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COMPASSION FATIGUE, SECONDARY TRAUMA STRESS, AND BURNOUT
AMONG LICENSED MENTAL HEALTH PROFESSIONALS

by

Kyle Lee Thompson

Dissertation

Submitted to the Faculty of

Olivet Nazarene University

School of Graduate and Continuing Studies

in Partial Fulfillment of the Requirements for

the Degree of

Doctor of Education

in

Ethical Leadership

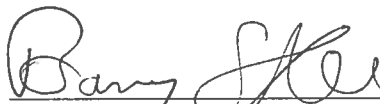
May 2017

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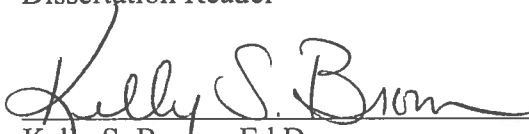
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DEDICATION

“I can do all things through Christ who strengthens me.” Philippians 4:13

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To my dad, Jack Lee Thompson, for without your example, support, and encouragement my life would be a lot different. I know you would be so proud of this moment in my life. I miss you, but I can still hear you cheering me on.

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“I know what I’m doing, I have it all planned out – plans to take care of you, not abandon you, plans to give you the future you hope for. When you call on me, when you come and pray to me, I’ll listen. When you come looking for me, you’ll find me. Yes, when you get serious about finding me and want it more than anything else, I’ll make sure you won’t be disappointed” Jeremiah 29:11-13 (The Message)

ABSTRACT

This quantitative research explored the presence of compassion fatigue (CF) and burnout (BO), and examined predictors that might include or exclude traumatic stress with the purpose of examining the levels of CF, secondary trauma stress (STS), BO, and use of career-sustaining behaviors (CSB) among licensed mental health professionals in order to improve the well-being of clinicians. This research sought to find the presence of CF, STS, and BO with descriptive analyses, and risk factors that appear predictive of these phenomena using regression analyses, and Pearson Product Moment Correlations to determine relationships between career-sustaining behaviors, the three phenomena, and the working lives of 37 licensed mental health professionals. The instruments used were the Professional Quality of Life Scale, the Burnout Measure, the Career-sustaining Behaviors Questionnaire, and a demographic questionnaire. Of the predictors investigated, both using more consultation ($\beta = .77$, $t(14) = 2.48$, $p < .05$) and developing new interests in work ($\beta = -.59$, $t(14) = -2.42$, $p < .05$) were statistically significant. There is a significant positive relationship between not being responsible to solve client problems and burnout, $r(35) = .462$, $p < .01$. Burnout appeared the most prevalent of the phenomena for the participants of the study. Future research could emphasize encouraging psychotherapists in their work by exploring the positive aspects of providing psychological help. Feeling pressure to serve can overwhelm helping professionals and inhibit their competent help. The researcher recommends that service providers be with other professionals, connecting, and sharing both triumphs and defeats.

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CHAPTER I

INTRODUCTION

Licensed mental health professionals can provide hundreds of hours of services to clientele and possibly be completely unaware of the impact such work has on their own personal lives. Merely listening to the hurts of clientele might lead the professional into personal struggles such as sleep disturbances, loss of focus with family, and overall fatigue. However, without the caring, empathic, compassionate mental health professional listening to the hurt, many people suffering from emotional, physical, and even spiritual disturbances would go untreated. Therefore, it is important for mental health workers to recognize the pitfalls or hazards that they may encounter during their work. These professionals are at risk for developing psychological disturbances such as compassion fatigue, secondary trauma stress, and burnout. Figley (1995) described compassion fatigue as stress resulting from aiding or desiring to aid a traumatized person. Secondary trauma stress occurs from the result of indirect exposure to another person's traumatic experiences (Figley 1995; McCann & Pearlman, 1990; Thomas & Wilson 2004). Pines and Aronson (1988) recognized burnout as "a state of physical, emotional, and mental exhaustion caused by a long-term involvement in situations that are emotionally demanding" (p. 9).

According to Stamm (2002), "Compassion is feeling and acting with deep empathy and sorrow for those who suffer" (p. 107). Mental health professionals possessing the skills of compassion and empathy will tend to be workers that are more

effective than those who lack in these skill areas (Bowen & Moore, 2014). Given the importance of compassion in the mental health field, instinctively improving the delivery of this skill will benefit clients. While compassion benefits the client, the one who provides compassion needs more attention than has historically been given (Figley, 1995). Those suffering from compassion fatigue need not suffer in vain (Stamm, 2002).

Compassion fatigue is a phenomenon in the mental health field that is getting more and more attention (Adams, Boscarino, & Figley, 2006; Bowen & Moore, 2014; Figley, 1995, 2002a, 2002b; Harr & Moore, 2011; Knight, 2010; Smart et al., 2014). Harr and Moore (2011) considered compassion fatigue as an occupational hazard for professional helpers. Figley (1995) associates compassion fatigue more with the study of traumatic stress. This investigation will explore the presence of compassion fatigue and examine predictors that might include or exclude traumatic stress. Figley reported the onset of compassion fatigue might begin by over exposure to client trauma and the clinician's experiences of complications at home or work because of a lack of support. Countertransference or desensitization might contribute to compassion fatigue (Kinnick, Krugman, & Cameron, 1996; Sabin-Farrell & Turpin, 2003). Additionally, a therapist may experience moral conflicts, boundary lines that skew, or ethical dilemmas that may trigger compassion fatigue (Forster, 2009). While conducting this investigation, this researcher brought together psychological disturbance terms in order to establish a better understanding of the impact experienced by professional helpers. Terms used included compassion fatigue, secondary trauma stress, and burnout. Other terms presented in the literature included trauma and vicarious trauma (Deville, Wright, & Varker, 2009). Further terms presented in the literature as having a positive impact on the work of

professionals included posttraumatic growth (Brockhouse, Msetfi, Cohen, & Joseph, 2011), compassion satisfaction (Harr & Moore, 2011), resilience (Lambert & Lawson, 2013), and self-compassion (Patsiopoulou & Buchanan, 2011).

These above-mentioned terms can tend to overlap from one to another, as well as present a wide number of definitions and concepts (Sabin-Farell & Turpin, 2003). The focus of this study was on the phenomena of compassion fatigue, secondary trauma stress, and burnout among licensed mental health professionals. Although recognizing the presence and possible impacts of other disturbances and nuances this investigator maintained focus on compassion fatigue, secondary trauma stress, and burnout, and made further recommendations for future investigative processes.

The struggles in people's lives do bring out these nuances and disturbances. Life is difficult and full of problems. No one can escape from instabilities in his or her personal lives. So why are not more people in treatment? According to Kessler, Sonnega, Bromet, Hughes, and Nelson (1995), mere exposure to a traumatic event might not result inevitably in psychological disturbance. All mental health workers are at risk to develop compassion fatigue or other psychological disturbances; however, risks for professional helpers working directly with the traumatized are higher (Stamm, 2002). Therefore, developing a plan to help the helper is in order. Second-hand exposure to trauma, not only direct experience, can lead to symptoms similar to that of post-traumatic stress disorder (Janoff-Bullman, 1992). Understanding compassion fatigue, by identifying it from the onset, and implementing preventable measures can keep caring professionals at work (Figley, 1995). When professionals are overwhelmed with their work, who cares for them? When this happens, caregivers who are overwhelmed with their work are no longer

effectively treating their clients and have possibly developed compassion fatigue (Gentry, Baranowsky, & Dunning, 2002). Figley (2002a) recognized the symptoms and began to sort through the complicating factors that make up the phenomenon of trauma.

Clinicians exposed to disturbing content of clients' lives may develop post-traumatic stress-like symptoms (Figley, 1995). Figley describes these symptoms as secondary traumatization or secondary trauma stress. Compassion fatigue and secondary trauma stress can be interchangeable terms (Figley, 1995; Salston & Figley, 2003). When compassion fatigue and secondary trauma appear separately, one can assume various populations can experience secondary trauma, but compassion fatigue remains unique to the helping professions (Elwood, Mott, Lohr, & Galovski, 2011).

The third term of interest for this study was burnout. Burnout has been associated with accumulating stress that wears down an individual. Freudenberger (1974) first introduced the term to the scientific literature. Freudenberger was concerned that burnout had crept its way into the lives of professional care workers and they were not equipped to combat this debilitating hazard. Mental health professionals experience emotionally demanding situations and are at risk for burnout. The concept of burnout describes a collection of effects that can occur over-time when a helping professional's caseload and expectations repeatedly exceed their personal capacity to meet such requirements (Maslach, 1982).

Furthermore, helping professionals who are continually exposed to the traumatic hurts and pains of their clientele might alter their personal view of themselves and, at times, the world (Sabin-Farrell & Turpin, 2003). No matter the differing opinions on terminology, mental health workers appear to be at risk of serious side effects of their

immediate work. The past two decades have seen an increased interest in research designed to help the helper. The exposure of professional therapists to the traumas of their clientele can be a daunting task to unravel. No matter how intimidating the duty may be, it is in the best interest of the profession to make inroads in order to keep competent workers in the profession (Figley, 2002a). Figley advocates for more attention towards the impact of working with the traumatized. This study explored compassion fatigue, secondary trauma stress, and burnout and how they might be responsible for serious risk to the mental health professional. Furthermore, this study provided information regarding the impact compassion fatigue, secondary trauma stress, and burnout have on the mental health worker. As a result, the researcher recommended possible alternatives to offset the negative impacts these psychological disturbances can have on the well-being of the mental health professional.

Statement of the Problem

The mental health field can be hazardous. Evans and Villavisanis (1997) stated, “The stresses encountered by a counselor stem from both the nature of the work and the role expectation of the profession” (p. 342). According to the American Counseling Association (2005) Code of Ethics, licensed mental health professionals are ethically bound to care for themselves, therefore, they should observe any potential signs of fatigue or impairment, and do no harm to their clients.

A lot of pressure is on these professionals to perform at high levels in order to bring healing to their clients. Pressures to obtain optimal results can lead to psychological disturbances, which can also lead to family or personal issues. Helping professionals must take care of themselves to establish a healthy balance of work and home life.

Bazarko, Cate, Azocar, and Kreitzer (2013), claimed high stress levels in the workplace result in negative outcomes, such as burnout, absenteeism, reduced productivity, and staff turnover. Reducing the stress is necessary, because studies have shown that highly stressed professional workers might be damaging to client well-being and best practices (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Scott, Hwang, & Rogers, 2006). The current study will introduce options that counselors might implement to mitigate the negative impacts of compassion fatigue, secondary trauma stress, and burnout. The cumulative effect of repeated exposure to clients' trauma without taking the necessary precautions can be devastating to the mental health worker.

The devastating effects of working with the traumatized may lead caring professionals towards emotional exhaustion, a phenomenon known as compassion fatigue (Adams et al., 2006; Craig & Sprang, 2010; Figley, 1995). These professionals might have difficulty recognizing the specific personal impacts expressing compassion and empathy has on them (Bowen & Moore, 2014). Counselors experiencing stress, distress, or impairment may not be able to offer high quality services to clientele and experience a decline in their quality of life (Lawson, 2007). Therefore, it is a "paramount necessity of carefully nurturing and regulating the self and ensuring the development of a self-protective, self-healing, and self-soothing way of being as a professional and as a full human being" (Danieli, 1996, p. 200).

As a result, mental health professionals have a responsibility to care for themselves. Clinicians who lack in self-care and experience compassion fatigue are more likely to be at risk for making poor professional judgments, such as misdiagnosis, poor treatment planning, or abuse of clients (Rudolph, Stamm, & Stamm, 1997). Figley (1995)

presented some likely risks for trauma therapists with a history of personal trauma including oversimplifying personal experiences and over-endorsing specific coping strategies found to be useful to the therapist. Mental health professionals may experience countertransference, a psychological state where the therapist reacts to information given by their client as if it was happening to him or herself. According to Danieli (1996), “countertransference reactions inhibit professionals from studying, correctly diagnosing, and treating the effects of trauma and they also tend to perpetuate traditional training, which ignores the need for professionals to cope with massive real trauma and its long-term effects” (p. 196). According to Salston and Figley (2003), “Therapists working with survivors will often experience reactions to hearing extremely violent and graphic stories, which keep the therapist from remaining present with the client” (p. 170). In order to shield themselves from the trauma, therapists may distance themselves from their clients, minimize the seriousness of their story, or experience corporeal responses and become overwhelmed with feelings of grief and helplessness (Danieli, 1996; Salston & Figley, 2003).

When helping a client work through difficulties a therapist is simultaneously carrying the load of hurt, pain, and anxiety. Therefore, a therapist may be more prone to shield himself or herself from the trauma, however this is not in the best interest of the client. To be effective, the treatment plan will most generally re-visit the trauma, and the therapist may experience secondary trauma. According to the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association [APA], 2013), posttraumatic stress disorder occurs only after a person is exposed to a traumatic event through direct personal experience of the event, witnessing

the event, or learning about the event experienced by someone close to the person. Given this distinction of posttraumatic stress, secondary trauma stress is thusly quite similar. Consequently, a therapist that is able to balance his or her schedule is important because providers of mental health services are extremely likely to encounter someone who has experienced trauma over the course of their life (Bride, 2004). A therapist is most generally in charge of his or her calendar, so not backing up highly traumatized clients could be helpful.

Posttraumatic stress disorder has received its fair share of research (Breslau, Davis, Peterson, & Schultz, 1997; Kessler et al., 1995; Stein, Walker, Hazen, & Forde, 1997; Switzer et al., 1999). These studies, which have provided meaningful contributions to the field, have focused on clients suffering from posttraumatic stress. However, a hole is present when it comes to the helpers' exposure to the trauma. As stated by Sprang, Clark, and Whitt-Woosley (2007), "Few epidemiological studies exist regarding compassion fatigue or secondary trauma among the various groups of helping professionals routinely exposed to trauma in the course of their work" (p. 261). The brain's response to the exposed trauma is key for the mental health worker to grasp. Sometimes the brain may respond positively and the worker may experience posttraumatic growth (Arnold, Calhoun, Tedeschi, & Cann, (2005). Other times the brain might experience interference from the trauma and the therapist may become distracted, develop clouded thinking, or disengage from the client (Rothschild & Rand, 2006). It is key for the therapist to know the brain's response to trauma as they are working with traumatized clientele. Clarity of thought is important, and the mental health professional has a responsibility to their clientele to perform at optimum levels (American Counseling

Association, 2005). In order to keep these performance levels high and maintain longevity in the field, mental health professionals must keep themselves healthy. Researchers have found that the introduction and utilization of career-sustaining behaviors might help reduce the risks related to secondary trauma stress, compassion fatigue, and burnout (Brodie, 1982; Kramen-Kahn & Hansen, 1998; Lawson, 2007; Lawson & Myers, 2011; Stevanovic & Rupert, 2004). Lawson and Myers found career-sustaining behaviors lower the risks of compassion fatigue and burnout.

Therapists exuding these positive behaviors are more likely to experience healthy outcomes and as the term suggests a sustained career. Professional helpers with a sense of self-worth and belief in their own ability to exert control may exercise careful health habits more, thus, aiding their well-being (Greenglass & Fiksenbaum, 2009). Studies have suggested that self-awareness, physical exercise, and clinical supervision may be able to mitigate the more negative aspects of compassion fatigue (Craig & Sprang, 2010; Bride, Radey, & Figley, 2007; Lawson, 2007; Figley, 2002a). Shapiro, Brown, and Biegel (2007) reported therapists are at risk for occupationally related psychological problems. The work of Shapiro et al. emphasized the intervention use of mindfulness to diminish the negative psychological impact. They found that decreasing perceived stress and negative affect might also lessen the risk. These researchers further reported that increases in positive affect and self-compassion could lead to psychological growth.

Mental health workers need this growth to stay healthy and competent in the field. “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 psychotherapists” (Figley, 2002a, p. 1440). It is the hope of this researcher that this study

will fulfill the purpose of examining the levels of compassion fatigue, secondary trauma stress, burnout, and career-sustaining behaviors among licensed mental health professionals in order to recommend possible mechanisms for ameliorating the well-being of clinicians.

Background

Traumatic stress became a topic of study in the 1980s, including the diagnosis of post-traumatic stress syndrome; the emphasis was on the victim or person directly affected with little thought given to those exposed to secondary trauma (Figley, 1995). According to Figley (1998), several factors suggested the need for the study of trauma, one of interest being increased knowledge of the growing exposure to trauma on the public and helping professionals. Figley's work built on the work established by Maslach (1982). Figley (1998) constructed upon the original diagnosis of work-related burnout and presented studies that focused on the trauma exposure of the helping professionals. The potential of adverse complications for the professional helper working with traumatized clients has been discussed within the psychological literature for at least two decades (Sabin-Farell & Turpin, 2003), and continues to be studied (Bowen & Moore, 2014). The 1990s saw hundreds of studies focusing on the traumatized victim, but continued to give little attention to those indirectly affected (Figley, 1995). The 2000s have shown an important need for investigations of compassion fatigue, because healthy, mentally fit, and devoted therapists are better equipped to provide services to the traumatized (Killian, 2008).

Traumatic world events, local and overseas have a high prevalence of influencing the lives of the general population (Bride, 2004). Bride and Sabin-Farell & Turpin (2003)

described these events in their studies. These events are not all inclusive, as trauma for one person might not be traumatic for another. According to studies by Breslau et al., (1997) and Stein et al. (1997), at least 40% of the general population of the United States has witnessed or experienced a traumatic event. These statistics are from records before the Terror Attacks of September 11, 2001; therefore, these percentages are most likely low estimates for today's real world. People receiving mental health services are at an even higher percentage of the traumatized (Bride, 2004). According to Switzer et al. (1999), at least 82% of clients receiving services in a mental health setting are there because of trauma. With such high rates of traumatized clientele, the strain of secondary trauma on the mental health professional is present and in need of understanding. Boscarino, Figley, and Adams (2004) stated, "Mental health professionals are an important human resource asset in the frontlines of our health care system and warrant our oversight and surveillance" (p. 7).

As the mental health profession develops more oversight, it is important to recognize the relationship that exists between the amount of trauma exposure and secondary trauma stress reported by therapists (Froman, 2014). Studies have shown that higher exposure rates to traumatized clients resulted in higher secondary trauma (Craig & Sprang, 2010; Sprang et al., 2007). Further research by Baird and Kracen (2006) found therapist exposure to traumatized clients increased the risk of secondary trauma stress in mental health professionals. While some researchers (Killian, 2008) have found no relationship between exposure rates and secondary trauma, the preponderance of literature suggests that there is an association between these phenomena. For example, Figley (2002a) concluded the closer a helper works with traumatized clients the more

likely the individual is to develop symptoms of secondary trauma stress. Figley (1995) described secondary trauma stress as a condition displaying many of the features of posttraumatic stress disorder, which can manifest itself within individuals who work with others who have experienced trauma. Both secondary trauma and posttraumatic diagnoses include features of stress. With stress being an ever-present force against clients and their workers, another phenomenon enters the psychological disturbance scene. This phenomenon is burnout.

Maslach (1982) reported burnout was a response to job stress fashioned by the demands of helping indigent clients. Working with impoverished clients and the direct exposure of their trauma can wear on a therapist, which makes Maslach's definition of burnout similar to secondary trauma stress. Burnout would later result in discussions about managerial stressors (Maslach & Florian, 1988). Figley (1995) was quick to distinguish burnout from secondary trauma stress. Figley found that burnout might arise from job stress alone, rather than working with highly demanding and possibly traumatized clients. McCann and Pearlman (1990) argued that while burnout and secondary trauma stress are similar in some ways, "the potential effects of working with trauma survivors are distinct from those of working with other difficult populations because the therapist is exposed to the emotionally shocking images of horror and suffering that are characteristic of serious trauma" (p. 134). Galek, Flannelly, Greene & Kudler (2011) found burnout to be related to years of service in one's position, while secondary trauma stress could come on rapidly and was unrelated to years of service. These researchers recommended counselors be not only familiar with their clients inner

battles, mannerisms, and habits but also to their own inner subtleties that may influence services and the possible harmful effects of their work.

Figley (1995) did not minimize burnout; moreover, he emphasized the importance that therapists know the risks of dealing with traumatized clients on a regular basis. Figley recognized the research done on burnout (Maslach, 1982; Pines & Aronson, 1988) was emphasizing an emotional exhaustion. In contrast to burnout, Figley emphasized that secondary trauma stress can happen suddenly, as burnout tends to develop more over time. Figley reported the following,

In addition to a more rapid onset of symptoms, with secondary trauma stress there is a sense of helplessness and confusion, and a sense of isolation from supporters; the symptoms are often disconnected from real causes, and yet there is a faster recovery rate. (p. 12)

As a result, Figley (1995) began using the term “compassion fatigue.” Figley described this more severe condition often experienced by mental health workers, social workers, and others in helping professions. He used a different term that was to him the same as secondary trauma stress, but landed softer on the ears of the sufferers.

In order to recover, professionals must be informed of the potential dangers of working with traumatized clients; it is also important to emphasize that the rewards of working with such populations outweighs the costs, which are accomplished through balancing care for self and others (Salston & Figley, 2003). According to Steed and Downing (1998), one’s ability to maintain a balance between personal and professional life is essential for the continued emotional well-being of therapists working with trauma victims. Greenglass and Fiksenbaum (2009) developed a theoretical model for therapist

well-being. The researchers linked social support and positive coping to affirmative mood and cognitive states. The authors used data from three different spheres to support the model. They found theoretical conceptions of coping that focus on negative states to be counterproductive to their research, which focused on the relationship between coping strategies and positive moods. Greenglass and Fiksenbaum concluded that a positive mood, feeling energetic and worthwhile, and seeing obstacles as challenges rather than threats described personal feelings of well-being.

Mental health professionals should be encouraged to develop a personal ideal for fighting compassion fatigue (Myers & Sweeney, 2004). Bowen and Moore (2014) found counselors' interactions with traumatized clients and their capacity to cope with those experiences can influence the counselor's state of being and their ability to remain emotionally present and compassionate with clients. Bowen and Moore went on to recommend continued investigations into counselor experiences with compassion fatigue within mental health settings. They further stated, "conducting qualitative studies to better understand this phenomenon may reveal the realities of being a mental health counselor in today's society" (p. 28).

In summary, although the psychological consequences of providing social support and care to the traumatized has been documented by researchers for over two decades, relatively few studies have focused on formal caregivers (Adams et al., 2006). Mental health professionals may experience the increased likelihood of adverse psychological outcomes because of their work (Figley, 2002a; Sabin-Farrell & Turpin, 2003). As a result, formalized scales exist to measure compassion fatigue, secondary trauma stress and burnout (Adams et al., 2006; Figley, 1995, 2002a) and according to the literature

(Craig & Sprang, 2010; Bowen & Moore, 2014; Bride et al., 2007; Figley, 2002a, 2002b; Lawson, 2007) further studies are needed to assist the mental health professional in successfully navigating their duties.

Research Questions

The researcher asked three research questions to guide the current study, which were:

1. To what extent are compassion fatigue, secondary trauma stress, and burnout present in the work of licensed mental health professionals?
2. What risk factors appear predictive of compassion fatigue, secondary trauma stress, and burnout in licensed mental health professionals?
3. What relationship exists between career-sustaining behaviors and compassion fatigue, secondary trauma stress, and burnout?

Description of Terms

The following definitions provide a more specific usage of terms used in this study. The terms appear in alphabetical order.

Burnout. Burnout is a state of physical, emotional, and mental exhaustion caused by a long-term involvement in situations that are emotionally demanding (Pines & Aronson, 1988). According to Pines and Aronson, burnout will display symptoms of exhaustion, helplessness, hopelessness, disillusionment, and negative attitudes. Burnout is a term linked to impairment comprising three areas: emotional exhaustion, depersonalization, and reduced personal accomplishment (Awa, Plaumann, & Walter, 2010).

Career-sustaining behaviors. Specific behaviors used to improve, extend, and make one's work experience more calm are considered career-sustaining (Brodie, 1982).

