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In imagining this one page in my mind’s eye at different points in the dissertation process did I derive quiet delight and motivation, so that I could bind my gratitude to something as significant as my completed dissertation.

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समस्ताः लोकाः सुखिनो भन्तु
कः शान्तिः शान्तिः शान्तिः

May all beings in existence be peaceful, happy, and free from suffering.
Om peace peace peace!
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Abstract

Mental health work can result in meaningfulness and satisfaction, but can also result in burnout and secondary traumatic stress from workplace demands and traumatic client stories. The present study investigated whether self-compassion and risk factors identified in the literature could predict secondary traumatic stress and burnout in a local sample of mental health professionals ($N = 98$). The 30-item Professional Quality of Life Scale, Version 5 (Stamm, 2010) and the 12-item Self-Compassion Scale – Short Form (Raes, Pommier, Neff, & Van Gucht, 2011) were administered in an online survey to mental health professionals from a variety of health organizations in the Midwest area. Greater self-compassion predicted statistically significant decreases in secondary traumatic stress and burnout. Less personal trauma history impact also significantly predicted less secondary traumatic stress, but not burnout. Recommendations to decrease compassion fatigue include creating an organizational culture prioritizing self-compassion through education, dialogue, and mindfulness programs.
Self-Compassion and Compassion Fatigue in Mental Health Professionals

Mental health professionals can find meaningfulness and fulfillment, referred to as compassion satisfaction, in their work helping the suffering. However, compassion fatigue, composed of burnout and secondary traumatic stress, can also result from the workplace demands and therapeutic exchanges that characterize mental health work and can significantly lower the professional’s quality of life. Approximately 25% of individuals in helping professions may experience elevated compassion fatigue (Stamm, 2010), with the impact on those affected potentially severe. The provider may experience posttraumatic stress and burnout with symptoms on a cognitive, emotional, somatic, spiritual, and behavioral level (Figley, 1995). These symptoms may also be detrimental to the provider’s personal relationships, relationships with clients and work performance, and to the organization (Stamm, 2010).

Compassion Fatigue

Joinson (1992) first coined the term compassion fatigue in a nursing magazine to describe nurses who were worn down by daily hospital emergencies. Using this recently coined term and building upon previous work regarding various forms of indirect traumatization such as secondary victimization (Figley, 1982), co-victimization (Hartsough & Myers, 1985), secondary survivor (Remer & Elliott, 1988a, 1988b), and vicarious traumatization (McCann & Pearlman, 1990), Figley (1995) broadened the construct of compassion fatigue to include mental health providers. The negative impact caregivers experienced as a result of empathic engagement with clients’ trauma material was the focus of considerable research, with foundational books on vicarious traumatization (Pearlman & Saakvitne, 1995) and secondary traumatic stress (Stamm, 1995) published in the 1990’s. Later, Stamm and Figley (1996) collaborated to further develop the concept of compassion fatigue and scales of measurement. Though the original
conceptualization of compassion fatigue was viewed as synonymous with secondary traumatic stress (Figley, 1995), compassion fatigue was later broadened to include both secondary traumatic stress and burnout (Stamm, 2010), differentiating it from vicarious traumatization (APA, 2013) which emphasizes deeper intrapsychic and interpersonal effects to the clinician (Pearlman & Saakvitne, 1995).

Secondary traumatic stress results from exposure to client’s traumatic material through one’s job as a helper (Figley, 1995; Stamm, 2010). Symptoms of secondary traumatic stress resemble posttraumatic stress symptoms and include re-experiencing the trauma, avoidance/numbing of reminders, and persistent arousal (Figley, 1995), as well as fear, sleep difficulties, and intrusive images (Stamm, 2010).

Burnout, the second component of compassion fatigue (Stamm, 2010), results from overall workplace demands, such as a very high workload or a non-supportive work environment, rather than specifically trauma (Stamm, 2010). Another distinction from secondary traumatic stress is that symptoms of burnout occur gradually rather than abruptly (Figley, 1995). Burnout symptoms may include feelings of exhaustion, frustration, and anger, as well as feeling overwhelmed, hopeless, and depressed (Stamm, 2010). Maslach (1981) described emotional exhaustion from engaging in emotionally demanding situations as “a key aspect of the burnout syndrome” (p. 99).

**Risk and Protective Factors for Developing Compassion Fatigue**

In an effort to identify risk and protective factors for developing compassion fatigue, researchers have investigated a myriad of variables; commonly studied variables include self-care, provider’s personal trauma history, and client exposure (Adams, Figley, & Boscarino,
Although self-care has been widely studied as a potential protective factor for compassion fatigue, a number of studies have found no association between these two variables (Adams et al., 2008; Bober & Regehr, 2006; Estassi, 2009; Ringenbach, 2009). Other researchers have found a significant difference in dimensions of professional satisfaction (e.g., satisfaction with workload, income, and chosen career path) in psychologists who assign greater importance to certain coping strategies and self-care (Stevanovic & Rupert, 2004). However, with regard to compassion fatigue and self-care, the findings have not been robust.

A number of researchers have found associations between secondary traumatic stress and personal trauma history, suggesting trauma history as a risk factor for developing secondary traumatic stress (Adams et al., 2008; Bober & Regehr, 2006; Jenkins & Baird, 2002; Nelson-Gardell & Harris, 2003). Nelson-Gardell and Harris (2003) found that all five scales of the Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998), namely Emotional Abuse, Physical Abuse, Sexual Abuse, Emotional Neglect, and Physical Neglect, correlated significantly with secondary traumatic stress. Jenkins and Baird (2002) found that counselors with trauma history had higher secondary trauma but not burnout scores. Adams et al. (2008) found both burnout and secondary trauma to be associated with personal life events.

Many researchers have also found client exposure, especially to clients with trauma background, linked to compassion fatigue (Adams et al., 2008; Baird & Kracen, 2006; Bober & Regehr, 2006; Craig & Sprang, 2010). Bober and Regehr (2006) found total hours per week spent providing counseling services positively correlated with posttraumatic symptoms and hours per week spent counseling traumatized individuals predicted posttraumatic stress symptoms.
Adams et al. (2008) found greater exposure to clients was associated with higher secondary trauma, but not burnout scores. Craig and Sprang (2010) found that the percentage of clients with posttraumatic stress disorder on the clinician’s caseload predicted both burnout and secondary traumatic stress.

