Madison-Colmore & Moore, 2002; Wihak & Merali, 2007). This competency also encourages counselors to work toward societal change by actively encouraging others to be less biased, prejudiced, and discriminating (Garza & Watts, 2010; Hansen, 2010; McDonald, 2010). According to Hopkins (1986), during counseling, there is often moments when the counselor and client work through their experiences of oppression in symbolic and real ways. Such moments can represent a compassionate connection between the counselor and client. Further, counselors who ascribe to an existential or humanistic approach are more likely to adhere to the multicultural competencies because of their egalitarian approach to the counseling dyad and ability to suspend judgment about the client’s worldview (Dollarhide, 2010; Lambie, 2006; Senge, Scharmer, Jaworski, & Flowers, 2004).
However, McCarthy (2005) and Wihak and Merali (2007) acknowledged the individualistic, Eurocentric approach to counseling and therapy in the United States and Canada. Wihak and Mearli suggested that counselors be open to shifting their worldview to “be” with the client and express compassion.

**Compassion and Professionalism**

A counselor who is capable of emotional sensitivity and awareness can experience higher levels of empathy, which in turn, may lead to higher levels of understanding. Upon understanding and feeling the individual’s suffering the counselor may become consumed with feelings of compassion which may impact the counselor personally and professionally (Figley 2002; Schauben & Frazier, 1995; Udipi, Veach, Kao, & LeRoy, 2008). Further, as counselors move from novice to expert they are expected to experience personal and professional development (Busacca & Wester, 2006; Dollarhide, 2010).

Counselor educators have been urged for several decades by counselors and researchers studying the helping professions to view professionalism as more than the attainment of knowledge and skills and find space to incorporate the personal beliefs and attitudes (Brown, 1991; Dikkargudem 2010; Larson, 1977; Larson & Daniels, 1998; Spruill & Benshoff, 1996; Van Minnen & Keijsers, 2000). Outcome research on the effectiveness of counseling has found that personality and disposition are effective factors in counseling, reiterating the need for research on “being” a counselor and the impact of compassion on counselors and clients (Carroll, 2001; Bradley & Florini, 1999; Lumadue & Duffey, 1999; Smaby, Maddux, Richmond, Lepkowski, & Packman, 2005).
Personological variables relate to the intuitive experience within the counseling dyad. These feelings can be based on the physical attributes, facial expression, actions, emotional response, and communication style of the individual. Although, these perceptions may be representative of the individuals “state” of being, they are valued as “traits” and can positively or negatively impact the counseling relationship (Sue, Capodilupo, Torino, Bucceri, Holder, Nadal, & Esquilin, 2007). In addition, client reactions to the variables listed above may impact counselor well-being and lead to compassion fatigue or satisfaction (Henderson, 2001; Killian, 2008).

In 2003, ACA established a task force on counselor well-being. This group worked to create awareness of impairment risks and promote wellness. The theoretical foundation of this task force was informed by research on burnout, compassion fatigue, vicarious traumatization, and secondary traumatic stress disorder (Figley, 1995; Lawson & Venart, 2006). The task force conducted a survey of members and inquired about their beliefs on counselor impairment. Based on the findings, three goals related to counselor vulnerability, wellness, and resilience were implemented, such as (a) focusing on strengths based prevention and resiliency education, to identify areas of vulnerability and provide strategies for wellness; (b) increasing access to resources for intervention and providing best practice criteria for counselor educators and supervisors; and (c) advocating on a state and national level to address the stigma related to counselors seeking mental health treatment (Lawson & Venart, 2006).
These goals gave meaning to the following definition of impairment:

Therapeutic impairment occurs when there is a significant negative impact on a counselor’s professional functioning which compromises client care or poses potential for harm to the client. Impairment may be due to substance abuse or chemical dependency; mental illness; personal crises (e.g., traumatic events or vicarious trauma, burnout, life crisis); and physical illness or debilitation. Impairment in and of itself does not imply unethical behavior (Welfel, 2005). Such behavior may occur in counselors who are not impaired (Lawson & Venart, 2006, p. 243). “Counselors who are impaired are distinguished from stressed or distressed counselors who are experiencing significant stressors, but whose work is not significantly affected. Similarly it is assumed that an impaired counselor has at some point had a sufficient level of clinical competence, which has become diminished as described above (Lawson & Venart, 2006).

Despite the work of this task force real life expectations and commonly held myths about counselor invulnerability prevent counselors from addressing issues related to self-care and the counselor-client dyad (King & Otis, 2007). However, as a result of the work done by this task force researchers and other counseling related organizations have found and support the need for counselor educators and supervisors to inquire about the process of “being” a professional counselor.

In 1993, ACES incorporated professional and personal development into their code of ethics and is currently in the process of demystifying the implications of those guidelines to explore “whose” values should be taught, “who” should teach and promote
these values, and “how and when” these values should be communicated (ACES, 2005; Gale & Austin, 2003; Herlihy & Corey 1996; Spruill & Benshoff, 1996). As a result, many researchers - studying the concept of professionalism and professional development in counselors and professional organizations dedicated to counseling - have found the need for counselor educators and field supervisors to inquire about the process of “being” a professional counselor and not just the student’s ability to pass the licensing exam (Baldo, Softas-Nall, & Shaw, 1997; Frame & Stevens-Smith, 1995; Spruill & Benshoff, 1996). Understanding the personal process of “being” a counselor often reveals the interpersonal dynamics (i.e., interactions with clients, site supervisors, professionals within and outside of the profession of counseling, family members, and other providers of professional development experiences) that counselors experience as they engage in the profession of counseling. The ethical guidelines developed by ACES encourage open discussions about the emotional experience with clients in supervision to promote counselor well-being.

**Compassion and Well-Being**

Creating and fostering a positive attitude toward emotional experiences with clients may increase the counselor’s well-being and prevent compassion fatigue and increase compassion satisfaction (Figley 2002; Killian, 2008; Lawson & Venart, 2006; Stamm, 2002; Updi et al., 2008). Researchers studying burnout in counselors have found that 39% of counselors working in human services settings experience burnout (Lambie, 2007). Compassion fatigue and burnout have been described as synergistic, and burnout can be a precursor to compassion fatigue (Gentry et al., 2002; Updi et al., 2008).
Researchers in counselor education and supervision have expressed the need to explore how counselors deal with countertransference, personal stress, and work issues as a way to prevent compassion fatigue; however, despite this recommendation, little research has been conducted in counseling (Dollarhide, 2010; Henderson, 2001; Hopkins, 1986; Lynch, 1999; McCann & Pearlman, 1990; Pines & Aronson, 1988; Welfel, 2005). In 1999, Lynch addressed the need for counselors to be aware of compassion fatigue and burnout by developing a program to create awareness and prevention of burnout and compassion fatigue. Further, the researcher emphasized the need for personal responsibility for addressing issues related self-care and job stress. In addition, Welfel (2005) presented a principal-based model for counselors to use in addressing nonegregious ethics infractions. This model highlights the “fallibility of all counselors and their power to recover from their mistakes” and identifies counselor emotional distress as a risk factor for burnout.

**Compassion and Job Satisfaction**

Counselors who work, live, and learn in a supportive community often develop a sense of compassion satisfaction that can help minimize/mediate the level of compassion fatigue experienced in their career; thus increasing a state of personal and professional well-being. Upon becoming a counselor, the person is expected to identify a mentor (e.g., supervisor), work with clients, manage stress, engage in professional development, and collaborate with colleagues (Bernard & Goodyear, 2004; Busacca & Wester, 2006). The process of accomplishing the above career-related tasks, result in stress. It is quite likely that this will cause the counselor to question if he/she is emotionally “fit” for the role of
The disconnection between the professional development requirements of counseling and the counselor’s willingness to participate in professional development activities and self-care has been found to result in compassion fatigue and a lack of professionalism (Frame & Stevens-Smith, 1995; Hensley, Smith, & Thompson, 2003; Lumadue & Duffey, 1999; Updi et al., 2008; Welfel, 2005).

**Summary**

A multidimensional approach to defining professionalism includes not only the character, spirit, skills, and values of the profession but also acknowledges the impact the profession has on the individual and how he/she interacts within society based on professional identity. This new way of “being” a professional, cooperative and universal, requires mental health professionals to collaborate more with other professionals, support persons of clients, and other individuals or organizations vested in the client’s welfare (Casto, 1994). A feminist perspective often helps to remove the emphasis from the importance of the boundaries and focuses on the overlap that exists between the professions, concern for client’s well being, and quality health care (Casto, 1994; Leiba, 1994; Rawson, 1994).

This ontological shift from positivist to a feminist perspective will allow the professional to be more open to accepting the input of other professionals and nonprofessionals within or outside of their discipline (Leathard, 1994). As our society becomes more diverse, mental health counselors will increasingly rely more on each other for support, especially as they navigate assisting clients who have different worldviews and values. Over the years, counseling scholars studying supervision have
found that students’ who are able to be accepting of others, emotionally stable when interacting with others, open-minded about the opinion of others, and empathetic to the experiences of others were rated as effective by their supervisors and clients, and expressed positive attitudes toward becoming a professional counselor (Smaby et al., 2005). It is likely that this “state” of being may positively impact the counseling dyad and can result in compassion satisfaction (Stamm, 2002).

According to Busacca and Wester (2006), counselors should embark upon a process of evaluating their personal motives and professional aspirations throughout their career. However, there is lack of research on counselors’ experiences with compassion, specifically the direct relationship between professional and personal growth and counselor’s ability to cope with emotional experiences with clients and remain professional with clients and committed to the profession (Welfel, 2005). Although many scales have been developed to measure compassion, there are a limited number of studies that explore the professional and personal impact of compassion on counselors (i.e., PC/LPC or PCC/LPCC; Figley, 2002a; Stamm, 2002). Additionally, few studies have included or emphasized narrative perspectives and experiences of counselors from diverse backgrounds (Bruhn, 2001).
CHAPTER 3

METHODOLOGY

Naturalistic inquiry is particularly well suited for identifying perceptions and emerging concepts related to compassion, and understanding how counselors experience and process emotional experiences with clients; and the influence those experiences may have on mental health counselors’ personal and professional development (Cashwell, Bentley, & Bigbee, 2007; Lawson & Venart, 2006; Magnuson, Wilcoxon, & Norem, 2003; Peavy, 1992; Ronnestad & Skovholt, 2003; Schmidt, 1994). Approaching this topic from an ecological and phenomenological perspective allows the researcher to assess the underlying mechanisms that shape counselors experiences with compassion within mental health counseling (Rogers, 1980; Hensley et al., 2003; Scarborough & Culbreth, 2008). The naturalistic paradigm assumes that there are multiple realities with differences among them that cannot be resolved through empirical analysis alone (Glesne & Peshkin, 1992; Lather, 2004; Lincoln & Guba, 1985; Major & Savin-Baden, 2010; Mason, 1996; Padgett, 2004).

In 2004, Lather asserted that empirical analysis’ claims of objectivity are overstated and mask hidden assumptions and values, whereas approaching research from a naturalistic approach allows assumptions to be revealed, values to be demystified, and empowers the individual or group that is being subjected to the researcher’s analysis.
Within counselor education and counseling in general, naturalistic inquiry is a useful research approach because it involves the interrelationship of observations and self-reported realities (Kelly, 1995; Major & Savin-Baden, 2010; May et al., 1958; Moustakas, 2001; Nelson & Jackson, 2003; Steenberger, 1990; Welfel, 2005). Examination of all of the parts of reality and the interrelation of those parts begins with the process of a complete understanding of the “whole” (Lather, 2004; Lincoln & Guba, 1985; Glesne & Peshkin, 1992; Senge et. al., 2004). In 1985, Lincoln and Guba asserted that “the whole is more than the sum of its parts; each part contains the whole within itself” (p. 53). Therefore, exploring diverse concepts of compassion from counselors’ perspective is essential.

