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EXAMINING THE RELATIONSHIP BETWEEN SELF-CARE AND PROFESSIONAL

QUALITY OF LIFE IN COUNSELING AND CLINICAL PSYCHOLOGY TRAINEES

by

BEVERLY SHARIFIAN

A thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Science in Clinical Psychology
Department of Psychology and Counseling

Eric Stocks, Ph.D., Committee Chair

College of Education and Psychology

The University of Texas at Tyler
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The University of Texas at Tyler
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This is to certify that the Master's Thesis of

BEVERLY SHARIFIAN

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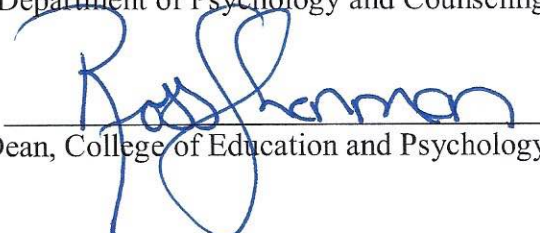
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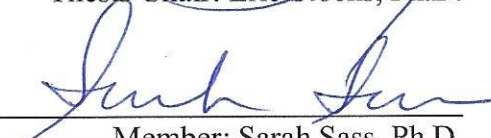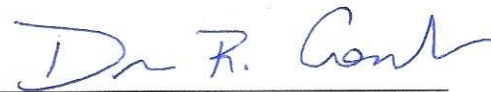Foremost, I would like to thank the members of my committee, Dr. Stocks, Dr. Sass, and Dr. Combs, for supporting this project. I would like to express my profound gratitude to my thesis advisor, Dr. Stocks, for his unwavering guidance, encouragement, and mentorship. I am indebted to the professors who helped distributed the survey and who guided me along the way. I would also like to extend my appreciation to Courtney Yotter for her valued contributions. Finally, I am grateful to each graduate student who took the time to participate in this study- thank you for making this project possible.

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Abstract

EXAMINING THE RELATIONSHIP BETWEEN SELF-CARE AND PROFESSIONAL
QUALITY OF LIFE IN COUNSELING AND CLINICAL PSYCHOLOGY TRAINEES

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The University of Texas at Tyler
July 2019

Helping professionals are systemically exposed to the suffering of their clients, resulting in

emotional and behavioral consequences. Stamm's (2010) theoretical framework for

professional quality of life is characterized by the positive (compassion satisfaction) and

negative (burnout and secondary traumatic stress) facets of the work of helping

professionals. Graduate students in the fields of counseling and psychology are

establishing life-long professional practices, caught between the demands of caring for

others and attending to their own needs. The present study assessed the frequency of self-

care practices among clinical psychology and clinical mental health counseling graduate

students to predict their professional quality of life, an undertaking that has been

overlooked in previous investigations. This study's contributions are unique given that

typologies of burnout were also assessed utilizing the Copenhagen Burnout Inventory (CBI;

Kristensen, Borritz, Villadsen, & Christensen, 2005), and programmatic differences were

explored. Results of bivariate regression analyses revealed that engagement in self-care

was a positive predictor of compassion satisfaction and a negative predictor of burnout. In

examining typologies, self-care was found to be an inverse predictor of work-related and client-related burnout. The implications of these findings are discussed in the context of academic training, organizational and institutional policies, and the developmental trajectory of helping professionals. Prospective investigations should seek to examine the relationship between compassion fatigue and self-care among counseling and clinical psychology trainees. Prevention, advocacy, and intervention efforts are salient to professional quality of life; thus, future explorations should evaluate the implementation and efficacy of these self-care initiatives.

Introduction

Mental health professionals are faced with the daily demands of empathically listening and responding to their clients' needs. Occupational hazards, such as fatigue and exhaustion, can adversely affect practitioner well-being (Figley, 2002; Radley & Figley, 2007). Self-care is considered to be "A set of skills thought to help manage stress and burnout as well as enhance daily psychosocial well-being" (Cook-Cottone & Guyker, 2017, p. 164), and has become increasingly prevalent in the dialogue surrounding the counseling and psychology professions. Personal well-being is considered to be an ethical imperative for practitioners in both fields who are at elevated risk of burnout (Schaufeli, 2003).

Stamm (2010) conceptualizes professional quality of life, as encompassing the favorable and unfavorable aspects of the work of helping professionals. Compassion satisfaction represents the constructive aspect, whereas burnout and secondary traumatic stress signify the adverse aspects, compounding to constitute compassion fatigue (CF). Figley (1995) branded CF as the "cost of caring" (p. 7). His model of CF integrates the constructs of empathy, empathic understanding, and empathic response (Figley, 1995; Figley, 2002). The ability to accurately perceive and undertake perspectives of clients renders mental health professionals vulnerable to vicariously experiencing the emotional expressions of those they treat. Figley's (1995; 2002) notion of costs imply that there are consequential emotional and behavioral sacrifices to mental health professionals, resulting in physiological and psychological changes, which could consequently develop into CF.