A few researchers have found younger participants to be more at risk for secondary trauma (Bober & Regehr, 2006; Nelson-Gardell & Harris, 2003) and burnout than older participants (Craig & Sprang, 2010), whereas other researchers have detected no associations with age (Adams et al., 2008; Eastwood & Ecklund, 2008; Jenkins & Baird, 2002).

**Self-Compassion**

Drawing from centuries of Buddhist philosophy, Neff (Neff, 2003a, 2003b) defined the term *self-compassion* in the psychological sciences. She described it as extending compassion towards oneself and conceptualized self-compassion as comprised of three components: 1) self-kindness, being kind towards oneself during pain or failure; 2) common humanity, perceiving one’s experiences as part of the shared human experience; and 3) mindfulness, holding thoughts and feelings in balanced awareness rather than over-identifying with them. Self-compassion has been positively correlated with markers of psychological health and negatively correlated with maladaptive patterns and distress (Amrani, 2010; Barnard & Curry, 2012; Ringenbach, 2009; Thompson & Waltz, 2008). Barnard and Curry (2011) found greater self-compassion correlated with greater positive affect, well-being, life satisfaction, happiness, emotional intelligence, mindfulness, social connectedness, and positive self-appraisals, and with decreased negative affect, depression, anxiety, thought suppression, avoidance, rumination, and negative appraisals. Ringenbach (2009) found that self-compassion had a negative correlation with burnout and secondary traumatic stress, when controlling for compassion satisfaction.
Researchers have found greater self-compassion linked to less burnout in samples such as clergy (Barnard & Curry, 2012) and therapists (Amrani, 2010). Thompson and Waltz (2008) discovered that self-compassion was negatively correlated with avoidance symptoms of posttraumatic stress in college students.

**Hypotheses**

Little research exists linking self-compassion with compassion fatigue. The research that does exist, namely the findings that greater self-compassion is correlated with decreased markers of stress, suggests that greater self-compassion might predict less compassion fatigue. However, no study has investigated self-compassion as a predictor variable for compassion fatigue. The purpose of the present study was to predict secondary traumatic stress and burnout as measured by the ProQOL 5 in mental health professionals, based upon the predictor variables of self-compassion, a protective factor measured by the Self-Compassion Scale – Short Form (SCS-SF; Raes et al., 2011), and the risk factors of impact of self-reported personal trauma history, amount of weekly client exposure, and amount of weekly exposure to clients with trauma history. Given the inconsistent findings of the relationship of age to compassion fatigue, age was used as a covariate in the analyses.

It was expected that greater self-compassion and a lesser degree of the risk factors of personal trauma history impact, exposure to clients, and exposure to clients with a trauma history would predict less secondary traumatic stress as measured by the ProQOL 5-STS.

It was also expected that greater self-compassion and a lesser degree of the risk factors of personal trauma history impact, exposure to clients, and exposure to clients with a trauma history would predict less burnout as measured by the ProQOL 5-BO.
Method

Participants

A sample of mental health professionals was recruited from a variety of mental health organizations in a Midwest city. Participants were not offered any incentives other than being provided the information to calculate their compassion fatigue and self-compassion scores after survey completion. Of the 105 initial respondents, four of the respondents were not used as they reported not currently working with at least one client with trauma history, and three of the respondents were not used due to missing responses for an entire study measure. Thus, the total sample size for the present statistical analysis was 98. Although it cannot be determined precisely, participant response rate appeared to be around 22%, based on estimates that the participating organizations had approximately 470 mental health professionals.

The current sample consisted of 23 males (23.5%) and 75 females (76.5%) between the ages of 22 to 75 years, with a mean age of 38.10 years ($SD = 11.16$). The majority of participants were Caucasian (88%). Approximately two-thirds of the sample was employed in either the field of social work (33%) or psychology (32%), followed by the fields of counseling (18%), medicine (8%), and nursing (3%), with 6% identified as “Other.” All participants had a college education, with 14% a Bachelor’s degree, 52% a Master’s degree, and 34% a Doctoral degree. The majority (81%) was licensed within their field of specialization, reported having specialized training working with trauma (65%), and worked primarily in an outpatient (76%) setting. Participants indicated that they had an average of 12 years ($SD = 9.36$) of clinical experience and worked 23 hours a week ($SD = 9.83$) in direct service with clients and 10 hours a week ($SD = 8.52$) in direct service with clients with trauma background, either primarily with children/adolescents (53%) or with adults (47%). Thirty-six percent of participants reported having personal trauma history and
the majority of this group endorsed currently being affected somewhat (86%) by this history. (Demographic information is presented in Table 1).

The current sample resembles national samples of psychologists and social workers in terms of female gender (68–79%) and Caucasian race (84–87%). The current sample as a whole is less experienced (an average of 12 years of clinical experience) than the national sample of social workers who have a median of 16 years of clinical experience (National Association of Social Workers, 2003). The current sample is slightly younger (approximately 38 years old) than the national sample of psychologists and social workers who are, on average, approximately 50 years old (American Psychological Association, 2015; National Association of Social Workers, 2003).

The current study utilizing 98 participants met the requirement for adequate power of .80 to detect a medium effect size of .15 with an alpha of .05 (Cohen, 1992; Faul, Erdfelder, Lang, & Buchner, 2007) for linear multiple regression with five predictor variables.

**Measures**

**Demographic Questionnaire.** An online demographic questionnaire was administered in order to obtain background information, including gender, age, race/ethnicity, educational level, professional field, licensure, years of clinical experience, specialized trauma training, inpatient versus outpatient setting, hours of direct client service per week, hours of direct service to clients with trauma history per week, primary exposure to trauma in children/adolescents versus adults, absence or presence of personal trauma history, and, if relevant, the level of impact of personal trauma history on a scale of 0 (not at all) to 4 (a great deal) (see Appendix A).