Compassion. Compassion is a feeling of deep sympathy and sorrow for another person who is troubled by hardship, accompanied by a strong desire to ease the pain of the individual (Compassion, 2003). Compassion is an emotional response that results from empathy and is synonymous with sympathy (Kinnick et al., 1996).

Compassion fatigue. Compassion fatigue is the stress resulting from aiding or desiring to aid a traumatized person (Figley, 1995). Compassion fatigue results from exposure to specific events encountered in dealing with trauma victims (Figley, 1995, 2002a; Jenkins & Baird, 2002). Compassion fatigue is possibly a direct consequence of being compassionate and empathetic towards those who are suffering (Figley, 2002a). Boscarino et al., (2004) best describe compassion fatigue as “reduced capacity or interest in being empathic” (p. 2).

Countertransference. The process that a therapist sees self in the people they are helping, or over identifying with a client, or meeting personal needs through a client (Corey, 1991).

Desensitization. Desensitization is the reduction of the capacity to reply with sympathy, empathy, or compassion to clients after repeated exposure to aversive stimulus over an extended period (Kinnick et al., 1996).

Empathy. Empathy is a counseling skill that allows for the understanding of someone else’s pain, suffering, and feelings (Richards, Campenni, & Muse-Burke, 2010).

Licensed mental health professional. A licensed mental health professional is a degreed professional that holds a state license that allows them to practice in the mental health field. Examples of licensed professionals may include social workers, counselors, psychologists, psychiatrists, and mental health nurses.

Mindfulness. According to Brown and Ryan (2003), mindfulness is being internally and externally aware of one's cognitions, emotions, and surroundings. Richards et al., (2010), agree that mindfulness is being aware of one's surroundings; however, they state, "a complete consensus has not been made among researchers on a more specific definition" (p. 251).

Posttraumatic growth. Posttraumatic growth is having a psychologically positive response to exposure to trauma (Arnold et al., 2005). Arnold et al. explain further that going through difficult and traumatic experiences can cause survivors and those indirectly impacted by the trauma to grow psychologically as they develop solid coping skills and learn from their experience. A study conducted by Brockhouse et al., (2011) found that higher levels of empathy resulted in lower amounts of posttraumatic growth.

Posttraumatic stress disorder. Posttraumatic stress disorder is defined by the Diagnostic and Statistical Manual of Mental Disorders (APA, 2013) as exposure to actual or threatened death, serious injury, or sexual violence directly, by witnessing the event, learning that the event happened to a close friend or family member, or experiencing repeated or extreme exposure to aversive details of the traumatic event. (p. 143)

Resilience. Resilience is the capability to manage oneself in the path of difficulty (Ward, 2003). Fink-Samnick (2009) defined professional resilience for mental health providers as a "commitment to achieve balance between occupational stressors and life challenges, while fostering professional values and career sustainability" (p. 331). Resilience matures over time and turns trials into opportunities (Hodges, Keeley, & Grier, 2005).

Secondary trauma stress. Secondary trauma stress occurs from the result of indirect exposure to another person's traumatic experiences, such that a helper acquires symptoms that are much like those of the traumatized person he or she is trying to help (Figley 1995; McCann & Pearlman, 1990; Thomas & Wilson, 2004). Secondary trauma stress develops over consecutive interactions with traumatized individuals (Galek et al., 2011). Secondary trauma stress has a relatively fast onset, according to Figley (1995), and it may even arise from a specific event.

Self-care. Self-care is the action of participating in activities that promote the well-being of self (Carroll, Gilroy, & Murra, 1999).

Self-compassion. Self-compassion is the feeling of care towards self without holding failures or shortcomings against oneself and admitting that any experiences one may encounter are natural (Neff, 2003).

Trauma. Trauma is physical harm to the body caused by violence, accidents, terrorism, or natural disasters (Boscarino et al., 2004). Trauma also has a psychological side that is an emotional wound, shock, or horror that can have long-lasting effects on the survivor (Adams et al., 2006).

Vicarious traumatization. McCann and Pearlman (1990) described vicarious traumatization as a psychological state that might cause serious mental effects brought on by working closely with a traumatized person or client. Pearlman and Saakvitne (1995) further added that the effects of vicarious traumatization happen over time as continuous exposure to the trauma is on the helping professional.

Well-being. Well-being is the overall health of a person, which includes physical, mental, and emotional parts of a holistic approach to being (Ohrt & Cunningham, 2012).

Significance of the Study

This study has provided needed information for both the academic and professional arenas of the mental health field. First, academia will receive the benefit of contributed data to the importance of educating future mental health professionals on the topics of compassion fatigue, secondary trauma stress, burnout, and career-sustaining behaviors. Professors, armed with these findings might be enlightened by the content and encouraged to stay vigilant in their work. Research has recommended that future classroom settings contain curriculum specifically targeting compassion fatigue and burnout (Harr & Moore, 2011). Furthermore, information from this study may provide knowledge for future therapists as they consider the field of psychotherapy.

Licensed mental health professionals will receive benefits from this research as it targets their overall well-being. Past researchers (Lambert & Lawson, 2013; Lawson, 2007; Orht & Cunningham, 2012; Richards et al., 2010) have expressed the importance of continued studies into the overall wellness of psychotherapists in order to preserve and nurture well-being within individual professionals. Learning what aids therapists to continue providing effective, ethical services to clients might lead to knowledge that may avert or decrease burnout in the helping professions (Kramen-Kahn, 1995). Past researchers, such as Bowen and Moore (2014), Figley (2002a), Pearlman and Saakvitne (1995), Shapiro et al., (2007) have recommended further work that will better equip the mental health worker with combative information to succeed in a field littered with trauma, brokenness, hurt, and loss. The current study has expounded upon these recommendations.

Psychotherapy is a relational process that interacts between client and therapist. The literature shows a good deal of research over the course of many decades on the therapeutic processes dealing most specifically with clients. After all, success comes down to the results of the client (Arnold et al., 2005). The therapist, however, has not been a considered factor, except for more recent work in the past two decades (Figley, 1995; 2002a), which has led to a growing number of researchers that have investigated the impact of psychotherapy on therapists themselves (Bowen & Moore, 2014; Lambert, & Lawson, 2013; Sprang, Craig, & Clark, 2011; Thompson, Amatea, & Thompson, 2014; Zeidner & Hadar, 2014). This investigation is a result of the recommendations of previous researchers whose aspirations have been to keep effective mental health personnel in the profession, which have made positive contributions to the betterment of their clientele.

The subsequent results and conclusions of this study may provide practical implications to advance the knowledge of the mental health field and possibly allow some generalizations for comparable organizations. The purpose of this study fulfilled a need identified by the literature. As a result, this research has taken the necessary steps to provide interested therapists and educators with informative measures to better themselves as representatives within the mental health field.

Process to Accomplish

In order to fulfill the goals of this investigation the researcher conducted a quantitative study and included two qualitative questions within his demographic questionnaire. Three Midwestern United States counseling agencies provided permission for their staff to participate on a voluntary basis. One of these agencies happened to be

that of the researcher. The overall population of the three agencies consisted of 95 licensed mental health professionals. To qualify for the study each professional had to have a minimum of a Master's degree and hold a current license by the state as a mental health professional. Licenses included psychologists, counselors, and social workers. The agencies involved provide generalized counseling services with some specialties for the traumatized and severely mentally ill.

Participants received survey packets consisting of the Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQol-5) (Stamm, 2009), the Burnout Measure (Pines & Aronson, 1988), the Career-sustaining Behaviors Questionnaire-Revised (CSBQ – R) (Kahmen-Kahn, 1995) and a demographic questionnaire. Copies of the investigation scales are located in Appendices A-D. The authors granted permission for use of their scales. The ProQol-5 is a 30-question instrument that utilizes a 5-point Likert Scale, ranging from 1 (never) to 5 (very often). Stamm designed the ProQol-5 to give total scores in the three component areas of compassion fatigue: compassion satisfaction, burnout, and secondary traumatic stress. According to Lawson (2007), “The construct validity of the ProQol-5 has been well established in the literature because the scale’s inter-correlations are relatively low, suggesting that the scale measures three distinct constructs” (p. 24). The CSBQ-R assesses the specific strategies participants use to function effectively and maintain a healthy professional role in their careers. Brodie (1982) developed the original questionnaire. Kahmen-Kahn (1995) adapted the original into a 22-question version, which used a 7-point Likert-type scale. The author’s intent of the scale is to show how often the participant demonstrates certain behaviors. Internal consistency reliability

coefficients for the CSBQ-R have been measured at .71 (Kramen-Kahn & Hansen, 1998), and .89 (Lawson & Myers, 2011), respectively. The Burnout Measure is a 21-item questionnaire that measures the three components of burnout: physical exhaustion, emotional exhaustion, and mental exhaustion. The writers designed the Burnout Measure to give one total score. The authors claimed test-retest reliability of the measure to be .89 for a one-month interval, .76 for a two-month interval, and .66 for a four-month interval (Pines & Aronson, 1988). In order to explain internal consistency Pines and Aronson stated alpha coefficients ranged between .91 and .93.

According to Leedy and Ormrod (2013), “Quantitative and qualitative research designs are appropriate for answering different kinds of questions” (p. 95). This study sought predictive answers along with a better understanding of a phenomenon, thus the need for this researcher to insert two qualitative questions within his demographic questionnaire. Creswell (2013) described phenomenological research as bringing commonality to experiences by participants. This investigator’s use of phenomenological questions captured the shared effects of compassion fatigue among mental health professionals, in particular the workers at his own agency. The limitations of a qualitative study included the time necessary to conduct interviews and sort through the transcriptions. Because of this limitation, this researcher conducted quantitative research with the insertion of two qualitative questions at the conclusion of his demographic questionnaire that opened up further thoughts, feelings, and influences of the three phenomena in question: compassion fatigue, secondary trauma stress, and burnout.

According to Moustakas (1994), in a phenomenological study it is only necessary to ask two broad questions: What is the experience with the phenomenon, and what

situations have affected those experiences? In order to answer research question one, which sought the presence of compassion fatigue, secondary trauma stress, and burnout in professional helpers, this researcher introduced these two questions. Moustakas recommended each statement gathered would establish equal weight, a step called horizontalization. According to Moustakas, a technique known as clustering helped this investigator establish core themes of the experience of the phenomena by the participants. Utilizing the themes, this researcher was able to construct an individual textual description (Moustakas). This researcher was then able to discuss common experiences of the participants, which captured the essence of the phenomena, which is termed essential, invariant structure by Creswell (2013). In order to analyze research question one the investigator used descriptive analyses with mean and standard deviations across the results of all three instruments. Categorical responses were analyzed using frequency counts and the researcher using some key demographic variables explored percentages and the results.

The researcher's design of research question two was to establish predictive factors of compassion fatigue, secondary trauma stress, and burnout among the participants. The investigator used his demographic questionnaire to gain information similar to that of other studies in the literature (Harr & Moore, 2011; Knight, 2010; Lawson, 2007; Lawson & Myers, 2011; Smart et al., 2014; Sprang et al., 2007; Thomas & Otis, 2010). Specific information sought by the investigator included gender, type of license, years in profession, average hours of work per week, percentage of clients that would fit the definition of traumatized (Adams et al., 2006; Boscarino et al., 2004), use of clinical supervision per month, and current case-load. The total scores of the Burnout

Measure, the total scores of the burnout and secondary traumatic stress subscales from the ProQol-5, and the demographic questionnaire provided the necessary data. The investigator also gleaned pertinent information from the Career-sustaining Behavior Questionnaire as predictors. The CSBQ-R provided how often certain behaviors being present may affect the severity or decline of the phenomena under study. In order to determine the predictive power of each variable, the researcher performed three regression analyses. The investigator did this in order to see what variables and in what combination provided the greatest predictive value of the phenomena.

The investigator analyzed the data for research question three, which was seeking the relationship between career-sustaining behaviors and the three phenomena of compassion fatigue, secondary trauma stress, and burnout, using Pearson Product Moment Correlations. The researcher examined the three main instruments' scores to determine the relationship between scores of these measurements. The investigator took the total scores from the ProQol-5 and correlated them with the three subscale scores.

Prior to the main investigation, the researcher conducted a pilot study that included the two qualitative questions on the demographic questionnaire. The investigator established the pilot to determine if the data acquired would add beneficial information in answering the research questions. The researcher sought participants with mental health licenses to complete the pilot. The investigator used an email database of mental health professionals obtained through a Midwestern United States counseling agency. The results of the pilot study showed evidence that the two broad questions added to the demographic questionnaire would contribute a benefit to the overall study. The researcher in confidential holding along with the other data gathered will keep the

answers received from the pilot study. Finally, the Internal Review Board of Olivet Nazarene University granted final permissions of this dissertation project.

Summary

Existing literature is pointing to an increasing need for the study of compassion fatigue and the impact such a phenomenon has on therapists (Bowen & Moore, 2014; Bride et al., 2007; Craig & Sprang, 2010; Figley, 1995, 2002a; Lawson, 2007). This study reflects the furtherance of recommendations in the compassion fatigue literature. It is the hope of this researcher that the knowledge presented will provide an expansive view of already completed research. The investigator's aim was to fulfill the call of past researchers in order to help therapists grasp the effects of compassion fatigue, secondary trauma stress, and burnout, which will assist them in remaining competent mental health workers providing the necessary help to many hurting people. In the following chapter the researcher will explore, review, and analyze the primary sources of scholarly literature related to compassion fatigue, secondary trauma stress, and burnout pertaining to licensed mental health professionals.

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

This chapter will review the existing research on compassion fatigue, secondary trauma stress, burnout, and career-sustaining behaviors among licensed mental health professionals. Clinicians of all backgrounds should take personal interest in knowing more about these psychological disturbances and the possible harm that could come to him or herself (Myers & Sweeney, 2004). According to Najjar, Davis, Beck-Coon, and Doebbeling (2009), the conditions of compassion fatigue, burnout, and secondary trauma stress have common characteristics. For example, compassion fatigue and burnout arise from similar emotional contact with clients, they can destructively affect the services provided by the mental health professional, they share risk factors of empathic ability and interpersonal demands, and they result in psychological distress (Jenkins & Baird, 2002).

The distress builds, over time, sometimes without the therapist's knowledge, all the while exposing the care worker to the effects of compassion fatigue, effects that scholars and researchers have documented over many centuries. For instance, in Exodus chapter 18, Jethro, Moses' father-in-law, makes the point to Moses that one person cannot carry the burdens of the masses. Jethro told Moses that he would burnout if he kept serving all the people; 'this is way too much for you – you cannot do this alone' (Exodus 18:17, The Message). Due to the damaging effects of overwork and unmanaged compassion fatigue (Trippany, White Kress, & Wilcoxon, 2004) further investigation of

the phenomena among mental health professionals is highly desirable to increase job satisfaction and the overall well-being of counselors (Lawson, 2007). As a result, this investigator's research design expounds upon the benefits of career-sustaining behaviors (Brodie, 1982; Kramen-Kahn, 1995; Lawson, 2007; Lawson & Myers, 2011; Rupert & Kent, 2007; Stevanovic & Rupert, 2004) and other quality of life components in order to identify positive mechanisms to promote the well-being of mental health professionals.

The mental health profession is full of empathetic and compassionate people and it is because of these qualities that the professional's wellness is in danger. Serving others comes natural for this group of helpers, sometimes coming at high costs, as professionals set aside regard for personal care (Figley, 2002a; Lawson, 2007; Richards, Campenni, & Muse-Burke, 2010). Bearing in mind the total number of individuals exposed to physical violence, natural disasters, accidents, terrorism, war and other major catastrophes, traumatic experiences are more and more common place for the general public (Collins & Long, 2003). In order to treat such horrific trauma, helping professionals find themselves exposed to considerable amounts of pain and brokenness. As caring workers display empathy and compassion, they will often sacrifice personal well-being in order to help trauma sufferers (Bride, 2007). Their extreme compassion and desire to help may cause professionals to overlook symptoms of secondary trauma stress.

The emotional and psychological risks associated with being a provider of mental health services to traumatized or susceptible clientele — and lack of professional self-care in response to these risks — have been given limited attention, if not ignored, in career training, and education (Dunkley & Whelan, 2006). Daily exposure to clients and the distress they experience may become emotionally draining on mental health workers,

resulting in situations that may cause secondary trauma stress, burnout, and compassion fatigue (Newell & Mac Neil, 2010). However, a study conducted by Stevanovic and Rupert (2004) of 286 psychologists, reported that not all mental health work must lead down a path of negative results. The authors found that the heavy lifting in the mental health field could possibly lead to good feelings and healthy living for therapists. These authors couched their study's language in a manner to qualify that these behaviors are not universal and acknowledged the presence of the need for self-care, but were pleased to report that helping professionals do receive satisfaction in helping others and seeing client growth. Therefore, Stevanovic and Rupert claimed, “. . . it appears that the majority of psychologists have ways of coping with the demands of their work that allow them to feel good about their accomplishments and avoid the unpleasant, demoralizing consequences of burnout” (p. 301). These authors used an adopted format of the Career-sustaining behaviors questionnaire, which Brodie (1982) describes improves, extends, and makes one's work experience more calm allowing for increased longevity and satisfaction among mental health professionals.

The goal of this investigator is to review the literature beginning with two skills (empathy and compassion) that successful mental health professionals utilize. Then the author describes, dissects, and processes the literature regarding the three main phenomena of compassion fatigue, secondary trauma stress, and burnout. Two other phenomena will be touched upon, trauma and vicarious traumatization. The researcher takes separately two additional problematic disturbances: countertransference and desensitization. Consequently, the importance of career-sustaining behaviors highlights the section of five quality of life components, which also includes self-care, self-

compassion, resilience, and mindfulness. A theme woven throughout the literature review is the effectiveness of spirituality in the life of the mental health professional. Finally, the review concludes with stressing the importance of wellness in the daily life of professional care workers.

Two Important Skills

Empathy

When considering counseling and the skills that may go along with an effective therapist, empathy is probably one that comes to mind. The therapeutic relationship relies on empathy; without empathy, the client's well-being may be at stake. A therapist lacking empathy will have a difficult time building rapport with clients, which will hinder client growth, because clients need their therapist to feel their pain. Therefore, there is a link between the value of the therapeutic relationship and the skill levels of the treatment professional (Wynn & Wynn, 2006). Wynn and Wynn claimed that empathy is essential within health care circles. The authors studied three specific types of empathy with direct observations of therapy sessions in order to establish a basis for how empathy actually may occur. They found it is not just important for the provider to be empathic, but moreover, the patient or client must be recognizing the actions of the therapist as indeed empathic. Wynn and Wynn stated, "Expressions of empathy made by the therapist are confirmed by the patient as having such a function through a next turn, as a demonstration of the patient's understanding of the therapist's prior turn as an expression of empathy" (p. 1,388).

In a study conducted by Bell, Limberg, Jacobson, and Super (2014), students created two clay masks. The first mask revealed how a student saw him or herself. The

second mask revealed how others perceive the student. This exercise forced students to discuss differences in authenticity of perceptions and discovered how different people may present themselves depending on surroundings. Bell et al. found that once students accepted the necessary reflection from others a connection between self-reflection and the building of empathy happened. Elliott, Bohart, Watson, and Greenberg (2011) claimed clients influence therapist empathy, “Clients who are more open to and able to communicate their inner experiencing will be easier to empathize with” (p. 47). However, the authors cautioned that not all clients would respond in a healthy manner to empathic therapy. Hurt, pain, and a distrustful past can lead clients to doubt true empathy. Therapists must be patient and not thrust empathy on their clients without a genuine positive regard for healing. Therefore, the pace of empathic treatment rests on the provider, which is a key part of successful psychotherapy.

Myers (2000) described empathy as including being nonjudgmental, attentive, open to discussing any topic, and paying attention to details. Elliott et al. (2011) concluded therapist empathy as an arbitrating process as being a principal factor to client change. These authors further found evidence that showed clients having the ability to perceive his or her therapist’s responses as genuine empathy resulted in better outcomes. Elliott et al. recommended that psychotherapists make empathy an essential part of the therapeutic process. Mental health providers unable to navigate through an empathic pathway may experience resistance or clients that withdraw. A professional may unintentionally avoid empathy because the details shared from his or her client may be traumatic and difficult to process. Studies have shown that therapists’ inability to separate themselves psychologically from the trauma may result in secondary trauma stress

(Salston & Figley, 2003; Sprang et al., 2011). However, Bowen and Moore (2014) found that the most effective therapists excel with using the skill of empathy. This leaves a catch-22 phenomenon, which pits mental health professionals against the conundrum of helping clients while keeping themselves healthy (Newell & Nelson-Gardell, 2014).

Newell & Nelson-Gardell (2014) claimed that professionals going into the mental health field, in particular social workers believe a sense of calling to the profession as opposed to a choosing. As a result, many workers are going into a profession because they have big hearts for broken people, but may not be aware of the dangers that loom. These providers portray the character trait of empathy. Bell et al. (2014) emphasized the need for self-awareness in the development of counseling skills, specifically empathy. These authors reported increasing self-awareness increases empathy within a practitioner. They further claimed that enhancing self-awareness, which has a direct correlation on increasing empathy, would improve client outcomes.

The capacity to comprehend the purposes of others is an important part of human communication (Kaplan & Iacoboni, 2006). Kaplan and Iacoboni studied neural circuitry in order to understand the actions of people. The discovery of mirror neurons established a priority for Kaplan and Iacoboni to monitor the actions between participants and the activities they witnessed or in which they participated. These actions and possible motivations intrigued the authors as they observed behavior that they later connected to empathy, because as one observes activity, emotions and intentions are experienced. Kaplan and Iacoboni suggest the results of their study may indicate that more empathic individuals spend more effort to determine the intention of the person they are interacting with in order to understand the complete context of information. Listening consequently

materializes as vital to the empathic process and basic to the fulfillment of client progression (Myers, 2000). As caseloads rise and pressures increase from institutional priorities, clinicians tire, become weary, are less empathetic and find themselves exposed to the risk factors of compassion fatigue, secondary trauma stress, and burnout (Figley, 1995).

Compassion

Kinnick et al., (1996) defined compassion as an emotional response that results from empathy and is synonymous with sympathy. Compassion is often difficult to separate from empathy, which is why many consider these terms synonymous (Wakefield, 1993). Regarding compassionate people, Wakefield asks are they more prone to be involved in the helping professions? Does holding the trait of compassion push one to care? Barnett (2007) set out to study the inner desires of mental health professionals and what factors might have led them down this professional path. In her in-depth study of nine therapists, Barnett found therapists sometimes chose their work because many people would confide in them, seek them out, and respect their input. Barnett reported personal pain, hurt, loneliness, childhood losses, and depression as reasons professionals enter the mental health field. Experience of pain and a deep desire to help others with similar hurts affected Barnett's participants in their decision to be helping professionals. Having a mutual understanding seemed to be a distinct feeling to the needs of others (compassion) and a willingness to comply in order to uphold emotional states of safety and well-being.

In a study to recognize stress and avoid burnout, Bruce (2009) expressed the concern that "perhaps part of the reason why we are burning out as a society is because

we are too accessible” (p. 58). Helping professionals with a desire to help hurting clients will sometimes make themselves more available than they should, because of the compassion trait contained within them (Adams et al., 2006). Being present, hearing the hurts, feeling the pain, and showing compassion can lead therapists down the slippery slope of compassion fatigue (Lawson, 2007). However, without the trait of compassion, the mental health professional is not as thoroughly equipped to manage the complexities of a hurting caseload (Kinnick et al., 1996). Lawson, Venart, Hazler, and Kottler (2007) studied counselor wellness where they explained therapists learn to see things as their clients’ do and model compassion by connecting to client’s pain. These authors stated,

That level of connection, commitment, and caring are among the greatest strengths that we counselors bring to the work that we do, and they are also among the characteristics that may make us vulnerable. Witnessing the cruelty and despair in our clients’ lives places us at risk; compassion fatigue, vicarious trauma, and burnout are a few of the potential consequences of that risk.