Schaufeli and Greenglass (2001) operationally define burnout as, "a state of physical, emotional and mental exhaustion that results from long-term involvement in work situations that are emotionally demanding" (p. 501). Barnett and Cooper (2009) outline the occupational risks inherent in the profession of psychology, which renders practitioners vulnerable to burnout. They caution that burnout is a form of impairment compromising the competence of practitioners. Self-care counteracts these effects (Barnett & Cooper, 2009; Smith & Moss, 2009).

Graduate programs in counseling and psychology are responsible for guiding and mentoring students throughout the various stages of their professional careers. Given the pronounced occupational risks, training should promote practices that seek to inoculate helping professionals against professional impairment. The development and maintenance of effective self-care practices may be related to providing ethically competent care. It is of interest, then, to examine the mechanisms of self-care and professional quality of life within this population. Such explorations can provide insight into the dynamic ways that these constructs influence one another, in addition to the preventative measures that should be taken in order to foster balanced professional practices and mitigate compassion fatigue.

Literature Review

Self-Care

Self-care involves the initiation of behaviors that foster wellness (Myers et al., 2012). The concept of self-care is comprised of several dimensions, including psychological, physical, spiritual, emotional, and interpersonal/support (Dorociak, Rupert,

Bryant, & Zahniser, 2017; Richards, Campenni, & Muse-Burke, 2010). Self-care practices

are a vital component of the ethical mandates that govern the field of psychology.

According to the American Psychological Association Code of Ethics, Principle A:

Beneficence and Nonmaleficence, states that "Psychologists strive to be aware of the

possible effect of their own physical and mental health on their ability to help those with

whom they work" (APA, 2017, p. 3). Smith and Moss (2009) endorse self-care as the most

robust counteractive force against professional impairment. Nevertheless, self-care has

been given remarkably little empirical attention in relation to helping professionals

(Dorociak et al., 2017).

Barnett and Cooper (2009) underscore the protective nature of self-care practices,

noting that psychology professionals are cognizant of the empirical evidence, yet fail to put

these standards into practice. Counseling professionals recognize the value of wellbeing

for their clients while habitually disregarding their own needs (O'Halloran & Linton, 2000;

Wolf, Thompson, Thompson, & Smith-Adcock, 2014). Smith and Moss (2009) emphasize

the obligation of program and faculty to appropriately prepare graduate students for this

line of work, immersing them in what Barnett and Cooper (2009) describe as a "culture of

self-care" (p. 17), throughout the initial stages of their professional development. They,

among others, stress the role of faculty members, professional organizations, supervisors,

and mentors in proactively establishing these standards in training (Barnett & Cooper,

2009; Barnett et al., 2009; Colman et al., 2016; Smith & Moss, 2009). Although the

requisite need for self-care is highlighted across publications, current research has yet to examine the observed self-care practices of counseling and psychology trainees.

Rummell (2015) investigated the general well-being of doctoral students enrolled in counseling and clinical psychology programs. The data suggests that the preliminary years of graduate school are the most burdensome and stressful for students. The psychological and somatic symptoms prevalent in this population were significantly more elevated than those of the general population, a finding that may be better understood embedded in the context of marked deficits in self-care behaviors and interventions. The paradox appears to be that despite the symptomatic and vulnerable state of these graduate students, their mental health and wellness needs are not being addressed appropriately (Rummell, 2015). El-Ghoroury, Galper, Sawaqdeh, and Bufka (2012) investigated the deterrents to wellness and self-care among psychology graduate students, deducing that time and financial limitations, as well as feelings of embarrassment, shame, and guilt thwart the utilization of self-care services.

A meta-analysis conducted by Colman and colleagues (2016) evaluated the effectiveness of self-care, postulating that self-care practices would culminate in positive outcomes among psychology graduate students. Seventeen studies with this particular population were included in the meta-analysis, which employed the PsycINFO database. Positive outcomes were observed, with the most substantial areas of benefit being self-compassion and life satisfaction, whereas the least impact was observed in the domain of stress-reduction. Additionally, Colman and co-investigators (2016) posit that the

mechanisms of self-care may involve the amelioration of student self-perceptions and attitudes. Nevertheless, there are considerable gaps in the literature further limiting our narrow understanding of self-care with respect to this vulnerable population.

Professional Quality of Life

Compassion Satisfaction

Compassion satisfaction is considered to be a counteracting force against compassion fatigue (CF), and as such, is a relevant construct within the sphere of professional quality of life (refer to Figure 1 on p. 55; Stamm, 2010). Stamm (2010) refers to compassion satisfaction as the constructive, rewarding quality of being a helping professional. A wide range of studies have examined the link between compassion satisfaction, self-care, burnout, and CF (Alkema, Linton, & Davies, 2008; Cetrano et al., 2017; Craig & Sprang, 2010; Kraus, 2005). In a study of hospice care providers, Alkema and colleagues (2008) discovered that engaging in spiritual and emotional forms of self-care predicted increased levels of compassion satisfaction. Thomas and Otis (2010) note that mindfulness is a positive predictor of compassion satisfaction, corroborating the relationship between these two constructs. Examinations of burnout and compassion satisfaction have led to the conclusion that compassion satisfaction significantly reduces the risk of burnout among mental health professionals (Kraus, 2005; Thompson, Amatea, & Thompson, 2014), signifying its potential capacity to enhance professional quality of life.