**Self-Compassion Scale – Short Form.** To measure self-compassion, the Self-Compassion Scale – Short Form (SCS-SF; Raes et al., 2011) was provided online (see Appendix
The SCS-SF consists of 12 items drawn from the 26-item Self-Compassion Scale (SCS; Neff, 2003b). Statements are ranked on a 5-point Likert-type scale, ranging from 1 (almost never) to 5 (almost always). Total possible scores range from 12-60, and higher scores indicate greater self-compassion. Only a total score was used in the current study because the six subscale scores are less reliable with the short form, ranging from .54 to .75. The total self-compassion score is computed by reverse scoring the items from three of the subscales and then computing a total mean. Although the SCS-SF does not have cut-off values, the mean for a sample of university students was 36 (SD = 7) (Raes et al., 2011).

The SCS-SF has a near perfect correlation with the original SCS when examining total scores, $r = .98$. Internal consistency reliability of the scale as a whole also remains equal to or greater than .86 in the samples tested by the scale creators. In the current study, the Cronbach alpha coefficient was .87, indicating good internal consistency. Confirmatory factor analysis demonstrated that the SCS-SF has the same higher-order factor structure as the SCS with a general higher-order self-compassion factor and six second-order factors relating to the six subscales. Although the psychometrics were mostly studied in undergraduates, this higher-order factor structure was also supported in the Dutch version of the SCS-SF in a sample of 185 Dutch participants with a mean age of 33.04 (SD = 10.60) who were recruited using snowball sampling via e-mail (Raes et al., 2011).

**Professional Quality of Life Scale, Version 5.** To measure compassion fatigue, the secondary traumatic stress and burnout scales of the Professional Quality of Life Scale, Version 5 (ProQOL 5; Stamm, 2010) were provided online (see Appendix C). The ProQOL 5 has 30 statements that are ranked on a 5-point Likert-type scale, ranging from 1 (never) to 5 (very often). There are a total of three subscales: Compassion Satisfaction, Burnout, and Secondary
Traumatic Stress. As relevant to the hypotheses, only the scores from the Secondary Traumatic Stress and Burnout subscales were used for the regressions. The subscale scores do not yield a composite score; thus separate regressions were computed for secondary traumatic stress and burnout. Each of the subscales has 10 items that are added together, with some items reverse scored, to yield the raw score for that subscale. Beginning with the ProQOL 5 version, the authors introduced the use of standard T-scores as part of the scoring process, to allow for comparisons between prior versions of the test after scores have been converted into T-scores and between the subscales of Compassion Satisfaction, Burnout, and Secondary Traumatic Stress. Norms at the 25th and 75th percentiles for the subscales are used to group the subscale scores into “Low,” “Average,” and “High” levels.

The ProQOL was developed from the reported results of over 1000 participants obtained over the course of multiple studies. The authors note that there is good construct validity supported by over 200 published papers. The three subscales reportedly measure separate constructs. Although there is shared variance of .34 between the Secondary Traumatic and Burnout scales due to both subscales capturing distress and negative affect, the authors emphasize that the two scales are distinct theoretically, with secondary traumatic stress additionally capturing fear (Stamm, 2010).

The scales have adequate internal consistency reliability. The alpha scale reliabilities of the Burnout, Secondary Traumatic Stress, and Compassion Satisfaction scales are reportedly .75, .81, and .88, respectively (Stamm, 2010), and, in the current study, they were .80, .87, and .89, respectively.
Procedure

Approval was obtained from Xavier University’s Institutional Review Board (IRB, see Appendix D) prior to data collection. Four of the participating organizations had their own respective IRBs but indicated that Xavier IRB approval would be sufficient, without further IRB approval required from their organizations. The remaining four organizations without IRBs approved the study through their research division or the relevant organizational representative.

The principal investigator initially surveyed five mental health organizations in a Midwest city, chosen to represent a variety of settings (outpatient/inpatient, private practice, university center, hospital, community mental health, school-based), populations served (children and adults), and professional fields. The principal investigator e-mailed the relevant organizational representatives requesting that they forward the e-mail provided to them by the investigator to the mental health professionals in their organization. The e-mail to the mental health professionals explained the study and included the Informed Consent Form, inclusionary criteria (at least 18 years old, some college education, and currently working with at least one client with trauma history), and the hyperlink to the online survey study on Qualtrics.

Due to an initial insufficient response rate, the principal investigator sent a reminder message to the organizational representatives to e-mail the study to potential participants. Also three additional organizations were contacted and included in the data collection for a final total of eight organizations surveyed. Participation was anonymous, and IP addresses were not tracked on Qualtrics.

Participants completed the online survey consisting of the Demographic Questionnaire, the SFS-SF, and the ProQOL 5. The Demographic Questionnaire was administered first. The SFS-SF and the ProQOL 5 were counterbalanced to control for possible order effects. After
participants completed the survey, they were shown a debriefing message and, for those participants interested in their scores, links were provided for self-score instructions of the ProQOL 5 and SFS-SF.

Results

The purpose of the present study was to predict the component factors of compassion fatigue, namely, secondary traumatic stress and burnout, in mental health professionals. The predictor variables included self-compassion and the risk factors of the impact of personal trauma history, amount of weekly client exposure, and amount of weekly exposure to clients with trauma history. Age served as a covariate in the study in order to account for the effects of this demographic variable which some studies had shown correlated with compassion fatigue.

For the Secondary Traumatic Stress and Burnout scales, raw scores were converted into T-scores ($M = 50$, $SD = 10$) based on the procedures outlined in the ProQOL 5 manual, and all statistical analyses were conducted using the T-scores. The means and standard deviations of the study variables are presented in Table 2.