Counselor impairment often occurs when counselors have persistently focused on the plight of clients while ignoring, dismissing, or minimizing their own needs for balance and self-care. (p. 5)

Compassion is a multifaceted response generated by the suffering of others (Forster, 2009). Forster claimed that compassion is supposed to render itself into compassionate behavior. Moving from response to behavior involves several factors. Therefore, situations requiring a compassionate response are important and may include an intense response to the situation. In addition, there is some recognition that the suffering comes without warrant. According to Forster, compassion occurs in response to

unfortunate circumstances that are beyond one's control; it is not a response to actions that might be blameworthy or a direct result of poor choices and outright negligence. Finally, Neff (2003) describes compassion as offering open-minded and thoughtful understanding to those who fail or do wrong, in order to normalize such failures. Furthermore, Neff emphasized compassion at its core should provide an inspiring vigor for development and change.

Successful therapists sometimes may find themselves hurting because of being empathetic and compassionate. These skills are unavoidable in the mental health field. As Figley (2002a) states, "They provide the tools required in the art of human service" (p. 1434). Therefore, mental health professionals need to be alert and care for themselves or they may fall prey to the psychological disturbances of compassion fatigue, secondary trauma stress, and burnout. If not taken seriously by professionals, these three phenomena may result in succumbing to the aforementioned vulnerabilities (Lawson, 2007). The following section will discuss each phenomena separately.

Three Phenomena of Mental Health Workers

Compassion Fatigue

Compassion fatigue can result in the caregiver experiencing a reduced capacity for or interest in being empathic (Adams et al., 2006). The theory behind this phenomenon is a stress process that vicariously experiences the effects of clients' traumatic life events (Boscarino, 2004). Compassion fatigue is an emotional response that occurs within a mental health professional as a response of the ongoing day-in and day-out processing of client details and life happenings (Forster, 2009). Forster emphasized the professional who experiences compassion fatigue undergoes a decrease in the

capacity to tolerate the suffering of others, because of often feeling confused, helpless, and distant from peers. Newell & Mac Neil (2010) reported compassion fatigue might progress and develop over time. This concept differs from Forster who claimed compassion fatigue might develop quickly, which supports Figley's (2002) belief that the onset can come fast because of only one traumatic event.

Initially, providers may experience little effects of compassion fatigue; however, as experience and exposure increases compassion fatigue may occur cumulatively over time (Newell & Mac Neil, 2010). Newell and Mac Neil claimed for mental health professionals who have treated victims of trauma, such exposure to secondary trauma stress might contribute to the overall experience of compassion fatigue. These authors also reported that mental health professionals who treat populations other than trauma victims might also experience compassion fatigue without experiencing secondary trauma stress. Clinicians in trauma practice find themselves exposed to risk factors that may contribute to the development of vicarious traumatization, secondary trauma stress, and compassion fatigue.

According to Ray, Wong, White, and Heaslip (2013), frontline mental health care professionals (FMHCP) working in several areas such as nursing, social work, psychology, psychiatry, and counseling are at risk for developing compassion fatigue, which may come on quickly without notice. FMHCPs often provide treatment to clients, which can result in physical and psychological disturbances in care providers, referred to as compassion fatigue. Ray et al. studied the relationships between compassion satisfaction, compassion fatigue, work life situations, and burnout among FMHCPs. The researchers used a convenience sample of all 430 FMHCPs listed in staff directories of

the mental health institutions in a Southwestern, Ontario community. Ray et al. claimed the literature is limited when it comes to compassion fatigue. The authors found FMHCPs that reported a trauma history had higher compassion fatigue than participants without a trauma history. According to the writers, this study provided new insights in how compassion satisfaction and compassion fatigue relate to FMHCPs' work life and burnout. Ray et al. reported higher levels of compassion satisfaction, lower levels of compassion fatigue, and increased person-job match in the six areas of work life, which are workload, control, reward, community, values, and fairness, predicted lower burnout in FMHCPs. The researchers further claimed this study to be the first linking compassion satisfaction and compassion fatigue to overall person-job match in the six areas of work life for FMHCPs.

According to Collins and Long (2003), compassion fatigue can set in when a clinician is exposed to clients or severely traumatized patients. The caregiver extends high energy levels of empathy, which wears the caregiver down over repeated exposure to traumatized victims or clients. Collins and Long concluded, "Compassion fatigue, like burnout, can challenge a caregiver's ability to render effective services and maintain personal and professional relationships" (p. 19). The participants of Collins and Long's study were 13 healthcare workers who treated victims from a 1998 bombing in Omagh, Northern Ireland. This bombing claimed the lives of 29 people, injured more than 370, including 60 seriously. The car bombing took place in a busy market area of Omagh. Surrounding communities felt impacted by the event, causing local authorities to set up a trauma response and recovery team that provided different levels of therapy to people in need. Collins and Long's research was threefold; it aimed to find the psychological

effects of caregivers working with traumatized victims of the Omagh bombing, coping mechanisms used by caregivers dealing with fatigue, and factors contributing to compassion satisfaction. Collins and Long found that working closely with highly traumatized cases would lead to some form of trauma for the caregiver. However, Collins and Long reported when compassion satisfaction was high, compassion fatigue was low.

Further researchers have claimed that mental health professionals with a current anxiety disorder, mood disorder, or personal trauma history may be at greater risk of experiencing these psychological disturbances (Dunkley & Whelan, 2006; Gardell & Harris, 2003; Lerias & Byrne 2003). Professionals with high caseloads of trauma-related situations despite having little clinical experience practicing with trauma clients are particularly vulnerable to the effects of these conditions (Lerias & Byrne, 2003; Pearlman & Mac Ian, 1995). Additional researchers found the use of negative coping skills in response to trauma work, such as suppression of emotions, distancing from clients, and reenacting abuse, are identified warning signs for these conditions (Dunkley & Whelan; Sabrin-Farrell & Turpin, 2003).

Killian (2008) studied compassion satisfaction, compassion fatigue, and burnout among licensed mental health professionals and proposed three hypotheses. The first was positive social support and work environment will lead to compassion satisfaction, and high work hours will lead to low compassion satisfaction. The second was poor work environment, stress at work, and high anxiety will predict burnout. Killians's third hypothesis believed poor work environment and history of personal trauma will predict compassion fatigue, and emotional awareness will have a lessening effect on compassion fatigue. The researcher's mixed-methods study consisted of a qualitative interview

process of 20 clinicians working in agencies providing mental health services. Killian found through the interviews that clinicians were able to identify work stress symptoms, which included muscle tension, headaches, and lack of energy. According to the writer, risk factors of compassion fatigue and burnout included high caseloads, personal history of trauma, lack of access to supervision, and poor work environments. The author further reported self-care, exercise, and spirituality represented a major role in all participant responses regarding warding off compassion fatigue and burnout.

Compassion fatigue has no boundaries. Those turning to spiritual assistance to cope with brokenness and strife have brought trauma to the clergy. Pastors, clergy, and rabbis are front-line mental health workers without the state credentialing and most likely proper schooling or training. However, people will often turn to their faith when in crisis (Taylor, Flannelly, Weaver, & Zucker, 2006). Turning to one's faith exposes the faith leaders to possible traumatization, which puts pastors, rabbis, and other workers at risk for compassion fatigue. According to Taylor et al., religion and spirituality are important ways in which American Jews cope with grief, crisis, traumatic stress, and loss. The authors recognized the important role rabbis play in helping the traumatized. Given the use of rabbis in times of calamity, Taylor et al. surveyed 66 rabbis to see how successfully they handled their exposure to traumatic events and traumatized persons. The researchers found that as years of service increased for rabbis less compassion fatigue was present. However, exposure to traumatic events revealed greater compassion fatigue in the participating rabbis. Taylor et al. cautioned, though the rabbis in their study overall, showed little compassion fatigue, that the general nature of ministry work would

tend to cause the workers to be susceptible to such phenomena as compassion fatigue and secondary trauma stress.

Spirituality does play an interesting role when it comes to compassion fatigue. Newmeyer et al. (2014) studied 22 mental health professionals working in a stressful, cross-cultural environment. These authors reported that spirituality serves as a protective factor in mitigating compassion fatigue. McClelland (1989) studied how students responded to watching a documentary film of Mother Teresa. McClelland's goal was to see if participant responses would be similar to previous studies. The film, despite the suffering displayed, inspired some participants. McClelland found a positive physiological response in a subgroup of those who were inspired by the film. He concluded that spirituality or the belief and trust or inspiration of religious work acted as a protective factor. Newmeyer et al. emphasized the importance of preventative measures to offset compassion fatigue. Their study sought such factors, because compassion fatigue, if gone untreated or ignored can contribute to the professional mental health worker's decreased empathy and desire to care for clients. Newmeyer et al.'s research hypothesized that spirituality plays a significant protective factor in mitigating compassion fatigue. They claimed that spirituality appears to have a relative moderating impact against compassion fatigue and might improve the overall quality of life of helping professionals, an effect they credit to Mother Teresa.

Finding mitigating factors to compassion fatigue, such as laughter and spirituality is encouraging. The symptoms of compassion fatigue on the mental health professional can be immense. Harr (2013) describes these symptoms as, "decreased self-esteem, apathy, difficulty concentrating, preoccupation with trauma, perfectionism, rigidity, or, in

extreme cases, thoughts of self-harm, or harming others” (p. 73). Looking back at the moderating effect spirituality has on compassion fatigue; Newmeyer et al. (2014) suggest one can link laughter also to playing a mitigating role (Moran, 2002). According to Moran, assertions speak to improved health from the effects of humor. Moran stated, “These claims have sometimes exceeded our knowledge of the changes brought by laughter, but research is increasingly indicating that humor is health-enhancing” (p. 143). In their study, Hee et al. (2015) studied 62 cancer patients to determine the overall effectiveness of laughter therapy on mood disturbances and self-esteem. The authors found a 14.12 – point reduction in overall mood disturbance in the experimental group as opposed to 1.21 – point reduction in the control group. Hee et al. further reported that self-esteem increased considerably within the experimental group. The authors concluded that laughter therapy is a viable tool that is noninvasive and can result in less mood disturbances and higher self-esteem. The value of laughter can be traced back to Old Testament writings where in Proverbs the writer proclaims that laughter (good cheer or merriment) is good medicine for the soul (Proverbs 17:22, NIV). The physical effects of laughter appear to be similar to those of exercise (Fry, 1994). Moran (2002) claimed humor assists the immune system and can contribute to emotional bonds between colleagues, thus possibly improving work settings, which may strengthen resolve and lower compassion fatigue (Harr, 2013).

A direct relationship seems to connect spirituality, laughter, joy, happiness, and good health. Even amongst the raging storms of life, no matter the circumstances or trauma clients may be dealing with, good health can be experienced through spiritual connections. Papazisis, Nicolaou, Tsiga, Christoforou, and Sapountzi-Krepia (2014)

examined the relationship between religious beliefs, self-esteem, anxiety, and depression. The authors questioned 123 nursing students, which 120 claimed a strong religious belief. They found that 87 students scored average in self-esteem and the more involved with spiritual activities the less depression was present.

Hatcher and Noakes (2010) found further evidence of hope in their study of providers of therapy to sex offenders. Although empathizing with a client's pain and suffering may lead to compassion fatigue, these authors concluded that providing care and treatment to sex offenders in Australia did not reveal any ill effects to the psychological well-being of their study's participants, who were 48 correctional facility treatment specialists. Complete work satisfaction with no ill effects were reported by 40 of Hatcher and Noakes' participants. These conclusions uphold the study of Kadambi and Truscott (2006) who found clinicians working with sex offenders reported rewarding aspects to their care providing. It would seem, therefore, Hatcher and Noakes' study represents a small portion of literature that claims compassion fatigue is not a direct effect of working with sex offenders. These authors explained that possibly the continuous exposure to sex offenders built a psychological resistance to the secondary trauma or compassion fatigue, which disproved the original hypothesis of distress, vicarious traumatization, and compassion fatigue would be the result of working with sex offenders.

Secondary Trauma Stress

The literature regarding secondary trauma stress in part conflicts between various studies of several authors. Researchers do not completely agree with the timing of the onset of secondary trauma stress, its causes, or its lasting effects. For instance, Figley

(1999) equates secondary trauma stress and vicarious traumatization. Tabor (2011), however, stresses a difference; vicarious trauma is when a helping professional feels impacted by just hearing the story of traumatized clientele. This section of the literature review will distinguish between differing opinions and theories. Secondary trauma stress has symptoms closely related to posttraumatic stress disorder, such as intrusive memories, avoidance, negative changes in mood, and changes in emotional reactions (Bush, 2009). Bush explained, “. . . after prolonged exposure to trauma and loss, caregivers begin to integrate the emotions, fears, and grief of their patients, ultimately increasing their own stress and emotional pain” (p. 25). The danger of over exposure to the care provider is the possibility of skewed cognitive schema resulting in trust, intimacy, safety, and self-control issues. Tabor describes secondary trauma for a witness as trauma coming from directly seeing a victim’s trauma or triggered by a memory of past trauma. Secondary trauma can commence by multiple exposures to the effects of one trauma, as evidenced by a survivor retelling his or her story from the terror attacks of 2001 on the World Trade Center. Furthermore, Figley (1995) believed witnessing an impactful event could trigger secondary trauma.

Tehrani (2007) adapted the Belief Inventory with the understanding it might be able to predict symptoms of secondary trauma. Tehrani surveyed 319 professionals and she found the strongest negative beliefs professionals experienced were thoughts that they should cope better, thoughts of being overwhelmed, and the belief the world is a dangerous place. Care workers who felt the most competent and learned from their experiences reported experiencing at times a high level of negative feelings and beliefs. The author asserted the more competent a worker the deeper the need for a challenge,

which sometimes over exposed good workers to negative feelings. The researcher reported professionals who felt they had done a good job or displayed a sense of completion or fulfillment experienced less negative beliefs. Professions that conveyed the highest percentage of spiritual beliefs were teachers, psychologists, doctors, and nurses. Tehrani learned psychologists and counselors gained most support from supervision. Having a competent person to rely on sharing the high demand of cases often brings relief and a shared sense of accomplishment. Further findings showed some care workers struggled with not being able to talk about their work due to confidentiality restraints, which brought great distress between clinical needs and the law. Tabor (2011) would argue that these disruptions in care workers' jobs are not a result of secondary trauma, but more vicarious traumatization.

Ben-Porat and Itzhaky (2009) examined the positive and negative implications of working in the field of family violence and experiencing the symptoms of secondary trauma stress, vicarious traumatization, and vicarious growth using a mixed-methods research paradigm. The research participants consisted of 143 social workers employed in the field of family violence, and 71 social workers who identified themselves as not working in the field of family violence. In addition, the study examined specifically the positive and negative changes that occurred in the therapists themselves, in their lives, and in their families because of their work. The authors were surprised to find, in the quantitative part of the study, that the two research groups revealed no significant differences in levels of secondary trauma stress. Ben-Porat and Itzhaky explained the lack of difference as the work in the field of family violence does not cause high levels of secondary traumatization among that specific population of therapists. A possible

tolerance or desensitization develops within therapists that find themselves regularly exposed to family violence clients. The authors concluded that therapists serving non-family violence clients might experience similar exposure to negative traumas, thus skewing the findings and purporting little to no differences in family violence work and work that lacks this modality.

Another similar study found Sabin-Farrell and Turpin (2003) raising questions about the presence of high levels of secondary traumatization among therapists working with trauma victims. According to these authors, evidence of secondary traumatization is scarce and unreliable, and even though the connections between exposure to work with trauma victims and secondary traumatization were significant, they were relatively low. A possible explanation for lack of significant differences between the two groups in levels of traumatization relates to the finding that the participants who did not work in the field of family violence reported no exposure to therapy with victims of that kind of trauma. Additionally, it is possible that the participants in that group experienced exposure to other client populations that influenced them to the same extent. For instance, Bride (2007) claimed that social workers in welfare services have frequent exposure to populations that have experienced various traumas such as childhood abuse and neglect, terror attacks, crime, assault, and war. Ben-Porat and Itzhaky's (2009) qualitative part of their study may have actually laid foundation to Sabin-Farrell and Turpin's view that existing instruments constructed to date for measurement of secondary traumatization might still not tap all of the content areas related to the phenomenon.

The phenomenon of secondary trauma stress is confusing, because many authors tend to differ on how to define the phenomenon and how similar this phenomenon is to

vicarious traumatization and compassion fatigue (Boscarino, Adams, & Figley, 2010; Craig & Sprang, 2010; Figley, 1995; Jenkins & Baird, 2002). These inconsistencies in the field lead to misguided or misunderstood concepts, which could prohibit positive change for clients and proper treatment for therapists suffering from one of these phenomena. These misunderstandings contribute to the confusion in the fields of the helping professional, leaving many discrepancies unanswered, which disseminates frustration because of this lack of unanimity (Najjar et al., 2009).

Consensus, however, does seem to lie in the helping fields without much cause for debate that working directly with traumatized clients can be detrimental to the health of the caretaker (Bercier & Maynard, 2013). Bercier and Maynard further added, “Indeed, mental health workers become more vulnerable to significant stress when they work with trauma victims, which can lead to negative consequences that can affect their clients” (p. 2). One negative consequence is a disturbance of therapists’ empathic skills. Pearlman and Saakvitne (1995) found therapists experiencing a therapeutic gridlock or having clients with unfinished treatment plans had experienced such disturbances. Bercier and Maynard found this unproductive or compromised care could be detrimental to the client who is seeking competent treatment.

Consequently, secondary traumatic stress could prove to be an impediment to workers who provide direct services to traumatized people (Figley, 1999). Service providers experiencing secondary trauma stress are in need of alternative measures to counteract the negative impacts of this phenomenon. In order to find an answer to how to best identify secondary trauma stress in the mental health worker, Bride, Robinson, Yegidis, and Figley, (2004) developed the Secondary Traumatic Stress Scale. Prior to

Bride et al.'s study instruments used in research on secondary traumatization only examined symptoms among trauma survivors who were directly exposed. The authors maintained such measures lack confirmation on trials of persons exposed indirectly to trauma. Bride et al. developed the Secondary Traumatic Stress Scale in response to the scarcity of mechanisms intended to measure specifically secondary trauma symptoms in mental health professionals. Bride et al.'s study included a sample of 287 licensed social workers who completed a mailed survey containing the Secondary Traumatic Stress Scale and other relevant survey items. The researchers found evidence for reliability, convergent and discriminant validity, and factorial validity. They concluded the Secondary Traumatic Stress Scale meets a need for reliable and valid instruments specifically designed to measure the negative effects of social work practice with traumatized populations. The authors further claimed that this new scale might provide the necessary data to introduce preventative and mitigating factors to improve the impact that secondary traumatic stress can have on social workers.

Finally, Rzeszutek, Partyka, & Golab (2015) examined 80 trauma therapists working with people after various kinds of traumatic events; the most predominant were family violence and abuse, sexual assault, road accidents, and death of a close person. Participants were required to have a master's degree in clinical psychology and a professional license in trauma therapy. The authors were interested in finding the severity of symptoms correlating with secondary trauma stress. The authors found a positive correlation between emotional reactivity and a negative correlation between both sensory sensitivity and perceived social support with secondary trauma stress symptoms. Rzeszutek et al. describe sensory sensitivity as, "one's ability to perceive stimuli and then

to regulate their response to stimuli by either seeking out further stimulation or removing excessive stimulation depending on the strength of the stimuli” (p. 217).

Sensory stimulation as described by Rzeszutek et al. may be fine for some; however, according to Newell and Mac Neil (2010) therapists afflicted with secondary trauma stress are more likely to isolate, which will inhibit environmental stimuli. Rzeszutek et al. argue for increasing sensory sensitivity in order to reestablish environmental stimuli. The authors claimed their study to be the first to explore the role of sensory sensitivity and recommend its need for further investigation. The researchers observed that their study did not reveal similar demographic results as other studies when it comes to higher secondary trauma stress symptoms. Other investigators found gender (female) (Sprang et al., 2007), age (Adams et al., 2006), years of experience (Knight, 2010), client load (Deville et al., 2009), and lack of supervision (Figley, 2002a; Pearlman & Saakvitne, 1995) to be significant factors that lead to potentially severe secondary trauma stress symptoms in mental health professionals. Therefore, Rzeszutek et al. recommended the further examination of secondary trauma stress symptoms and the impact on clinical effectiveness, as well as building upon already established research (Newell & Mac Neil, 2010) that links this phenomenon to overall quality life of mental health professionals.

Burnout

Professionals in the mental health field tend to burn out more frequently because their work setting may be stressful, day-to-day operations are often emotionally demanding, and the providers themselves share similar characteristics with each other (Bruce, 2009). Bruce claims that people experience burnout because of too much stress

over a period. This is reason for him to believe that finding the optimal stress level of a person will help in promoting healthy living. According to Bruce, mental health professionals focus their attention on the needs of others. Over time, the boundary between helping others and taking care of oneself becomes unclear because the care provider remains attentive on the needs of the client. Ignoring this boundary for too long will impair self-care practices, leading to burnout.

Concerned for the burned out professional Jacobson (2012) sought to find the prevalence of risk for compassion fatigue and burnout among a national sample of employee assistance programs' (EAP) professionals and their potential for compassion satisfaction. EAP provide a majority of the mental health services to adults within the workplace. The author utilized a survey design that included a cross-section of EAP professionals living in the United States. Jacobson claimed exposure to traumatized employees could lead to negative reactions by the trained EAP workers, which might include compassion fatigue and burnout. The researcher examined past reports that clinicians were ill prepared by their graduate programs, because of a lack of formal training and preparation to work with traumatized clients.

Regardless of all the material available, most professionals receive little or no formal education regarding traumatic stress (Courtois, 2002). However, Witmer and Granello (2005) talked about the importance of a "saturation approach" (p. 268) to wellness within counselor education programs in order to help all counselors and counselor trainees make healthy changes in their lifestyle that would be enduring and widespread. Even with these high recommendations for education reform programs have been slow to incorporate such studies. Fortunately, Jacobson (2012) found employee

assistant program professionals experienced low to moderate risk of compassion fatigue and burnout, and moderate to high potential of compassion satisfaction. She reported that her study provided an overall significant risk predictor of compassion fatigue and burnout, while being a significant predictor for potential of compassion satisfaction. The researcher claimed low risk of burnout in her study; “the present population’s low risk is encouraging and the possible correlation with high potential for compassion satisfaction as a potential buffer from burnout deserves additional research” (Jacobson, 2012, p. 69). According to Killian (2008), overall coping skills had no significance in the level of impact burnout has on the individual. It appeared clear to the writer that clinicians working in teams reported less stress and social support was the most significant factor in compassion satisfaction. Finally, Killian stated that there is no real evidence that the utilization of positive coping skills guards a professional from traumatic stress, which gets to an important aspect: burnout is alive and a real phenomenon, and will catch up with the unsuspecting mental health provider, but not just that profession.

Burnout crosses over into all professions. Burnout research comes from many areas, including psychology, medicine, religion, business, and others in order to better educate and equip workers for the rigors of the daily grind (Aiken et al., 2002; Evans & Villavisanis, 1997; Francis, Robbins, & Wulff, 2013; Galek et al., 2011; Jacobson, 2012; Maslach & Goldberg, 1998, Maslach & Jackson, 1981). Maslach and Goldberg stated, “Job burnout has long been recognized as a problem that leaves once enthusiastic professionals feeling drained, cynical, and ineffective” (p. 63). Craig and Sprang (2010) found age to be a predictor for burnout; as age increased, burnout decreased. Inpatient care workers, according to Craig and Sprang, suffer more from burnout than outpatient

workers, which treat similar patients. The authors reported therapists experienced stress levels that exceeded optimal levels. High stress levels, brought on from working closely with traumatized clients, according to Craig and Sprang, contributed to burnout, and compassion fatigue. The researchers concluded that the best predictor of reducing compassion fatigue and burnout, while increasing compassion satisfaction was the use of evidence-based practices. However, Craig and Sprang claimed that the research on evidence-based practices is limited. They asserted, “The recent movement in mental health toward evidence-based practice has called for manualized, empirically tested interventions that demonstrate evidence of ameliorating psychological symptoms” (p. 322). Killian (2008) found work stress brought home, low office morale, and low affirmation all predicted burnout, which are not demonstrating evidence of improving symptoms.