Naturalistic inquiry seeks to increase knowledge related to mental health counselors and experiences with compassion in counseling. For this study, the constant comparative method is utilized to increase the understanding of counselors’ experiences with compassion, how these experiences are processed, and methods of recognizing the impact of compassion on counselors from diverse backgrounds (Bandura, 1977; Bruhn, 2001; Furr & Carroll, 2003; Fuson, 1942; Lambie, 2006; Wilkerson & Bellini, 2006). This qualitative research approach is essential, due to the lack of prior research on compassion specifically focused on counselors who are diverse. Further, it will allow theory to emerge as counselors’ realities are explained, creating grounded theory.
The grounded theory approach is a summation of diverse data, which represents the realities of the population and phenomenon under study (Erlandson, Harris, Skipper, & Allen, 1993; Glesne & Peshkin, 1992; Lincoln & Guba, 1985). Using the grounded theory approach, researchers are often tempted to provide an objective perspective of counselor experiences with compassion; however, it does reduces the researcher’s ability to inform readers of the mosaic that exists within the concept of compassion and ideas behind the process counselors experience, while “being” a counselor (Busacca & Wester, 2006; Griffin, 1993; Hensley et al., 2003; Lambie, 2006; Lewis, 2008; Lumadue & Duffey, 1999; Senge et al., 2004; Wilkerson & Bellini, 2006).

**Research Investigation**

This research investigation examined counselors’ perceptions and attitudes toward compassion and the impact of “being” a compassionate counselor. A major consideration of this study was the question of how compassion is defined. Following careful consideration of the need to provide a working definition of compassion within the domain of counseling, this study will be comprised of two phases. Phase one defined and examined common characteristics contributing to compassion of mental health counselors. It was achieved through individual interviews conducted with experienced counselors working in a variety of mental health settings throughout the state of Ohio. Individuals included in this phase of examination were selected through the process of purposeful sampling (Averch, 2004; Glesne & Peshkin, 1992; Lather, 2004; Lincoln & Guba, 1985).
Each counselor was selected, according to (a) the person’s unique knowledge related to “being” a counselor; (b) the need to develop a knowledge base that represents a variety of divergent perspectives and constructions of reality in the examination of the this topic; (c) the individual’s familiarity with the recent changes within the field of counselor education, supervision, and counseling; (d) the individual’s years of experience in the profession; and (e) personal experiences that impacted his/her development (Ivey & Van Hesteren, 1990; Ronnestad & Skovholt, 2003; VanZandt, 1990).

Phase I also examined diverse perspectives of counselors within the profession to enhance the understanding of compassion within counseling (Kippner, 2001). Demographic variables were utilized to assess the diversity of the participants to compare themes that emerged. For this study, the researcher attempted to find diversity in race, sex, age, work environment, training environment, and years of experience. The individual interviews with mental health counselors provided thick descriptions of the thoughts, beliefs, actions, practices, and processes for each participant. The purpose of these interviews was to explore the dimensions of compassion within counseling to identify common characteristics of the domain/construct (Erlandson et al., 1993; Padgett, 2004).

**Research Questions**

1. How do mental health counselors perceive compassion?
2. How do mental health counselors perceive compassion fatigue?
3. How do counselors perceive mental health compassion satisfaction?
4. What factors positively and negatively shape their perceptions of compassion fatigue and satisfaction?

**Research Design**

**Theoretical Framework**

The design of this naturalistic inquiry into identifying perceptions and emerging concepts related to compassion in counseling was remarkably influenced by the principles, methods, and practices implemented by Glesne and Peshkin (1992), Lincoln and Guba (1985), and Lather, (2004). The researcher also chose naturalistic inquiry because it provided the most effective method for discovering the subjective meaning and multiple realities of “being” a professional counselor and allows for this researcher to be personally involved in the process. As a professional counselor, the researcher is aware of her potential bias and utilized reflective journaling to monitor the impact her professional values have on the study (See Appendix I) [Glesne & Peshkin, 1992; Lather, 2004; Yeager, 1999]. Specifically, the researcher allowed time during the interview to discuss the goals of the research and answer any questions about the research presented by the interviewee. In addition, the research team, see appendix J for a brief description of these participants, reviewed the results further enhancing theory development and increasing the credibility of the process.

Because qualitative studies are invariably interpretive in nature, this researcher’s interpretive lens is shaped by feminist theories as well as race theories (Crenshaw, 1989). Both guided the design, execution, and analysis for this study.
These theories were used simultaneously because neither framework alone captures this researchers experience as an African American woman (Crenshaw, 1989). Each theory focuses on the most privileged group members (i.e., White females or Black males) thus marginalizing those who are multiply-burdened by discrete sources of discrimination. Crenshaw (1989) stated:

Black [African American] women are sometimes excluded from feminist theory and antiracist policy discourse [race theory] because both are predicated on a discrete set of experiences that does not often accurately reflect the interaction of race and gender. These problems of exclusion cannot be solved simply by including Black [African-American] women within an already established analytical structure. Because the intersectional experience is greater than the sum of racism and sexism, any analysis that does not take intersectionality into account cannot sufficiently address the particular manner in which Black [African-American] women are subordinated. (p. 140)

As an African-American woman the researcher has experienced what some have referred to as “unnatural” or discrete forms of discrimination that are not captured in general feminist theories or race theories. Although both account for the dynamics of power and privilege both fail to acknowledge the interaction of race and gender in American society. However, the researcher also recognized the possibility that her presence may limit the participants’ willingness to discuss their experiences with diversity within mental health counseling.
Additionally, this researcher acknowledges the danger of allowing her experiences as an African-American woman to override the stories of the participants during analysis and synthesis of the data (Wong, 1998). This acknowledgement also contributes to what Lincoln and Guba (1985) refer to as authenticity of the process. Authenticity implies that the findings represent a range of different realities, a sophisticated understanding of the phenomenon (i.e., ontological authenticity), an opportunity for participants to appreciate the viewpoints of other counselors (i.e., educative authenticity), and an opportunity to stimulate and empower participants based on what they learned about the experiences of others (i.e., catalytic/tactical authenticity; Lincoln & Guba, 1985; Seale, 1999). In order to balance participants’ needs with the needs of the researcher (i.e., completion of dissertation, openness and honesty) were essential. Participants were informed that a major reason for our interaction was the completion of the dissertation. However, the researcher was also honest in telling participants of the researcher’s desire to shed light on the affective development of counselors in an attempt to lessen the occurrence of counselor burnout, and that the researcher would not engage in qualitative research if their voices were not crucial to understanding the impact personally and professionally when witnessing client suffering.

Credibility and transferability emerged from the thick descriptions provided by the counselors. Lincoln and Guba (1985) developed these terms to express the concepts of validity within qualitative research. Many qualitative researchers believe that naturalistic inquiry provides a more appropriate format for the study of natural human groups than experimental methods that depend on the concept of external validity used in
most deductive studies (Edelman, 1977; Glesne & Peshkin, 1992; Lincoln & Guba, 1985; Padgett, 2004). In this study, triangulation, peer debriefing, and member checking were utilized to ensure the credibility of the findings. The researcher believes that the voices of the participant’s best describe the characteristics that define the domains/constructs under study and without the active involvement of the participants throughout the research process credibility would have been limited (Lather, 2004; Wong, 1998). Multiple techniques were implemented to achieve credibility, including: data, investigator, and methodological triangulation (Glesne & Peshkin, 1992).

1. Data Triangulation was implemented by the following sources (See Appendix H for additional demographic information):
   a) Counselors who were licensed in the state of Ohio as PC/LPC/PCC/LPCC.
   b) Counselors who had many years of experience as counselors as well as counselors who are new to the profession.
   c) Counselors who work in a variety of settings with a diverse population of clients.
   d) Counselors who utilize various theories and techniques when working with clients.
   e) Counselors who are from various racial and/or ethnic backgrounds.
   f) Counselors who are male and female.

2. To ensure investigator triangulation, the following techniques were implemented:
a) A Research team, comprised of individuals experienced in mental health counseling and qualitative research methods, was formed (See Appendix J).

b) Peer debriefing involves enlisting support of skilled colleagues to discuss evolving suppositions and findings of the study. This allows the researcher to challenge presumptions or interpretations of the study (Lincoln & Guba, 1985).

c) In addition, member checking was done to ensure accurate interpretations of the data and demystify any assumptions made as a result of personal subjectivity (Glesne & Peshkin, 1992). It consisted of asking the participants to provide their reactions to the themes as they emerged.

3. The methodological triangulation techniques utilized were (See Appendix H & I for more information):

   a) Individual interview data

   b) Counselor demographic questionnaires

Transferability refers to the steps taken by the researcher to increase the ability of the findings to be generalized to other similar cases (Lincoln & Guba, 1985). To enhance transferability, the researcher and participants provided “thick descriptions” by discussing questions concerning the meanings counselors attach to their environment.
For example, interview questions were posed related to interpersonal and intrapersonal dynamics to shed light on the sense counselors’ make of their personal and professional lives while holding a counseling license in the state of Ohio.

**Sampling**

Phase I participants were identified through the process of purposive sampling and networking, also termed snowball sampling (Erlandson et al., 1993; Glesne & Peshkin, 1992; Mason, 1996). Purposeful sampling means selecting groups or categories to study on the bases of their relevance to your research questions, theoretical position, and analytical framework, your analytical practice and, most importantly, that flow logically from the objectives of the project (Erlandson, et al., 1993; Lincoln & Guba, 1985; McLaughlin & Jordan, 2004). The goal of this research was to capture a group of experts with unique perspectives into ‘being’ a counselor and experiencing compassion (Gelatt, 1995; Hopkins, 1986).

A diverse group of mental health counseling experts, with diverse experiences related to the profession of counseling, provided a rich basis of information upon which to understand the concept of compassion within counseling. Participants were selected on the basis of their expertise and experience related to mental health counseling. Attempts were made to include diverse racial and gender groups in the study. Participants were solicited through electronic communications and telephone. Members of the Ohio Mental Health Counselors Association (OMHCA) who have opted to be on the association list serve (n=277) received an e-mail seeking their participation, a participants’ data sheet, and consent to participate form (see appendices B, C, and D).
Seven of the sixteen participants identified themselves as members of OMHCA. All other selected participants were identified through networking done by the researcher. Following completion of the participation agreement, appointments were made with each participant for an interview either face-to-face or telephone. Participants, in Phase I, participated in an interview to gain understanding into the behaviors, actions, beliefs, and processes associated with “being” a compassionate counselor. By using the words of the participants to construct a way of understanding counselors’ experiences with compassion theories that are relevant to counselor education and training can emerge (Seale, 1999).

Incorporating counselors who are dedicated to mental health counseling increased the chances that individuals participating were more knowledgeable about the requirements and expectations of mental health professionals, thus increasing the likelihood of representing a theory-informed sample and increasing transferability (Erlandson, et al., 1993). The process of selecting individuals for participation in the study is exemplary of a sampling technique described as “networking” historically this process has been termed snowballing (Glesne & Peshkin, 1992). The researcher prefers the term “networking,” because the process is purposeful and requires work on the part of all individuals involved in the study. In addition, purposive sampling provided typical and divergent data to maximize the range of information obtained about the context (Erlandson et al., 1993). The size of the sample in qualitative research is subjective. Mason (1996) suggested that the number of participants in qualitative research is
dependent upon “the logic through which the researcher intends to develop and test social explanations” (p. 99). Therefore, based on the multiple experiences that the researcher was interested in exploring a diverse pool of participants was selected (i.e., race, age, years of experience, theoretical orientation).

**participant selection.**

After gaining IRB approval to conduct this study (See Appendix K), each member of OMHCA was e-mailed a letter introducing the researcher and explaining the study, one informed consent form requiring the participant’s signature, and one demographic questionnaire to be filled out by the participant.