The assumptions for conducting a multivariate regression regarding multicolinearity, outliers, normality, linearity, and homoscedasticity were met. In order to test the study hypotheses, separate hierarchical multiple regressions were conducted for secondary traumatic stress and burnout, using predictors of self-compassion and the four risk factors (impact of personal trauma history, hours of weekly direct service, and hours of weekly direct service to clients with trauma background), and controlling for the influence of age. Age was entered at Step 1 and, because there was no theoretical reason to enter the predictor variables in a particular order after controlling for age, the remaining predictor variables were entered simultaneously at Step 2. The analyses were computed using an alpha level of .05.
The first clinical hypothesis stated: It is expected that greater self-compassion and a lesser degree of the risk factors of personal trauma history impact, exposure to clients, and exposure to clients with a trauma history will predict less secondary traumatic stress as measured by the ProQOL 5-STS. Age was entered at Step 1 of the hierarchical regression, but this model was not significant and only accounted for .5% of the variance in secondary traumatic stress. After entry of the remaining predictor variables at Step 2, the combination of predictors was statistically significant and accounted for 34% of the variance in secondary traumatic stress, $F(5, 92) = 9.46, p < .001, R^2 = .34$. At Step 2, both self-compassion ($p < .001$) and personal trauma history impact ($p = .001$) were significant contributors to the model of secondary traumatic stress, with greater self-compassion and less personal trauma history impact predicting less secondary traumatic stress (see Table 3).

The second clinical hypothesis stated: It is expected that greater self-compassion and a lesser degree of the risk factors of personal trauma history impact, exposure to clients, and exposure to clients with a trauma history will predict less burnout as measured by the ProQOL 5-BO. A second hierarchical multiple regression was computed to determine the relationship between the predictor variables and burnout. Age was entered as a covariate at Step 1 and was significantly negatively correlated with burnout, accounting for 7% of the variance in burnout. At Step 2, the combination of predictors was statistically significant and accounted for 37% of the variance in burnout, $F(5, 92) = 10.69, p < .001, R^2 = .37$. The predictor variables explained an additional 30% of the variance in burnout, after controlling for age ($p < .001$). In the final model, self-compassion ($p < .001$) was the only significant contributor to the model, with greater self-compassion predicting less burnout (see Table 4).

In summary, both models of secondary traumatic stress and burnout were significant at
Self-compassion was found to be a significant individual contributor in both models ($p < .001$) in the predicted direction (i.e., greater self-compassion predicted less secondary traumatic stress and burnout). Less impact of personal trauma history also predicted less secondary traumatic stress.

A Pearson correlational matrix was completed to examine the correlations among study variables, including secondary traumatic stress, burnout, compassion satisfaction, self-compassion, age, years of clinical experience, hours of direct service, and hours of direct trauma service (see Table 5). Self-compassion was significantly correlated with all three ProQOL 5 subscales, and these correlations were moderate to large. Personal trauma history impact was significantly negatively correlated with self-compassion, $r(96) = -.23, p = .02$, and positively correlated with secondary traumatic stress, $r(96) = .40, p < .001$, and burnout, $r(96) = .22, p = .02$. Age and years of clinical experience were significantly positively correlated with self-compassion, $r(96) = .29, p = .004$; $r(96) = .23, p = .02$, respectively, and significantly negatively correlated with burnout, $r(96) = -.27, p < .001$; $r(96) = -.22, p = .03$, respectively.

**Post-hoc Analyses**

In order to understand the degree to which mental health professionals in the sample were experiencing secondary traumatic stress and burnout as measured by the ProQOL 5, subscale $T$-scores were categorized based on the cut-offs of 43 or below and 57 or above corresponding to the 25th and 75th percentiles, respectively, as described in the ProQOL 5 manual (Stamm, 2010). Of the mental health professionals, 21% scored “High” for secondary traumatic stress and 22% scored “High” for burnout. Overall, the distribution of scores was approximately similar to that of the normative sample utilized to create the cut-offs, with approximately 25% in the “Low” and “High” categories and 50% in the “Average” category. (Stamm, 2010) (see Table 6 for
percentages of the study sample that fell into varied compassion fatigue risk and protective levels).

Due to unequal sample sizes, as well as less than adequate power to examine mean differences between demographic groups from the demographic questionnaire for secondary traumatic stress, burnout, and compassion satisfaction, independent t-tests and ANOVAs were not conducted.

**Discussion**

The purpose of the present study was to predict secondary traumatic stress and burnout in mental health professionals based on self-compassion and risk factors, including impact of personal trauma history, amount of weekly client exposure, and amount of weekly exposure to clients with trauma history, with age serving as a covariate. Because no study had investigated self-compassion as a predictor variable for compassion fatigue, the researcher was especially interested in whether greater self-compassion would predict less compassion fatigue.

Both of the study hypotheses were supported, as it was found that the combination of predictors, including age, personal trauma history impact, client exposure, exposure to clients with trauma background, and self-compassion, significantly predicted secondary traumatic stress and burnout beyond the influence of age. Self-compassion was a significant contributor in both models, with greater self-compassion predicting less secondary traumatic stress and less burnout. Additionally, less personal trauma history impact significantly predicted less secondary traumatic stress, but not burnout.

Among the subscales of the ProQOL 5, secondary traumatic stress and burnout were significantly positively correlated, \( r(96) = .53 \). In the ProQOL 5 manual, Stamm (2010) noted a similar correlation of \( r = .58 \) between secondary traumatic stress and burnout due to both
subscales capturing distress and negative affect, but emphasized that the two scales were distinct theoretically, with secondary traumatic stress additionally capturing fear.

Although the current study found significant correlations between the impact of personal trauma history and both secondary traumatic stress and burnout, the results of the regressions support that individuals with personal trauma history may be particularly vulnerable to the secondary traumatic stress component of compassion fatigue but not to burnout. This finding makes conceptual sense given that secondary traumatic stress, but not burnout, so closely mirrors posttraumatic stress disorder that may result from unresolved personal trauma history. Figley (1995) conceptualized personal trauma history as being evoked by exposure to clients’ trauma and exacerbating secondary traumatic stress. In line with the idea that personal trauma history may exacerbate secondary traumatic stress, Jenkins and Baird (2002) found that counselors with interpersonal trauma histories scored higher on the secondary trauma subscale, but not the burnout subscale of the Compassion Fatigue Self-Test. Jenkins and Baird (2002) found trauma history to be more prevalent than in the current study. They found that 55% of mental health workers reported a sexual assault or domestic violence history compared to the 36% in the current study who reported trauma history.