The problem of growing burnout in the medical field and the need for improving symptoms led Brooks, Bradt, Eyre, Hunt, & Dileo (2010) to research creative ways to reduce burnout. The authors investigated the effects of music therapy and creative drawings of mandalas on various aspects of burnout in nurses. The researchers utilized a mixed methods study of 65 medical personnel and randomly assigned each participant to either a music-guided imagery group or a wait-list control group. The writers sought to discover if music is a viable treatment for burnout and stress, if music combined with imagery will reduce stress and burnout, and what effects creative drawings of mandalas by the participants has on burnout in nurses. The authors found music imagery led to associations of well-being, feelings of relaxation, rejuvenation, and empowerment. The writers concluded music therapy was a positive technique to reduce stress and burnout;

however, the time involved to conduct the therapy was too consuming and made it difficult for participants to attend all sessions. The authors also found that some participants feared being terminated if they openly admitted burnout. Overall, the researchers reported an improvement in the physical state of participants who participated in the music imagery and drawing exercises. Brooks et al. recommended medical staffs receive burnout support and that music imagery is a cost effective, non-threatening technique organizations can utilize.

Seeking effective ways to keep ministers in ministry, Parker and Martin (2011) investigated the motivation of clergy to take an active role in their personal well-being. The researchers sought to find predictors for burnout and occupational well-being in clergy, and the effect failure acceptance has on clergy well-being. Parker and Martin surveyed 200 clergy using the Maslach Burnout Inventory and the MES-W motivational engagement test, which resulted in a cluster analysis. The authors found that success-oriented people have the highest job engagement and lowest burnout, and self-protecting people have the lowest engagement and highest burnout. Similarly, Lawson et al. (2007) claimed, “It’s time we put ourselves first—not only because it is the right thing to do for our clients, but, more important, because it is the right thing to do for ourselves” (p. 6). Lawson et al. in their study on counselor impairment emphasize the importance of taking care of self, not as a selfish motive, but as a necessity to care competently for clients.

Therapists do not go into their line of work thinking they will burn out or have compassion fatigue or secondary trauma stress overcome them. Mental health professionals desire to help and sometimes their helping hurts (themselves). Therapists may become therapists because of personal trauma or hurt. Barnett (2007) claimed

counselors in training may present as tough on the outside with little problems, but actually may have a history of pain that contributes to their choice to help others. Helping the hurting might vicariously hurt the helper (Ennis & Horne, 2003). Therefore, Mander (2004) asserted that it might be best in the hiring process to look for the patient in the helper and for teaching purposes look for the helper in the patient. For Mander, a therapist must be willing to put himself or herself in the shoes of the client. Mander further stated, “It is a truism in the profession that the therapist cannot take the patients further than they have come themselves and that the empathic understanding indispensable for therapeutic work depends on reflected experiences of having been where the patient is” (p. 162). Furthermore, Barnett’s study found that abandonment, a sense of loss, and a lack of childhood intimacy contributed to career choices. She later determined that because of a lack of closeness or people to confide at young ages, these therapists became confidants of others as they aged. As a result, therapists can have unmet needs met through being a helper, but also unaware of potential risks of the profession.

Consequently, a mental health professional must be aware of the costs of therapy to his or her own being and his or her need for self-care. The amount of self-care after experiencing trauma affects counselors either positively or negatively in their personal and professional lives (Lambert & Lawson, 2013). Counselors who take care of their emotional, social, physical, and spiritual needs are healthier and in a better position to provide competent mental health services to their clients (Lawson, 2007). Sorting through the phenomena of compassion fatigue, secondary trauma stress, and burnout can be taxing. Bush (2009) puts these three phenomena in perspective, she states, “they reinforce

one another; burnout is emotional exhaustion, compassion fatigue is loss of self, vicarious trauma is a change in cognitive schema, and secondary trauma has symptoms similar to posttraumatic stress disorder” (p. 26). Even with this in-depth description, other disturbances exist and are worthy of mention. Vicarious traumatization and direct trauma have their own place in the literature; while similar in some ways, they are also quite distinct from one another.

Two Additional Psychological Disturbances

Vicarious Traumatization and Direct Trauma

Researchers have linked vicarious traumatization to the three main phenomena of this study, compassion fatigue, secondary trauma stress, and burnout (Dunkley & Whelan, 2006; Sabin-Farrell & Turpin, 2003; Salston & Figley, 2003; Smart et al., 2014). Dunkley and Whelan found the links and comparisons to be confusing among the literature. Pearlman and Saakvitne (1995) described vicarious traumatization as the process therapists experience when engaging in the empathic relationship with clients and the exposure to client trauma. Direct trauma differs from vicarious trauma in that trauma is a specific injury, damage, or harm brought directly to the body caused by violence, accidents, terrorism, or natural disasters (Boscarino et al., 2004). Trauma does however, have a psychological side that can inflict emotional wounds, shock, or horror that can have long-lasting effects on the survivor (Adams et al., 2006).

Sprang et al., (2007) articulated possible mental health consequences can befall clinicians exposed to vicarious trauma. The authors’ purpose was to explore variables that might influence responses to vicarious exposure to traumatic stress by examining compassion fatigue, compassion stress, and burnout among mental health professionals in

a rural state. The researchers sought to find the degree compassion fatigue, compassion stress, and burnout varied as a function of provider characteristics. Sprang et al. received 1,121 completed surveys. The survey packets included the Professional Quality of Life Scale and specific questions about the provider's practice methods. The researchers found 146 providers in their sample to be at high risk for compassion fatigue and/or burnout. Further results showed the authors that females suffered more from compassion fatigue and burnout, and specialized training enhanced compassion satisfaction, while reduced compassion fatigue and burnout. Sprang et al. concluded that providers that mix up caseloads with difficult and easy cases suffer less compassion fatigue and burnout. The authors reported limited resources, geographical isolation, few colleagues, and high demanding caseloads resulted in an atmosphere of burnout risk among rural clinicians. Sprang et al. further reported an unexpected find; psychiatrists experienced higher levels of compassion fatigue than other professionals did. The authors recommended special trainings for mental health providers to educate on the risks of compassion fatigue, compassion stress, and burnout.

Pearlman and Mc Ian (1993) explored the relationships among aspects of trauma therapy, aspects of the therapist, and the therapist's current psychological functioning. Their research included 188 therapists. They developed a questionnaire in which they asked participants a variety of questions about their work with trauma survivors. The questions related to the amount of exposure to client trauma. The goal of the study was to operationalize and measure vicarious traumatization. Pearlman and Mc Ian found therapist's personal trauma history to be such an influential factor that they divided the sample into two subsamples: those with and those without a personal trauma history. An

overwhelming percentage of therapists in the study claimed a history of personal trauma, 112, or 60%. Within this group, therapists with two years or less experience showed more disruption to their work, which the authors term vicarious traumatization. According to Pearlman and Mc Ian, a new therapist may be more prone for vicarious traumatization, which may cause a loss of focus or meaning, and possibly a questioning of career choice. Knight (2010) also found that years of experience could influence the impact of vicarious trauma. Knight asked 81 students and 72 field instructors from an Eastern United States University to participate in her study; 42 students and 51 field instructors participated. The researcher used the Professional Quality of Life Scale and the Attachment Belief Scale. Knight found students exhibited more signs of indirect trauma than their instructors did. The writer reported a significant difference in vicarious trauma experienced by students. The researcher discovered that both students and field instructors with less experience exhibited more signs of vicarious trauma. Knight concluded that the length of exposure to trauma could affect the impact of vicarious trauma. Knight further explained the more students worked with mandated and aggressive clients the more vicarious trauma they experienced.

Brady, Guy, Poelstra, and Brokaw (1999) explained that psychotherapists regularly provide services to survivors of sexual abuse trauma, which vicariously exposes the therapist to such trauma. The authors' purpose in this study was to address the effects of trauma work on women. The writers sought to find what influence sexual abuse therapy has on clinicians. The researchers asked to what extent professional psychologists should worry about psychological harm resulting from work with trauma survivors. The authors wanted to know the concerns training programs should have about exposing

trainees to clinical work with sexually abused clients. Brady et al. used a randomized national sample of 1,000 women psychotherapists. The authors found therapists with higher levels of exposure to sexually abused clients reported more trauma symptoms, but no significant disruption in cognitive schemas. The researchers found spiritual well-being to be higher for clinicians seeing more survivors of sexual abuse. However, Brady et al. claimed that spiritual challenges did arise, because therapists' faith came into question when faced with their clients' stories of trauma. Brady et al. stated, "Conducting therapy with trauma survivors, forces therapists to question their own sense of meaning and hope" (p. 387). The authors further claimed that vicarious traumatization might result in negatively affecting a professional's spiritual life. Thus, Pearlman and Saakvitne's (1995) assessment seems accurate.

We have come to believe over time that the most malignant aspect of vicarious traumatization is the loss of a sense of meaning for one's life, a loss of hope and idealism, a loss of connection with others, and a devaluing of awareness of one's experience . . . best described as spirituality. (p. 160)

Two Factors That May Disguise as Secondary or Vicarious Trauma

Historically, countertransference and desensitization best described the experience a mental health professional has in the therapeutic setting. In order to remain engaged in the therapeutic alliance the professional care worker must recognize disturbances that may inhibit productive work. Countertransference and desensitization might be such inhibitors, although some may argue, including Figley (2002), that desensitizing to a client's pain may strengthen the therapeutic alliance. The investigator discusses these two factors in more depth in order to differentiate from the main phenomena of this study.

Countertransference

Countertransference may take place in the therapeutic relationship between a therapist and client and sometimes describes the experience of the individual clinician (Cunningham, 2003). Countertransference developed as an identified problem for therapists before such phenomena as vicarious traumatization (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). Countertransference is the process that a therapist sees him or herself in the people him or her help, over identifying with a client, or meeting personal needs through a client (Corey, 1991). Countertransference can also have a lasting effect on a therapist's cognitive schema, beliefs, or expectations of him or herself (McCann & Pearlman, 1990). However, countertransference cannot sufficiently account for the horrific trauma that sometimes besets the mental health professional in the course of working with traumatized clients (Cunningham, 2003). The study of countertransference laid the foundation for work on vicarious traumatization (Pearlman & Saakvitne, 1995). For instance, the works on both origins have combined the painful descriptions, moods, and judgments that can guide work with trauma survivors (McCann & Pearlman, 1990). As clients describe the specifics of their trauma, the counselor can experience similar conditions of fear, grief, and helplessness (Dunkley & Whelan, 2006). However, the concept of vicarious traumatization is larger than countertransference as it not only considers characteristics of the counselor, but also of the situation (McCann & Pearlman, 1990). Consequently, researchers have turned attention to the deeper causes and predictors of vicarious traumatization and other trauma stressors, such as compassion fatigue and secondary trauma stress.

Desensitization

Hearing the same story with the same hurt, pain, and anguish repeatedly can be taxing for the professional caretaker. Mental health professionals find themselves in the frontlines of care often and sometimes develop coping mechanisms that shut out clients. This negative coping describes the work of desensitization. According to Kinnick et al. (1996), desensitization develops in order for therapists to remain engaged. However, therapists are actually disengaged, because the emotional stress they are feeling is so strong that they have to form a buffer zone of resistance. Unfortunately, the therapeutic alliance breaks down as the client and clinician drift apart, because the clinician desensitizes from the hurt (Kinnick et al.). Kinnick et al. liken desensitization to the saturation method used by advertisers: once the audience, in this case, the clinician, finds himself or herself exposed to the same stories in constant berating, he or she shuts off the listening ears as a protective measure. When this happens, it is difficult for the therapist to show true empathy (Wynn & Wynn, 2006), which is key for all therapeutic relationships (Conoley, Pontrelli, Oromendia, Bello, & Nagata, 2015; Duan & Hill, 1996; Elliott et al., 2011; Meyers, 2000; Wynn & Wynn, 2006). Conversely, desensitization can be a mechanism therapists use to defray the sharp pains of secondary trauma stress (Figley, 2002a). When this happens, Figley asserts that

It is important to desensitize the therapist to traumatic stressors. In doing so, she or he has greater ability to face and work through the various issues associated with causing and retaining the traumatic stress reactions. The methods for desensitization psychotherapists are no different than those for other traumatized clients. There should be a good match between the preferences of the therapist-

client and the desensitization method utilized by the treating therapist. The method should minimize the degree of discomfort and should maximize the exposure to the stimuli which most accounts for the distressing reactions. The result of such methods, of course, should substantially decrease or eliminate the unwanted emotional reactivity linked to the traumatic stressor(s). (p. 1438)

Quality of Life Components for the Mental Health Professional

In order for the mental health professional to obtain optimal working results, he or she must participate in life fulfilling measures. Some of these measures therapists obtain through the actual therapeutic work, like resilience and posttraumatic growth. Others take a more cerebral effort on part of the worker, which are self-compassion, mindfulness, and self-care. Utilizing some form of these life components is necessary for the mental health professional's positive productivity in life and work. The investigator takes time to discuss these five qualities of life at length in this section.

Self-compassion

Self-compassion differs from compassion in one simple way: compassion is affected by the suffering of others, whereas self-compassion is affected by one's own suffering (Neff, 2003). Neff further described self-compassion as not avoiding or disconnecting from one's suffering, facing it, and being active in the healing process for oneself. She explained, "Self-compassion also involves offering nonjudgmental understanding to one's pain, inadequacies, and failures, so that one's experience is seen as part of the larger human experience" (p. 87). Neff and Vonk (2009) reported self-compassion as a significant predictor of happiness, optimism, and positive affect. Higher self-compassion is associated with greater psychological well-being and provides a buffer

against acute stressors (Neff, Kirkpatrick, & Rude, 2007). In a different study, Neff, Rude, and Kirkpatrick (2007) described self-compassion as being kind and understanding to oneself amongst suffering and attempting to understand shortcomings with recognizing that pain and failure are inevitable. These researchers concluded self-compassion involves well-adjusted consciousness of one's emotions with facing, rather than avoiding, hurt and brokenness.

Neff, Kirkpatrick, and Rude (2007) examined self-compassion to determine its link to well-being. Their study of 91 undergraduate students used a laboratory setting to examine how self-compassion might be a protective factor against anxiety. The authors created a job interview in which participants described his or her greatest weakness. The researchers hypothesized that the students with higher levels of self-compassion would report less anxiety. Neff, Kirkpatrick, and Rude reported significantly less anxiety for those participants that utilize self-compassion.

Intrigued by self-compassion, mindfulness, and the inability to find a study incorporating both phenomena, Van Dam, Sheppard, Forsyth, and Earleywine (2011) examined the cross-sectional capacity of mindfulness and self-compassion in order to predict symptoms of anxiety, depression, worry, and a measure of well-being. The authors used an international sample of 504 people reporting generalized anxiety and depression. Van Dam et al. explained self-compassion might indirectly develop and have other implications with mindfulness. According to Raes (2010), self-compassion has a link to resilience, as growing evidence proposes self-compassion contributes to psychological well-being, which could be an important protective factor, promoting emotional resilience.

Additionally, Patsiopoulos and Buchanan (2011) explained that counselors are skilled at offering compassion to clients, but might lack this in their own self-care practice. The authors' purpose was to investigate how counselors practice self-compassion in counseling. The writers sought to find how counselors cultivated self-compassion given the myriad of challenges that arise in their practice. The researchers conducted a narrative research design, investigating 15 experienced therapists' use of self-compassion. The authors provided three separate interviews, one screening, and two follow-ups. Patsiopoulos and Buchanan found self-compassion had a profound impact on counselors, and played a significant role in recoveries from family of origin wounding and abuse. The writers concluded the practice of self-compassion showed a powerful way of emotionally transforming lives, which cultivated balance, clarity, openness, wisdom, joy, creativity, freedom, job satisfaction, and burnout prevention.

Finally, the goal of Finlay-Jones, Rees, and Kane (2015) was to develop a better understanding of self-compassion as a mechanism to help trainee and professional psychologists build resilience, as well as examining the correlation self-compassion has with stress. These authors used Structural Equation Modelling (SEM) to test an emotion regulation model of self-compassion and stress among 198 participants. After controlling for age and neuroticism, self-compassion appeared to be a significant predictor of stress symptoms, with emotion regulation difficulties mediating this relationship. In SEM terms, the authors explained self-compassion did not have a direct impact on stress symptoms. However, self-compassion did reduce emotion regulation difficulties.

Mindfulness

Brown and Ryan (2003) describe mindfulness as being characteristically a state of cognizance, thus suggesting, “because of inherent capability, discipline, or inclination, individuals may differ in the frequency with which they deploy attention and awareness and also that there are intra-individual variations in mindfulness” (p. 824). Shapiro, Brown, and Biegel (2007) reported therapists are at risk for occupationally related psychological problems. The writers’ purpose was to examine the effects of Mindfulness-Based Stress Reduction (MBSR) for therapists in training. The authors sought to find the relationship between mindfulness practice and mental health outcomes. The researchers wanted to know how MBSR achieved its beneficial effects, and the effectiveness of MBSR in enhancing the mental health of therapists in training. Participants were Master of Arts in Counseling Psychology students from a Jesuit University and recruited by the writers voluntarily; 64 students participated. The writers presented MBSR interventions with 22 students, and administered pre- and post-tests, while the other students served in a control group. Shapiro et al. administered five scales regarding mindfulness, attitude, stress, reflection, and compassion. The writers found participants in MBSR intervention reported decreases in perceived stress, negative affect, as well as increases in positive affect and self-compassion. The authors reported an increase in mindful attention and awareness from pre to post-test scores, which predicted a drop in rumination, trait anxiety, and perceived stress, while finding increases in self-compassion. The researchers concluded that MBSR is helpful, as it lowers stress and enhances emotional regulation.

Richards et al. (2010) claimed mental health professionals are susceptible to impairment and burnout, which might negatively affect clinical work. The writers’

purpose was to explore the link between self-care by mental health professionals and their general well-being. The authors sought to find the relationship between self-awareness and mindfulness, and explore whether the path from self-care to well-being would be stronger if it went through mindfulness or self-awareness. The researchers utilized a sample of 148 mental health professionals living in Northeast United States. Richards et al. administered self-care surveys, the Self-Reflection & Insight Scale, the Mindful Attention Awareness Scale, and the Schwartz Outcomes Scale. The writers found self-awareness and mindfulness positively correlated; as self-awareness increased so did mindfulness and vice versa. The authors reported mindfulness was a significant mediator in relationship between self-care importance and well-being. The researchers concluded in order to receive full benefit of well-being from perceiving self-care as important, one must achieve a state of mindfulness.

Thomas and Otis (2010) claimed intrapersonal skills or abilities that might function to reduce risk by increasing resilience and improving work satisfaction in professionals has received little attention. The writers' purpose was to examine the relationships of mindfulness, empathy, and emotional separation to several aspects of professional quality of life, including compassion fatigue, burnout, and compassion satisfaction. The authors sought to find how mindfulness, empathy, and emotional separation related to compassion fatigue, burnout, and compassion satisfaction. Thomas and Otis randomly selected 400 licensed social workers from the Kentucky Board of Social Workers. The writers received 171 completed packets with usable data. The authors used the Professional Quality of Life R – IV, the Five-Facet Mindfulness Questionnaire, the Interpersonal Reactivity Index, and the Maintenance of Emotional

Separation Scale. Thomas and Otis found mindfulness and emotional separation were associated with compassion satisfaction and burnout, and emotional separation was associated with compassion fatigue. The authors concluded that increased emphasis on the intentional management of internal emotional states might be as important for clinicians as it is for clients.

Thompson et al., (2014) shared work stress and its potential results of compassion fatigue and burnout occur when individuals see the environment as taxing or exceeding their personal coping resources. The writers sought to discover if counselors' compassion fatigue and burnout is associated with perceptions of working conditions, and if gender predicted the level of compassion fatigue or burnout. The researchers wanted to know if the length of time in the field, and the use of personal resources could predict counselor compassion fatigue or burnout. Thompson et al. emailed potential participants from a convenience sample generated from the American Mental Health Counselors Association and other professional associations. The researchers received 213 usable surveys, which included completed data on five scales regarding work conditions, coping, mindfulness, traits, and quality of life. The writers concluded mindfulness attitudes lowered burnout.

Self-care

Professional mental health providers have implemented many forms of self-care. Bowen and Moore (2014) stressed the importance of self-care for the general well-being of clinicians. Bowen and Moore found that therapists receiving individual therapy benefited his or her personal health. The authors further acknowledged that therapists might be stigmatized for seeking their own therapy and advocate for its elimination (as such stigmas could suggest the therapists are weak or incompetent). Lambert and Lawson

(2013), because of their study of 125 mental health workers who responded to Hurricanes Katrina and Rita, claimed the practice of self-care helped posttraumatic growth and lowered burnout and compassion fatigue. These authors concluded the level of self-care following experiences with vicarious trauma influences whether counselors will have positive or negative effects in their personal and professional lives. Patsiopoulou and Buchanan (2011) stressed the importance of education and training in the development of self-care, because mental health professionals might not know how to treat themselves.

Sprang et al. (2011) observed that every day child welfare workers have exposure to traumatic events in the daily course of their jobs. The authors' purpose was to describe predictors of secondary traumatic stress and burnout in helping professionals with specific focus on the unique responses of child welfare workers. The writers sought to find strategies that would enhance self-care. The researchers recruited professionals from six states and Toronto, Canada. The authors received 668 completed packets via Survey Monkey. The researchers recommended the need for organizations specializing in child welfare to implement positive coping mechanisms specific to these settings in order to develop healthy work-life balance, which should include a self-care regiment.

A profession that works parallel and at times right beside the mental health practitioner is nursing. Nursing counts for a large portion of research regarding compassion fatigue; more than 68% of literature tends to have a nursing or medical field application. Aycock and Boyle (2009) completed a national survey to identify resources available to oncology nurses to counter the phenomenon of compassion fatigue. The survey results had a sample of 103 oncology chapter presidents of the Oncology Nursing Society, which represented 45% of the United States' chapters. The results showed that

46 or 45% of the participants did not receive an opportunity for knowledge and skill development in coping, adaptation, and emotional self-care. In fact, none of the participants reported that his or her employer required further education programs for preparing nurses for working with the dying. Aycock and Boyle recommended nurses experiencing physical and emotional fatigue should identify ways to renew their strength and well-being. Oncology nurses may find it helpful to build upon non-clinical strengths.

Consequently, Wood, Linley, Maltby, Kashdan, and Hurling (2011) asserted that existing positive psychology research has focused exclusively on having personal strengths rather than using strengths. The authors' purpose was to validate the Strengths Use Scale and present the first test of whether strength use leads to improved well-being. The writers sought to find the psychometric properties of a new Strengths Use Scale and if the use of strengths led to various indicators of well-being. The researchers recruited local community in Central and Northern England. Wood et al.'s design included three separate testing times: start, three months, and six months. The authors had 207 people complete all three phases of the Strengths Use Scale. The writers found that people who reported greater use of their strengths developed greater levels of well-being. The authors reported, at both three and six months, greater strength use related to greater self-esteem, vitality, positive affect, and lower perceived stress. Aycock and Boyle (2009) found that a renewal in religious faith might be a positive strength to engage to combat compassion fatigue. Others may use music or art as helpful support tools (Brooks et al., 2010; Cheek, Bradley, Parr, & Lan, 2003; Hilliard, 2006).