Compassion satisfaction is also implicated in the prevention of CF, given that high rates of compassion satisfaction are correlated with diminished CF (Figley, 2002; Turgoose

& Maddox, 2017). This suggests that a reciprocal relationship between compassion

satisfaction and CF may exist. Moreover, the simple awareness of compassion satisfaction

can help inoculate mental health professionals against developing CF (Figley, 1995;

Stamm, 2010). Merriman (2015) highlights the implications of these findings for trainees,

who may benefit substantially from psychoeducation. She recommends cultivating this

awareness through the practice of journaling, which may be considered a form of self-care.

The significance of compassion satisfaction as a protective factor against CF is echoed

throughout the literature (Alkema et al., 2008; Stamm, 2010; Turgoose & Maddox, 2017).

Burnout

The definition of burnout varies extensively across various researchers and tools of

measurement. Maslach and Leiter (2016) conceptualize burnout as an interpersonal and

transactional process, consisting of three elements: exhaustion, cynicism, and professional

inefficacy. Kristensen and co-investigators (2005) elaborate on Schaufeli and Greenglass'

(2001) interpretation of burnout, elucidating that "the additional key feature is the

attribution of fatigue and exhaustion to specific domains or spheres in the person's life" (p.

196). Burnout is a multidimensional construct, and as such, presentations of burnout are

complex (Lee, Cho, Kissinger, & Ogle, 2010).

Burnout negatively affects physical health and well-being (Kaeding et al., 2017;

Lanham, Rye, Rimsky, & Weill, 2012; Puig, Baggs, Mixon, Park, Kim, & Lee, 2012). The

American Counseling Association addresses burnout in their code of ethics in the context

of professional competence and impairment, affirming that "Counselors refrain from

offering or accepting professional services when their physical, mental, or emotional problems are likely to harm a client or others. They are alert to the signs of impairment, seek assistance for problems, and, if necessary, limit, suspend, or terminate their professional responsibilities" (ACA, 2014, p. 13). The ability to discern burnout and take appropriate action is integrally related to a clinician's capacity to provide competent care.

Lim, Kim, Kim, Yang, and Lee (2010) describe two dimensions of burnout, which have emerged from the literature: individual variables, such as gender, and work-related variables, such as work environment. Their meta-analysis reviewed fifteen articles with the objective of assessing the effect of individual and work-related variables on burnout. Inclusion criteria was contingent on employing the Maslach Burnout Inventory to quantify burnout (MBI; Maslach, Jackson, & Leiter, 1996) and limiting the participant pool to psychotherapists, counselors, or psychologists. The results pointed to age as the most fundamental variable in the prediction of burnout among mental health providers, characterized by an inverse relationship.

The literature reveals conflicting findings concerning practitioner age and level of experience vis-à-vis burnout. Some researchers contend that younger practitioners with fewer years of experience in the mental health field are considered to be more susceptible to burnout (Browning, McDermott, & Scaffa, 2019; Lim et al., 2010). In contrast, a study of 284 counseling psychology doctoral students by Kovach Clark, Murdock, and Koetting (2009) yielded low levels of burnout across participants. Lanham and co-investigators (2012) cite literature contradicting this finding, which purports that greater experience is

positively correlated with burnout (Lasalvia et al., 2009; Linley & Joseph, 2007). Dorociak and colleagues (2017) suggest that, consistent with previous findings (e.g. Thompson et al., 2012), rates of burnout decline as clinicians age, while professional well-being enhances with age. Given their demographics, counseling and psychology trainees can help inform this area of research, which is lacking accord and consistency.

Additional variables implicated in predicting burnout include early maladaptive schemas (Kaeding et al., 2017) and workplace-specific gratitude (Lanham et al., 2012), while Kovach Clark and colleagues' (2009) analysis extrapolated global stress, advisor support, and sense of community as predictors of burnout. Level of education may also give rise to burnout; however, this can be mitigated by counselors' sense of accomplish and competence (Lim et al., 2010). These findings validate the notion of burnout as a multidimensional, rather than unidimensional construct (Lee et al., 2010; Lim et al., 2010). Self-care engagement and utilization, however, has not been given ample consideration as a potential predictor of burnout.

Based on their data, Lee and colleagues (2010) established three patterns of counselor burnout, with the most typical profile illustrating low rates of burnout as measured by the various subscales of the Counselor Burnout Inventory (CBI; Lee et al., 2007). They concluded that counselors who did not experience burnout rated their level of job satisfaction and positive self-esteem higher than those who did. Use of the Copenhagen Burnout Inventory (CBI; Kristensen, Borritz, Villadsen, & Christensen, 2005) in this study

could have helped to differentiate between the various domains of burnout (personal, work-related, and client-related).