The participants in study included members of OMHCA, as well as individuals that were recommended by other study participants. All participants were licensed Professional Counselors or Professional Clinical Counselors. All persons who completed participant demographic sheets participated in the study. A summary describing the diversity of the participants is outlined in the table below (for a more comprehensive description, see Appendix H).
Gender | Race | Mean Age | Mean Years Experience | Highest Degree | Setting
---|---|---|---|---|---
13 females | 6 AA | 45 | 11 | 10 MA/MS/MEd | 7 Comm/Agency
3 males | 9 White | | | 6 PhD/EdD | 3 Comm. Agency/PP
 | 1 Latina | | | | 2 School
 | | | | | 2 College Agency/PP
 | | | | | 2 PP

Table 1. Summary of participants by gender, race (AA=African American), mean age, mean years of experience, degree attainment, and work setting (PP=Private Practice)

**Site of Study**

Individual interviews with mental health counseling experts in Phase I took place at an agreed upon location between the researcher and mental health counseling expert. Accommodations for the individual interviews were specifically designed to assure convenience of time and place and optimal level of comfort for the expert. Special precautions were taken to avoid interfering with the individual’s work schedule. Further, all individual interviews were conducted in a manner to insure anonymity for the participants; each was informed that all interviews will be kept confidential. In addition, participants were informed that pseudonyms will be used in the presentation of data and results.

**Data Collection**

Methodological triangulation was utilized to maximize the probability that the findings and presentation of the findings are credible (Glesne & Peshkin, 1992; Lincoln & Guba, 1985). The first method of inquiry consisted of the individual interviews.
In 1992, Glesne & Peshkin stated that interviews provide elaborate responses that provide affective and cognitive underpinnings of research participants’ perceptions. Phase I interviews were loosely structured- and contained open ended depth probing questions - designed to facilitate the experts sharing of information about personal and professional development, and compassion within counseling, to identify common characteristics of the domains/constructs. The individual interviews began with the simple question: “What have been your experiences with compassion satisfaction and/or compassion fatigue within mental health counseling?” In addition, participants were asked to describe how they have learned to process experiences with compassion when working with clients.

Member checking was an ongoing process, at each distinct phase of the study. In other words, participants were extended an opportunity to solidify and clarify their thought processes. Lincoln and Guba (1985) defined member checking as an informal process established to determine accuracy of information. These informal member checks occurred at the conclusion of each Phase I interview and after themes were established as a result of data analysis across experts (see Appendix E).

The researcher took notes throughout the interview process and focused primarily on reactions of the participant in regard to the researcher’s presentation of the transcribed data. Again, feedback from each participant was obtained in Phase II through electronic communications (i.e., e-mail). Participants were asked to submit their reactions or comments to the themes. Some participants requested clarification on how to provide their feedback to the table.
In these cases, the researcher consulted with the participants as needed to ensure that they were able to provide their reactions to the themes (See Appendix F for e-mail sent to participants and list of themes).

**instrumentation.**

The primary data collection instrument was the phase one individual interviews (See Appendix A for interview protocol). The concepts and themes that emerged from this naturalistic inquiry were analyzed in a manner that capitalized on tacit (i.e., intuitive) knowledge and propositional knowledge that is, information that was expressed through language (Edelman, 1977; Glaser & Strauss, 1967; Kegan & Lahey, 2001; May et al., 1958; Senge et al., 2004). To this end, Glaser and Strauss (1967) stated: “the root source of all significant theorizing is the sensitive insights of the observer himself” (p. 251). Throughout data collections, the researcher attempted to find “sensitive insights” that pertain to “being” a compassionate mental health counselor. To this end, it is likely that the researcher’s personal experience, as a counselor and trainer of counselors, contributed to expectations and assumptions made by the participants; therefore, to prevent this from occurring, the researcher discussed with the participants the influence her title or “presence” had on their responses and level of comfort with sharing information about their experiences with compassion within counseling and the impact those experiences had on their personal and professional development (Erlandson et al., 1993). Additionally, the researcher’s personal experience “being’ a mental health counselor was incorporated to provide additional insights into the study (May et al., 1958; Rogers, 1980; Yeager, 1999).
**Interactive Analysis and Grounded Theory**

Naturalistic inquiry does not work with a fixed or predetermined theory design. Rather, this research process permits themes to emerge naturally from the inquiry. In keeping with the concept of emergent design and grounded theory, data analysis was ongoing and emerged throughout the study. The theory that evolved was a result of examining and analyzing “raw units of information” also termed “data bites” to inductively form theory about compassion within counseling. The emergent categories of meaning were coded into “data bites” of information through the application of the “constant comparative method,” as described by Glaser and Strauss (1967). Ongoing or constant comparison of “data bites” collected from participant interviews was compared with existing coded categories of “data bites.” This process continued throughout the data collection process, until a full range of categories or counselor characteristics were identified, and the relationships between categories were established.

The relationship between categories were constantly examined and reshaped by incoming data, constructing, deconstructing, and reconstructing themes as they emerged (Kegan & Lahey, 2001; Major & Savin-Baden, 2010). The data for this inquiry was based on information collected from the actual words and syntax used in interviews. Analysis was conducted through procedures developed for and advocated by Glaser and Strauss (1967) and Major and Savin-Baden (2010).
Text of the transcribed interviews was examined for participant described events, actions, concepts, and processes that when integrated with ongoing data collection emerged as concepts, actions, and processes that are common among compassionate mental health counselors. The individual interview process (i.e., data collection) was considered a part of the procedure of data analysis. This is because the process of collecting and analyzing new data provided direction for the next stage of data collection and analysis. Therefore, the process of data collection and data analysis were considered “mutually shaping.” Glaser and Strauss (1967) found that this process helps “facilitate the generation of theories and helps the researcher analyze the full range of types or continuum of the category under study, how it is pronounced or minimized, manor of consequences, relation to other categories and other properties” (p. 106).

Data Analysis

Collected data consisted of text, specifically the words of the participants. Audiotapes of the interviews were transcribed to describe counselors’ experiences with compassion satisfaction and compassion fatigue in mental health settings. The text of the face-to-face interviews were transcribed verbatim from the tape-recorded interviews.

Stage One Analysis

Analysis of the data was completed within a two-stage process. The first stage incorporated the actual data collection process within the field. The primary focus was on the data generated by each participant.
During the interview, the researcher focused primarily on the overall question related to counselors’ experiences with compassion fatigue and satisfaction within mental health counseling. The researcher was cautious to maintain the balance between structure within the interview and allowing the content to evolve (Averch, 2004; Yeager, 1999).

**Stage Two Analyses**

During stage two, across case analysis was used. The researcher focused on core categories that appear across and throughout the interviews. This process helped identify commonalities across cases. The process of editing quotes was applied to provide a format for determination of emergent core categories and themes. This researcher used member checking to avoid the tendency to lead or guide the research.

Phase II of the study clarified the understanding of characteristics identified by Phase I as common experiences with compassion as well characteristics that impact counselor well-being. Core categories that appeared across and throughout the interviews were summarized and participants in Phase I reacted to the themes that emerged. Upon completion of Phase I and Phase II, all participants were entered into a drawing for one of 5-$25 gift cards from Barnes & Noble Bookstore.

**editing quotes.**

Following each interview, this researcher transcribed the content verbatim. First the content was read to identify major points of importance. As each interview was completed, transcribed, and reviewed, new data bites were compared with previous data bites, and filed into the category that best fit the context of the data bite.
During this process, certain data bites did not fit with any category and were placed in a separate category to assess fit with themes that emerged as the interviews proceeded (Erlandson et al., 1993; Major & Savin-Baden, 2010). Upon categorizing all of the data bites, each category was given a name. According to Erlandson, et al. (1993), these categories helped with the process of categorizing data bites but may not fully capture the meaning of the information until the completion of the study, the final name for the category emerged after triangulating the data.

**Coding.**

Coding is the process described and used by Strauss (1987) for naming and conceptualizing data. The process of coding is a multi-tiered process beginning with open coding and progressing to more selective coding as the analysis of the data bites progresses. Some codes emerged directly from the words of the participant. Other codes that emerged were “sociologically constructed” and assigned by the researcher based on the integration of prior knowledge of the topic with participant data bites. Core categories is the name that Strauss gave to categories from which theory evolves (Strauss, 1987). Data bites, within the categories, were examined based on the following: (a) frequency of appearance, (b) relatedness to other categories, and (c) implications posed for the development of themes. This procedure is associated with determining the importance of identified categories, coded terms, and the building of these categories into a collection of themes.
Researcher Subjectivity

According to Glesne and Peshkin (1992), all research is laden with values and objectivity is ideal but subjectivity is what researchers have to live with and acknowledge how his/her personal experiences impact all parts of the research process. For example, as stated earlier, the researcher is an African American female counselor working in a mental health setting in Ohio. The researcher is also a board member of the Ohio Mental Health Counselors Association and currently working toward her Ph.D. in Counselor Education. The experiences the researcher has had thus far as a professional counselor provided invaluable information on the history of compassion within the helping professions as well as direct experience with being compassionate toward clients, colleagues, supervisors, and trainees. However, these experiences have shaped the researchers assumptions entering the study, which were as follows:

1. Counselors experience compassion, regardless of the work environment.
2. Many counselors burnout, and leave the profession, within 5 years.
3. Counselors of diverse backgrounds are underrepresented in research.
4. The affective development of counselors is devalued in Counselor Education.

Trustworthiness

The concept of trustworthiness is related to the degree to which the findings of the study are accepted by the participants of the study and the larger community represented by the study (Glesne & Peshkin, 1992; Lincoln & Guba, 1985; Mason, 1996).
As themes emerged from the study member checking was used to ensure that the themes were grounded in the perspectives of the participants to increase the trustworthiness of the study, allowing the findings to be generalized to other contexts. Lincoln and Guba (1985) established guidelines to address the issue of trustworthiness within the process of naturalistic inquiry These criteria have been utilized to replace the positivist standards for establishing trustworthiness through the process of external and internal validity, objectivity, and reliability. In the naturalistic approach to inquiry transferability is utilized in the place of external validity, credibility serves to replace internal validity, dependability replaces reliability, and confirmability is used in place of objectivity. These guidelines have been used by many qualitative researchers and the techniques have been refined to ensure that the research that is published is just as rigorous as findings obtained through quantitative research (Erlandson et al., 1993; Glesne & Peshkin, 1992; Lincoln & Guba, 1985; Mason, 1996).

**Methodological Triangulation**

Mason (1996) refers to multiple triangulations as a process that contributes to validation of qualitative analysis. In this study theoretical and methodological triangulation were used throughout the interview process. Theoretical triangulation was utilized to bolster the credibility of the study. The purpose of gathering data in two phases was to determine how definitions of compassion differ, change, or alter over time, space and context. One criterion for persons selected through purposive sampling for Phase I of the study was diversity related to personal demographics, work setting, and theoretical orientation.
The overarching goal was to identify counselors’ experiences with compassion fatigue and satisfaction in relationship to well-being and job satisfaction. Utilization of a multiphase approach leads to a broader understanding of the use of language regarding compassion in the field (Erlandson et al., 1993; Glesne & Peshkin, 1992; Lather, 2004). Methodological triangulation was implemented to provide improved probability of credible interpretations of the data collected, entered, and analyzed through the interview process. Each participant was asked to provide feedback on the summary of the interview; providing an opportunity to clarify information and increase credibility. This study utilized analytic bracketing as outlined in Ahern (1999). Bracketing helped minimize the distortion of the data and minimized the impact of expectations and biases held by this researcher. Bracketing is a strategic move on the part of the researcher, where assumptions about reality are suspended in an effort to more clearly examine the lived experiences of those being observed (Senge et al., 2004). The goal was to reduce the experiences and reactions into recognizable groups and their associated properties.