Another important aspect of self-care includes nurses not neglecting their own physical health while caring for others (Scott et al., 2006). This behavior is very common

in the mental health worker, as clinicians will often get lost in the care of his or her client and forget about themselves (Figley, 2002a). Balance in life is important for professional care providers in order to maintain perspective on work and spending time with family (Lawson, 2007; Sprang et al., 2011). Finding renewal from spiritual means can bring life back to the helping professional (Bowen & Moore, 2014; Brady, Poelstra, Browkaw, & Guy, 1999; Lawson, 2007; Newmeyer et al., 2014), while recalling the reasons he or she might have gone into the helping trades may rejuvenate the commitment to the profession (Aycock & Boyle, 2009). In conclusion, if strengths use naturally leads to well-being over time, such interventions may be a way to build long-term individual resilience and ideal effectiveness as clinicians (Wood et al., 2011).

Resilience

Ward (2003) describes resiliency as, “a concept that identifies and explains the critical coping skills used by individuals, families, and communities when they are beset by chronic or immediate difficulties” (p. 18). Simply put, resilience copes with the dynamics that weaken a care worker’s resolve (Fink-Samnack, 2009). Lenz, Oliver, and Sangganjanavich (2014) stated providing mental health services is a physically, psychologically, and emotionally exhausting endeavor. The authors’ conducted a study in order to evaluate the perceptions of four intern students participating in a model of supervision that integrated wellness while completing a counseling internship at a community-based trauma clinic. The researchers wanted to know in what ways counselors in training perceived models that integrated wellness as being useful to personal and professional development, and what tools emerged from participating in this model. Lenz et al. found involvement in wellness development, during training,

empowered students to adopt a lifestyle that may promote resilience beyond graduation if maintained. Hodges et al., (2005) stressed, “Resilience is an essential element for practice in a chaotic practice world. As changing health care patterns emerge, expectations shift. New skills, or at least new perspectives on emerging challenges, are needed to solve problems” (p. 548).

According to Hodges et al., (2005) teaching resilience early in educational curriculums will provide health care professionals needed skills to fend off compassion fatigue, beginning as students and carrying into career paths. These coping skills are numerous and can be different for all clinicians. Tjeltveit and Gottlieb (2010) claimed, “By learning to enhance their resilience and minimize their vulnerabilities, psychotherapists can learn to avoid ethical problems and move toward ethical excellence” (p. 99).

Tjeltveit and Gottlieb (2010) proposed utilizing the DOVE concept: desire, opportunities, values, and education. Each section of the DOVE, according to the authors, can foster ethical behavior and professional resilience. The authors claim that using the continuum contained within each dimension ranging from protective strength to significant vulnerability to major risk factor, will enhance resilience, and help minimize vulnerabilities. Desire to help denotes a resilience because it can maintain work even in the face of adversity. Certainly, many contend that goodness and kindheartedness is at the soul of what it means to be a professional, and without it, there would be no true professions. Brokenness presents therapists with opportunities to seek better health and healing for their clients. A drive to succeed can keep the working professional focused on

the end result, which finds clients meeting goals and experiencing a sense of accomplishment.

The second dimension of DOVE is opportunities. The mental health professional's desire to help clients should avail positive opportunities for healing. However, these positive opportunities for clients can present difficulties for the professional. According to Tjeltveit and Gottlieb (2010), when a psychotherapist is vulnerable to the stresses of work, it may become difficult to focus on asking key questions, focus on evaluating the client carefully, think adequately about the consequences of accepting the client, or obtain the emotional energy to refuse to treat a client and refer them. Consequently, opportunity can build resilience or be devastating to the therapeutic processes.

The third dimension is values, which can promote resilience. Clinicians tie professional values to personal values that arise from individual experience, reflections, and traditions. According to Tjeltveit and Gottlieb (2010), values usually lead people in positive directions and help accomplish worthwhile goals. Proper education, the fourth dimension, can prepare psychotherapists for the trench work that stands before them. Being aware of the dangers that may be lurking is a valuable tool for professional care providers to have. Tjeltveit and Gottlieb emphasize the following:

Not all trainees in professional preparation programs have the opportunity to acquire these skills at an optimal level. Too many professionals complete their training without the emotional education and awareness needed to avoid self-deception and to act in the prudent, considered manner that society expects and that represents professional ethical excellence. (p. 105)

Thus, mental health professionals find themselves trapped and possibly making poor decisions that can result in forfeiture of license, or other consequences.

Posttraumatic Growth

Brockhouse et al. (2011) explained therapists who work with traumatized individuals could experience psychological growth following this vicarious exposure to trauma. The authors' purpose was to examine the variables that may moderate vicarious posttraumatic growth in therapists. The writers sought to find how vicarious exposure to trauma positively predicted growth in therapists. The researchers wanted to know how coherence, perceived organizational support, and empathy moderated the relationship between trauma and growth. The writers examined 118 therapists working directly with trauma clients. Brockhouse et al. used a Career Exposure Scale, Sense of Coherence Scale, Perceived Organizational Support Scale, and the Post Traumatic Growth Inventory. The researchers found a high sense of coherence, high empathy, and moderate organizational support. The authors noted therapists receiving personal therapy had more posttraumatic growth. The writers concluded that empathy played a moderating role; less empathy equaled more growth. Furthermore, therapists with the lowest levels of empathy only reported the positive relationship between vicarious exposure to trauma and growth; medium levels of empathy related to a lesser degree.

Despite the threatening tendency that vicarious traumatization, secondary trauma stress, and compassion fatigue have on the mental health professional, working with trauma can have positive results (Arnold et al., 2005). Researchers have suggested that a therapist's awareness and even unconscious responses to clients' trauma stories can help to assist healing (Pearlman & Saakvitne, 1995). Additionally, mental health clinicians

may experience psychological growth when they achieve a better understanding of clients' resistance or reluctance to share hurtful feelings (Barrington & Shakespeare-Finch, 2013). Brady et al. (1999) reported that clinicians who work with trauma survivors sometimes feel fulfilled with unintended work rewards, such as gains in relationship skills, heightened awareness of resilient people, the satisfaction of observing clients' growth, and their own personal growth and spiritual well-being. Ben-Porat and Itzhaky (2009) also concluded that mental health workers might experience psychological growth, which can enrich therapists' lives, while increasing an appreciation of life and their understanding of themselves and others, and empower them to form new relationships and strengthen existing ones.

Additionally, through vicariously experiencing the trauma of their clients, therapists may reap the benefits of posttraumatic growth without suffering the same intensity of pain as their clients (Triplett, Cann, Calhoun, & Reeve, 2012). Barrington and Shakespeare-Finch (2013) expounded upon Triplett et al.'s theory by expressing the importance of knowing how trauma workers can foster such positive outcomes on clinical implications, such as enhanced clinician well-being, role retention, and improved therapeutic outcomes. Arnold et al. (2005) examined 21 trauma workers who reported some type of negative response because of working with traumatized clients. However, these authors found it interesting that all the therapists concurrently reported some positive endings such as gains in empathy, compassion, tolerance, sensitivity, and improved interpersonal relationships, which is consistent with Ben-Porat and Itzhaky's (2009) findings. Further results from Arnold et al. revealed a deepened appreciation for human resilience, matching Brady et al.'s (1999) study, a greater appreciation of life, a

desire to live more meaningfully, and experiences of positive spiritual change. These findings support the theory of McCann & Pearlman (1990) that if a trauma worker engages in similar processes to that of the survivor they might also successfully incorporate and convert their vicarious trauma experience to maximize the possibility of growth. Understanding how trauma workers foster such positive outcomes has important clinical implications (Barrington & Shakespeare-Finch).

It is exactly these implications that caused Barrington and Shakespeare-Finch (2013) to study 34 frontline clinical, managerial, and administrative staff members at Queensland Program of Assistance to Survivors of Torture and Trauma. All participants engaged in a semi-structured interview. The goal of the interview was to examine the experiences of working with refugee survivors, with a particular focus on how clinicians made sense of the upsetting stories they heard and whether they experienced any positive outcomes because of their work. According to Barrington and Shakespeare-Finch, vicarious trauma comes before vicarious growth. Therefore, these authors state, “It is impossible for a trauma worker to experience significant growth without first feeling somewhat traumatized by their work” (p. 94). Within their study, they found all participants reported some form of vicarious trauma. Some clinicians even reported post-traumatic stress disorder symptoms because of working so closely with traumatized refugees. The authors found all participants experienced some philosophical change, because of making sense of their work with refugees. The workers commonly described an opening of their mind or increasing sense of cognizance followed by a positive spiritual change. Twelve participants explained a positive change within their inner-self and 12 improved interpersonal relationships. Notwithstanding the innate stressors of

working with refugees, all the participants of Barrington and Shakespeare-Finch claimed preoccupation with the positive influences they experienced. The authors added, “The fact that they preferred to talk about the benefits of their work indicates that theories of vicarious traumatization fail to represent the total vicarious experience of clinicians who support refugee survivors” (p. 100). The writers concluded that the psychological distress of these clinicians apparently lessened because they were able to make meaning of their experience and grow from it.

Career-sustaining Behaviors

Another protective armor that therapists use to stay well is the use of career-sustaining behaviors. Coping skills for mental health professionals may include career-sustaining behaviors, a concept developed by Brodie (1982), and further examined and revised by others (Kramen-Kahn, 1995; Lawson, 2007; Lawson & Myers, 2011; Stevanovic & Rupert, 2004; Rupert & Kent, 2007). Kramen-Kahn and Hansen (1998) studied 208 psychotherapists in order to examine rewards, hazards, and career-sustaining behaviors. Career-sustaining behaviors empower clinicians to create specific strategies for managing and promoting resiliency in the face of job-related stressors. The use of career-sustaining behaviors positively related to rewards and negatively correlated with hazards. Thus, it appears that participants experiencing less stress and more rewards portrayed more career-sustaining behaviors. The most highly rated career-sustaining behaviors were a sense of humor, perceiving client problems as interesting, engaging in leisure activities for renewal, seeking case consultation, and engaging in leisure activities for relaxation. Kramen-Kahn and Hansen also found gender differences in the experience of rewards and the use of career-sustaining behaviors. They found women reported

greater rewards, more overall use of career-sustaining behaviors, and more specific use of five behaviors, which were continuing education, personal therapy, positive self-talk after a challenging day, and self-talk to put aside thoughts of clients.

Stevanovic and Rupert (2004) studied 286 licensed psychologists in order to examine stresses and satisfactions regarding their work. According to Stevanovic and Rupert, psychologists working in professional practice encounter many challenges as they attempt to provide competent services, practice within ethical standards, and make a living in a high demanding profession. Although the mental health profession is demanding, Stevanovic and Rupert believe that for the most part psychologists appear able to cope and feel good about their work, which keeps them healthy and able to avoid burnout. Stevanovic and Rupert found a high satisfaction among their sample.

Psychologists reported several coping mechanisms to keep them happy and content with their profession. These researchers cautioned that even though their sample was adequate, making a generalized statement to the entire psychology profession would not be prudent. However, they did mention that a large population of satisfied clinicians connects good strategies and behaviors for keeping mental health workers healthy and able to carry out their duties. Stevanovic and Rupert reported similar results as that of Kramen-Kahn and Hansen's (1998) study on career-sustaining behaviors. The two studies found the four behaviors in common to be maintaining a sense of humor, perceiving the client's problem as interesting, engaging in leisure activities for renewal and relaxation, and seeking case consultation. The authors did conclude that psychologists participating in less career-sustaining behaviors were more susceptible to burnout and professional impairment.

Rupert and Kent (2007) studied 595 psychologists to determine professional activities, work demands and resources, career-sustaining behaviors, and levels of burnout. They claimed seven career-sustaining behaviors to have significant differences between genders. These behaviors were (a) seek case consultation, (b) discuss work frustrations with colleagues, (c) spend time with friends, (d) maintain self-awareness, (e) maintain balance between personal and professional lives, (f) vary work responsibilities, (g) try not to feel a sense of responsibility for client problems. A study completed by Lawson (2007) regarding counselor wellness found the top five career-sustaining behaviors utilized by his sample of 500 counselors were maintain a sense of humor, spend time with partner or family, maintain balance between professional and personal life, maintain self-awareness, and maintain control over work responsibilities.

Comparing the previously mentioned studies, it appears maintaining a sense of humor was the most utilized career-sustaining behavior among participants. Both psychotherapists and psychologists frequently used recognizing a client's difficulties as fascinating and pursuing consultations with colleagues as important. Stevanovic and Rupert (2004) found behaviors of participating in peer support groups and receiving clinical supervision to be among the career-sustaining behaviors reported as being least important to professionals. Several studies of career-sustaining behaviors used by mental health providers have recorded that participants tended to utilize a wide variety of career-sustaining behaviors (Kramen-Kahn & Hansen, 1998; Lawson, 2007; Lawson & Meyers, 2011; Rupert & Kent, 2007; Stevanovic & Rupert, 2004). Rupert and Kent found 17 strategies that were given mean ratings of over five (out of seven) and six strategies with ratings above six. These scores indicate that either a relatively high percentage (68%) of

career-sustaining behaviors were moderately or highly important. Rupert and Kent's claims that mental health providers find career-sustaining behaviors to be important is similar to the finding of Stevanovic and Rupert, where these authors reported an even higher percentage (76%) of career-sustaining behaviors listed by their participants as important.

Finally, Lawson and Myers (2011) stated counseling educators, counseling students, and professional counselors all face challenges to optimal well-being. The writers' purpose was to address gaps in the literature concerning counselor wellness in relation to professional quality of life and career-sustaining behaviors. The researchers sought to find the levels of wellness, professional quality of life factors, and career-sustaining behaviors among professional counselors. The writers wanted to know the relationship between wellness, professional quality of life, and career-sustaining behaviors among professional counselors, and if any differences were present when compared to normed samples in allied professions. Lawson and Myers surveyed 1,000 randomly selected members of the American Counseling Association; and received 506 usable surveys. The writers utilized the Professional Quality of Life III – Revised, Career-Sustaining Behaviors Questionnaire, and the 5F-Wel Scale. The authors found participants reported greater wellness than previous research, along with higher positive professional quality of life factors, like compassion satisfaction and lower negative factors, such as compassion fatigue and burnout. Lawson and Myers concluded more career-sustaining behaviors present in a clinician resulted in lower compassion fatigue, burnout, and higher compassion satisfaction.

The use of career-sustaining behaviors is just a part of the puzzle for keeping mental health professionals well. This investigator began the literature review with defining the two most needed skills to be an effective clinician. Then the three main phenomena of the study received an in-depth description, followed by two other psychological disturbances. The researcher examined countertransference and desensitization in order to differentiate these disturbances. The writer emphasized the importance of self-compassion, resilience, mindfulness, self-care, and posttraumatic growth in order to ward off unhealthy schema. All these pieces culminate in presenting the importance and goal of this study: keeping the mental health professional well so they can enjoy a long career helping the hurting and broken.

Keeping the Mental Health Professional Well

According to Figley (2002), mental health professionals work hard at helping clients move to a healthier place in life, often ignoring their own personal well-being. In contrast, Burck, Bruneau, Baker, and Ellison (2014) claimed, “Despite the stress of postgraduate education, students in various mental health and medical disciplines are aware of the need for personal wellness and engaged in activities to enhance their optimal development” (p. 40). Zeidner and Hadar (2014) explained health care professionals working with traumatized clients find themselves exposed to excessive stress, which may result in compassion fatigue, burnout, and secondary trauma stress. The authors’ purpose was to explore predictors of professional quality of life and well-being in healthcare practitioners. The writers sought to find how emotional intelligence and ability-based emotion regulation positively related to compassion satisfaction, which links to clinician well-being (Smart et al., 2014). Zeidner and Hadar wanted to find if positive affective

states result in compassion satisfaction, and the positive adaptive coping strategies linked to compassion satisfaction. Zeidner and Hadar administered six different scales to 89 mental health practitioners and 93 physicians from seven major hospitals and six private clinics in Northern and Central Israel. The authors found self-reported emotional intelligence positively linked to compassion satisfaction, with positive affect linked to higher satisfaction. The writers reported satisfaction in all clinicians with patient improvements and emotional competencies positively related to higher problem-focused coping. The researchers concluded practitioners high in emotional intelligence were more likely to select problem-focused strategies, which increased compassion satisfaction and ultimately overall professional quality of life and well-being.

Understanding wellness for counselors in training, or developing counselors, is important as this has implications for their counseling career and the profession as a whole (Burck et al., 2014). Bazarko et al., (2013) examined mindfulness and the impacts of being aware of self and the inner emotions one has can assist medical care personnel in staying well. These authors studied nurses by implementing a Mindfulness-based Stress Reduction program. The authors set up three measurement periods: baseline at beginning, two-month stage, and four-month stage. The writers utilized the Brief Serenity Scale, Copenhagen Burnout Inventory, Jefferson Scale of Physician Empathy, and a Self-Compassion Scale. Seventy-two nurses participated; however, 36 nurses completed all three stages. The authors observed that nurses finishing the four-month program were healthier with improved well-being. Bazarko et al. found that nurses completing the program reported maintaining their practice was simpler. Bazarko et al.'s results expound on the findings of Brown and Ryan (2003). Brown and Ryan studied mindfulness and

how psychological well-being is impacted by being mindful, which at the time did not focus on outcomes like Bazarko et al. Brown and Ryan, however, did claim, “A direct route through which mindfulness may enhance well-being is its association with higher quality or optimal moment-to-moment experiences” (p. 824).

Stress and burnout influence teachers’ professional lives, mental and physical well-being, according to a study by Cheek et al. (2003). The writers’ purpose was to determine the effectiveness of music therapy techniques as an intervention for teacher burnout. However, the authors found parallel work with the mental health industry. Cheek et al. found lower levels of burnout in teachers using music therapy techniques in conjunction with cognitive behavioral interventions. Given the use and knowledge of cognitive behavioral work, the researchers determined mental health professionals could benefit also from music therapy. Cheek et al., further added music could be effective without music knowledge. The writers recommended that future research in stress, burnout, and well-being be in collaboration between mental health counselors, educators, and researchers.

Spirituality, according to Newmeyer et al., (2014) played a significant role in stress reduction and enhanced psychological well-being. The authors examined 22 mental health providers and concluded that spirituality provided a basis for an enhanced quality of life, and participants who embraced this identity were able to give purpose and meaning to their career. Burck et al., (2014) also found spirituality as a descriptor of wellness in the therapists taking part in their study. These authors reported that wellness included physical and emotional health. The physical components included exercise, nutrition, and recreational activity, while the emotional part included mental well-being,

having social support, and using relaxation methods. Additionally, the researchers reported physical and emotional health as working together in achieving wellness. Furthermore, other mental health professionals according to Richards et al. (2010) linked self-care to self-awareness or mindfulness; however, these authors concluded that such a link is not necessary for overall wellness. Richards et al. recommended counselors should be mindful of self and adhere to practices that enhance overall well-being, which to them was an emphasis on self-care.

According to Linley & Joseph (2007), research on the well-being of therapists has been practically fixated entirely on the negative costs of caring, rather than the personal development and fulfillment that therapists may themselves experience as they seek to empower these changing experiences in their clients. Linley and Joseph explored the negative and positive costs of caring in 156 therapists in order to take a deeper look into the results and compare them to the overall well-being of clinicians. The authors found the therapeutic relationship as the best predictor of psychological changes and compassion satisfaction, which fostered positive well-being. Linley and Joseph reported therapists who either had been, or were currently receiving personal therapy in respect to their therapeutic work reported positive psychological changes and less burnout. Further reports included therapists who had been working in the profession for many years gave inclinations towards less positive psychological change and higher burnout, leading the authors to state, “A lifetime career in therapeutic work may not be conducive to personal satisfaction and growth” (p. 398). Linley and Joseph concluded that mental health professionals are responsible for the clients they attend to, and must be at their best in the

therapeutic process, which includes the importance of maintaining personal well-being in order to avoid the negative effects of compassion fatigue and burnout.

Ohrt and Cunningham (2012) shared professional counselors suffer from burnout and impairment. The authors' purpose was to discover how work environments influence the sense of wellness in professional counselors. The writers sought to find how a professional counselor related to the concept of wellness. The researchers desired to know how a professional counselor's perceptions of their agency influenced their sense of wellness. Ohrt and Cunningham recruited 10 participants through a mixture of criterion based and snowball sampling strategies. The writers utilized a general demographic questionnaire and conducted individual and group interviews. The authors found five themes emerged from their study: resources, time management, occupational hazards, agency culture, and individual differences. The writers found that overall environment might play the more important role in wellness. The researchers concluded counselor wellness might increase when agencies have consistent treatment team meetings and individual supervision sessions. Ohrt and Cunningham emphasized the point that counselor wellness is an important element of ensuring effective and ethical services to clients. The authors recommended counselors and clinical directors should advocate for reasonable caseloads and encourage wellness days for staff.

Augustine and Anuradha (2015) conducted exhaustive in-depth interviews of eight school counselors, all possessing post-graduate degrees, and training in counseling. These authors found a healthy mind, defined as emotionally, psychologically, and spiritually well balanced, would mutually support a healthy body. In other words, a healthy body with a healthy mind creates a state of well-being. According to Augustine

and Anuradha, balance of mind is one of the most vital characteristics of a developed person. Their study showed that a balanced state of mind is an attainable phase in human life, which leads to the feeling of well-being. The authors emphasized the understanding of psychological well-being to be sharp thinking, positive behavior, and a good personality. Psychological well-being includes an inner freedom, happiness, and harmony. Augustine and Anuradha concluded, "Psychological well-being can be viewed as a gift the counsellor gives to himself or herself" (p. 187).

Conclusion

Mental health professionals who care for clients who have experienced trauma or other maladaptive behaviors may encounter compassion fatigue, secondary trauma stress, and burnout. These phenomena can have devastating effects on the mental health clinician as well as inhibit the care they provide to clients. Although there has been an urgency on creating treatment modalities that assess and treat trauma or other forms of brokenness for those who directly experience various types of trauma, it appears that little effort is being made to find effective interventions to assist the helpers (Bercier & Maynard, 2013) . While there may be some features or techniques of trauma treatment that can impact or be adapted to treat compassion fatigue, secondary trauma stress, and burnout, the mental health field cannot assume that trauma interventions intended to treat original clients will be effective in treating compassion fatigue, secondary trauma stress, or burnout among mental health professionals. Like all other interventions, those with informative evidence utilized to further the field of mental health must implement interventions intended to assist mental health professionals. According to Bercier and Maynard, while it is important to provide effective interventions to clinicians who may be

experiencing the phenomena of compassion fatigue, secondary trauma stress, and burnout, it seems logical to encourage more work in these areas to gather more clearly defined evidence. Continuing research will benefit mental health professionals, organizations as a whole, and their clients.

As Adams et al. (2006) found, secondary trauma stress and burnout directly influences compassion fatigue. In another study, Adams, Figley, and Boscarino (2008) found, psychological problems arising from caregiving are equal in importance with secondary trauma stress and burnout. These authors' purpose was to assess the difference between secondary trauma stress and burnout, and to examine the utility of secondary trauma in predicting psychological distress. The writers sought to find the factors that increase or decrease the level of secondary trauma stress and burnout. Adams et al. (2008) desired to find how working with traumatized clients relates to secondary trauma and burnout, while seeking the predictive power of the trauma and burnout for psychological health. The researchers found exposure to clients traumatized by the terror attacks of the World Trade Center increased secondary trauma stress, but not burnout. The investigators found secondary trauma and burnout were related to psychological problems. Adams et al. (2008) concluded more work is necessary to better specify the risk and protective factors for compassion fatigue and psychological consequences. Boscarino et al. (2004) reported that their study supported the concept that compassion fatigue is a unique feature of the workplace environment and is not merely a different conceptualization for negative life events. These authors recommended that mental health professionals need oversight and surveillance to help minimize compassion fatigue, secondary trauma stress, and burnout.