The occurrence of ethical dilemmas increases the magnitude of burnout among counselors (Mullen, Morris, & Lord, 2017), while organizational factors, such as work environment, may exacerbate burnout among mental health professionals (Lim et al., 2010). Notably, mental health providers employed in agency settings may be at significant risk of burnout compared to those in private practice, who have increased independence (Cunningham, 2010; Lim et al., 2010). This renders the CBI (Kristensen et al., 2005) a particularly useful measure for the purpose of isolating the effect of these factors on specific indices of burnout.

Compassion Fatigue

Empathy is a critical component in compassion fatigue (CF), one that is absent in the conceptualization of the often-conflated construct of vicarious trauma (Figley, 1995). There is ongoing dispute about whether the constructs of vicarious trauma and compassion fatigue are distinct or overlapping (Figley, 1995; Merriman, 2015). Sinclair, Raffin-Boucha, Venturato, Mijovic-Kondejewski, and Smith-Macdonald (2017) describe several proposed models of CF, on which there is no consensus, and which may vary by profession (e.g. physicians versus mental health clinicians). Turgoose and Maddox (2017) offer a definition of CF based on Figley's (1995) and Stamm's (2010) formulations, describing it as "The emotional and physical fatigue experienced by professionals due to their chronic use of empathy in helping others in distress" (p. 173). Although CF has often been linked

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with trauma, client suffering can induce CF in conjunction with deficient occupational support and self-care practices (Radley & Figley, 2007; Merriman, 2015).

Stamm (2010) measures compassion fatigue by means of the secondary traumatic stress subscale (STS) on the Professional Quality of Life 5 questionnaire (ProQOL; Stamm, 2010). The burnout subscale is also considered to be an element of CF, as higher scores on both subscales indicate elevated risk of CF. Stamm (2010) conceptualized this scale specifically for use with therapists. However, contrary to expectation, the counseling and psychology professions have been substantially overlooked in the literature, as there is a paucity of data on CF relevant to helping professionals.

In a review of 32 studies, Turgoose and Maddox (2017) parsed out the psychosocial factors predictive of CF among mental health practitioners. Their findings indicated that risk factors for compassion fatigue include: (a) the professional's history of trauma, (b) a form of empathy, which induces personal distress, and (c) a heavy caseload. Female counselors tend to report higher rates of CF (Thompson et al., 2014). Further differences may be prevalent in relation to stage of professional career, as Dorociak and colleagues (2017) found that psychologists employed for over twenty years were less inclined to feel burdened by heavy caseloads. Furthermore, occupational setting may affect this relationship, provided that experienced psychologists were more frequently employed in private practice settings (Dorociak et al., 2017). Turgoose and Maddox (2017) explain the complex, bidirectional relationship between empathy and CF. Increased empathy can exacerbate CF, whereas the development of CF can deplete feelings and displays of

empathy. The authors propose that longitudinal studies are critical in furthering our understanding of this relationship. Mental health professionals may be more prone to CF if they have experienced trauma themselves, given that empathy was found to moderate the relationship between CF and personal history of trauma (Turgoose & Maddox, 2017).

A study by Thompson and colleagues (2014) involving 213 mental health counselors revealed that favorable working conditions were inversely related to CF and burnout. A counterintuitive finding of this study was that longer length of time spent working as a counselor was correlated with reduced levels of compassion fatigue and burnout; this, however, aligns with the prevailing research on burnout (Dorociak et al., 2017; Rupert, Miller, & Dorociak, 2015). It would be reasonable to infer from these findings that graduate students and trainees are the group most vulnerable to the development of CF. Nevertheless, further investigation is merited in consideration of O'Brien and Haaga's (2015) discovery that novice and advanced therapist trainees are more resistant to CF compared to nontherapists. Merriman (2015) underscores the importance of psychoeducation within supervisory relationships regarding the risks and symptoms, as well as preventative factors of CF. This can facilitate counselor development, bearing in mind that CF can interfere with professional growth.

Examining the Relationship between Self-Care and Professional Quality of Life

How does professional quality of life relate to the practice of self-care? Sinclair and colleagues (2017) emphasize the role of self-care in mitigating and preventing CF among health care providers, noting that negative correlations between dimensions of self-care, as

well as various activities, which constitute self-care, have been established in relation to CF. Sorenson, Bolick, Wright, and Hamilton's (2016) literature review found self-care to be the most crucial factor in the prevention of CF among health care providers. Due to the current dearth in literature, data from health professionals must be extrapolated to mental health practitioners.

A study by Beaumont, Durkins, Hollins Martin, and Carson (2016) evaluated the relationships between self-compassion, compassion satisfaction, compassion fatigue, and well-being among student counselors and psychotherapists in their final year of graduate school. The investigation revealed a significant correlation between elevated self-compassion and reduced levels of reported CF and burnout, resulting in enhanced well-being. This study, which was considered the first of its kind relative to this population, found self-compassion to be a protective factor against burnout. One could theoretically extend Beaumont and colleagues' (2016) findings to conclude that cultivating self-compassion is a form of self-care.