**Member Checking**

Member checking is the process of having participant’s review the data and clarify information (Erlandson et al., 1993; Glesne & Peshkin, 1992; Lather, 2004). In both phases of this project, participants had an opportunity to provide feedback and impact the construction of the constructs. Members were asked to review and comment on the accuracy of the categories that emerged. The goal of member checking was to provide the most accurate information possible.
The evaluation of accuracy of the conceptual interpretations that emerged across participants, related to compassion within mental health counseling and the impact on personal and professional development, was examined to assure the most truthful and accurate description of the information is presented. The process of participants’ evaluating the accuracy, credibility, and overall fit of the data enhanced the trustworthiness of the study. Mason (1996) indicated the use of member checking is one process of refining the data collected. It is also considered a method for establishing “face validity” in qualitative research.

**Credibility**

Credibility is the extent to which the findings of this study and future interpretations are reflective of the points of view held by the participants. The research design included four techniques to increase the probability of credible findings. The four techniques were: (a) prolonged engagement, (b) triangulation of methods, (c) peer debriefing, which consisted of consulting with experts in the field at various stages of the study, and (d) member checks (Glesne & Peshkin, 1992; Lether, 2004; Mason, 1996). Transferability is a demonstration of the applicability of the study’s findings within another context. The findings of this study contain thick descriptions of the constructs that are defined enabling future researchers to transfer the findings of the study to the study of compassion within helping professionals. Dependability is the ability for others to recreate the study and identify similar findings.
In this study the researcher kept records on the data gathering process, the actual data, as well as the process of analysis, and this information is available for those who would like to recreate the study.

In this study, confirmability was obtained with the use of reflexive journal, triangulation during the data collection phase and the data analysis phase, and a confirmability audit was conducted at the end of the study. The researcher maintained a record that details all facets of the inquiry process and is available to all of the dissertation committee members and any other interested parties. The reflexive journal includes the researcher’s thoughts, feelings, and frustrations associated with the research process as well as notes about the evolution of the theory.

**prolonged engagement.**

Prolonged engagement with the experts occurred through the process of the initial interviews and as feedback from summaries across cases. Allowing the experts to serve a major role in the study increased their trust in the research process and facilitated genuine feedback to the definitions and theories that evolved from the process. The process of these interactions allowed the researcher to eliminate distortions, misinformation, and misinterpretations, and personal biases toward the data. The probability that findings are credible is greatly improved with the process of triangulation of methods, as outlined in Lather (2004), Lincoln & Guba (1985), and Mason (1996).

By using different methods of data collection the uncertainty of the findings has been greatly reduced. Triangulation of the methods was accomplished with member checking, prolonged engagement, and the reflexive journal.
Triangulation of the data analysis consisted of peer debriefing; during which time interpretations of the research were discussed, evaluated and analyzed seeking out researcher biases that needed to be identified and addressed in the writing process. Peers consisted of fellow graduate students, counselor educators, and members of society who are familiar with qualitative research, human development, and the domain of counseling.

**Expected Outcomes and Implications**

Naturalistic inquiry relies on theory that emerges from the data (i.e., a posteriori) rather than precedes the data (i.e., a priori; Glesne & Peshkin, 1992; Lincoln & Guba, 1985; Mason, 1996; Padgett, 2004; Yeager, 1999). Each phase of this study was designed to permit the researcher to explore and develop theory as it emerges from the context under study (Erlandson et al., 1993 p. 50). The conceptual structure of this naturalistic inquiry relied heavily upon the ontological axiom of multiple realities; and the epistemological axiom of participant and inquirer interactions which influence one another throughout the data collection process (Lather, 2004; Senge et al., 2004; Yeager, 1999). As a result of these naturalistic axioms, the design and procedures were not fully defined by this researcher, prior to implementation. Rather, the researcher capitalized on these axioms to support the emergent design of the study. The goal of the design was to provide balance between a sufficient amount of structure to address the complexity of the topic and sufficient flexibility to facilitate the unfolding of interactions between the researcher, the participants, and the context of the study (Mason, 1996).
Further, the goal of this study was to identify perceptions and emerging concepts related
to counselor experiences with compassion fatigue and satisfaction within mental health
counseling. It is likely that the findings of this research will inform and educate
counselors and counselors educators on the multiple realities of “being” a compassionate
counselor from diverse perspectives. Thus, gaining an understanding of how counselors
can be more intentional in their work and how counselor educators can be more
intentional in their explanation of the hazards and benefits of “being” a compassionate
mental health counselor.
CHAPTER 4

Phase One Results

Chapter four was designed to present the common and unique views of professional counselors’ experiences with compassion when working in mental health settings. The focus of chapter four is presentation of the results from the phenomenological analysis of Phases I and II. Particular attention was paid to emergent themes from the sixteen professional counselors interviewed in this study. Therefore a synthesis of the findings led to theories that gave voice to the process by which they have come to develop these meanings (i.e., themes), and the impact that context had on their perception of compassion within mental health counseling. To this end, the following research questions were asked:

1. How do mental health counselors perceive compassion?
2. How do mental health counselors perceive compassion fatigue?
3. How do counselors perceive mental health compassion satisfaction?
4. What factors positively and negatively shape their perceptions of compassion fatigue and satisfaction?
Demographic Characteristics

The following table offers a brief description of the gender, race, age, years of experience, level of education, and work environment distribution of the participants:

<table>
<thead>
<tr>
<th>Gender</th>
<th>Race</th>
<th>Age</th>
<th>Years Experience</th>
<th>Highest Degree</th>
<th>Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>female</td>
<td>AA</td>
<td>Age&lt;50</td>
<td>Exp&lt;10</td>
<td>MA/MS/Med</td>
<td>Community Agency (43.7%)</td>
</tr>
<tr>
<td>(81.3%)</td>
<td>(37%)</td>
<td>(56%)</td>
<td>(50%)</td>
<td>(62%)</td>
<td></td>
</tr>
<tr>
<td>male</td>
<td>White</td>
<td>Age&gt;50</td>
<td>Exp&gt;10</td>
<td>PhD/EdD</td>
<td>Comm. Agency/PP (18.7%)</td>
</tr>
<tr>
<td>(18.8%)</td>
<td>(56%)</td>
<td>(43%)</td>
<td>(50%)</td>
<td>(38%)</td>
<td>School (12.5%)</td>
</tr>
<tr>
<td></td>
<td>Latina</td>
<td></td>
<td></td>
<td></td>
<td>College Agency/PP (12.5%)</td>
</tr>
<tr>
<td></td>
<td>(6%)</td>
<td></td>
<td></td>
<td></td>
<td>PP (12.5%)</td>
</tr>
</tbody>
</table>

Table 2: Summary of participants (percentages) Gender, Race, Age, Years of Experience, Level of Education (MA=Master of Arts, MS=Master of Science, PhD=Philosophy doctorate, EdD=Educational doctorate), Work Setting (See Appendix H) for full description of each participant.

Theme Emergence

This researcher encouraged participants to react to the concept of compassion on a continuum with fatigue at one end and satisfaction at the other. Participants were then asked about their experiences with the following categories (not in any particular order) in relationship to compassion fatigue and satisfaction (a) client population, (b) work environment, and (c) coping mechanisms.
As the interviews evolved, several themes emerged. Within the category of populations served, the following client populations were identified as contributing to both fatigue and satisfaction (not in any particular order): (a) Borderline Personality Disorder, (b) abuse victims, (c) substance abusers, (d) chronically mentally ill, (e) children, (f) disabled/low IQ, and (f) low socioeconomic status/impoverished. When discussing the client populations with the participants, two subthemes emerged: (a) sources of compassion and (b) affective experiences for counselors. Within the category of work environment the following themes were identified as impacting counselor experiences with compassion fatigue and satisfaction (a) work setting (i.e., private practice, agency, and school), (b) caseload/workload, (c) supervisor, and (d) theoretical approach. Within the category of counselor coping strategies the following themes were identified (a) experience working in the field, (b) self-care, (c) spirituality/religion, and (d) humor.

Erlandson et al. (1993) indicated that presentation of results in qualitative research can be presented through an analysis of themes that best describe the data. The thick descriptions and detailed accounts of Phase I interviews that follow represent an effort on the part of the writer to accomplish this task. Narratives were selected on the basis of their representation of emerging themes across cases. The overall goal was to identify a continuum of ideas as presented by the participants in this phase of the research that would enhance the readers understanding of counselors’ experiences with compassion in mental health counseling (Major & Savin-Baden, 2010).
The constant comparative method was utilized to identify emergent themes from the data bites collected. Emergent themes were selected based on frequencies of occurrence across interviews, with emphasis placed on the theme within the interview and the relevance of each theme to the study.

**Identification of Individual Perspectives and General Themes**

In 1994, Moustakas indicated that understanding the individual’s unique and subjective expressions of the phenomenon under study is the primary goal in phenomenological research. Identification of ideas as expressed in themes presented by the participants provided voice from the perspective of professional counselors (Erlandson et al, 1993; Major & Savin-Baden, 2010).

Individual beliefs related to compassion fatigue and compassion satisfaction within mental health counseling emerged through a review of each individual transcription. The constant comparative method was utilized to identify emerging themes, which were selected based on the frequency within discussion, with emphasis placed on the theme within the interview, and the relevance of each theme of the study.

**Presentation of Findings**

Qualitative research requires the researcher to disclose the intricate details of the research process. This spirit of openness increases the trustworthiness of the study and allows the quality of the relationship built between the researcher and participants to emerge for the reader of these findings and the participants of the study (Chenail, 1995).
According to Chenail (1995), researchers should be as open and honest as possible, when reporting their findings, to allow readers to decide for themselves whether the findings are trustworthy:

One of the beauties of qualitative research is how qualitative researchers seek out these places of character and aspect and attempt to make the events and happenings of these parcels of data come alive for the reader. To this artistic end, qualitative researchers have to think how to create "round" informants instead of "flat" ones in their writings. Researchers have to work hard at developing the details of these plots so that their readers can have a sense of where the data was naturally occurring when it was originally encountered by the researcher. It is important that readers have a clear picture of the data's setting so that they can begin to have a perspective from which to judge the observations being made by the researcher regarding the data. Without the setting, and the developed characterization, there can be no context and with no context for the data, there can be no significant meaning in the analysis (para. 18).

Taking an ecological approach to the presentation of data will lessen the impact this researcher has on the ability for the reader to understand and empathize with the experiences of the participants.

To ensure a comparative thematic analysis, the researcher was guided by the procedures of grounded theory (Glesne & Peshkin, 1992; Mason, 1996). The researcher created data bites from the transcribed interviews and broke them down into manageable interpretive parts following sequential coding steps.
Emerging themes were identified with 100% consensus from the sub group of research participants who initially responded and were the first to complete Phase II of the study. At this point, the author sought confirmation of the themes and sub-themes by conducting Phase II of the study. Based upon the data obtained in Phase II and the reactions to the themes and sub-themes that emerged, the researcher developed multiple assertions further explaining how counselors experience compassion fatigue and satisfaction within mental health settings in Ohio. Although the participants were willing to share their stories with the researcher, each participant was assigned a pseudonym to preserve his/her identity and maintain the trust between the researcher and the participants.

**Client Populations and Compassion**

Within Phase I interviews, all participants discussed their ability to work with certain client populations as contributing to their experiences with compassion fatigue and satisfaction, as evidenced by this response:

Bowen: Describe the relationship between compassion and mental health counseling?

Elizabeth: I see myself as a compassionate person and compassion plays an important role. But it is not a learned characteristic. Those that don’t have that quality don’t stay in this line of work for very long.

Bowen: So do you experience compassion in your work with clients?
Elizabeth: I experience it with 90% of my clients…I experience fatigue when working with clients who have gotten themselves into an uncomfortable situation on their own but are interested in change, like an unfaithful spouse. The unfaithful spouse comes to counseling to make everything alright but he/she isn’t interested in change.

Bowen: And compassion satisfaction?

Elizabeth: There was a young woman with breast cancer. She was one of the most resilient people I have ever known. She continued to be hopeful and concerned about her family, positive, it was just amazing. She went through all of that and came out with so much strength and gratitude…I was getting as much as I was giving.