Taken as a composite, the literature suggests that a growing amount of research has verified the need for continuing investigations into how compassion fatigue, secondary trauma stress, and burnout are affecting today's mental health professionals (Bowen & Moore, 2014; Bride, 2004; Figley, 1995, 2002; Zeidner & Hadar, 2014). Further research calls for the need for well-being in these critical helping roles (Bazarko et al., 2013; Lawson, 2007; Lawson & Myers, 2011; Richards et al., 2010). Additionally, empirical studies have recommended that the more career-sustaining behaviors utilized by clinicians results in less compassion fatigue, secondary trauma stress, and burnout (Brodie, 1982; Kramen-Kahn & Hansen, 1998; Lawson, 2007; Lawson & Myers, 2011; Stevanovic & Rupert, 2004). Further studies imply teaching coping skills, the importance of self-care and well-being to the mental health student will better prepare psychotherapists for the future (Harr & Moore, 2011; Lambert & Lawson, 2013; Lawson, 2007; Orht & Cunningham, 2012; Richards et al., 2010). Finally, research has indicated that mental health professionals should have trainings and educational opportunities made available to them, which would present the risks involved with compassion fatigue, secondary trauma stress, and burnout (Sprang et al., 2007; Thomas & Otis, 2010). Such trainings would present skills associated with quality of life, such as mindfulness, self-compassion, resilience, and self-care (Bazarko et al., 2013; Brown & Ryan, 2003; Figley, 2002b; Fink-Samnick, 2009; Hodges et al., 2005; Lambert & Lawson, 2013; Neff, 2003; Patsiopoulous & Buchanan, 2011; Richards et al., 2010; Shapiro et al., 2010).

Summary

The abundance of research accumulated especially in the last two decades calls for action in the psychotherapeutic world. The present study attempted to fill the gap in

the literature that connects the importance of educational preparation in conjunction with keeping oneself well in order to keep competent mental health professionals working and leading successful careers while assisting broken, hurt, and traumatized clientele. The following chapter includes an in-depth review of the quantitative methodologies and two qualitative questions used in conducting this study, and describes how these methodologies assisted in answering the three research questions generated within the research.

CHAPTER III

METHODOLOGY

Introduction

There is minimal research on the impact compassion fatigue has on health (Sabo, 2006). What has been clinically accepted, however, are physical and emotional exhaustion and illness (Radziewicz, 2001). General symptoms of emotional overextension can affect a person's physical, emotional, behavioral, and spiritual function (Aycock & Boyle, 2009). Radziewicz explained,

many of these symptoms lead to maladaptive coping mechanisms including the self-destructive behaviors of overworking, hyperactivity, procrastination, overeating, and substance dependency including drugs, alcohol, cigarettes, caffeine, and foods high in carbohydrates and fat. If there is no intervention, breakdown often shows itself as physical and psychological exhaustion, loss of drive, or illness. (p. 858)

It is of the utmost importance to keep the mental health professional well. Seeking improved educational processes, communicating specific aspects of awareness, and prevention may be helpful for improving the concerns of compassion fatigue, secondary trauma stress, and burnout. Consequently, this study examined the presence of the three main phenomena of compassion fatigue, secondary trauma stress, and burnout among licensed mental health professionals. It was the aim of this researcher to find predictive factors of these aforementioned phenomena, consider the use of career-sustaining

behaviors by mental health workers, and how such behaviors may relate to his or her work. This dissertation was an applied research study intended to provide important data for assisting mental health professionals in their daily work. This study, exploratory in nature, attempted to address a particular gap within the compassion fatigue literature, and to understand possible factors that could provide valuable knowledge to keep mental health workers well and employed in a profession that is tedious, stressful, and impactful. This chapter provides a systematic examination of the research methodology utilized including a description of the study's population, participants, data collection, analytical methods, and limitations.

In order to examine the intricacies of the three main phenomena of this study the researcher sought to find answers to the following research questions:

1. To what extent are compassion fatigue, secondary trauma stress, and burnout present in the work of licensed mental health professionals?
2. What risk factors appear predictive of compassion fatigue, secondary trauma stress, and burnout in licensed mental health professionals?
3. What relationship exists between career-sustaining behaviors and compassion fatigue, secondary trauma stress, and burnout?

Research Design

This segment describes the methods and procedures exercised to answer each research question and stipulates the conjectural underpinnings for the specific methodology utilized by the researcher. The project used a quantitative design; however, the investigator did insert two qualitative questions as part of his demographic questionnaire in hopes of providing an opportunity for the participants to comment

directly on experiences with the study's three main phenomena of compassion fatigue, secondary trauma stress, and burnout. These two qualitative questions were phenomenological in nature, which allowed the researcher to examine common experiences by the participants (Creswell, 2013). Prior to the inclusion of these qualitative questions, the investigator piloted them to determine if the study would benefit. Leedy and Ormrod (2013) emphasized the use of pilot studies in order to eliminate weaknesses or maximize possible strengths.

The researcher established the pilot questions after work modeled by Moustakas (1994), who emphasized phenomenological studies only need to ask two broad questions: What is the experience with the phenomenon, and what situations have affected those experiences? Therefore, the researcher asked the following questions:

1. What is your experience with the phenomena of compassion fatigue, secondary trauma stress, and burnout?
2. What situations have affected the experiences with compassion fatigue, secondary trauma stress, and burnout?

These questions, along with the rest of the demographic questionnaire appear in Appendix D. According to Moustakas, a technique known as clustering helped this investigator establish core themes of the experience of the phenomena by the participants. The investigator noted matching themes. Leedy and Ormrod (2013) explained that a pilot study helps determine the feasibility prior to use in the larger study and as a result, this researcher found the information to be a benefit to the overall project and established the qualitative questions as a permanent fixture to the demographic questionnaire. Utilizing the themes, this researcher was able to construct an individual textural description

(Moustakas, 1994). The investigator was then able to discuss common experiences of the participants, which captured the essence of the phenomena, which is termed essential, invariant structure by Creswell (2013). Thus, the investigator used these two questions to answer research question one, which sought the presence of compassion fatigue, secondary trauma stress, and burnout in professional helpers. The demographic questionnaire sought further information such as, gender, type of license, years in profession, average hours of work per week, percentage of clients that would fit the definition of traumatized (Adams et al., 2006; Boscarino et al., 2004), use of clinical supervision per month, and current caseload.

Furthermore, to analyze research question one the investigator used descriptive analyses with mean and standard deviations across the results of all three instruments, which included the demographic questionnaire, the Burnout Measure, and the Professional Quality of Life scale. According to Leedy and Ormrod (2013), descriptive research “can reveal the multifaceted nature of certain situations, settings, processes, relationships, systems, and people” (p. 140). Categorical responses were analyzed using frequency counts and the researcher used some key demographic variables to explore percentages and the results. Counting the number of times a theme or behavior is present across participants helps in determining its contribution to the overall phenomena (Salkind, 2012).

In order to answer research question two, which sought predictive factors of compassion fatigue, secondary trauma stress, and burnout, the researcher used total scores of the Burnout Measure (Pines & Aronson, 1988), the total scores of the burnout and secondary traumatic stress subscales from the Professional Quality of Life Scale

(ProQol-5) (Stamm, 2009), and the demographic questionnaire. The investigator collected information from the Career-sustaining Behavior Questionnaire (CSBQ-R) (Kramen-Kahn, 1995) as predictors. The CSBQ-R provided how often certain behaviors being present correlated to the severity or decline of the phenomena under study. To determine the predictive power of each variable, the researcher performed three regression analyses. The original authors granted permission for the use of the aforementioned scales. Copies of these permissions are located in Appendix E.

Research question three sought to determine what relationship exists between career-sustaining behaviors and compassion fatigue, secondary trauma stress, and burnout among licensed mental health professionals. The CSBQ-R and the ProQol-5 established the necessary data. The investigator utilized Pearson product moment correlation to determine the relationship between variables. According to Leedy and Ormrod (2013), the Pearson is most widely used by researchers when seeking correlations.

Population

The investigator obtained feedback from the pilot in writing via email. The researcher obtained an email database of 40 area-licensed clinicians from a Midwestern State counseling agency. Four emails returned undelivered and one clinician responded she did not have a current license. The investigator received 9 completed pilot forms for analyses.

The participants in this research study were licensed mental health professionals from three Midwestern United States' counseling agencies. One of these agencies was that of the researcher. A total population of 95 licensed clinicians work at these three

sites. The investigator collected 37 completed survey packets, a response rate of 38.9%. Of the 37 respondents, 9 were male (24%), 26 were female (70%), and two declined to answer. The mean age was 41. Professional licenses held were licensed professional counselors (3), limited licensed professional counselors (12), social workers (18), and psychologists (2). One participant chose not to share what license they hold. The average years in the profession was 8.5. Overall, average hours of work per week was 31.75. Two participants claimed to have no clients that fit the trauma definition and four participants declined to answer this question. For those participants answering the trauma question the overall percentage of clients seen with trauma was 56.4%. The average amount of hours of clinical supervision participated in monthly was 2.5. The average caseload for each participant was 19.

Data Collection

The investigator compiled all measurement scales into individual packets with specific instructions and hand delivered to three Midwestern United States' counseling agencies prior to the start of the study. These agencies granted permission for their staff to participate. The researcher made the surveys available for participants from August 10, 2015 through January 23, 2016. The investigator sent reminder emails to the agency directors on three separate occasions in order to achieve a higher response rate.

The research packets included an introductory cover letter, a copy of the Internal Review Board approval from Olivet Nazarene University, the demographic questionnaire, the Professional Quality of Life scale, the Burnout Measure, and the Career-sustaining Behavior Questionnaire; these materials were contained in a large manila envelope. The investigator included an instruction sheet with several modes of

communication available should anyone have any questions along with a reply envelope for the signed consent, in order to keep the packets separate and protect confidentiality. The reader can reference Appendix F for a copy of the participants' cover letter with instructions.

The investigator collected completed survey packets from the individual agencies. Each agency created a collection area near the front desk for participants to place completed packets. Upon picking up the completed packets, the researcher coded each reply and packet. The investigator then created databases within SPSS to begin the analysis.

Analytical Methods

The researcher used several analytical methods to examine and interpret the data collected through the study. Descriptive research is designed to “use a variety of strategies to measure complex variables” (Leedy & Ormrod, 2013, p. 191) and helps the researcher understand how events that are occurring in the present relate to other factors by organizing and describing characteristics of a collection of data (Salkind, 2012; 2014). For these reasons, this investigator implemented descriptive statistics in this study to identify frequencies in responses to research question one in order to examine the possible existence of compassion fatigue, secondary trauma stress, and burnout.

The researcher used parametric statistics to determine predictive factors of the phenomena in research question two. For this question, the investigator applied multiple-regression analyses. According to Leedy and Ormrod (2013), regression analyses allows a researcher to examine how effectively one or more variables can

predict another variable. Salkind (2014) further explains using regression analyses is best when examining relationships between variables when more than two are present.

Another key analytic to this study was the examination of correlations between various variables, such as the participants' answers to the ProQol-5 and the Burnout Measure and the types of career-sustaining behaviors the participants claim to use. These correlations were especially important when looking at research question three, as well as the predictive factors of compassion fatigue, secondary trauma stress, and burnout. Correlation cannot prove causation, as Salkind (2014) contends that having a great marriage does not automatically make a spouse a good parent. However, finding a correlation in data does prove positive and points at the nature of a relationship, be it positive or negative (Leedy & Ormrod, 2013). The specific correlative test performed in this study was Pearson product moment correlation. Salkind (2014) explains when determining relationships it is best to accumulate as much data as possible in order to get the "truest representation" (p. 84).

Additionally, in the open-ended qualitative questions on the demographic survey content analyses allowed the researcher to develop patterns within the participants' responses. Qualitative research allows depth, according to Leedy and Ormrod (2013), the investigator can "capture and study the complexity of phenomena" (p. 139). This reasoning is why the researcher implemented phenomenological questions. According to Leedy and Ormrod, "a phenomenological study tries to answer the question, what is it like to experience such-and-such?" (p. 141). Quite often, the researcher has had personal experience with the phenomena and is seeking further information or clarity among peers. Such an understanding was the desire of this investigator, as it was the purpose of

this study to examine the levels of compassion fatigue, secondary trauma stress, burnout, and career-sustaining behaviors among licensed mental health professionals in order to recommend possible mechanisms for ameliorating the well-being of clinicians.

Limitations

The present study offered a number of valuable findings to the literature; however, there were limitations to the study. In this section, this investigator discusses these limitations and the most meaningful or those having the greatest impact, including how the findings might directly affect the study. The limitations, several in number, are not in a particular order of importance. One of the agencies in this study has suffered many budget cuts, causing what their director described as “low morale”. Low morale or a fear of job loss due to these budget cuts may affect the participants from this organization to post scores that do not accurately reflect the true purpose of study surveys. This same agency may also be giving a lower response due to agency stressors, which may lower overall response rates. Two of the agencies have religious affiliations, which could skew scores versus non-religious organizations making for difficulty in generalizing. One of the agencies in the study is the organization the researcher co-founded and is currently the director, which could influence potential answers, if staff answer what they think the investigator wants to know. Furthermore, the researcher’s name was included in the cover letter that accompanied the survey packets. In the event that a participant knew the researcher personally, this could have skewed responses or influenced participation.

This study took place in the Midwestern United States, which typically shares a religiously conservative worldview. Answers may be more consistent along religious

lines, as the sample may have a higher Christian participant rate. Religious affiliation was not a demographic that the researcher sought. Additionally, personal biases of the investigator that self-care is vital to the longevity of the mental health professional could affect the flow of the investigation. The overall population used for this project is small (95). The smaller the population the more difficult it is to generalize to a larger population.

The researcher presented the surveys to the organizations at the same time, but the responses by participants were not all completed at the same time, which could alter responses based on mood at the time surveys were filled out. The majority of participants completed their surveys in late summer or early fall, which could influence answers as the weather is better and generally, workloads are lighter, versus winter schedules. Consequently, the results may indicate less stress, compassion fatigue, and burnout.

Finally, the reliance upon participant self-reported data on the surveys could cause for a limitation. Robson (2011) explained that some might doubt the credibility or objectivity of participants reporting on something in which they are centrally involved. Because self-reported data limits the ability to independently verify the information, this presents a methodological limitation to the study.

Summary

Chapter three of this dissertation project provided a map of what this researcher did. It avails a systematic plan of the answers to each research question. It has been the goal of this investigator to be thorough and detailed and present a guide for future replication. In order to acquire as full a portrayal as possible of the licensed mental health professional's experience with compassion fatigue, secondary trauma stress, and burnout,

the researcher followed the recommendation of Moustakas (1994) and Creswell (2013) to use phenomenological inquiries to enrich the depth of information. This method in conjunction with quantitative data formed “contributions to a single, greater whole” (Leedy & Ormrod, 2013, p. 258). The representation of mental health professionals that develops from this study is multi-faceted. One facet that has the probability for further study will commence examination in chapter 4. Following, in the fourth and final chapter, the researcher will report results of the data collection and analyses, inferences depicted, and implications and recommendations offered.

CHAPTER IV

FINDINGS AND CONCLUSIONS

Introduction

This investigation has explored the presence of compassion fatigue and examined predictors that might include or exclude traumatic stress. The data collected through this research project reported a direct impact that the three main phenomena of compassion fatigue, secondary trauma stress, and burnout have on the work and lives of mental health professionals. The researcher tested and analyzed the relationship between career-sustaining behaviors and the psychological disturbances of compassion fatigue, secondary trauma stress, and burnout in order to find possible ameliorations affording mental health workers' positive well-being. In this final chapter, the investigator will summarize the content of the previous three chapters and then provide the results of the data collection, the analysis of the research questions, and discuss interpretations of the findings. Finally, the researcher presents the conclusions, implications, and recommendations resulting from this investigation.

Chapter one introduced the topics of compassion fatigue, secondary trauma stress, and burnout. This chapter provided a brief background of the phenomenon and introduced the reader to the key terms found within the study. The researcher shared the problem statement, significance of the study, and the process to accomplish. The process to accomplish includes a brief overview of the research procedures and methodology. For each research question the investigator described what would be accomplished, what data

would be collected and from where and how it would be analyzed. The significance of the study explains the rationale as to how this research is important to the well-being of mental health professionals.

The phenomena of this study (compassion fatigue, secondary trauma stress, and burnout), as the literature review in chapter two indicates, can be overwhelming to the mental health worker resulting in disturbances such as, “decreased self-esteem, apathy, difficulty concentrating, preoccupation with trauma, perfectionism, rigidity, or, in extreme cases, thoughts of self-harm, or harming others” (Harr, 2013, p. 73). The literature review also presented protective factors that could possibly mitigate the harmful effects of the phenomena. The overall well-being of mental health workers concludes chapter two, however, the emphasis or repeating theme of the literature review begged for further studies when it comes to compassion fatigue, secondary trauma stress, and burnout. Research has concluded with evidence that mental health workers have a need to be well and it is the responsibility of the helping professions to further investigate positive solutions to keeping these professionals healthy and serving the needs of broken clientele.

Chapter three presents the methodology utilized for this study. Here the researcher goes in-depth to explain who participated in the study, where the study took place, the instruments used, and the type of data collected. The author highlights limitations of the study and concludes by emphasizing the importance of qualitative data gathered along with the quantitative pieces; working together these parts will provide the basis for the author to highlight implications and make recommendations.

In order to examine the depth of the three main phenomena of this study the researcher sought to find answers to the following research questions:

1. To what extent are compassion fatigue, secondary trauma stress, and burnout present in the work of licensed mental health professionals?
2. What risk factors appear predictive of compassion fatigue, secondary trauma stress, and burnout in licensed mental health professionals?
3. What relationship exists between career-sustaining behaviors and compassion fatigue, secondary trauma stress, and burnout?

Findings

Pilot Study

The researcher conducted a pilot study prior to the full investigation, in order to allow for the inclusion of two qualitative questions as part of the demographic questionnaire. The specific questions asked were:

1. What is your experience with the phenomena of compassion fatigue, secondary trauma stress, and burnout?
2. What situations have affected the experiences with compassion fatigue, secondary trauma stress, and burnout?

The pilot study yielded thought-provoking answers to the two questions. In order to determine the importance of the stated answers the author used the transcriptions of each participant and listed “every expression relevant to the experience,” (Moustakas, 1994, p. 120), a concept defined by Moustakas as horizontalization, which gives equal weight to all expressions.

The participants in the pilot study came from a population of 40 mental health providers and included nine participants, four males and five females. Three participants are LPCs (licensed professional counselors), two LLPs (limited licensed psychologists), three LLPCs (limited licensed professional counselors), and one MSW (master of social work). The responses provided by the participants in the pilot study revealed several themes, such as demanding work schedules, healthy habits, and lack of resources. The researcher grouped the themes and categorized them as descriptors of necessary and sufficient data explaining the connection to the phenomenon. Once the author established themes, Moustakas' (1994) phenomenological research method suggests clustering similar themes together, which culminates in core essences. Then this researcher determined the compatibility of each theme to the overall expression of the experience relating to the phenomenon. This process led to an individual textural description of each participant's experience. The entire list of themes are located in Appendix G.

Upon examining the seven main themes from the pilot study, the investigator determined that all participants answered with affirming that his or her work schedule is demanding. Nevertheless, seven out of nine participants gave references to healthy habits and the knowledge that these habits can have a positive impact on one's life and career. Seven participants also mentioned that a lack of resources contributes to tired and weary workers, which leads to burnout feelings. As tired as these providers are, they still report pushing themselves very hard, and then find themselves working harder than their clients, which they report as not healthy behavior. Four of the nine participants emphasized the importance of having a good supervisor who lends positive support, advice, and comfort.

Three participants further reported how having a spiritual connection in their lives is most beneficial for their weary souls.

Research Question 1

To what extent are compassion fatigue, secondary trauma stress, and burnout present in the work of licensed mental health professionals?

The researcher collected quantitative and qualitative data to answer research question one. The data is categorical (nominal) and interval. The source of the data is coming from the Professional Quality of Life survey and the Burnout Measure. The researcher used total scores from these scales as well as the answers to the two qualitative questions that appeared on the demographic survey that explained in the previous section regarding the pilot study. The investigator used descriptive analyses with comparing means within the study group of participants across the results of all three instruments. Categorical responses, such as personal life stress and family pressures, client suicides or attempts, and back-to-back appointments without breaks were analyzed using frequency counts and this researcher examined particular demographic variables to explore percentages and the results. For a complete list of these responses, consult Appendix H.

Research question one seeks to establish how prevalent compassion fatigue, secondary trauma stress, and burnout are in the lives of providers. When searching for the existence of a variable it is most appropriate to use the means and standard deviations to locate the range of data and determine if the existence makes sense based on the balance or lack thereof in the distribution of data (Salkind, 2014). Participants in this study consisted of 37 licensed mental health professionals, 27 females, and eight males, with two participants not providing an answer to this item on the questionnaire. The female

participants on average reported higher burnout scores, lower compassion fatigue, and lower secondary trauma stress scores than their male counterparts (see Table 1). Social workers scored on average the highest in burnout, followed by psychologists and counselors, respectively. Overall, the participants scored low to average in burnout, low in secondary trauma stress, and average in compassion fatigue and satisfaction. In conclusion, it appears that the three phenomena are present in the lives of the mental health professionals within this study; however, for the participants of this study those levels are not, on average in a descriptive analysis statistically significant.

Table 1

Mean and Standard Deviation Report of Total Scores of Test Instruments

Gender		ProQolCS	ProQolBO	ProQolSTS	BOmeasure
Female	Mean	41.2963	21.3148	21.1111	3.0681
	N	27	27	27	27
	SD	3.9303	4.64747	5.63869	0.97674
Male	Mean	39.8750	20.3750	18.7500	2.8513
	N	8	8	8	8
	SD	4.67325	3.70087	5.72588	0.66821
Total	Mean	40.9714	21.1000	20.5714	3.0186
	N	35	35	35	35
	SD	4.08358	4.41555	5.66354	0.91105

Note. The Professional Quality of Life Scale (ProQol). Maximum score of 50 for each ProQol subscale; The Burnout Measure has a maximum score of 7, however according to Pines and Aronson (1980), a score of 1 or 7 is highly unlikely.

When comparing the means of the Professional Quality of Life subscales and the Burnout Measure to the results of the overall test scores, it first appears that the scores

represent low to average results with the phenomenon in question. However, when one looks deeper, outliers appear that may help better explain the presence of compassion fatigue, secondary trauma stress, and burnout. The ranges of scores seem wide, especially with the Burnout Measure where the range was 4.09 and the maximum range possible is 6.0. The lowest possible score a participant could have on a subscale of the Professional Quality of Life scale is 10. One participant scored an 11 and another participant a 12. These scores would indicate for these two participants, if accurate, almost zero burnout, or secondary trauma. Consult Table 2 for these scores.

Table 2

Descriptive Statistics with Range (Minimum and Maximum)

<u>Instrument</u>	<u>Range</u>	<u>Minimum</u>	<u>Maximum</u>
ProQol Compassion Satisfaction	17	31	48
ProQol Burnout	19	11	30
ProQol Secondary Trauma Stress	22	12	34
Burnout Measure	4.09	1.29	5.38

According to Stamm (2009), burnout, compassion satisfaction, and secondary trauma stress scores on the ProQol (Professional Quality of Life) between 23 and 41 fall in an average category. The total mean score for all participants in the burnout subscale was 21.1, which falls in the low burnout range. In the ProQol, the minimum score of one participant was 11 on the burnout scale, which is more than two standard deviations below the mean, which implies a potential skewing of the mean. When outliers are present, Salkind (2014) suggests that possibly the investigator could consider mode or

median scores as a better source of accuracy. When looking at the mode and medians (see Table 3), however, these scores suggest that there are little adverse effects from burnout as examined in this study. Therefore, the findings of the means, mode, and medians actually show similar results that the participants of this study report low levels of secondary trauma stress and burnout, and levels approaching high compassion satisfaction, which would indicate compassion fatigue levels at more than tolerable levels.

Table 3

Descriptive Statistics with Mode and Median

<u>Instrument</u>	<u>Mode</u>	<u>Median</u>
ProQol Compassion Satisfaction	40*	41
ProQol Burnout	19	21
ProQol Secondary Trauma Stress	24	20
Burnout Measure	2.52	2.71

Note. *Multiple modes exist. The smallest mode is presented.