In the current study, exposure to clients was measured in terms of weekly hours of direct service and weekly hours of direct service to clients with trauma background. Clinicians worked an average of 23 hours a week in direct service with clients and 10 hours a week in direct service with clients with trauma background, meaning that, on average, 44% of their direct service time was spent with clients with trauma background. Surprisingly and contrary to the literature (Adams et al., 2008; Baird & Kracen, 2006; Bober & Regehr, 2006; Craig & Sprang, 2010), the amount of weekly client exposure and the amount of weekly exposure to clients with trauma
history were not found to be significant predictors of either the secondary traumatic stress or burnout components of compassion fatigue. One way of understanding this discrepant finding is that client exposure and compassion fatigue, including the components of secondary traumatic stress and burnout, were assessed differently in this study as compared to past research. Bober and Regher (2006) investigated only the secondary traumatic stress component of compassion fatigue. These authors measured client exposure based on hours per week consistent with the current study, but utilized the Impact of Event Scale (Zilberg, Weiss, & Horowitz, 1982) as compared to the ProQOL 5-STS used in the current study to measure secondary traumatic stress. Craig and Sprang (2010) utilized an earlier version of the ProQOL (Stamm, 2005) than was used in the current study but they measured exposure to clients with trauma history based on the percentage of clients with PTSD on the mental health worker’s caseload. In addition to these possible measurement discrepancies, the current study asked participants to indicate how many hours a week they spent in direct service with clients with trauma background, not more precisely with the amount of active exposure to clients’ sharing of their trauma. Because, by definition, the experience of secondary trauma occurs after the provider’s exposure to client’s trauma, future research may want to more specifically capture the provider’s amount of active exposure to secondary trauma when working with clients. Future research might also investigate other client factors which could add to the strain leading to burnout, such as treating more severe personality disorders, greater suicidal or homicidal risk, and case management issues.

Although the covariate of age was not a significant predictor for either secondary traumatic stress or burnout in the final models of the current study, age and years of clinical experience were significantly positively correlated with self-compassion and negatively correlated with burnout, such that as age and years of clinical experience increased, self-
compassion increased and burnout decreased. These findings add to other investigations linking younger age to greater burnout (Craig & Sprang, 2010) and secondary traumatic stress (Bober & Regehr, 2006; Nelson-Gardell & Harris, 2003). Perhaps as workers mature, the greater life experience and perspective acquired lead to greater self-compassion and also protect against burnout. Alternatively, those who had more compassion fatigue at a younger age may have left the field, and the ones still working may have had greater self-compassion or coping all along. Future research could investigate the factors that lead to less self-compassion and greater burnout in younger, more inexperienced practitioners, such as students, interns, and early career professionals.

The distribution of secondary traumatic stress, burnout, and compassion satisfaction scores was similar to the scale’s normative sample, which includes over 1000 participants in the helping professions obtained over the course of multiple studies, suggesting generalizability of the study sample. The ProQOL scale was normed such that about one in four professionals obtain elevated scores for secondary traumatic stress and burnout. In the current study, about one in four to five mental health professionals obtained elevated scores for secondary traumatic stress and burnout. These results support that, statistically, compassion fatigue is not a particular vulnerability for mental health workers as a group. However, for those 20-25% of providers who are suffering from compassion fatigue, their symptoms present a clinical concern for both the provider who is engaged, on average, in 23 hours of direct service each week and the clients who are in treatment with these providers.

Similarly, current demographic data suggest that personal trauma history is not uncommon in mental health workers. Over one-third of the sample endorsed personal trauma history, with most (86%) endorsing currently being somewhat affected by this history. Previous
research (Ringenbach, 2009) found even greater rates of reporting, with 50% of mental health workers endorsing the question “Do you have trauma in your personal history? (yes / no).” The current rate of reporting may have been impacted by the use of the more specific operational definition of trauma provided in the *Diagnostic and Statistical Manual of Mental Disorders-5* (5th edition, American Psychiatric Association [APA] 2013). In the current study, based on the DSM-5, the Demographic Questionnaire noted that trauma could include direct or witnessed trauma or exposure from learning the trauma happened to loved ones, and participants were provided examples of what constitutes trauma. However, Ringenbach’s (2009) study was completed prior to the publication of the DSM-5 and did not operationalize the term “trauma,” which may have pulled for a broader understanding of trauma history in the respondents. Future research should be aware of potential reporting differences based on the extent to which “trauma” is operationalized.

Although the self-compassion scale does not have clinical cut-offs, the mental health workers sampled in the current study scored slightly higher ($M = 40.28$, $SD = 8.01$), but within one standard deviation of the mean of the undergraduate sample ($M = 36.00$, $SD = 7.33$) utilized by the scale creators (Raes et al., 2011).

The findings of the current study support that one’s attitude towards the self, when more self-compassionate, significantly predicts less secondary traumatic stress and burnout. Some scholars have conceptualized self-compassion as an adaptive coping strategy to stress (Allen & Leary, 2010; Neff, 2003a). Based on Neff’s (2003a) conceptualization of self-compassion as including self-kindness, common humanity, and mindfulness, self-compassion may create the psychological space for mental health professionals to be kind to themselves during pain or failure, to perceive their experiences as part of the shared human experience, and to mindfully
hold thoughts and feelings in balanced awareness rather than over-identifying with them. This more accepting attitude may allow mental health professionals to respond more adaptively to work stressors, such as challenging client material and workplace demands (Patsiopoulos & Buchanan, 2011) and thereby decrease compassion fatigue. Future research utilizing the long form of the Self-Compassion Scale could yield information about the particular components of self-compassion, including self-kindness, common humanity, and mindfulness, that may be related to decreased compassion fatigue and increased compassion satisfaction.

The current study accounted for 34% of the variance in secondary traumatic stress and 37% of the variance in burnout. Although the models produced for each of these two factors were robust and statistically significant, there is still room left to uncover additional factors that may account for the unexplained variance. Such factors could include type of organizational setting, the balance of work demands and resources, and the amount of clinical experience, educational level, and specialized trauma training of the provider. Based on the literature review, the author chose the risk factors with the most pervasive evidence to investigate as predictor variables, including degree of personal trauma history, amount of client exposure, and amount of exposure to clients with trauma history. Future research with a greater sample size could investigate additional variables as predictors of compassion fatigue.