Most counselors indicated that the following client populations contributed to experiences with compassion fatigue (a) Borderline Personality Disorder, (b) abused victims, (c) substance abusers, (d) those with chronic mental illness, (e) children, (f) disabled/low IQ, and (g) low socioeconomic status (impoverished). When working with these populations, the participants discussed the subtheme of suicidal/homicidal ideation. Within the subtheme of affective responses most of the participants used the active voice (i.e., draining and rewarding) when describing his/her affective responses to experiences with compassion fatigue or satisfaction.
In addition, most indicated that their ability to cope with feelings of helplessness and hopelessness (i.e., their own as well as clients) is impacted by their level of self-care and ability to create emotional distance from the client’s actions or decision to end his/her life. For example, Gina [White, female, 3-- years of experience] stated:

“Obviously you [I] care about people, you [I] want them to survive, you [I] want them to get it, you [I] want them to see their worth…but they could go out there and choose not to survive. So you’ve got these heavy issues weighing on your mind, kind of all the time. They can’t help but to want you to feel some of their pain. So there’s an antenna out there, a sticky antenna reaching out to you [me].”

This individual further stated:

To cope I tell myself it is what it is, and I’ve done my best. I don’t want them to harm themselves or anyone else. You know, if they do, I guess I will just have to deal with that, but it’s hard to do because you still have thoughts, so it’s a challenge.

Another counselor noted progress in her ability to work with suicidal clients as she gained more experience. For example, Lauren [White, female, 19--years of experience] stated: “Crisis pre-screen when the client is not hospitalized, but has suicidal ideation, used to create a lot of worry; but now I recognize I did what I thought was best.” Whereas Brian [African American, 3--years experience], emphasized compassion satisfaction when working with suicidal clients.
When discussing his experiences while working with a mother with a history of suicidal ideation he stated: “I got her to open up and really divulge what was bothering her. Helping her feel a sense of safety within my office just building that trust [being compassionate] and helping her realize that there is something she needs to say. I worked with her for over a year and helping her find her voice and the ability to say “My life isn’t over” - she used to say-“I don’t deserve to be here”. Seeing that change in her made me feel good.

Most counselors acknowledged that their ability to remain compassionate with suicidal/homicidal clients is enhanced by processing their experiences with colleagues, supervisor, their own therapist, or peers within the field. All involved in the study at some point expressed experiencing fatigue and some stated that burnout can occur if they remain silent about the impact suicide/homicide has on their professional work and personal well-being. For example, Gina [White, female, 3--years of experience] also stated: “It’s so intense, this person is homicidal this person is suicidal, this person tried to hang themselves…, I mean that’s dark stuff, and to try to make light of it.”

Another counselor even discussed one experience with compassion fatigue, when a client committed suicide. Leslie [White, female, 14--years of experience] stated: “He finally did it, he committed suicide…It’s hard when clients are a member of your community, my kids went to school with him.” The counselor became tearful when discussing her work with this client and his multiple suicide attempts and drug addiction.
Despite expressions of frustration when working with suicidal clients, those working with substance abusers expressed experiences with compassion satisfaction, when working with clients who experience “dark stuff” and behave in ways that have been termed as “unnatural” to some. For example, Athena [African American, female, 5--years of experience] stated: “Working with clients who have hit rock bottom and are ready for change is satisfying when they accomplish their goals.”

Although most of the counselors in the study work with adults, those who work with children and adults with limited IQ also expressed experiencing compassion fatigue. Lauren [White, female, 19--years of experience] asserted: “It’s hard [draining] to introduce new techniques to children and those with limited IQ.” Counselors working with these populations also expressed frustration when describing their work with families, teachers, or other professionals engaged in the client’s life, who may not be working in the client’s interest. As an example of this, Cheryl [African American, female, 3--years of experience] stated: “Confidentiality is tough. I work with children. Deciding what to share with parents was difficult to cope with.” Further, many of the participants were able to describe client attributes that bring them compassion satisfaction. Most counselors stated that clients who were willing to engage in the counseling process and motivated to make changes in his/her life were satisfying. “I’ve met clients who have worked [engaged in counseling] and have gone on, and I think that knowing them and being in their life for the time I’ve been in their lives has been absolutely wonderful,” stated Tony [White, male, 15--years of experience].
Another counselor, Athena [African American, female, 5--years of experience] asserted:

“I think people can reach the goals that you set for them, as long as you raise the bar gradually and they start to look at themselves. A lot of it has to do with their own belief, their own self-esteem, and their value. And if you value them they will start to value themselves.”

In addition, all of the participants expressed experiences with compassion fatigue and satisfaction, when working with clients with limited economic resources. These statements often included children, chronically ill, and individuals with low IQ. Further, those who expressed fatigue reported their stress was related to systemic issues as characterized by the following statements: “I work in a poor community with limited means. Many of my clients are on Medicaid.” Lauren [White, female, 19--years of experience], went on to say: “I work with young children and they may have to go home to no electricity and I am unable to find resources for them and ethically I can’t help them.” Milinda [African American, female, 3--years of experience], discussed her passion for working with impoverished children and her frustration with the system: “A lot of people write them [students] off because of where they come from. They don’t value them because they don’t come from money.” However, Milinda was not the only participant to find satisfaction working with those who have limited or no resources. Tony [White, male, 15--years of experience] stated: “I treat people who have been fired [terminated] from other public agencies due to no money, no Medicaid, no SSDI, no SSI, and do not have access to entitlement programs.”
The counselor went on to say “Working in the free clinic has brought me the most satisfaction experienced in my life.”

When asked how he is able to remain compassionate, despite frustration with the systemic health care crisis Tony stated: “If you have the gift of healing you find another way to earn your living.”

While this way of “being” a counselor may appear idealistic, many of the participants expressed finding compassion satisfaction through pro bono work of some kind either through direct client care or through advocacy.

**Work Environment and Compassion**

When discussing work environment and compassion most participants were reluctant to disclose their experiences and were concerned about the confidentiality of their stories. Participants in the study worked in agencies, private practice, or schools. Counselors working in agencies expressed fatigue from (a) productivity demands, (b) managed care requirements, (c) lack of supervisor support, and (d) client resistance to treatment method. Many participants stated that interactions with supervisors impact them personally and professionally. Jennifer [White, female, 13--years of experience] asserted: “People leave and positions are not filled…caseloads increase and people are overworked…and that is bad for clients and staff.” However, many of the participants working in agencies stated that they derive satisfaction from their work environment and stated that (a) discussing clients with colleagues, (b) having an empathetic and supportive relationship with his/her supervisor, and (c) teaching clients coping strategies within the theoretical approach used by the agency is “rewarding, fun, and validating.”
Although schools are not agencies, the counselors working in school settings suggested that isolation is common and may lead to fatigue. However, they were able to express moments of compassion satisfaction when they had the opportunity to process client interactions with other mental health counselors who work in their school district or similar setting. For example, Cheryl [African American, female, 3--years of experience] stated: “they [professional counselors] understand what it is like “being” a mental health counselor in a school setting.” She went on to say the following: “We meet [once a week] we see that [team meeting at the end of Friday] as a time to build each other back up so we don’t have to go home with that baggage [compassion fatigue].”

Counselors working in private practice also expressed that isolation can lead to fatigue and feelings of helplessness; however, they also expressed satisfaction from their work environment. For example, Cara [White, female, 20+-years of experience] who worked in an agency for over 20 years discussed the transition from an agency to a private practice, she stated:

I have more autonomy over my schedule since going into private practice…however, sometimes it can be isolating, but I make sure that I spend time with my peers who also have private practices. We get together occasionally.

When discussing the subtheme of supervisors some counselors expressed a desire for supervision from their agencies and others discussed a preference to discuss experiences with compassion fatigue and satisfaction with their peers.
Lauren [White, female, 19--years of experience] articulated: “I used to conduct a small group play therapy with sexual abuse victims. Clients weren’t disclosing and getting supervision increased my self-esteem.” Regardless of setting, all of the participants expressed internal feelings of isolation, even when peers, colleagues, or supervisors were accessible if they were unsure of their decisions related to client treatments and outcomes, and described their hesitation to reach out for support due to a fear of being judged as unprofessional or unethical. However, one counselor described a 40 year relationship with his “personal consultant” and stated:

Tony: I pay him. Sometimes we talk about clients, sometimes about my life. Sometimes about mental health care.

Bowen: How long have you been working with your personal consultant?

Tony: I have been in this business for 40 years; I started working on a 24-hour crisis hotline before there was licensure for counselors or psychologist.

Coping and Compassion

When discussing coping mechanisms all participants were aware of the necessity for self-care, however many admitted that they do not implement the skills that they know are effective to cope with fatigue. Within the category of coping mechanisms, the following themes emerged: (a) experience, (b) self-care, (c) spirituality/religion, and (d) humor.
When discussing the influence experience (e.g., amount of time practicing as a professional counselor) has on her ability to cope with compassion fatigue, Cara [White, female, 20+-years of experience], asserted: “As I spend more time in the field I have found more ways to cope, things that used to bother me don’t bother me anymore.” Other counselors discussed their ability to reframe interactions with clients, colleagues, and supervisors as a healthy coping skill. As an example of this, Gina [White, female, 3--years of experience] posed: “How much are we willing to apply what we teach [Cognitive Behavioral Therapy]?” Brian [African American, male, 3--years of experience] articulated his ability to incorporate his professional beliefs into his personal life. While conducting his interview he pointed to a quote that was framed on his office wall it read:

NEVER be content with someone else’s definition of YOU
Instead, define YOURSELF by your own beliefs
YOUR OWN TRUTHS
Your own understanding of who YOU are and how you came to be
And NEVER be content until you are happy with the unique person you are!

When this researcher inquired about the meaning and purpose of this artifact, he stated: “this quote reminds me that the client’s story is not my story. Although I allow my self to experience compassion fatigue momentarily I reframe the experience. When time is up [break between clients], that is where it stops, it is my job not my life”. Other counselors also discussed the struggle to resist getting “caught up” in client stories and stressed the need for self-care physically and emotionally.
When discussing self-care many of the participants stated that engaging in physical exercise and eating healthy are common coping mechanisms. Some even stated that engaging in these activities can help the body endure more fatigue. Gina [White, female, 3--years of experience] stated:

I get seven hours a sleep a night… I try to eat nutritiously. I know that I need my body to work for me because my job is stressful. I need it to work for me so I feed it. I exercise and I do those very practical things.

However, despite most counselors being able to articulate the need to eat healthy, many admitted that this is an area of self-care that is difficult to maintain. This topic was primarily expressed by female counselors, and the topic of eating habits did not arise for male participants. As for coping emotionally, many participants discussed the impact compassion fatigue has on their family dynamics and acknowledged the dangers of bringing home “baggage” [compassion fatigue]. Elizabeth [White, female, 33--years of experience] described feeling “lucky’ because her spouse is also a therapist, she stated: “bringing home baggage isn’t a problem, my husband understands what it is like and he is willing to listen to me and helps me process my experiences with clients.”

Most counselors expressed the use of spirituality/religion as a coping strategy to cope with compassion fatigue and a source of satisfaction when engaging with clients. as evidenced by the following interview excerpt.

Bowen: So one part of coping that you mentioned is prayer, would you say that spirituality or religious beliefs impact your experiences with compassion fatigue and/or satisfaction?
Gina: For me it [spirituality/religion] impacts it [experiences with compassion] a lot and it’s always in the form of satisfaction…Like I said before were holistic body, mind, spirit; and just being mindful and paying attention to all of the above. And you know for me prayer takes it off me and puts it onto God, that may not sound like coping but its good to be able to let go (sighs).

Bowen: I’m not here to judge. I am trying to get a sense of how counselors who are more existential, or have a humanistic perspective, understand spirituality and coping.

Gina: I use it all. I use my spirituality and I use CBT.

In addition, it was interesting to learn that some counselors view other counselors as having a “God like complex,” and Cara [White, female, 20+-years of experience] stated: “God like complex may lead to increased fatigue when clients do not meet the counselor’s expectations.” Another counselor stated: “Those who lack spirituality may experience more fatigue.”