Research Question 2

What risk factors appear predictive of compassion fatigue, secondary trauma stress, and burnout in licensed mental health professionals?

The data collected by this researcher includes possible risk factors that might predict compassion fatigue, secondary trauma stress, and burnout. The collected data will be quantitative and qualitative and be categorical, ordinal, and interval. The data will come from all four scales of measurement used in this study, which are the Professional

Quality of Life, the Burnout Measure, the Career-sustaining Behaviors Questionnaire, and the demographic questionnaire. The researcher used a correlation comparing variables to answer research question two. This researcher used multiple regression analysis to predict an outcome from two independent variables. According to Salkind (2014), additional variables added must make a “unique contribution” (p. 294) in order to understand the dependent variable which in this case are the answers given by the participants on the four test instruments. The investigator did this in order to see what variables and in what combination provided the greatest predictive value of the phenomena of compassion fatigue, secondary trauma stress, and burnout. Further comparisons of mean scores with the ProQOL scale showed which predictors might have factored into mitigating the impact of the three phenomena examined in this study.

This investigator utilized a significance level of .05 for this study. According to Salkind (2014), significance level is the risk associated with not being completely sure that the results found came from what was tested or by chance. Choosing a significance level of .05 shows that there is a 5% or lower chance that the results happened other than by the tests conducted. This researcher conducted multiple regression analyses predicting burnout from the variables in the career-sustaining behavior questionnaire. Overall, the regression was not significant, $F(22, 8) = 2.01, p > .05, R^2 = .85$. Taken together there was greater than a 5% chance that the career-sustaining behaviors did not predict burnout. Of the behaviors investigated, both “using more consultation” ($\beta = .77, t(14) = 2.48, p < .05$) and “developing new interests in work” ($\beta = -.59, t(14) = -2.42, p < .05$) were significant. These regression analyses show less than 5% chance that these variables

happened by chance, which for this study shows taken separately these behaviors are significant factors in mitigating burnout.

The investigator conducted further multiple regression analyses predicting burnout from the variables in the demographic questionnaire. Overall, the regression was significant, $F(6, 24) = 2.67, p < .05, R^2 = .40$. Combined together the variables in the demographic questionnaire are significant factors to measure when predicting burnout. Of the predictors investigated, hours worked ($\beta = .58, t(30) = 2.88, p < .05$) was significant. This researcher found the Professional Quality of Life Scale providing overall significance when conducting multiple regression analyses with compassion satisfaction. Overall, the regression was significant $F(29, 6) = 66.61, p < .01, R^2 = 1.00$.

Appendix I lists a summation of the risk factors for compassion fatigue, secondary trauma stress, and burnout along with the frequency of their appearances. This study found three of these factors to be of significance: number of hours worked, case consultation available, and lack of desire to develop new interests at work. Other regression analyses that proved no significance in this study are located in Table 4 and Appendix J.

Table 4

Summary of Regression Analyses that Proved No Statistical Significance with the Demographic Data

Variable	ProQol CS			ProQol STS		
	B	SE	β	B	SE	β
Age	-.003	.074	-.009	-.069	.106	-.148
Years	.212	.106	.473	.037	.153	.055
Hours	-.030	.060	-.116	.138	.087	.356
Trauma	-.021	.022	-.187	.031	.032	-.190
Supervision	.233	.382	.128	-.535	.549	-.200
Caseload	-.063	.057	-.255	-.001	.082	-.002

The ProQOL mean scores could indicate what protective factors aid providers in their work. The mean scores are located in Appendix K. The researcher deciphered several individual predictors from this instrument. The three highest mean scores of the ProQol scale were having beliefs that sustain the provider, the feeling of happiness over choosing the mental health profession, and getting satisfaction from being able to help people. The three predictive factors that scored the highest in contributing towards compassion fatigue, secondary trauma stress, and burnout were feeling bogged down by the system, feeling worn out as a helper, and being overwhelmed with too high of what seems like an endless caseload.

Research Question 3

What relationship exists between career-sustaining behaviors and compassion fatigue, secondary trauma stress, and burnout?

The data for research question three is quantitative and was measured on an interval scale. The researcher retrieved the data from the answers on the Career-sustaining Behaviors Questionnaire. This researcher used Pearson Product Moment Correlations based on Salkind's (2014) recommendation, as this method proves effective when seeking to find a relationship between two variables that contain interval data.

The career-sustaining behaviors that influenced the results of the three phenomena in this study the most were “maintaining objectivity regarding the clients’ problems” and “not feeling responsible to solve clients’ problems”. The researcher found a significant negative relationship between not feeling responsible to solve the clients’ problems and compassion satisfaction, $r(35) = -.391, p < .05$. In addition, there is a significant positive relationship between maintaining objectivity regarding client problems and compassion satisfaction, $r(35) = .469, p < .01$. The variable maintaining objectivity with client problems was also found to have a significant negative relationship with secondary trauma stress, $r(35) = -.347, p < .05$. Furthermore, not feeling responsible to solve client problems was found to have a significant positive relationship with secondary trauma stress, $r(35) = .387, p < .05$. Finally, these same two variables showed significant relationships with burnout. There is a significant positive relationship between not being responsible to solve client problems and burnout, $r(35) = .462, p < .01$ and there is a significant negative relationship between maintaining objectivity with client problems and burnout, $r(35) = -.472, p < .01$.

The researcher found five other career-sustaining behaviors to have a significant relationship with burnout, and three more behaviors having a significant relationship with

compassion satisfaction. The first behavior with a significant negative relationship with burnout was “how often are you renewed/energized by working with clients” ($r(35) = -.352, p < .05$). The second behavior was “to what extent do you maintain a balance between time by yourself and time with other people” ($r(35) = -.512, p < .01$). The third behavior was “to what extent do you use personal therapy with a therapist as a means of maintaining and/or improving your functioning as a psychotherapist” ($r(35) = .379, p < .05$). The fourth behavior with a significant relationship with burnout was “how often do you use leisure activities as a way of helping yourself to relax from work” ($r(35) = -.381, p < .05$). Finally, the last behavior was “how renewed are you by your participation in these leisure activities” ($r(35) = -.498, p < .01$).

Pearson Product Moment Correlations showing significant relationships between career-sustaining behaviors and compassion satisfaction were “how often are you renewed/energized by working with clients” ($r(35) = .602, p < .01$). The second was “how frequently do you develop new interests in your professional work” ($r(35) = .435, p < .05$). Finally the third was “how often do you use leisure activities as a way of helping yourself to relax from work” ($r(35) = .406, p < .05$).

Conclusions

Research Question 1

To what extent are compassion fatigue, secondary trauma stress, and burnout present in the work of licensed mental health professionals?

Research has shown that compassion fatigue, secondary trauma stress, and burnout are real and present in the lives of mental health practitioners (Figley, 1995; Lawson, 2007; Lawson et al., 2007). In order to contribute to the literature and assist in

the well-being of mental health workers, this researcher sought to find the actual presence of compassion fatigue, secondary trauma stress, and burnout within the work of three Midwestern United States' counseling agencies. Of the three, burnout proved to be the most prevalent experience for the participants of the study. This researcher found the presence of burnout through horizontal theme building and clustering of phenomenological data gathered in the qualitative questions that appeared within the demographic questionnaire. This is consistent with Bruce (2009) and Killian (2008), as these authors claimed burnout could creep in and wear down a clinician over time.

Compassion fatigue did score in the average range according to the results from the ProQOL. According to Figley (2002a) and Ray et al. (2013), compassion fatigue can come on quickly without notice, which may contradict qualitative data from this study, as this investigator found participants reporting compassion fatigue building over time rather than coming on quickly. The findings of this study are consistent with Newell and Mac Neil (2010) and Collins and Long (2003) who found compassion fatigue builds over time and establishes cumulative effects. Collins and Long found repeated exposure to trauma victims could wear a clinician down over time, often resulting in compassion fatigue. The responses from participants in this study were consistent with the findings by Collins and Long. Those who scored in the average range could fall 'victim' to a worsening of their symptoms quickly, and with little notice.

Participants reporting a caseload that is high in trauma clients (50% or higher), which for this study was 23 out of 37 or 62.2%, considered themselves highly vulnerable for all three phenomena; compassion fatigue, secondary trauma stress, and burnout. It is interesting to note that four participants chose to leave the answer blank on what

percentage of trauma clients he or she serves even though this investigator gave definitions of trauma on the demographic questionnaire. Higher percentages of trauma clientele parallels the research of Lerias & Byrne (2003). Lerias and Byrne examined predicting factors for traumatization. In their study they found the higher the number of clients a clinician has that have experienced one or more traumatic events the more apt these clinicians are to suffer from vicarious traumatization. The more trauma clients a clinician has on his or her caseload, the more exposure he or she has to higher levels of secondary trauma. Scores on the ProQol Secondary trauma subscale showed lower amounts of the phenomenon, but according to Bride (2007), clinicians can often sacrifice their own well-being for the good of their clients, which could explain this study's results. Male participants scored on average 2.361 points lower than their female colleagues on the secondary subscale suggesting they experience lower levels of secondary trauma. This may be consistent with Barnett's (2007) findings who claimed males might not always give accurate assessments of self when reporting data.

Overall, the phenomena of compassion fatigue, secondary trauma stress, and burnout were present but were below what was expected given the studies of Figley (1995), Lawson (2007), and Bowen and Moore (2014). Extreme answers were present within the study group. As one participant wrote, "burnout, yes, I have it". Another participant commented, "I am so tired and worn out, at least now I can call this feeling something". Contrary to these two answers, another participant wrote, "I feel really good, and I love helping people, I do not think I have any of these things". This same participant scored a 1.29 on the Burnout Measure. The lowest possible score was a 1.00. The author of this instrument (Pines & Aronson, 1980), made it clear that a score of 1.00

is highly unlikely and if a participant scores 2.00 – 3.00, the author put a disclaimer on the Burnout Measure “be sure you are answering honestly”. To examine this participant further, her score on the compassion satisfaction subscale was 48 out of 50; her score on the burnout subscale was 11 out of 50 (a score of 10 would indicate a zero level of burnout); and finally her secondary trauma subscale score was 12 out of 50 – indicating almost no existence of secondary trauma stress. These scores are contrary to Newell and Mac Neil (2010), who claimed secondary trauma stress, will be present in any clinician that works with traumatized clients. The participant under study here reported her clientele is 70% trauma related. Outliers do exist; nevertheless, this researcher would have to agree with Lawson that not all mental health professionals are honest with themselves when it comes to their own health and well-being. Lawson further reported that most clinicians could recognize compassion fatigue, secondary trauma stress, and burnout in other care providers before they would see these phenomena in themselves. It is possible that the clinician that reported close to zero existence of the phenomena of this study has good coping skills and gets energized by her work.

Research Question 2

What risk factors appear predictive of compassion fatigue, secondary trauma stress, and burnout in licensed mental health professionals?

Overall, regression statistics showed years in the profession, number of hours worked, percentage of trauma clients, supervision available, and caseloads to be significant predictive factors of the phenomena of this study. Killian (2008) found the number of clients on a caseload to be a significant risk factor for clinicians, as cases rose, so did compassion fatigue and burnout. This study's findings are consistent with Killian's

report that workers experienced less compassion fatigue and burnout when they received regular supervision that was competent and fulfilling.

The participants of this study did not report high scores of compassion fatigue, burnout, and secondary trauma stress. The participants in this study, overall, appear to utilize positive self-care and healthy habits. However, the investigator did conclude certain factors could predict the phenomena. Predictors include preoccupation with clients, being easily startled, difficulty in separating work from home, and being bogged down by the system. To clarify, “being bogged down by the system” is a specific question from the Professional Quality of Life Scale and refers to the bureaucracy within an organization that sometimes keeps workers from performing their jobs well. Harr (2013) concluded that preoccupation with clients is harmful and can lead to compassion fatigue. Clinicians are empathetic, caring, and compassionate, among other positive attributes, and in their helping, can fall victim to preoccupation. The preoccupation comes out of the desire to help the hurting and often the care provider is unaware of the effects of their work. One participant in this study, stated, “I care so much for the people I am helping that I did not realize that my own health was being impacted in a negative way”. Keeping healthy boundaries is important to the well-being of care providers. Taylor et al. (2006) found similar results when they studied clergy and rabbis helping traumatized congregants. According to Taylor et al., pastors become consumed with helping that they lose sight of healthy boundaries, a conclusion that this investigator concurs with when it comes to the mental health professional.

Multiple regression analyses conducted within this study only showed significance between the Professional Quality of Life Burnout Subscale and the

demographics of years in the profession, number of hours worked, percentage of trauma clients, supervision available, and caseloads. Nevertheless, mean scores from the ProQol and Career-sustaining Behavior Questionnaire did reveal interesting data. For instance, the participants produced a mean score of 6.03, out of a possible 7.0, with the career-sustaining behavior of “maintaining a sense of humor about their work”. A score of 7 meant humor is, to a great extent, important to the health of mental health professionals. Furthermore, the ProQol mean score asking the participants if they have beliefs that sustain them was 4.62, out of a possible 5.0. It is therefore, the conclusion of this researcher that negative factors of clinical work, such as compassion fatigue, secondary trauma stress, and burnout might be mitigated by laughter in the workplace and holding to a personal faith. This investigator will discuss further data points regarding humor in the following section.

Research Question 3

What relationship exists between career-sustaining behaviors and compassion fatigue, secondary trauma stress, and burnout?

Pearson correlations examine the relationship between two variables (Salkind, 2014). This researcher used Pearson to reflect the quality of the relationship between these variables. It is important to know that correlations are between variables and not individual participants. The test instruments revealed two career-sustaining behaviors as significant with all three of the phenomenon of this study, compassion fatigue, secondary trauma stress, and burnout. The career-sustaining behaviors of “maintaining objectivity regarding your clients’ problems” and “feeling responsible for solving your clients’ problems” were in fact these two behaviors having significance among compassion

fatigue, secondary trauma stress, and burnout. Of the articles studied for the literature review portion of this study, only Rupert and Kent (2007) mentioned either of these two behaviors. It is interesting to make note that Rupert and Kent reported, “feeling responsible for solving your clients’ problems” (p. 93) as one of seven behaviors to have a significant difference between genders. These researchers stated, “Given the large number of strategies that were rated by women as more important, these differences may simply reflect a general tendency for women to be more likely to endorse strategies as important to their well-functioning than men” (p. 93). The gender difference was not a part of this study; however, recognizing that these differences may exist could be reason for further examination.

Stevanovic and Rupert (2004) reported receiving clinical supervision as a least important career-sustaining behavior in their study, which are in contrast to the qualitative answers given from both the pilot study and the results of this research. Supervision, according to the participants is an important career-sustaining behavior. However, the Pearson score did not reveal any statistical significance regarding this behavior. Other behaviors reported by the participants which brought growth and satisfaction and scored statistically significant for sustaining and prolonging the careers of the participants included “feeling energized by working with clients”, “developing new interests in professional work”, and “using leisure activities to relax from work”. For example, in this study, the mean score of using leisure activities was 5.81, out of 7.00. This score is similar to the findings of Lawson (2007) that it is important to participants to be involved in leisure as frequently as possible. Lawson studied counselor wellness and impairment and emphasized the importance of a balanced life with emotional, social,

physical, and spiritual needs. Other career-sustaining behaviors that significantly correlated with burnout were “maintaining balance between self and others”, “seeking personal therapy”, and “receiving renewal from leisure activities”. Maintaining balance is consistent with Lawson’s study, which reported balancing time between self and others as one of the top five behaviors that clinicians should implement to stay well.

This study’s results regarding the overall importance of career-sustaining behaviors were similar with the findings of Rupert and Kent (2007). These authors used 25 behaviors, which added three behaviors that specifically targeted spiritual beliefs or values. Rupert and Kent reported 17 behaviors receiving mean scores above 5.00 and six additional behaviors above 6.00. These researchers used the same 7-point Likert scale as this study. This investigator’s study used the original 22 behaviors created by Kramen-Kahn (1995) and found only nine mean scores above 5.00 and one above 6.00. “Maintaining a sense of humor” received the highest mean score for both this study (6.03), and Rupert and Kent (6.13). Two other behaviors received identical mean scores when comparing Rupert and Kent’s study to this investigator’s work were “Maintaining objectivity regarding client problems” (5.48) and “perceiving client problems as interesting” (5.25).

Consequently, the one behavior that did receive a mean score above 6.00 was “maintaining a sense of humor”, which is cited by several researchers as a top five behavior (Lawson, 2007; Kramen-Kahn & Hansen, 1998; Rupert & Kent, 2007; Stevanovic & Rupert, 2004). This study seems in contrast to Lawson and Meyers (2011), who concluded that the more career-sustaining behaviors a clinician utilizes the less compassion fatigue and burnout they have. Lawson and Meyers reported 17 behaviors

with mean scores above 5.25 on the same 7.00 scale. Rupert and Kent claimed that a mean score above 5.00 emphasized importance by the participant as an effective career-sustaining behavior. When comparing these same thoughts to this investigator's study it appears his participants put less emphasis on career-sustaining behaviors, because only nine had a mean score above 5.00. According to Lawson and Meyers, less emphasis in career-sustaining behaviors should indicate higher compassion fatigue scores. In contrast to Lawson and Meyers, the overall scores of this study reveal less compassion fatigue, secondary trauma stress, and burnout, even though the participants' mean scores would indicate less of an emphasis on career-sustaining behaviors.

Implications and Recommendations

Based on the findings of this research, several implications and recommendations emerge and might be beneficial for practitioners. Implications that cross over from academia to the professional counseling room include results supporting the need for higher education to provide within its curriculum coursework that informs and teaches on the effects of trauma (Dunkley & Whelan, 2006). Once he or she is engaged with a client in a counseling session a clinician may not be open to the possibilities that compassion fatigue, secondary trauma stress, or burnout could affect them (Lawson, 2007). The results of this study brings credence to Lawson's appeals for professionals to look at themselves when looking at the hazards of the industry.

By examining the effects of compassion fatigue, secondary trauma stress, and burnout among licensed mental health professionals, this study systematically addressed a recognized industry need (Bowen & Moore, 2014) to mitigate the complicating factors of these phenomena and, in addition, enhance the psychological well-being of clinicians.

Results of this study delineated clear evidence that compassion fatigue, secondary trauma stress, and burnout are real and present among the participants. Further questions arise when considering this study, such as what does a clinician do when they become aware of a psychological condition, such as compassion fatigue, secondary trauma stress, or burnout? A future study could assess for the job security of clinicians or lack thereof, if, and when one or more of these phenomena should present themselves. Awa et al. (2010) made the assertion that clinicians will not always be honest with supervisors regarding their overall health in fear of losing their jobs. It was the goal of this researcher to gather informative data to help keep professional care workers in their line of work helping others. Figley (2002a) made it clear that a problem exists for clinicians when it comes to the onset of compassion fatigue, secondary trauma stress, and burnout. This problem, according to Figley, lacks emphasis and awareness to these phenomena and must be more openly acknowledged in order to keep workers healthy and clients healing.

The participants' scores in this study were statistically significant in eight different career-sustaining behaviors on at least one of the three phenomena. Two of the behaviors scored significantly in all three areas. Therefore, the implication of sustaining behaviors is important to the life of the mental health professional. The importance is not in which behavior is used, but possibly in the consistency of its use. Brodie (1982) created career-sustaining behaviors for psychotherapists in order to find out how these workers sustain themselves. Further study could seek out behaviors similar to Brodie's (1982) original study and focus on the frequency of use by mental health professionals.

This study also furthered the understanding of the predictive factors of compassion fatigue, secondary trauma stress, and burnout in several ways. First, this

study provided empirical evidence that compassion satisfaction is present among licensed mental health professionals who participated in this study. Not only was it present, statistical data reported that combined ten qualities of life significantly improved clinician satisfaction with his or her job. Secondly, the demographic data collected, such as, hours worked, number of supervision hours available, and percentage of trauma clients, provided overall significance when predicting burnout among clinicians. However, the same data proved no significance with secondary trauma stress, which was contrary to studies conducted by Adams et al. (2006), Devilly et al. (2009), Figley (2002a), Knight (2010), and Pearlman and Saakvitne (1995). When considering previous research by Rzeszutek et al. (2015), Newell, and Mac Neil (2010), along with the current study, it is the recommendation of this investigator that future studies examine the combination of demographics in order to establish a better basis for the psychological disturbances.

Additionally, the current study extended the research of Forster (2009) who reported on moral conflicts, skewed boundary lines, or ethical dilemmas that may trigger compassion fatigue. Forster emphasized moral stress as a major contributor to compassion fatigue. Forster further recommended that future studies include burnout and secondary trauma stress, a connection that this investigator's study endeavored to examine. While exploring the three phenomena of compassion fatigue, secondary trauma stress, and burnout this researcher found similarities that cross between each psychological disturbance. Consequently, this researcher recommends further studies seek delineations into these similarities in order to enhance awareness for the mental health professional. This line of thinking concurs with Figley (2002a), who believes that

future researchers conduct investigations to address compassion and compassion fatigue, aspects that Elwood et al. (2011) studied on secondary trauma. According to Figley, professional therapists have admitted denying the onset of compassion fatigue, secondary trauma stress, or burnout. This denial is consistent with this study, therefore, this investigator must agree with Figley who recommended further studies in conjunction and or combination of compassion fatigue, secondary trauma stress, and burnout. Mental health professionals will benefit from gaining more knowledge on how to mitigate the effects of these phenomena.

Furthermore, this study was key for both its clinical and academic offerings by responding to researchers and experts who called for further research into compassion fatigue, secondary trauma stress, and burnout (Adams et al., 2006; Bowen & Moore, 2014; Figley, 1995, 2002a, 2002b; Harr & Moore, 2011; Knight, 2010; Smart et al., 2014). Lawson (2007) argued that until the philosophies of compassion fatigue and all its components such as trauma, and burnout, are taken seriously by helping professionals, academia, and professionals would fall short of having an arsenal to combat them. This study indicates that the participants have experienced compassion fatigue, secondary trauma stress, and burnout. These phenomena are not going to disappear. Researchers must recognize the importance of keeping our helping professionals healthy by finding new and creative ways of staying well. Moreover, future research could emphasize encouraging psychotherapists in their work by exploring the positive aspects of providing psychological help, such as psychological growth and compassion satisfaction. Killian (2008) studied compassion satisfaction in conjunction with compassion fatigue. He recommended combating the fatigue with satisfying behaviors. Whether future studies

combine the components or single them out, implications would support a positive outlook (Killian) versus a negative consequence.

Educating future care professionals is paramount to the ongoing success in the mental health industry. Licensure regulations stipulate specific coursework needed to complete certain programs. Future studies of this nature should investigate the following: How does teaching future clinicians about the risks of compassion fatigue, secondary trauma stress, and burnout affect their careers? This type of question would most likely require some form of a longitudinal study. The answer to this question would coincide with Patsiopoulos and Buchanan's (2011) study, as they sought answers for clinicians to better treat themselves. Similarly, it could prove valuable to the mental health field to conduct qualitative investigations, studying participant experience following self-care implementations. Such studies might help determine if participants actually implemented educative processes, and, if so, which ones were effective and how were they practiced. Future research could examine client perceptions of their caretaker. For example, future researchers could record by audio or video at different stages of counseling, before and after self-care practices.

Within the qualitative portion of the study, found in the demographic questionnaire (Appendix D), some of the participants made suggestions for future improvement with compassion fatigue, secondary trauma stress, and burnout. Eleven participants, or 29.7%, emphasized the importance of living a balanced life with focus on one's family. Six participants, or 16.2%, reported gaining strength from colleagues and an additional six stressed the importance of attending trainings. The final theme, suggested by four participants, or 10.8%, stressed the necessity of self-care. These freely

disclosed suggestions, given without prompting, indicates to this investigator an understanding by the participants that the phenomena of compassion fatigue, secondary trauma stress, and burnout exists; furthermore, showing a care for their colleagues and peers and the need for further studies.