**Limitations**

The results of this study should be considered in light of its limitations. First, this study relied exclusively on self-report measures, which are subject to biases. However, the anonymous nature of the surveys may have aided in safeguarding against a more favorable presentation by professionals. The distribution of compassion fatigue and self-compassion scores were also
comparable to the normative samples, supporting that the sample self-reported in a balanced manner.

Second, based on the literature, a 27% response rate was expected and identified as conservative (Adams et al., 2008; Craig & Sprang, 2010). The somewhat lower than expected response rate estimated at 22% may limit generalizability.

The characteristics of the sample, mental health workers from the Midwest area who were primarily Caucasian women working in the fields of social work or psychology, may also limit generalizability to other geographical, racial, gender, or professional groups. However, although certain groups may have been largely underrepresented in the study sample, the current sample resembles the national sample of social workers (National Association of Social Workers, 2003) and psychologists (American Psychological Association, 2015) in terms of gender and race. These fields are largely comprised of Caucasian (84-87%) and female (68-79%) treatment providers. The distribution of secondary traumatic stress and burnout scores in the current study also closely resembles that of the normative sample drawn from over 1000 cases from multiple studies, suggesting generalizability (Stamm, 2010).

Third, although the sample size yielded adequate power to test the study hypotheses through regression analyses, a larger sample size would have enabled the researcher to conduct post-hoc analyses, such as comparing mean differences between groups, with at least .80 power.

Clinical Implications

One major contribution of this study is that it is an applied study with professionals in the field who have maturity, considerable training, and clinical experience. The results of the current study suggest that taking steps to increase self-compassion may decrease both secondary traumatic stress and burnout in mental health professionals, while taking steps to decrease the
impact of personal trauma history may decrease the secondary traumatic stress component of compassion fatigue. Unlike other variables investigated in the literature, which may include organizational demands such as size of client load, especially involving clients with a trauma history, or demographic variables like age, developing the protective factor of self-compassion has tremendous potential to lead to positive outcomes. Organizations could create a culture that promotes self-compassion through education, practice, and dialogue about self-compassion and self-care. Based on the current findings indicating relationships between younger age and greater burnout and less self-compassion, organizations with students, interns, and early career professionals, as well as graduate schools, should consider creating a climate that promotes protective factors related to compassion fatigue. Mindfulness programs, such as mindfulness-based stress reduction (MBSR), could also be utilized, because recent research suggests that such mindfulness interventions are associated with increased self-compassion, among other benefits (Birnie, Speca, & Carlson, 2010; Boellinghaus, Jones, & Hutton, 2014; Felton, Coates, & Christopher, 2013; Roeser et al., 2013; Shapiro, Astin, Bishop, & Cordova, 2005; Shapiro, Brown, & Biegel, 2007). Practicing self-compassion and attending to personal trauma lead to a culture of balance in which mental health professionals are more able to optimally care for themselves and thus more healthfully for others over the course of their career.
References


Estassi, N. E. (2009). *Self-care practices of therapists in avoiding burnout and vicarious traumatization while working with families who have been exposed to violence* (Doctoral dissertation). Available from ProQuest Dissertations & Theses Full Text. (UMI No. 3360667.)


National Association of Social Workers. (2003). *Demographics of social workers*  


Table 1

*Demographics and Descriptive Statistics for the Provider Sample*

<table>
<thead>
<tr>
<th>Demographic Variable</th>
<th>Study Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(N = 98) (%)</td>
</tr>
<tr>
<td>Professional field</td>
<td></td>
</tr>
<tr>
<td>Counseling</td>
<td>18 (18.4)</td>
</tr>
<tr>
<td>Medicine</td>
<td>8 (8.2)</td>
</tr>
<tr>
<td>Nursing</td>
<td>3 (3.1)</td>
</tr>
<tr>
<td>Psychology</td>
<td>31 (31.6)</td>
</tr>
<tr>
<td>Social Work</td>
<td>32 (32.7)</td>
</tr>
<tr>
<td>Other</td>
<td>6 (6.1)</td>
</tr>
<tr>
<td>Education</td>
<td></td>
</tr>
<tr>
<td>Bachelor’s degree</td>
<td>14 (14.3)</td>
</tr>
<tr>
<td>Master’s degree</td>
<td>51 (52.0)</td>
</tr>
<tr>
<td>Doctoral degree</td>
<td>33 (33.7)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>23 (23.5)</td>
</tr>
<tr>
<td>Female</td>
<td>75 (76.5)</td>
</tr>
<tr>
<td>Age in years</td>
<td>Range</td>
</tr>
<tr>
<td></td>
<td>22-75</td>
</tr>
<tr>
<td></td>
<td>M (SD)</td>
</tr>
<tr>
<td></td>
<td>38.10 (11.16)</td>
</tr>
</tbody>
</table>
Table 2

*Means and Standard Deviations for Study Variables*

<table>
<thead>
<tr>
<th>Study Variables</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age in years</td>
<td>38.10</td>
<td>11.16</td>
</tr>
<tr>
<td>Hours of Direct Service</td>
<td>23.27</td>
<td>9.83</td>
</tr>
<tr>
<td>Hours of Direct Trauma Service</td>
<td>10.23</td>
<td>8.52</td>
</tr>
<tr>
<td>Personal Trauma History Impact</td>
<td>0.71</td>
<td>1.01</td>
</tr>
<tr>
<td>Personal Trauma History Impact*</td>
<td>2.00</td>
<td>.49</td>
</tr>
<tr>
<td>Self-Compassion</td>
<td>40.28</td>
<td>8.01</td>
</tr>
<tr>
<td>Secondary Traumatic Stress T-score</td>
<td>50.00</td>
<td>10.00</td>
</tr>
<tr>
<td>Burnout T-score</td>
<td>50.00</td>
<td>10.00</td>
</tr>
</tbody>
</table>

Note: For all ProQOL subscales based on T-scores, \( M = 50 \) and \( SD = 10 \).