Dorociak and colleagues (2017) compared professional psychologists in various stages of their careers (early, mid, and late) to determine differences in utilization of self-care strategies. The late-career group experienced less burnout and increased well-being relative to the other groups. The authors propose that in accordance with the existing burnout literature, psychologists in the late stages of their careers may be more adept at balancing professional demands and personal well-being (Dorociak et al., 2017). This is in contrast to early career psychologists who may not have established self-care strategies as

safeguards against burnout and who report less frequent implementation of self-care practices.

Dorociak and colleagues (2017), along with other researchers (e.g., Barnett & Cooper, 2009; Dearing, Maddux, & Tangney, 2005), advocate for professional development opportunities, mentoring programs, and early efforts aimed toward cultivating self-care in light of their research on psychologists in the initial stages of their careers. They proclaim that these individuals experience elevated levels of burnout and stress due to the developmental trajectory of their careers, thus making resources aimed at self-care essential to their well-being and professional competence. A study by Goncher, Sherman, Barnett, and Haskins (2013) found self-care utilization to be a partial mediator in the relationship between perceptions of self-care emphasis in their respective doctoral programs and the quality of life of 262 clinical psychology doctoral students. Programmatic perceptions of self-care and self-care utilization accounted for half of the variance in the doctoral students' professional quality of life, substantiating that graduate training is a critical period during which the practice of self-care should be instilled in trainees.

Occupational burnout, and particularly the component of exhaustion, among mental health professionals is negatively correlated with physical health and wellness (Puig et al., 2012). Adequate nutrition and exercise, which may be considered fundamental forms of self-care are compromised when practitioners experience job burnout. The relationship between occupational factors and CF was not substantiated in Thompson and colleagues'

(2014) study, which the authors postulate may be due to the association among contextual factors and burnout. The data suggests that compassion satisfaction and mindfulness, which were categorized as the counselor's personal resources, predicted lower levels of burnout, while maladaptive coping and emotion-focused coping predicted higher levels of burnout. Researchers have also examined wellness as a correlate of professional quality of life. Lawson and Myers (2011) discovered a positive association between wellness and professional quality of life, while Puig and colleagues (2012) encourage screening for diminished levels of wellness and elevated burnout rates among trainees in order to intervene with self-care strategies. Moreover, Browning and co-investigators (2019) propound that older counselors may have developed protective factors against CF, considering that burnout was found to be more prevalent among younger participants, making this a critical area for future research within this population.

The Role of Mindfulness

Merriman (2015) states that although the literature has not sufficiently explored the factors that may alleviate and protect against CF, counselor self-awareness and self-reflection are considered to be effective buffers (Merriman, 2015). Jon Kabat-Zinn (2011) operationalizes mindfulness as constituting awareness, presence, and a nonjudgmental outlook. Several researchers have endorsed mindfulness as an effective means of self-care for graduate students (Christopher, Christopher, Dunnagan, & Schure, 2006; Dorian & Killebrew, 2014; Sünbül, Malkoç, Gördesli, Arslan, & Çekici, 2018; Tarrasch, 2015), while others have affirmed the beneficial impact on mental health professionals and counselors in

particular (Friedman, 2017; Richards et al., 2010; Williams, Richardson, Moore, Gambrel, & Keeling, 2010). Hotchkiss (2018) discovered that mindful self-care practices mediate the relationship between compassion satisfaction and burnout among hospice workers, but this association has yet to be explored among mental health professionals. Mindful self-care integrates the quality of mindfulness into the traditional domains and conceptualization of self-care (Cook-Cuttone & Guyker, 2017).

Qualitative studies by Christopher and Maris (2010) detected attitudinal and cognitive changes among counseling and psychotherapist trainees following an applied and didactic graduate course on self-care and contemplative practices. These changes included enhanced awareness, compassion, and acceptance. Increased overall wellbeing was also an indicator of the capacity for mindfulness to prevent or alleviate CF, burnout, and vicarious traumatization (Christopher & Maris, 2010). The participants also noted improvements in their interpersonal relationships and interactions. On the basis of their results, the authors conclude that mindfulness is an essential tool for the implementation of self-care strategies and practices in graduate programs. Mindfulness was also considered to be a potential protective factor against CF in Turgoose and Maddox's (2017) review of the literature, although empirical evidence is limited.

Browning and colleagues (2019) investigated transcendent strengths, which they describe as adaptive internal resources that connect individuals to their higher purpose and self-actualizing tendencies, as predictors of the quality of life of 98 master's level counselors. The strengths of hope, gratitude, and spirituality demonstrated a positive

correlation with compassion satisfaction and a negative correlation with burnout and secondary traumatic stress, which in conjunction, measure CF. Controlling for demographic variables revealed that hope has a significant, positive, correlation with compassion satisfaction, while gratitude and spirituality were negative predictors of burnout. Spirituality, an established element of self-care, as well as mindfulness practices, which may incorporate gratitude, should be given further consideration in future studies.