Generally speaking, many counselors expressed the relationship between spirituality and compassion satisfaction, when working with clients. Most participants expressed experiencing meaning and purpose in their life when he/she is able to connect with a client on a spiritual level Other participants expressed very private experiences with their belief and expressed an uncertainty if this method of coping has had any influence on their experiences with compassion.
But, these individuals were adamant that their religious/spiritual practices were essential to their “being” a compassionate counselor. Cara [White, female, 20+-years of experience] stated: “I meditate, I breathe, [and] I put it [compassion fatigue] onto a higher power.” As further evidence of this point, Elizabeth [White, female, 33--years of experience] illustrated this point with the following:

Elizabeth: I believe in God, I’m a Christian. That doesn’t mean that there’s only one way.

Bowen: So you’re a Christian and you believe in God. Do you think your beliefs assist with your coping with compassion fatigue or help you derive satisfaction when working with certain populations?

Elizabeth: It’s support for me and that’s how I look at it…does it help me work with clients, that one I don’t know. Does it keep me grounded, I have no idea…It’s just something I choose to do.

When discussing humor as a coping mechanism, most of the counselors were frustrated with the use of humor by other counselors. Many of the counselors believed that jokes tend to relate to their clients and discussed the tendency of their peers to “make fun of” and “mock” client suffering. Some participants considered this behavior as a mechanism for the counselor to distance themselves from the reality of the client’s suffering. Others stated that it is a sign of burnout and a lack of professionalism. In particular, Gina [White, female, 3-- years of experience] asserted: “I see people who have been compassionate, but now they laugh at clients.”
Another participant, Natalie [White, female, 7--years of experience] stated: “It helps me cope, others are joking about them why shouldn’t I?”

Overall, all of the participants acknowledged compassionate counselors are those who consistently empathize with clients despite therapeutic technique and the clients’ ability to achieve treatment goals. Shelly [African American, female, 20+- years of experience] stated; My goal is to connect with a human being…If you blow it up front with rapport [fail to accomplish the following], being genuine, caring [compassionate], then none of the other stuff matters, you might as well forget it. It doesn’t matter what theoretical perspective you come from, it’s too late. Even in school we teach the microskills with person centered but those should be realized with any theoretical perspective you’re versed in.

**Phase II Results**

All counselors who participated in Phase I were sent an invitation to react to the themes and engage in Phase II of the study. Data analysis, in this phase, was completed using phenomenological and grounded theory procedures as previously described. This chapter will describe counselor reactions to the themes. Utilization of thick description and detailed accounts from Phase II reactions will be presented as they emerged from the data analysis process. The emergent themes represent a continuum of ideas that evolved throughout Phase II data collection and analysis (see Appendix F). The goal of this phase is to present their reactions in a way that provides an additional voice to counselors understanding of other counselors experiences with compassion fatigue and satisfaction within mental health settings.
It is hoped that the reactions to categories, themes, and subthemes provide a format in which counselors’ experiences with compassion fatigue and satisfaction can be further demystified and provide the participants with insight into this phenomenological research project. The constant comparative method was utilized to verify the significance of emergent themes from the data bites collected. As in Phase I of the study, emerging themes were selected based on the frequencies of occurrence across the reactions to the initial themes, with emphasis placed on the theme within the interview and the relevance of each theme to the study.

Reactions to Client Populations

Within Phase I, all participants provided reactions to the phenomenon that all populations identified can create experiences of compassion satisfaction and fatigue. Shelly [African American, female, 20+-- years of experience] stated: “I think these are all what one might consider as challenging populations that sometimes can be an impetus for compassion fatigue. However, I also see these as rewarding groups to work with and particularly when you see success being achieved with these individuals.” Whereas, Natalie [White, female, 7--years of experience] stated:

I’m surprised to see that the same areas that fatigue some provide satisfaction for others. However, I guess that makes sense as I figure that the fatigue is created when the counselor is struggling and not seeing progress with these clients, whereas the satisfaction comes from when success with these clients does occur.
When reflecting on themes related to suicidal/homicidal ideation most participants expressed strong reactions to clients diagnosed with borderline personality disorder and expressed difficulties when working with clients with Axis II disorders.

Jim [White, male, 3-- years experience] stated:

Most of these [client populations] are not much more challenging to me except for Axis II. They require me to be vigilant of my own boundaries and this is WORK.”

He went on to say: “My fatigue will be higher for crisis [suicidal ideation]. I have to get it right in terms of asking the right questions.

London [Latina, female, 10--years of experience] agreed with themes related to sources of satisfaction (i.e., instillation of hope, client self-acceptance, helping client feel heard) and stated: “I agree that my major sources of compassion fatigue and satisfaction relate to suicidal clients. Being able to connect with a human being and save a life are probably one of the most anxious yet deepest experiences I have had.” She went on to express her experiences with this phenomenon in relationship to her diversity. For example, she asserted: “As a person of color and international, nothing compares to connecting emotionally with a human being. We all experience pain, regardless of how we express it and/or how we seek help.”

Reactions to Work Environment

When responding to themes related to type of work environment most participants expressed that they were not surprised by the themes that emerged, however a few participants expressed extreme reactions to the themes identified by others.
For example, Natalie [White, female, 7--years of experience] stated: “I’m surprised to see that others have said that they experience satisfaction from being able to see clients without having to charge them. However, maybe these counselors are already financially set. I know as a young counselor in the field, being able to get paid for what I do is a big source of satisfaction.” Leslie [White, female, 14--years of experience] went on to describe the additional burden of private practice that counselors working in agencies do not experience, and stated: “Each setting is unique to its own stressors school, agency, private; all have their own unique issues.” she went on to say: “In private practice—75% of time devoted to billing and office management, while 25% of time spent with clients.”

Whereas, reactions from counselors working in agencies were varied, Jim [White, male, 3--years experience] stated: “No billing issues for me.” Natalie [White, female, 7--years of experience] stated: “I agree that it is frustrating to have to terminate counseling early due to insurance benefits. I do offer clients to self pay but they don’t want to do so. This is frustrating when you see that the client is making progress and doubt that they will be able to keep it up without counseling.” Overall most participants working in agencies or organizations with a hierarchy expressed frustration with the constant struggle to balance having compassion for themselves, their clients, and their employer.

When discussing supervisors and compassion fatigue and satisfaction most participants’ did not react to the themes provided. Of those who did provide reactions, most agreed that having a supervisor who is accessible and concerned but not overly involved created experiences of compassion satisfaction for the counselor.
Jim [White, male, 3 years experience] stated: “Supervisor is mostly hands-off except when I request input. I’m generally ok with this.” Other counselors working in agencies expressed a desire for more structure from supervisors to increase opportunities for peer debriefing: “I am convinced the absenteeism would significantly change for the better if we had [a] routine venue of processing. I am sure that burn-out and feelings of fatigue would be greatly lessened.” Another counselor expressed disappointment in her supervisory dynamic when reacting to the sub-theme of supervisors (i.e., fatigue: lack of support from supervisor and productivity main priority instead of counselor well-being): “It is very hard when your supervisor does not share the same belief and passion for what we do in our agency.” Overall, work environment appeared to impact counselors’ ability to cope more than day-to-day work with clients for those working in agencies and schools.

**Reactions to Coping Mechanisms**

When reacting to themes related to coping and compassion fatigue and satisfaction most participants described their reactions in one word (i.e., yes or accurate). However, many counselors expressed reactions to themes related to coping and spirituality and religion. Natalie [White, female, 7--years of experience] stated: “I never really thought about counselors having a God Complex as they talk about doctors having, but now that you share that, I can see how some of us do take on that mentality.” She went on to say: “It’s like if the clients just keep coming and do some work, we can help them make some miracles come true.”
Jim [White, male, 3--years experience] offered a unique perspective when reacting to religion and spirituality and coping, and discussed the process of others showing the counselor compassion as he/she changes as a result of new religious/spiritual coping strategies: “Yes. [Counselors] need to celebrate cultural differences and be curious. Be open to change in me too.” A counselor educator, Shelly [African American, female, 20+- years of experience] stated: “Wish more therapists would recognize the value of spirituality in counseling.”

When discussing humor as a coping strategy most counselors reacted to the ability to experience compassion satisfaction when laughing with clients. Several participants stated: “[Humor] should be used more often.” Other counselors stated: “[I] Try to laugh with [clients] only.” Some counselors expressed a sense of relief to learn that others use humor as a coping skill for life in general and stated: “Glad to see others are using it too.” One counselor educator agreed that counselors should learn to laugh more with clients and colleagues. Another counselor simply questioned the data bite that some counselors “mock client suffering” as a coping mechanism for compassion fatigue. It appeared that they were unable to process this state of “being” a counselor.

Summary

Participants for Phase II were also asked “Do you feel that the data represented in your context aligns with what we have learned from other contexts?” Most of the participants stated “yes for the most part.” None of the participants stated “no” or indicated that the findings do not capture their experiences with compassion fatigue and satisfaction.
When asked if there are any additional comments you would like to make regarding the study, most participants reflected on the importance of the topic and what they learned from engaging in the process. Leslie [White, female, 14--years of experience] stated: “Worthwhile topic – good challenge to stay healthy when promoting good health to others – same for all healthcare providers.” Lauren [White, female, 19--years of experience] stated: “I’m interested in the spirituality component. Seems having faith may lessen fatigue. This may be consistent with other research. Very good summary of key points.”

One counselor discussed how the process of engaging in the interview and reacting to the themes provided an opportunity to reflect on “being” a counselor. Jennifer [White, female, 13--years experience] stated: “Participating in the interview allowed time for re-evaluating what/why I do this type of work, helped to affirm the meaning and purpose, also all of the stressors involved.” She went on to say: “Seems like the better counselors are able to use self-care and manage stress, the better able [they are] to do the work.”
CHAPTER 5
SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

As mentioned in the previous chapter, the following themes emerged; within the category of populations served, the following client populations were identified as contributing to both fatigue and satisfaction (not in any particular order): (a) Borderline Personality Disorder, (b) abuse victims, (c) substance abusers, (d) chronically mentally ill, (e) children, (f) disabled/low IQ, and (f) low socioeconomic status/impoverished.

When discussing the client populations with the participants, two subthemes emerged: (a) sources of compassion and (b) affective experiences for counselors. Within the category of work environment, the following themes were identified as impacting counselor experiences with compassion fatigue and satisfaction (a) work setting (i.e., private practice, agency, and school), (b) caseload/workload, (c) supervisor, and (d) theoretical approach. Within the category of counselor coping strategies the following themes were identified (a) experience working in the field, (b) self-care, (c) spirituality/religion, and (d) humor. The following section details each of these themes and sub-themes and answers the research questions that were the basis of the study.
Research Question 1

*How do mental health counselors perceive compassion?*

Using interpretivism (Mason, 1996) and Humanism (Moustakas, 2001) as the theoretical underpinnings, the meanings counselors attribute to experiences with compassion within mental health counseling was explored. According to interpretivistic and humanistic assumptions, human beings are active creators of meanings and their perceptions of experiences impact the way in which they live their lives personally and professionally. However, the inclusion of counselors from diverse backgrounds required the inclusion of feminist and critical race theories to bring voice to their unique experiences. These theories, when applied simultaneously, take the position that race and gender have significant meaning in human life and offers a framework for how race and gender affect minority women’s experiences with compassion in mental health settings (Crenshaw, 1989; McNeill et al., 1995).

**client populations and compassion.**

When analyzing the data related to category one (compassion satisfaction with client populations), the researcher expected that clients with Borderline Personality Disorder and Substance Abusers who have a history of suicidal ideation would be identified by participants as contributing to experiences with compassion fatigue. What the researcher did not expect was the importance of “not being able to understand clients experiences” with suicidal ideation or substance use on counselor experiences with compassion fatigue.
In addition, this researcher found it interesting that the most rewarding client populations for some represent the most draining client populations for others. Most participants either laughed or sighed, prior to expressing stories related to clients that represented their experiences with fatigue or satisfaction while working in mental health settings.