*\( n = 35 \) or only those participants who endorsed having personal trauma history.*
Table 3

**Hierarchical Regression Analysis for Secondary Traumatic Stress**

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>-.06</td>
<td>.09</td>
<td>-.07</td>
</tr>
<tr>
<td><strong>Step 2</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>.08</td>
<td>.08</td>
<td>.09</td>
</tr>
<tr>
<td>Hours of Direct Service</td>
<td>-.02</td>
<td>.10</td>
<td>-.02</td>
</tr>
<tr>
<td>Hours of Direct Trauma Service</td>
<td>.11</td>
<td>.11</td>
<td>.10</td>
</tr>
<tr>
<td>Personal Trauma History Impact</td>
<td>2.87</td>
<td>.87</td>
<td>.29**</td>
</tr>
<tr>
<td>Self-Compassion</td>
<td>-.56</td>
<td>.11</td>
<td>-.45***</td>
</tr>
</tbody>
</table>

$R^2 = .34$

Note: $R^2 = .005$ for Step 1 (ns); $\Delta R^2 = .34$ for Step 2 ($p < .001$)

** $p < .01$, *** $p < .001$. 

**
Table 4

*Hierarchical Regression Analysis for Burnout*

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>-.24</td>
<td>.09</td>
<td>-.27**</td>
</tr>
<tr>
<td><strong>Step 2</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>-.10</td>
<td>.08</td>
<td>-.11</td>
</tr>
<tr>
<td>Hours of Direct Service</td>
<td>-.02</td>
<td>.10</td>
<td>-.02</td>
</tr>
<tr>
<td>Hours of Direct Trauma Service</td>
<td>.01</td>
<td>.11</td>
<td>.01</td>
</tr>
<tr>
<td>Personal Trauma History</td>
<td>.95</td>
<td>.85</td>
<td>.10</td>
</tr>
<tr>
<td><strong>Impact</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Compassion</td>
<td>-.67</td>
<td>.11</td>
<td>-.54***</td>
</tr>
</tbody>
</table>

\[ R^2 = .37 \]

Note: \( R^2 = .07 \) for Step 1 (\( p = .007 \)); \( \Delta R^2 = .30 \) for Step 2 (\( p < .001 \))

** \( p < .01 \), *** \( p < .001 \)
Table 5

*Pearson Correlational Matrix for Study and Demographic Variables*

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Secondary Traumatic Stress</td>
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<td></td>
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<tr>
<td>2. Burnout</td>
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<tr>
<td>3. Compassion Satisfaction</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>4. Self-Compassion</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>5. Age</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Years of Clinical Experience</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>7. Hours of Direct Service</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Hours of Direct Trauma Service</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Personal Trauma History Impact</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: *p < .05, ** p < .01.
Table 6

*Post-hoc Analyses of Compassion Fatigue Risk and Protective Level Distribution*

<table>
<thead>
<tr>
<th>ProQOL-5 Factors</th>
<th>Low %</th>
<th>M</th>
<th>Average %</th>
<th>M</th>
<th>High %</th>
<th>M</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secondary Traumatic Stress</td>
<td>32.7</td>
<td>41 (n = 32)</td>
<td>45.9</td>
<td>49 (n = 45)</td>
<td>21.4</td>
<td>66 (n = 21)</td>
</tr>
<tr>
<td>Burnout</td>
<td>30.6</td>
<td>39 (n = 30)</td>
<td>46.9</td>
<td>50 (n = 46)</td>
<td>22.4</td>
<td>64 (n = 22)</td>
</tr>
<tr>
<td>Compassion Satisfaction</td>
<td>24.5</td>
<td>36 (n = 24)</td>
<td>50.0</td>
<td>51 (n = 49)</td>
<td>25.5</td>
<td>62 (n = 25)</td>
</tr>
</tbody>
</table>

Note: For all ProQOL subscales based on T-score, $M = 50$ and $SD = 10$. Cut-off scores of $\leq 43$ and $\geq 57$ were determined by the ProQOL 5 manual (Stamm, 2010), using the 25th and 75th percentiles.
Appendix A

Demographic Questionnaire

1. Gender:
   a. Male
   b. Female
   c. Transgender
   d. Prefer not to respond

2. Age: ___

3. Race/Ethnicity:
   a. African American
   b. Hispanic
   c. Asian
   d. Caucasian
   e. Native American
   f. Multiracial/multi-ethnic
   g. Other________________________
   h. Prefer not to respond

4. Please indicate your highest level of education:
   a. High school graduate
   b. Some college
   c. Bachelor’s degree
   d. Master’s degree
   e. Doctoral degree
5. Please indicate your professional field:
   a. Counseling
   b. Education
   c. Medicine
   d. Nursing
   e. Psychology
   f. Social Work
   g. Other. Please indicate: _____________________

6. Are you licensed in your professional field?
   a. Yes
   b. No
   c. Licensure not required

7. Approximately how many years of clinical experience do you have (including supervised experience gained during training)? ________

8. Have you had specialized training working with trauma?
   a. Yes
   b. No

9. Would you consider your practice primarily inpatient or outpatient?
   a. Inpatient
   b. Outpatient

10. Approximately how many hours a week do you currently spend in direct service with clients? ________________

11. According to the *DSM-5* (APA, 2013):
1) Direct trauma exposure includes but is not limited to physical assault or abuse, sexual violence, exposure to war, torture, being kidnapped, natural or human-made disasters, or severe motor vehicle accidents.

2) Witnessed trauma exposure includes but is not limited to observing threatened or serious injury, unnatural death, physical or sexual abuse of another person due to violent assault, domestic violence, accident, or war or disaster.

3) If the trauma exposure occurred through learning that the trauma happened to close family or friends, the event must be of a violent or accidental nature such as violent personal assault, suicide, serious accident, or serious injury.

Using the above definition of trauma, approximately how many hours a week do you currently spend in direct service with clients with trauma background?