O'Brien and Haaga (2015) underline the influence of clinical programs in cultivating resilience and curtailing the adverse consequences of burnout and CF. Shapiro, Brown, and Biegel (2007) assert that the implementation of mindfulness practices facilitated the well-being of counseling trainees, underscoring its necessity as a form of self-care throughout graduate training. Schure, Christopher, and Christopher (2008) taught self-care to master's level counseling students through a mindfulness-based stress reduction (MBSR) course, which unequivocally improved their personal and professional development. Self-care can serve to enhance interactions with others, and particularly clients (Merriman, 2015). Faculty and supervisory relationships should seek to educate, address, and foster these skills throughout graduate training, while researchers should not underestimate the considerable implications for the professional quality of life of helping professionals.

Overview of the Present Research

It is evident upon reviewing the literature that the complex associations among self-care and professional quality of life have yet to be thoroughly examined, particularly in

relation to helping professionals. Extant research has been markedly heterogeneous, examining the variables of interest in different contexts and utilizing various scales of measurement. This creates considerable limitations in the replication of findings and generalizability of results. This is further compounded by the subsisting variability regarding conceptualizations of CF (Figley, 1995; Sinclair et al., 2017), as well as the fact that CF is theoretically confounded with related constructs (Craig & Sprang, 2010). Despite these limitations, corollary conclusions drawn from research on health care professionals (Sinclair et al., 2017; Sorenson et al., 2016) substantiate the efficacy of self-care as a protective factor against compassion fatigue. Researchers have only begun to investigate the relevant variables implicated in shaping the professional quality of life of mental health practitioners (Beaumont et al., 2013). The aggregate data suggest that overall well-being (Lawson & Myers, 2011; Puig et al., 2012), self-compassion (Beaumont et al., 2013), career trajectory (Dorociak et al., 2017), mindfulness (Christopher et al., 2006; Christopher & Maris, 2010; Richards et al., 2010), and transcendent strengths (Browning et al., 2019) are all implicated in cultivating and preserving professional quality of life. The tendency to implement and engage in self-care strategies may be a skill that is contingent on professional development and experience (Dorociak et al., 2017), as well as the perceived perceptions of self-care among graduate faculty and mentors (Goncher et al., 2013). What is unmistakable is that graduate training is a formative period for establishing persistent, balanced professional practices.

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Why the Present Study Matters

Existing research has examined the underpinnings of professional quality of life and self-care in isolation from one another, providing an insular perspective. Researchers have validated the relationships among these constructs in a fragmented manner, neglecting to consider the direct associations between them. A comprehensive view of the relationship between self-care and the various domains of professional quality of life has yet to be undertaken. Despite the axiomatic role of mindfulness on self-care and professional quality of life, mindful self-care has only been considered in investigations of hospice workers (Hotchkiss, 2018). In view of this, the present study seeks to examine the effect of self-care on the professional quality of life of counseling and clinical psychology trainees utilizing the Mindful Self-Care Scale (MSCS; Cook-Cottone & Guyker, 2018).

Several studies (Browning et al., 2019; Dorociak et al., 2017; Lim et al., 2010) have yielded data suggesting that younger, less experienced counselors in the early stages of their careers may not have acquired the skillset to promote work-life balance and prevent CF. These findings render graduate students a population of interest. Current understandings of burnout have relied on data derived from the Maslach Burnout Inventory (MBI; Maslach, Jackson, & Leiter, 1996), while the subdimensions of burnout have not been assessed. Moreover, numerous researchers have proposed that the overall wellness of counseling students typically exceeds that of the general public (Myers, Mobley, & Booth, 2003; Roach & Young, 2007), yet investigators have not considered programmatic differences in self-care engagement among clinical and counseling psychology students.

Swords and Ellis (2017) contend that the wellbeing of trainees warrants further exploration. These investigations are germane to our understanding of practitioner impairment through the lens of professional development and training. Maladaptive tendencies and deficiencies in self-care should be addressed by means of preventative and interventional approaches throughout the preliminary years of training and practice. The present findings will be a fundamental initial step in the advancement of these standards in training.

Hypotheses

Hypothesis I

Based on the assumption that mindfulness and self-care behaviors enhance professional quality of life, I hypothesize that self-care as measured by the MSCS (Cook-Cottone & Guyker, 2018) will predict overall professional quality of life. Specifically, I predict that graduate students who score higher on self-care will also score higher on compassion satisfaction and lower on both burnout and secondary traumatic stress. Therefore, I predict that compassion satisfaction will have a positive regression coefficient, while burnout and secondary traumatic stress will have negative regression coefficients in the analyses reported here.

Hypothesis II

As an exploratory hypothesis, the typologies of burnout will be examined as measured by the CBI (Kristensen et al., 2005) to determine whether various domains of burnout are related to self-care. Existing research has not examined subdimensions of burnout in relation to self-care. I hypothesize that self-care will predict the various types of

burnout experienced, such that graduate students who score higher on self-care will score lower on personal burnout, work-related burnout, and client-related burnout. Therefore, negative regression coefficients are predicted for all burnout variables.

Hypothesis III

Given the greater emphasis in Clinical Mental Health Counseling (CMHC) programs on holistic wellness compared to Clinical Psychology (CP) programs, I hypothesize that CMHC graduate students will engage in self-care practices to a greater degree than CP graduate students. Specifically, I predict a significant difference in the mindful self-care scores of CMHC and CP graduate students, such that the former will score higher than the latter.