**work setting and compassion.**

When analyzing the data from category two (compassion satisfaction and mental health work environments), the researcher was surprised by the isolation experienced by private practitioners who participated in the study. Based on the analysis, it was evident that the number of staff members in relationship to the expected workload, as well as the leadership style of the supervisor influenced many of the counselors’ ability to cope with fatigue, while at work. Counselors’ ability to experience compassion satisfaction and fatigue appeared to be less impacted by the treatment modality and more influenced by the work culture.

**coping and compassion.**

When analyzing the data from category three (coping mechanisms) for Phase I and Phase II divergent experiences with the use of humor to cope with compassion emerged. For some participants, experiencing their colleagues use of humor to cope was viewed as unhealthy coping and possibly a sign of burnout, whereas other counselors embraced humor to express compassion to their clients and connect with them spiritually. However, the counselors’ decisions to disclose on any level to colleagues were viewed as a healthy form of coping, and were described as more effective than silence about troubling client situations.
Research Question 2

*How do mental health counselors perceive compassion fatigue?*

**client populations and compassion fatigue.**

Overall, most of the counselors were hesitant when disclosing about their experiences with compassion fatigue. Some counselors mentioned that they were embarrassed about their affective responses to client stories (i.e., countertransference, hopelessness) and felt isolated when contemplating about how to cope with difficult clients. Some counselors even stated that their work environment was supportive, and compassion fatigue was short lived. These counselors keenly understood, as a state of being, that counselors have to learn to process compassion stress throughout their career (Figley, 2002a). Additionally, some of them were surprised to learn about other counselors’ ability to find humor in human suffering as a way to cope with fatigue.

Research Question 3

*How do counselors perceive mental health compassion satisfaction?*

Overall, the counselors were excited to share their experiences with compassion satisfaction. Some counselors mentioned that engaging in the research process was an opportunity to reflect on why they decided to become counselors and “renewed” their passion for “being” a counselor. Other counselors stated that, regardless of the clients they are working with, individuals who are able to find hope and create personal goals represented positive experiences with clients and they are able to “store those moments [of satisfaction] and retrieve those feelings,” when they are feeling fatigued.
When discussing work environment and compassion satisfaction, all of the counselors stressed the importance of balancing their work load and the importance of supportive supervisors, colleagues, and/or peers. Counselors who articulated positive experiences in their work environment laughed, when reflecting on dynamics with colleagues and gave tribute to their peers, colleagues, and supervisors for helping them navigate their development as counselors. All of the participants with more than 10-years of service emphasized the need for new counselors to find a way to appreciate the “baby steps” that clients make to remain hopeful that people are capable of “change” if they are willing to be patient and accept the client where they are.

**Research Question 4**

*What factors positively and negatively shape their perceptions of compassion fatigue and satisfaction?*

Based on the findings of this study compassion within counseling is a construct that counselors are interested in discussing. Conceptualizing the construct of compassion allowed counselors to discuss openly about their experiences with difficult clients and professional dynamics of mental health care settings. The information gleaned from this study can be used to assist with new counselor training, as well as create awareness, for those in supervisory roles, about the hidden psychological dangers of “being” a mental health counselor.
Previous studies on compassion focused on trauma on a large scale (Adams et al., 2008; Alkema et al., 2008; Boscarino, et al., 2004; Carmel & Friedlander, 2009; Roberts, Flannelly, Weaver, & Figley, 2003; Smith, 2007; Wee & Myers, 2002). This study demonstrates how day-to-day client crisis can have similar impact as working on large disaster relief over a significant period of time (McAdams, & Keener, 2008). Similar to Figley’s research findings on work fatigue and caseload, the more responsibilities a counselor has the more likely he/she is going to feel fatigued and may become susceptible to burnout (Figley, 2002b).

Coping Mechanisms and Compassion

In 2003, ACA established a task force on counselor well-being. Three goals related to counselor vulnerability, wellness, and resilience were implemented, (a) focusing on strengths based prevention and resiliency education, to identify areas of vulnerability and provide strategies for wellness; (b) increasing access to resources for intervention and providing best practice criteria for counselor educators and supervisors; and (c) advocating on a state and national level to address the stigma related to counselors seeking mental health treatment (Lawson & Venart, 2006). Based on the findings of this research project, studying compassion satisfaction may add more insight into counselor source of resiliency and provide increased understanding on the affective development of counselors. In addition, the voices articulated in this study may reduce the stigma related to counselors seeking mental health treatment or intensive supervision to address issues of compassion fatigue and systemic issues within mental health settings which may impair counselor functioning.
Recommendations for Counselor Educators

Based on the findings, counselor educators are encouraged to incorporate curriculum and experiential activities that address the affective development of counselors (Dollarhide, 2010). Terms such as compassion can be explored and discussed to enhance the counselors’ ability to better understand themselves and connect with clients (Bradley & Fiorini, 1999; Busacca & Wester, 2006). In addition, counselor educators should discuss wellness within counselor education and encourage trainees to process difficult client situations to enhance trainees' development of a “personal process” for taking responsibility for nonaggressive ethical violations that may impact the counselor-client dyad and counselor well-being (Holcomb-McCoy, & Bradley, 2003; Welfel, 2005). Concurrent research should be conducted to develop evidenced based ethics training that addresses counselor fallability (Holcomb-McCoy, & Bradley, 2003; McAdams, & Keener, 2008; Welfel, 2005). For example, the Accelerated Recovery Program (ARP) for distressed students (Gentry et al., 2002) and the PATHWAYS program are models that align with findings of this study. Counselor educators interested in understanding the affective development of their trainees may find this program easy to implement into their existing curriculum (Baldo, et al., 1997).

Recommendations for Supervisors

Individuals providing supervision for counselor trainees or newly licensed counselors can utilize the findings of this study to normalize experiences with compassion fatigue and satisfaction when discussing cases with supervisees.
In addition, these findings can create awareness for supervisors of the affective warning signs for counselor distress or burnout. If the warning signs are noticed and discussed in a timely manner, perhaps supervisors can assist counselors with developing a plan of action to decrease experiences with fatigue and enhance the counselor’s ability to find satisfaction in their work. In 2001, Henderson referred to this process of addressing the affective development of supervisees as normative, restorative, and supportive. In order to enhance the process of affective development in counselors, supervisors must attend to the “swings in supervisees’ self-confidence, optimism and locus of control, and the impact of these on the quality and quantity of the work they do” (p.93). In addition, these recommendations align with ACES (1977) recommendations for training programs to address the personal development of counselors, as well as ACA recommendations for personal development of counselors to enhance counselor competency when working in cross cultural counseling dyads (McNeill et al., 1995; Dollarhide, 2010). Overall, the diversity within this study can help fill the void described by McNeill et al. (1995) as “a dearth of information available on the unique training needs of racial and ethnic minorities by shedding light on perceptions of compassion within mental health counseling that may are underrepresented or missing from the literature. Create awareness, in trainees, for the affective warning signs for counselor distress or burnout (Figley, 2002a).

**Recommendations for Counselors**

Overall, all counselors should seek out support from peers, supervisors, and/or colleagues when experiencing compassion fatigue in a timely manner.
In addition, self-care is an ongoing task that should be attended to throughout the professional’s career. Therefore, all counselors should be encouraged to develop a personal model for resiliency to combat compassion fatigue and enhance compassion satisfaction when working in mental health settings (Myers & Sweeney, 2004; Sweeney, 2001). As evidenced by the findings of this study, the counselor’s perspective of interactions with clients and his/her ability to cope with those experiences can impact the counselor’s state of “being” and their ability to remain emotionally present and compassionate with clients (Witmer, & Young, 1996; Ronnestad, & Skovholt, 2003).

**Recommendations for future Studies**

Continued investigation into counselor experiences with compassion fatigue and satisfaction within mental health care are recommended. Utilizing qualitative studies to understand this phenomenon reveals the realities of “being” a mental health counselor in today’s society. As our society becomes more diverse and systemic in our approach to mental health care, mental health professionals will be expected to collaborate more with other professionals, support persons of clients, and other individuals or organizations vested in the client’s welfare (Casto, 1994). A feminist perspective removes the emphasis from the importance of the boundaries and focuses on the overlap that exists between the professions, concern for client’s well being, and quality health care (Casto, 1994; Leiba, 1994; Rawson, 1994).
This ontological shift from positivist to a feminist perspective will allow the professional to be more open to accepting the input of other professionals and nonprofessionals within or outside of their discipline (Leathard, 1994). As our society becomes more diverse, counselors will increasingly rely more on each other for support, especially as they navigate assisting clients who have different worldviews and values (McDonald, 2010; McNeill et al., 1995).
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APPENDIX A

PHASE ONE INTERVIEW GUIDELINES
Appendix A

Phase One Interview Guidelines

➢ What were your hopes and expectations when you decided to pursue a career as a mental health counselor?

➢ What are the three most stressful aspects of your job?

➢ What are the three most rewarding aspects of your job?

➢ What coping strategies do you use to cope with these stresses?

➢ Do some treatments or populations have an influence on your personal or professional functioning?

➢ Do you ever feel hopeless when working with clients?
  ○ if so please explain what that is like for you?

➢ Do you take action before or during the sessions to cope with traumatic stories you hear?

➢ Do you talk to colleagues about what clients tell you?

➢ Do you ever feel sad or depressed as a result of your work?

➢ What is the impact of emotions on the interactions between you and your most rewarding interactions with clients?

➢ What is the impact of emotions on the interactions between you and your most challenging clients?

➢ What do you find necessary when working with victims of trauma?

➢ Does having the ability to recognize and accept your power as a counselor contribute to your effectiveness?
➢ To what degree does being open to change contribute to your effectiveness as a counselor?

➢ What impact does your life history have on your effectiveness with patients?

➢ What impact does your understanding of professional ethics, and values have on your effectiveness as a counselor?

➢ What impact does having a sense of humor have on your effectiveness as a counselor?

➢ What impact does theoretical orientation have on your effectiveness as a counselor?

➢ Do you generally tend to live in the present? If yes, what impact does this have on your well-being as a counselor?

➢ What role does a tolerance for ambiguity play in your effectiveness as a counselor?

➢ To what degree does your ability to celebrate diversity impact your effectiveness as a counselor?

➢ Do you think clients perceive you as compassionate?

➢ Are you satisfied with the level of compassion you experience in your work environment? Explain.

➢ What are five verbs you would use to describe compassion within counseling?

➢ Do you feel comfortable discussing compassion fatigue or satisfaction at work?

➢ What do you see as the difference between burnout and compassion fatigue?

➢ Are there any traits that you have that you believe clients may misinterpret?
Appendix B

Phase One

Potential Participants Explanatory Letter

(Date)

(Address of Potential Participant)

Dear (Name of Potential Participant)

I am writing to seek your assistance. I am a Ph.D. candidate in the College of Education and Human Ecology, Counselor Education at The Ohio State University. For my dissertation I am conducting a qualitative study examining counselor experiences with compassion within mental health settings. My study is being conducted under the supervision of my dissertation advisor, Dr. James L. Moore III, professor in the College of Education and Human Ecology, Counselor Education. The purpose of this study is to explore contributing factors to compassion satisfaction and compassion fatigue within a mental health setting.

Currently, there is a lack of information on experiences with compassion for counselors (PC/PCC). My study will attempt to illuminate similarities and differences with how compassion is experienced and impacts the professional and personal lives of counselors. I believe your insights on counseling will lead to greater understanding of how compassion is experienced for counselors. It is my hope that mental health counselors will use the knowledge gained from this study to improve their skills as well as self-care.