_____________________

12. Is your work with clients with trauma background mostly with children/adolescents or adults?
   a. Children/adolescents
   b. Adults

13. Would you describe yourself as having personal trauma history, as described in Question 11 above, excluding exposure to client material?
   a. Yes
   b. No

14. If you answered “Yes” to the previous question, to what extent does the trauma currently affect you?
   a. Not at all
b. Somewhat

c. A fair amount

d. A great deal
Appendix B

**Self-Compassion Scale – Short Form**

The Self-Compassion Scale – Short Form (SCS-SF; Raes, Pommier, Neff, & Van Gucht, 2011) is not reproduced in this document. The measure can be downloaded through Dr. Kristin Neff’s website at http://self-compassion.org.
Appendix C

**Professional Quality of Life Scale, Version 5**

The Professional Quality of Life Scale, Version 5 (ProQOL 5; Stamm, 2010) is not reproduced in this document. The measure can be downloaded through the official ProQOL website at http://www.proqol.org.
Appendix D

IRB Approval Letter

July 27, 2015

Pooja Amatya
c/o Christine Dacey
ML 6511

Re: Protocol #15-002, Self-Compassion and Compassion Fatigue in Mental Health Professionals

Dear Ms. Amatya:

The IRB has reviewed the materials regarding your study, referenced above, and has determined that it meets the criteria for the Exempt from Review category under Federal Regulation 45CFR46. Your protocol is approved as exempt research, and therefore requires no further oversight by the IRB. We appreciate your thorough treatment of the issues raised and your timely response.

If you wish to modify your study, including the addition of data collection sites, it will be necessary to obtain IRB approval prior to implementing the modification. If any adverse events occur, please notify the IRB immediately.

Please contact our office if you have any questions. We wish you success with your project!

Sincerely,

Morell E. Mullins, Jr., Ph.D.
Chair, Institutional Review Board
Xavier University

MEM/sb
Summary

Title: Self-Compassion and Compassion Fatigue in Mental Health Professionals

Problem. More research is needed on protective factors for compassion fatigue. It is estimated that approximately 25% of mental health workers experience elevated compassion fatigue, which includes secondary traumatic stress from exposure to clients’ traumatic material and burnout from workplace demands (Stamm, 2010). The impact on such professionals who are affected can be severe; these providers can experience posttraumatic stress symptoms and emotional exhaustion which negatively impact their work performance and relationships with loved ones, clients, and the organization (Figley, 1995; Stamm, 2010). The most widely studied protective factor, self-care, has not led to conclusive findings (Adams et al., 2008; Bober & Regehr, 2006; Estassi, 2009; Ringenbach, 2009). Although little research exists linking self-compassion and compassion fatigue, the research that does exist suggests that greater self-compassion predicts less compassion fatigue (Ringenbach, 2009). The purpose of the present study was to investigate whether self-compassion and risk factors identified in the literature, including impact of personal trauma history, amount of weekly client exposure, and amount of weekly exposure to clients with trauma history, predicted secondary traumatic stress and burnout, after controlling for the influence of age.

Method. Participants were 98 mental health professionals from a variety of organizations in the Midwest area. They were administered a demographic questionnaire, the 30-item Professional Quality of Life Scale, Version 5 (Stamm, 2010) measuring compassion fatigue, and the 12-item Self-Compassion Scale – Short Form (Raes et al., 2011) in an anonymous, online survey. Participants had a mean age of 38.10 years ($SD = 11.16$ years) and an average of 12 years of clinical experience ($SD = 9.36$). The participants identified as belonging to the fields of social
work (32.7%), psychology (31.6%), counseling (18.4%), nursing (3.1%), medicine (8.2%), or other (6.1%).

Findings. Separate hierarchical multiple regressions were conducted for secondary traumatic stress and burnout using the predictors of self-compassion and the four risk factors of impact of personal trauma history, hours of weekly direct service, and hours of weekly direct service to clients with trauma background, with age as a covariate. In order to control for the influence of age, age was entered at Step 1, and the remaining predictor variables were entered at Step 2. The combination of predictors, namely self-compassion and personal trauma history, was statistically significant for secondary traumatic stress, $F(5, 92) = 9.46, p < .001, R^2 = .34$. Self-compassion alone was statistically significant for burnout, $F(5, 92) = 10.69, p < .001, R^2 = .37$. Greater self-compassion predicted statistically significant decreases in secondary traumatic stress ($B = -.56, p < .001$) and burnout ($B = -.67, p < .001$). Less personal trauma history impact also significantly predicted less secondary traumatic stress ($B = 2.87, p = .001$), but not burnout. Surprisingly, client exposure and client exposure to clients with trauma history were not found to be significant predictors. Younger age, $r(96) = -.27, p < .001$, and less clinical experience, $r(96) = -.22, p = .032$, were correlated with greater burnout but did not serve as significant predictors.

Implications. The results of the current study suggest that taking steps to increase self-compassion and decrease the impact of personal trauma may decrease secondary traumatic stress in mental health professionals. Individuals with less self-compassion who are younger and less experienced may be particularly vulnerable to burnout. Based on the current results, it is recommended that organizations and individuals prioritize practicing self-compassion in order to decrease the negative consequences of compassion fatigue. Education and dialogue on self-
compassion (Patsiopoulos & Buchanan, 2011) and mindfulness interventions (Birnie et al., 2010; Boellinghaus et al., 2014; Felton et al., 2013; Roeser et al., 2013; Shapiro et al., 2005, 2007) could be utilized to create a culture of self-compassion.
Press Release

Mental health workers can experience positive and negative consequences related to their clinical work. Negative consequences include burnout or emotional exhaustion from workplace demands, and secondary traumatic stress or stress from being exposed to clients’ traumatic stories. The current study investigated whether self-compassion and risk factors identified in the literature predict burnout and secondary traumatic stress in mental health professionals after controlling for the influence of age. Results from the study indicated that greater self-compassion predicted statistically significant decreases in secondary traumatic stress and burnout; less personal trauma history impact also significantly predicted less secondary traumatic stress, but not burnout. It is recommended that organizations and individuals prioritize incorporating self-compassion in order to decrease the negative consequences of secondary traumatic stress and burnout.