Method

Participants

Participants included a convenience sample of counseling and clinical psychology graduate students from the University of Texas at Tyler. A total of 47 graduate students consented to the survey. However, data were missing from nine of the participants. Participants ranged from 21 to 54 years of age ($M = 27.69$, $SD = 6.84$). 58% (22) of the total participants were enrolled in the clinical psychology program and 42% (16) were enrolled in the clinical mental health counseling program. The sample was 90% female and 5% male, with 5% of participants who did not disclose their gender. The total sample comprised of 63% Caucasian, 8.7% Hispanic or Latino, 2.2% African American, and 2.2%

Middle Eastern participants. 2.2% of participants identified with more than one ethnicity.

Please refer to Table 1 for participant demographics.

Procedure

Once IRB approval was granted for this study, graduate students enrolled in the

Clinical Psychology and Clinical Mental Health Counseling programs at the University of

Texas at Tyler were invited to participate in the study via various methods of

communication, including Facebook groups and pages relevant to psychology and

counseling at UT Tyler, announcements and emails sent out by professors in both

programs, word of mouth, and visits to counseling and clinical psychology graduate

classes. Participation was voluntary and there was no incentive offered to volunteers.

Participants were asked to provide consent in order to complete an online survey, which

was administered via Qualtrics. Participants anonymously completed the surveys utilizing

personal electronic devices. The estimated survey response rate was 22% (47 out of a total

of 210 participants consented to the survey). This estimate does not accurately account for

duplicates or participants who may have accessed the survey via Facebook posts or word of

mouth.

Statistical Analyses

IBM® SPSS version 24 for macOS Mojave was used to analyze the data. This study

employed a cross-sectional, correlational design. The data was initially plotted to assess for

assumptions of normality. Variables of interest included mindful self-care (MSCS; Cook-

Cottone & Guyker, 2018), professional quality of life measured by the domains of

compassion satisfaction, burnout, and secondary traumatic stress (ProQOL; Stamm, 2010),

and type of burnout measured by the subdimensions personal burnout, work-related burnout,

and client-related burnout (CBI; Kristensen et al., 2005). The sample sizes varied based on

the variables assessed, as one participant was missing data relevant to the three professional

quality of life subscales, while two participants were missing data to relevant to the work-

related and client-related burnout variables. Bivariate linear regression analyses were

conducted for each domain of professional quality of life and burnout separately, utilizing

self-care as the predictor variable. Finally, independent samples t-tests were conducted to

examine the differences between students enrolled in the clinical psychology and clinical

mental health counseling programs, on the basis of frequency of self-care and the various

types of burnout experienced.

Materials

Self-Care Measure

Mindful Self-Care Scale (MSCS). The MSCS (Cook-Cottone & Guyker, 2018) is a

33-item questionnaire, which measures the tendency to engage in self-care behaviors with

mindful awareness. Cook-Cottone and Guyker (2017) purport that mindful self-care can be

a protective factor in the prevention of occupational and academic burnout, in addition to

mental distress. There are six subscales, which quantify various domains of self-care,

including: Mindful relaxation (6 items), physical care (8 items), self-compassion and

purpose (6 items), supportive relationships (5 items), supportive structure (4 items), and

mindful awareness (4 items). The scale also includes three additional items that are not

factored in to the composite score, but that seek to individually assess global self-care tendencies. Items are scored on a 5-point Likert-type scale ranging from 1 (Never, 0 days) to 5 (Regularly, 6 to 7 days). Items include, "I did something intellectual (using my mind) to help me relax (e.g. read a book, wrote)," and "I maintained balance between the demands of others and what is important to me." The reverse-scored item, "I did sedentary activities instead of exercising (watched tv, worked on the computer)," appears on the physical care subscale. Mindfulness, however, appears to only be measured by the mindful awareness subscale, which includes items such as "I had a calm awareness of my body." For this reason, the construct is referred to as self-care throughout the present study. The psychometric properties of the MSCS are sound, marked by strong internal consistency (Cook-Cottone & Guyker, 2017). Cronbach's $\alpha = .87$ for the overall scale in the present study.

Burnout Measure

Copenhagen Burnout Inventory. The CBI (Kristensen, Borritz, Villadsen, & Christensen, 2005) is a 19-item questionnaire designed to measure three sub-dimensions of burnout; namely, personal burnout (6 items), work-related burnout (7 items), and client-related burnout (6 items). Items are measured according to a 5-point Likert-type scale, which ranges from 1 (always or to a very high degree) to 5 (never/almost never or to a very low degree). Scoring requires responses to be rescaled from 0 to 100, and elevated scores correspond to elevated degrees of burnout. Items include: "How often do you feel worn out?" (personal burnout); "Do you have enough energy for family and friends during

leisure time?" (work-related burnout, reverse-scored); and "Do you sometimes wonder how long you will be able to continue working with clients?" (client-related burnout). According to Borritz and colleagues (2006) the subscales demonstrated high internal reliability (Cronbach's α = .85-87). The subscales have good face validity, criterion validity, and divergent validity (Kristensen et al., 2005). Cronbach's α = .94 for the overall scale in this study, and .90, .87, and .81 for the relative domains of personal, work-related, and client-related burnout.