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You have been selected to participate in this study because of your decision to work in a mental health setting within Ohio. The time commitment requested is approximately 3 hours. There will be one face-to-face interview lasting approximately one and one-half hour. There will also be a post interview follow-up lasting approximately one and one-half hour (format to be determined by the researcher and the participant). The post interview will consist of reviewing summaries of the data. At this time I will answer any questions you have about the project and solicit your feedback on the themes that have emerged across interviews. This process is designed to maximize accuracy in data collection.

Your participation in this project is voluntary. Data and reports will be handled in a manner that maximizes the information while preserving the confidentiality of each participant. Names and/or other identifying data will not appear in any part of the study. No audio taping will be conducted without your expressed written consent. All audio tapes will be destroyed at the completion of this research project. You may choose not to answer all of the questions, not to complete the second phase of the process or withdraw your consent and discontinue participation in any stage of the research project.

It is expected that your experience in this project will be an exciting process providing insights into your beliefs of what contributes to compassion fatigue or satisfaction in the field of mental health counseling. However, there is always the possibility that you may experience some distress as a result of the interview process. In preparation for any distress experienced I have developed a list of resources for support for counselors within Ohio to assist a participant should the need arise.
By responding to this letter you will have self-identified as a participant in this study. Please complete the data sheet enclosed in this packet and return to me in the self-addressed stamped envelope provided or as an attachment to this e-mail. When I receive your completed data sheet and consent to participate I will promptly contact you to begin the interview process.

Please feel free to call me with any questions or thoughts you have related to this project. Your participation is greatly appreciated. I am looking forward to meeting with you in the near future.

Sincerely,

Nikol V. Bowen, MA, PC
APPENDIX C

PARTICIPANT DATA SHEET
Participant Data Sheet

Instructions: Please answer each question as completely and accurately as possible.

1. Name:________________________________________________
2. Sex: __________________________________________________
3. Age:__________________________________________________
4. Race/Ethnicity:__________________________________________
5. education level/degree (s):_________________________________
6. Credential:_____________________________________________
7. Employer:______________________________________________
8. telephone number:_______________________________________
9. years in current position:__________________________________
10. total years of practice:____________________________________
11. area of specialization:____________________________________
12. theoretical orientation:____________________________________
13. professional organizations/affiliations:_______________________
14. list of any additional professional activities or areas of interest
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
**Consent Form**

I consent to participate in the research project examining compassion within counseling. The authorized representative (Nikol V. Bowen) for the principal investigator (Dr. James L. Moore III) has explained the purpose of the study, the procedures to be followed and the expected time commitment required.

I have been informed that the individual interview and post interview follow-up will be audio tape recorded. I have been informed that these tapes and the information obtained from the tapes will be a part of the research material for the study. I am aware that the investigator will code information and guarantees that my identity will be kept confidential and will not appear in any reports originating from the study. Names, identifying information, audio tapes, and follow-up reports will be destroyed upon successful completion of the research project.

I have been informed that participation in the study is voluntary. I am aware that questions regarding research process are welcomed. I am aware that I can refuse to answer or participate in any portion of the research process. I further understand that I can withdraw consent and discontinue participation at any point in the project.

I have been informed that there is a possibility that I might experience some distress as a result of exploring past professional/personal experiences. I am aware that a list of resources is on file that the principal investigator may refer me to should the need arise.
I acknowledge that I have read and fully understand the consent form. My signature indicates my agreement to voluntarily participate in this research. A copy of this consent agreement has been given to me.

______________________________  ________________________________
Participant Signature                Witness

______________________________  ________________________________
Investigator Signature                Authorized rep. for the principal investigator
APPENDIX E

MEMBER CHECKING QUESTIONNAIRE PHASE I
Member Checking Questionnaire Phase I

These questions were asked at the close of the Phase I interview. Participants were encouraged to contact the researcher to discuss any questions or concerns about the content of their interview.

Do you feel that the summaries capture your experiences as a counselor?

Are there any additional comments you would like to make to enhance the data provided?

Do you feel that the data collected accurately represented the characteristics of compassionate counselors?

Are there any additional skills, values, or strategies that contribute to your ability to cope with the job related stress
# Phase I themes

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<tr>
<th>Compassion Fatigue</th>
<th>Clients</th>
<th>Compassion Satisfaction</th>
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<tr>
<td><strong>Populations</strong></td>
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<td>• Abuse Victims</td>
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<td>• Disabled/Low IQ</td>
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<td><strong>Sources of fatigue</strong></td>
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<td>• Suicidal/homicidal</td>
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<td>• Inability to hospitalize without psychiatric approval</td>
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<td>• Determining level of safety</td>
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<td>• Completed suicide</td>
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<td>• Inability to understand clients experience</td>
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<td>• Desire to save the client</td>
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<td>• Vicarious trauma</td>
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<td>• Fear of being held liable</td>
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<td>• Limited resources to provide to client</td>
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<td>• Working with resilient clients</td>
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<tr>
<td>• Having to terminate clients prematurely due to insurance policy guidelines</td>
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<td>• Conducting groups/experiences that are enjoyable for clients</td>
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<td>• Ability to serve clients until goals are met</td>
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<td>Satisfaction</td>
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<tr>
<td>• Used as a barrier to prevent feeling client pain</td>
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<td>• Easy going work environment, enjoy time with colleagues</td>
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Dear Participant,

Thank you for participating in Phase I of the study on compassion within mental health counseling. Your stories have enriched our data. When analyzing the data from phase I three main categories emerged: (1) experiences with compassion related to client populations, (2) work environment, and (3) coping strategies. Please provide your reactions to the tables listed below. The tables below do not contain quotes from the study. This phase of the study is designed to elicit your feedback on the themes that have emerged from the interviews. In addition to your responses to the table, I have listed two open-ended questions as an opportunity for you to reflect on the themes. The feedback received from this phase will be incorporated into the next phase of data analysis. As a reminder you are not required to complete this part of the study to be entered into the drawing for the Barnes and Noble Gift Card, however your participation is highly valued, and I hope you will take time to participate. Please complete this form and e-mail it as an attachment to bowen.36@osu.edu.
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Participant Reaction
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Do you feel that the data represented in your context aligns with what we have learned from other contexts?  
Answer:  
________________________________________________________________________  
________________________________________________________________________  
________________________________________________________________________  

Are there any additional comments you would like to make regarding the study:  
Answer:  
________________________________________________________________________  
________________________________________________________________________  
________________________________________________________________________  
________________________________________________________________________
APPENDIX H

PARTICIPANT DEMOGRAPHIC INFORMATION
## Participant Demographic Information

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<thead>
<tr>
<th>Name</th>
<th>Gender</th>
<th>Age</th>
<th>Race</th>
<th>Degree</th>
<th>Credential</th>
<th>Years of Practice</th>
<th>Theoretical Orientation</th>
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<tr>
<td>Jim</td>
<td>M</td>
<td>50</td>
<td>White</td>
<td>MS</td>
<td>LPCC</td>
<td>3</td>
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<td>Shelly</td>
<td>F</td>
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<td>LPCC-S/CRC</td>
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APPENDIX J

PROCESS CONSIDERATIONS
Process Considerations

Self-Reflective Monitoring

Throughout the research process, this writer maintained a reflexive journal that indicated her thoughts and actions throughout the data collection/interviewing process. Prior to each interview and after each interview this researcher made note of her uncertainties and experiences with the participant. Frequently, the journal entries were referenced to enhance the researcher’s ability to capture nonverbal reactions that were memorable as participants reacted to summaries of their statements during the interview process. E-mails related to Phases I and II of this research project were sent and received to collect demographic information, clarify logistics of the interview, and to clarify reactions to themes.

Engaging in reflexive journaling throughout this project allowed this writer to become an instrument within the study (Lincoln & Guba, 1985; Major & Savin-Baden, 2010). Although this process was necessary to enhance the confirmability of the findings, it was difficult at times, for this researcher, to maintain self-awareness and unearth biases that were brought to the research process. However, when biases were detected, this researcher would note them and journal about how they may hinder the project. For example, prior to one interview this researcher noted reactions to the participants’ demographic information sheet and disclosed any assumptions and journaled about any information that might distort perceptions of the client's willingness or ability to be a compassionate counselor.
In a constant effort to avoid categorizing the data gathered in a way that coincided with this writer’s biases, review of the reflexive journal was conducted during the data analysis and coding processes to minimize the impact of the biases on the final themes and discussion. As mentioned earlier, reviewing the journal also served to remind the researcher of nuances that occurred during the interview that may not be captured by the audiotaped recordings. In addition, a reflexive journal helped clarify the researchers thought process throughout the writing process. The journal entries captured fears, hopes, frustrations, and disappointments experienced by this researcher throughout the process. While this journal was a useful tool to enhance the research process, it is not likely that this journal had a major impact on the research process, but is a practice that lessens the likelihood of the researcher misusing the instrument [herself] while assessing the role of compassion for counselors working in mental health care.

**Research Issues**

The primary research issue centered on confidentiality of the participants within the study and clients they discussed during the interview. During the interview, several of the participants appeared preoccupied with the tape recorder and on several occasions requested reassurance that their name would not be disclosed. Other participants were protective of their client’s rights to confidentiality, and did not want their client’s name to be disclosed, as they discussed the clients that represented their experiences with compassion satisfaction and fatigue.
These issues were resolved during the interview and this writer took precautions during data analysis to further ensure the confidentiality of all participants, especially when selecting quotes to use in the written report. In addition, one participant opted not to be tape recorded but authorized the use of several quotes captured during the interview.
APPENDIX I

DESCRIPTION OF RESEARCH TEAM MEMBERS
Description of Research Team Members

Principal Researcher #1: Nikol Bowen

The principal researcher of this study is an African American female is currently a doctoral student focusing on counselor education at The Ohio State University. She has worked as a licensed professional mental health counselor for 2 years and is very active in the state of Ohio advocating for mental health care. Her work as a counselor has been in acute care, middle school, and collegiate setting. She has also had experience in transcription and identification of emergent themes.

Research Team Member #2:

Research team member #2 is an African American female with over 15 years experience as licensed professional mental health counselor and over 5 years as a counselor educator. She is experienced in qualitative and quantitative research in counselor education and training.

Research Team Member #3:

Research team member number 3 is an African American female with 2 years experience as a licensed professional counselor working in community agencies and schools.

Research Team Member #4

Research team member #4 is a White female with over 14 years experience as a licensed professional counselor working in community agencies and in private practice.
Appendix K: IRB Approval
April 1, 2010
Protocol Number: 2010E0198
Protocol Title: COMMON CHARACTERISTICS OF COMPASSIONATE MENTAL HEALTH PROFESSIONALS: A QUALITATIVE STUDY, JAMES MOORE, NIKOL BOWEN, WELLNESS AND HUMAN SERVICES
Type of Review: Request for Exempt Determination

Dear Dr. Moore,

The Office of Responsible Research Practices has determined the above referenced protocol exempt from IRB review.

Date of Exempt Determination: 03/31/2010
Qualifying Exemption Category: 2

Please note the following:

- Only OSU employees and students who have completed CITI training and are named on the signature page of the application are approved as OSU Investigators in conducting this study.
- No changes may be made in exempt research (e.g., personnel, recruitment procedures, advertisements, instruments, etc.). If changes are needed, a new application must be submitted.
- Per university requirements, all research related records (including signed consent forms) must be retained and available for audit for a period of at least three years after the research has ended.
- It is the responsibility of the Investigator to promptly report events that may represent unanticipated problems involving risks to subjects or others.

This determination is issued under The Ohio State University's OERP Federalwide Assurance #00000478. All forms and procedures can be found on the OERP website – www.orrp.osu.edu. Please feel free to contact the OERP staff contact listed below with any questions or concerns.

Cheri Petrey, MA, Certified IRB Professional
Senior Protocol Analyst—Exempt Research
Office of Responsible Research Practices
Ohio State University
830 Kenny Road
Columbus, OH 43210
phone: 614.688.0399
fax: 614.688.0366
e-mail: petrey.5@osu.edu

Exempt Determination
Version 1.1