Finally, this study revealed two themes, which when taken apart and tested, were not statistically significant. However, these themes (humor and spirituality) were consistent with the findings of several other researchers. Studies by Lawson (2007), Newmeyer et al. (2014), Papazisis et al. (2014), and Tehrani (2007) emphasized spirituality as a combatant to compassion fatigue and burnout. Harr (2013), Hee et al. (2015), and Moran (2002) emphasized humor as a way to ward off compassion fatigue, secondary trauma stress, and burnout. The current study's highest mean score on the Professional Quality of Life Scale was 4.62 out of 5.0. On this 5-point Likert scale a score of 5 meant very often and a score of 4 meant often. The question that received the 4.62 mean score was, "I have beliefs that sustain me". This means 92.4% of the participants answered very often for having beliefs that sustain them. Furthermore, the highest mean score for the Career-sustaining Behaviors Questionnaire was 6.03 out of 7.0 where 7 meant very supportive. The question was, "To what extent is maintaining a sense of humor about your work supportive to you as a clinician?" Future research should consider examining spirituality and humor as mitigating factors to compassion fatigue, secondary trauma stress, and burnout.

Nevertheless, the overarching theme of this research project has been to recommend methods, techniques, or behaviors that will assist mental health professionals with mitigating the effects of compassion fatigue, secondary trauma stress, and burnout.

Helping professionals can be overwhelmed with assisting hurting people, because they can feel pressure to serve. Professionals might not be in touch with negative risks attributed to exposure to client brokenness. Therefore, the investigator conducted this study to assist clinicians with positive behaviors or techniques to help keep professionals healthy and performing well in their duties as mental health professionals. Consequently, this researcher found that maintaining objectivity regarding client problems, and not feeling responsible for solving client problems, are two practices that can help mitigate the impact of compassion fatigue, burnout, and secondary trauma stress.

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Appendix A

Professional Quality of Life Scale (ProQOL)

Professional Quality of Life Scale (ProQOL)

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

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

	1=Never	2=Rarely	3=Sometimes	4=Often	5=Very Often
_____ 1. I am happy.					
_____ 2. I am preoccupied with more than one person I [help].					
_____ 3. I get satisfaction from being able to [help] people.					
_____ 4. I feel connected to others.					
_____ 5. I jump or am startled by unexpected sounds.					
_____ 6. I feel invigorated after working with those I [help].					
_____ 7. I find it difficult to separate my personal life from my life as a [helper].					
_____ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].					
_____ 9. I think that I might have been affected by the traumatic stress of those I [help].					
_____ 10. I feel trapped by my job as a [helper].					
_____ 11. Because of my [helping], I have felt "on edge" about various things.					
_____ 12. I like my work as a [helper].					
_____ 13. I feel depressed because of the traumatic experiences of the people I [help].					
_____ 14. I feel as though I am experiencing the trauma of someone I have [helped].					
_____ 15. I have beliefs that sustain me.					
_____ 16. I am pleased with how I am able to keep up with [helping] techniques and protocols.					
_____ 17. I am the person I always wanted to be.					
_____ 18. My work makes me feel satisfied.					
_____ 19. I feel worn out because of my work as a [helper].					
_____ 20. I have happy thoughts and feelings about those I [help] and how I could help them.					
_____ 21. I feel overwhelmed because my case [work] load seems endless.					
_____ 22. I believe I can make a difference through my work.					
_____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].					
_____ 24. I am proud of what I can do to [help].					
_____ 25. As a result of my [helping], I have intrusive, frightening thoughts.					
_____ 26. I feel "bogged down" by the system.					
_____ 27. I have thoughts that I am a "success" as a [helper].					
_____ 28. I can't recall important parts of my work with trauma victims.					
_____ 29. I am a very caring person.					
_____ 30. I am happy that I chose to do this work.					

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/www.isw.edu/~bhstamm or www.proqol.org. This test may be freely copied as long as (a) author is credited, (b) no changes are made, and (c) it is not sold.

Appendix B

Burnout Measure

Burnout Measure

How often do you have any of the following experiences? Please use the scale by writing a number next to each phrase.

1	2	3	4	5	6	7
Never	Once in a great while	Rarely	Sometimes	Often	Usually	Always

- | | |
|---------------------------------------|---|
| 1. _____ Being tired. | 12. _____ Feeling worthless. |
| 2. _____ Feeling depressed. | 13. _____ Being weary. |
| 3. _____ Having a good day. | 14. _____ Being troubled. |
| 4. _____ Being physically exhausted. | 15. _____ Feeling disillusioned and resentful. |
| 5. _____ Being emotionally exhausted. | 16. _____ Being weak and susceptible to illness |
| 6. _____ Being happy. | 17. _____ Feeling hopeless. |
| 7. _____ Being "wiped out." | 18. _____ Feeling rejected. |
| 8. _____ "Can't take it anymore." | 19. _____ Feeling optimistic. |
| 9. _____ Being unhappy. | 20. _____ Feeling energetic. |
| 10. _____ Feeling run-down. | 21. _____ Feeling anxious. |
| 11. _____ Feeling trapped. | |

Computation of Scores:

Add the values you wrote next to the following items:

1,2,4,5,7,8,9,10,11,12,13,14,15,16,17,18,21 = _____ (A)

Add the values you wrote next to the following items:

3,6,19,20 = _____ (B)

Subtract (B) from 32 = _____ (C)

Add (A) and (C) = _____ (D)

Divide (D) by 21 = _____

This is your Burnout Score.

1 & 7 are highly unlikely to score

2 & 3 = you are doing well, go over your scores & be sure you are answering honestly

3 & 4 = examine your work & life, evaluate your priorities & consider possible changes

4+ = you are experiencing burnout to the extent that you must do something about it

5+ = indicates an acute state and need for immediate help

Appendix C
Career-sustaining Behavior Questionnaire

Career-sustaining Behavior Questionnaire

The following questions inquire about behaviors that help sustain you in your work as a psychotherapist. **Write in one number for each question based on the scales below.**

1	2	3	4	5	6	7
Very seldom						Very frequently

1. _____ How frequently do you refrain from discussing a clinical case with a supervisor or peer level colleague because you feel s/he may not have time and/or be too burdened by other cases to listen?
2. _____ How frequently do you refrain from discussing a clinical case with a supervisor or peer level colleague because of fear that s/he will criticize your way of handling it?
3. _____ How frequently do you feel the need for more case consultation than is presently available to you?
4. _____ How frequently do you leave your consultation room between therapy sessions?
5. _____ How frequently do you use self-talk (talking to yourself in a positive and supportive manner) when you have had a day in which your interactions with clients have been challenging?
6. _____ At the end of a workday, how frequently do you utilize self-talk to put aside thoughts or clients?
7. _____ How often are you renewed/energized by working with clients?
8. _____ On workdays, how frequently do you engage in some solitary renewing activity (e.g., exercise, meditation, reading)?
9. _____ How frequently do you develop new interests in your professional work? (Examples are learning a new therapeutic technique or undertaking a consultation project.)
10. _____ How frequently do you attend continuing education seminars and programs?
11. _____ How frequently do you do things to increase your physical and psychological comfort during a therapy session (e.g., brief relaxation technique)?

1	2	3	4	5	6	7
Not at all successful						Very successful

12. _____ How successful are you in utilizing the interpersonal supports, which are available to you?

1	2	3	4	5	6	7
Not at all reduced						To a great extent

1	2	3	4	5	6	7
Not at all supportive						Very supportive

13. _____ Does your own perception of your professional competence reduce your job-related stress?

14. _____ To what extent is maintaining a sense of humor about your work supportive to you as a clinician?

1	2	3	4	5	6	7
Not at all						To a great extent

15. _____ To what extent do you maintain a balance between time by yourself and time with other people?

16. _____ To what extent do you use personal therapy with a therapist, as a means of maintaining and/or improving your functioning as a psychotherapist?

1	2	3	4	5	6	7
Very infrequently						As frequently as possible

17. _____ How often do you use leisure activities as a way of helping yourself to relax from work?

1	2	3	4	5	6	7
Not at all renewed						Very renewed

18. _____ How renewed are you by your participation in these leisure activities?

19. _____ Overall, how renewed are you by your participation in continuing education seminars/programs?

1	2	3	4	5	6	7
To a small extent						To a great extent

20. _____ In general, to what extent do you maintain objectivity regarding your clients' problems?

21. _____ In general, to what extent do you perceive your clients' problems as interesting?

22. _____ In general, to what extent do you feel responsible for solving your clients' problems?

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Appendix D

Demographic Questionnaire

Demographic Questionnaire

1. Gender (circle one) Male Female
2. Age: _____
3. Type of License:

4. Years in Profession: _____
5. Average Hours of Work per Week: _____
6. Percentage of current clients that fit the trauma definition provided:

Trauma is physical harm to the body caused by violence, accidents, terrorism, or natural disasters (Boscarino, Figley, & Adams, 2004). Trauma also has a psychological side that is an emotional wound, shock, or horror that can have long-lasting effects on the survivor (Adams, Boscarino, & Figley, 2006).

7. How many hours of Clinical Supervision do you participate in each month? _____
8. What is your current caseload? _____

(For questions 9 & 10, please feel free to use more space and attach your answers.)

9. What is your experience with the phenomena of compassion fatigue, secondary trauma, stress, and burnout?
10. What situations have affected your experiences with compassion fatigue, secondary trauma stress, and burnout?

Adams, R.E., Bosarino, J.A., & Figley, C.R. (2006). Compassion fatigue and psychological distress among social workers: A validation study. *American Journal of Orthopsychiatry*, 76(1), 103-108.

<http://dx.doi.org/10.1037/0002-9432.76.1.103>

Boscarino, J. A., Figley, C. R., & Adams, R. E. (2004). Compassion fatigue following September 11 terrorist attacks: A study of secondary trauma among New York City social workers. *International Journal of Emergency Mental Health*, 6(2), 57-66.

Appendix E

Permissions

Permission Letters

Thank you for completing the form for permission to use the ProQOL. This page provides access to permission letters. It also specifies the terms of use.

Please read the [FAQs](#) if you have questions about use. Most of the time you will find your answer there.

If you wish to use the ProQOL for non-commercial purposes, simply download the Permission to use the ProQOL form below. The form and associated will be an e-mail with our office so that we will know you requested permission. Make sure to keep a copy of the information you submitted with your use permission form. Together, the information you submitted and this page are your permission. These letters are not sufficient without a copy of the use permission form.

In the spirit of helping others, we assume that you will use the ProQOL for good. By submitting your form and downloading the permission, you agree to the following conditions:

- You agree to always use the ProQOL or work associated with it in an ethical manner consistent to human rights policies of the United Nations including [The United Nations Convention on the Rights of the Child](#). You may have other requirements based on your setting such as permission from a Human Subjects committee such as is common at Universities. The ProQOL.org does not have a Human Subjects review process. You must find that locally.
- You agree to always use the ProQOL in a culturally sensitive way.
- If you collect data, you agree to manage and protect your data in the legal and ethical management of data in your employment, training or volunteer setting. For example, if you are from the United States or a European country doing research in a developing nation, you will be held to the procedures of your organization in the United States or European country.
- You, or someone with whom you work, will not profit directly from selling the ProQOL or products that end in large part on the ProQOL. The ProQOL can be freely used as part of a school course, training curriculum or in a book or presentation if it is not the substantial part of the work.
- We encourage you to review and use the Best Practices Parameters from the International Society for Traumatic Stress Studies. To find more about these, go to the International Society for Traumatic Stress Studies website at www.istss.org. Among others there are parameters for [Trauma Research](#) and [Teaching and Training about Trauma](#), and [International Trauma Guidelines](#).

I wish you the very best as you use the ProQOL. Please do consider donating a copy of your data. You can find more information about data donations at the [Source Data](#) page on the ProQOL site.

Beth Hodouk Stearns
Developer and Director, ProQOL.org

Permission to Use ProQOL – This permission must accompany any other permission

Additional Permissions – Make sure that you have the above Permission to use letter above.

Permission for Worded Changes

Most worded changes do not need additional permission. Here are the guidelines for permission to edit worded changes. You may substitute the appropriate target group for / [helper] if that is not the best form. For example, if you are working with teachers, replace / [helper] with teacher. Word changes may be made to any word in italicized square brackets to make the measure read more smoothly for a particular target group. You may not substantially change the wording of a question (because it may negate the known reliabilities and validity of the measure).

Permission for Format Changes

No additional permission is needed to change the format of the ProQOL, such as re-typing it to fit into a training package or for accessibility (e.g., a disability or language). You may not change the format to provide a public online form that returns a score to an end user. If you wish to do this type of application, it falls under the Permission to Reprint below. You may put the ProQOL in a format that returns the score to a user for research or training as long as the link is not publicly advertised. Here is the guidance for format changes. You are granted permission to convert the ProQOL into other formats such as a computerized or taped version for the visually impaired if you are required to provide documentation for changing words to make the measure more appropriate to your target population, provide the requester this page and the Permission to use letter from above.

Permission to Translate

You will find the existing translations at [translations page](#). They may be of use to you as you work on your translation. If you are updating one of the older versions of the ProQOL to the current, v5 version, you can find the side-by-side comparison of the 1r to 5 on the [translations page](#). Any translations or permission improvements you can offer would be graciously accepted. When you finish your translation, I hope you will send a copy to us so that we can post it for others to use.

http://proqol.org/permission_letters.html

12/30/2014

Permission to Reprint

The ProQOL is a publicly available measure that is free for non-commercial use. If you wish to publish the ProQOL in a print or electronic media outlet, you will need what is called permission to reprint. Obtaining permission is usually a simple process because we work with you to make the ProQOL available to as many people as possible.

Examples of media outlets we can generally give permission for reprint without any special permission:

- Print Media: newspapers, newsletters, books, journals and similar venues
- Electronic Media: non-commercial online use that do not return data to the end user, podcast, webinars, books on tape, news media and similar venues
- Examples of media outlets that require special negotiated permission:
 - Print, videos, website forms other than research programs, particularly if they return automated scoring, commercial online training courses, commercial training programs in which the ProQOL could be interpreted as adding to the monetary value of the class and other similar uses. [Click here](#) to discuss additional permissions.
 - Electronic Media: non-commercial online use that do return data to the end user. [Click here](#) to discuss additional permissions.

SPN Profile Message: Burnout Measure

REPLY REPLY ALL FORWARD

Elliot Aronson <elliot@ucsc> [Mark as read](#)

Wed 3/11/2015 8:51 PM

To: Kyle Thompson;

You have my permission. Thanks for asking. Good luck with your research.

Cordially,

Elliot Aronson

Barbara <heartfelt@lto.com>

Tue 1/20/2015 8:46 PM

Kyle,

I'm currently on vacation and will not return to my office until next Monday. So I want to respond to you now even though this is my personal account and not my professional email. I give you permission to use my questionnaire. If I can be of any additional help to you please let me know. I wish you the best in completing your dissertation. I would love to know when you've completed it. Keep working - it will happen. I would also like to hear about your research. Warmly, Barbara

Sent from my iPhone

REPLY REPLY ALL FORWARD

Kyle Thompson

[Mark as unread](#)

Tue 1/20/2015 2:42 PM

Sent from

To: Barbara Kramen-Kahn, Ph.D. <barbara@barbaramkramenkahn.com>

You replied on 2/11/2015 8:31 PM.

At 10:35 AM -0400 3/11/15, Kyle Thompson wrote:

> Dear Dr. Aronson,

>

> Good morning, I hope this finds you well. My name is Kyle Thompson and I am

> a current student working on my dissertation. I have come upon The Burnout

> Measure. This is included in your work "Career Burnout", that you

> co-authored with the late Dr. Pines.

>

> My topic of study is: Compassion fatigue, secondary trauma stress, and

> burnout among licensed mental health professionals.

>

> In my research I would like to use your scale "The Burnout Measure". I am

> seeking your permission to do so. I appreciate your work in our industry.

> Thank you for considering my request.

>

> Blessings on you,

>

> Kyle Thompson

Dr. Kramen-Kahn,

I am most interested in your scale Career-sustaining Behaviors Questionnaire.

I would like to know how to obtain permission to utilize this scale in my dissertation.

I appreciate you taking time to consider my request.

Thank you for your work in the profession.

Kyle Thompson

Appendix F

Cover Letter with Instructions

Cover Letter with Instructions

August 26, 2015

Thank you for your willingness to participate in my research project. This introductory page should explain the process. If you should have any questions, please do not hesitate to contact me. You may reach me using any of the following methods:

Kyle Thompson

(cell) - texting is fine

(office)

(work email)

(school email)

1. Verify contents of research packet
 - a. instruction page with contact information
 - b. introductory letter
 - c. IRB approval (informed consent document)
 - d. ProQol (green)
 - e. Burnout Measure (goldenrod)
 - f. Career-sustaining Behaviors (blue – 2 pages stapled)
 - g. Demographic (white)
 - h. reply envelope () – attn. Kyle)
2. If missing anything; please contact Kyle ASAP, via one of the methods above
3. Peruse the consent form
 - a. sign form if consenting to participate
 - b. make a copy if you would like one
 - c. put signed original in reply envelope
 - d. seal envelope and place at front counter of your business for pick up
4. Complete the enclosed scales (attach extra sheets to the demographic questionnaire if needed)
5. Once completed, put all completed scales in the large envelope and seal contents
6. Bring large sealed envelope to the front counter of your business for pick up

Thank you for participating in my project. Your help is most appreciated! If you would like a copy of the results please contact me via one of the methods mentioned above.

Thank you,

Kyle Thompson MA, LPC

Appendix G

Horizontalization Themes of Pilot Study Participants

Table A1

Horizontalization Themes of Pilot Study Participants

Theme	Frequency
Demanding work schedule ...pushed by supervisors, lack of affirmation, back-to-backs with no breaks; changing jobs every 4-5 years	9
Healthy habits ...self-care retreats; time alone; have fun; positive self-talk; healthy reframes	7
Lack of resources ...overloaded; bureaucracy; powerless to connect clients; low pay	7
Supervision ...invaluable to have good supervision	4
Busy lifestyle ...working harder than the client	4
Colleague support ...generation of thoughts/ideas and not being on an island; humor	4
Spiritual influence ...Prayer and reflection	3

Appendix H

Contributors to Compassion Fatigue, Secondary Trauma Stress, and Burnout

Table A2

Contributors to Compassion Fatigue, Secondary Trauma Stress, and Burnout

Phenomena	Contributor	Frequency
Compassion fatigue	Personal life stress & family pressures	14
Secondary Trauma	Client suicide/attempt; death of client	8
	Chronic exposure to abused/neglected children	6
	Client trauma mirroring personal experiences	6
Burnout	Back-to-back appointments without breaks	13
	Supervisors not available	5
	Administrative politics	4

Note. $n = 37$.

Appendix I

Risk Factors of Compassion Fatigue, Secondary Trauma, and Burnout

Table B1

Risk Factors of Compassion Fatigue, Secondary Trauma, and Burnout

<u>Risk Factor</u>	<u>Frequency</u>	<u>Percentage of participants</u>
Working too many hours	13	35.1%
Lack of colleague consultation/interaction	11	29.7%
Lack of desire for new interests at work	9	24.3%
Back-to-back appointments without breaks	6	16.2%
Caseload too high	6	16.2%
No time for self	6	16.2%
Disconnected with family/life	6	16.2%
Politics within organization	5	13.5%
Rise in personal anxiety	5	13.5%
Inadequate or lack of supervision	5	13.5%
Preoccupation with clients	4	10.8%
Unhappy with self	3	8.1%
Feeling trapped	2	5.4%
Lack of production	1	2.7%
Lack of motivation	1	2.7%
Loss of caring	1	2.7%

Note. $n=37$.

Appendix J

Summary of Regression Analyses that Proved No Significance with Career-sustaining Behaviors

Table C1

Summary of Regression Analyses that Proved No Significance with Career-sustaining Behaviors

Variable	BO measure			ProQol CS			ProQol STS		
	B	SE	β	B	SE	β	B	SE	β
CSB 1	-.025	.120	-.063	.656	.780	.307	-.170	1.017	-.062
CSB 2	-.025	.154	-.044	.093	1.003	.027	-2.007	1.308	-.450
CSB 3	.125	.121	.031	-.655	.789	-.299	1.421	1.028	.508
CSB 4	.028	.093	.066	.285	.606	.128	.301	.791	.105
CSB 5	-.133	.138	-.270	-.292	.897	-.112	-.164	1.170	-.049
CSB 6	.108	.144	.243	-.318	.938	-.135	1.692	1.223	.562
CSB 7	.057	.236	.068	2.284	1.537	.515	1.561	2.004	.276
CSB 8	.124	.114	.282	-.104	.739	-.045	-.460	.963	-.155
CSB 9	-.162	.110	-.338	1.071	.718	.422	-1.736	.936	-.536
CSB 10	.094	.141	.212	-.339	.919	-.144	.039	1.198	.013
CSB 11	.042	.128	.076	1.427	.833	.494	1.295	1.086	.351
CSB 12	-.085	.163	-.146	-.521	1.060	-.168	-.584	1.382	-.147
CSB 13	-.031	.125	-.051	.583	.811	.216	.080	1.058	.023
CSB 14	.111	.176	.154	-1.139	1.141	-.300	-2.436	1.488	-.502
CSB 15	-.082	.153	-.138	-1.677	.998	-.530	.833	1.301	.206
CSB 16	.081	.099	.195	.412	.643	.187	.499	.839	.178
CSB 17	-.046	.229	-.061	1.034	1.489	.259	-2.160	1.942	-.424
CSB 18	-.221	.360	-.236	1.439	2.342	.291	.897	3.053	.142
CSB 19	-.044	.112	-.091	-.566	.726	-.219	-.044	.947	-.001
CSB 20	-.373	.215	-.452	-.090	1.400	-.021	-1.454	1.826	-.260
CSB 21	.064	.158	.106	-.227	1.029	-.070	1.141	1.124	.324
CSB 22	.016	.133	.032	.049	.862	.018			

Note. The Career-sustaining Behaviors (CSB) appear in Appendix C.

Appendix K

Mean scores of the ProQOL

Table D1

Mean scores of the ProQOL

Question	Mean Score
I am happy	4.0811
I am preoccupied with more than one person I [help].	2.8649
I get satisfaction from being able to [help] people.	4.4324
I feel connected to others.	4.0270
I jump or am startled by unexpected sounds.	2.6216
I feel invigorated after working with those I [help].	3.7297
I find it difficult to separate my personal life from my life as a [helper]	2.5405
I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].	1.5811
I think that I might have been affected by the traumatic stress of those I [help].	2.2973
I feel trapped by my job as a [helper].	1.7838
Because of my [helping], I have felt “on edge” about various things.	2.2973
I like my work as a [helper].	4.2432
I feel depressed because of the traumatic experiences of the people I [help].	2.0270
I feel as though I am experiencing the trauma of someone I have [helped].	1.8108
I have beliefs that sustain me.	4.6216
I am pleased with how I am able to keep up with [helping] techniques and protocols.	3.8108
I am the person I always wanted to be.	3.9054
My work makes me feel satisfied.	4.1351
I feel worn out because of my work as a [helper].	2.7838
I have happy thoughts and feelings about those I [help] and how I could help them.	3.8649
I feel overwhelmed because my case [work] load seems endless.	2.7568
I believe I can make a difference through my work.	4.2432
I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].	1.5833
I am proud of what I can do to [help].	4.1622
As a result of my [helping], I have intrusive, frightening thoughts.	1.5135
I feel “bogged down” by the system.	3.0541
I have thoughts that I am a “success” as a [helper].	3.7297
I can’t recall important parts of my work with trauma victims.	1.5946
I am a very caring person.	4.2973
I am happy that I chose to do this work.	4.4865

Note. The ProQOL uses a 5 point Likert Scale. 1 = Never; 2 = Rarely; 3 = Sometimes; 4 = Often; 5 = Very Often.