Professional Quality of Life Measure

Professional Quality of Life Scale (version 5). The ProQOL 5 (Stamm, 2010) contains three subscales which measure three distinct constructs: Compassion satisfaction (CS), burnout (BO), and secondary traumatic stress (STS). Burnout and secondary traumatic stress are both considered to be elements of compassion fatigue, while compassion satisfaction is a standalone construct (Stamm, 2010). Nevertheless, all three subscales are conceptually distinct. There are 30 items on the scale, which are measured using a 5-point Likert-type scale ranging from 1 (never) to 5 (very often). Respondents are asked to rate the frequency with which they experience the following: "I get satisfaction from being able to help people" (CS); "I feel connected to others" (BO, reverse-scored item); and "I am preoccupied with more than one person I help" (STS). There are five reverse-scored items, which appear on the burnout subscale. The average score for all three subscales is 50 with a standard deviation of 10 (Stamm, 2010). Empirical support for the construct validity of the ProQOL 5 is strong (Hemsworth, Baregheh, Aoun, & Kazanjian,

2018; Stamm, 2010). Stamm (2010) reports Cronbach's alphas of the CS, BO, and STS

scales as .88, .75, and .81, respectively. Cronbach's $\alpha = .84$ for the overall scale in the

present study, and .93, .82, and .86 for the subscales of CS, BO, and STS, respectively.

The ProQOL is the most widely used measure for compassion fatigue (Hemsworth et al.,

2018; Stamm, 2010). Please refer to Appendix B for a copy of the above questionnaires.

Results

Hypothesis I

I hypothesized that self-care would positively predict professional quality of life, as

evaluated in a bivariate linear regression. Preliminary analyses indicated that the

assumptions of normality were not violated. Self-care was entered as a predictor of

compassion satisfaction (CS), indicating that self-care was a positive predictor of graduate

students' level of CS, $F(1, 35)= 23.95$, $p < .001$, two-tailed. Self-care accounted for 39% of

the variance in CS (adjusted $R^2 = .39$) and had a positive relation to CS overall (see Table 2

for coefficients).

When self-care was entered as a predictor of burnout (BO) in a bivariate linear

regression, results revealed that self-care significantly predicted graduate students' level of

BO, $F(1, 35)= 28.62$, $p < .001$, two-tailed. Self-care accounted for 43% of the variance in

BO (adjusted $R^2 = .43$) and was a negative predictor of BO (see Table 2 for coefficients).

Finally, self-care was entered as a predictor of secondary traumatic stress (STS) in a linear

regression. Results revealed that self-care did not predict STS among graduate students,

$F(1, 35)= 2.07$, $p = .16$, two-tailed (see Table 2 for coefficients).

In order to provide an alternative test of this hypothesis and compare various levels of self-care frequency, additional exploratory analyses were conducted. A median split was conducted in order to create two groups, which represented participants who scored low on self-care frequency and those who scored high on self-care frequency. Subsequently, independent samples t-tests were conducted. It was found that those who scored high on self-care had significantly higher levels of CS (M= 45.00, SD= 4.54) compared to those who scored low on self-care (M= 37.33, SD= 6.31), $t(35)$= 4.31, $p = < .001$, d= 1.40, two-tailed. Those who scored high on self-care had significantly lower levels of BO (M= 17.23, SD= 4.79) than those who scored low on self-care (M= 24.54, SD= 5.54), $t(35)$= 4.28, $p = < .001$, d= 1.41, two-tailed. There was no significant difference between the two groups on levels of STS, $t(35)$= .65, $p = .52$, two-tailed.

Hypothesis II

I hypothesized that self-care would predict various types of burnout. Upon determining that the assumptions of normality for the respective dependent variables were not violated, self-care was entered as a predictor of personal burnout in a bivariate linear regression. Results revealed that self-care did not significantly predict graduate students' level of personal burnout $F(1, 36)$= 3.95, p= .05, two-tailed (see Table 3 for coefficients).

Self-care was entered as a predictor of work-related burnout in a bivariate linear regression. Results indicated that self-care was a significant predictor of graduate students' level of work-related burnout, $F(1, 34)$= 4.94, p= .03, two-tailed. Self-care accounted for

10% of the variance in work-related burnout (adjusted $R^2 = .10$) and negatively predicted work-related burnout (see Table 3 for coefficients).

Self-care was entered as a predictor of client-related burnout in a bivariate linear regression. Results indicated that self-care was a significant predictor of graduate students' level of client-related burnout, $F(1, 34)= 8.97$, $p= .01$, two-tailed. Self-care accounted for 19% of the variance in client-related burnout (adjusted $R^2 = .19$) and negatively predicted client-related burnout (see Table 3 for coefficients).

Hypothesis III

I hypothesized that CMHC students would engage in self-care more frequently than their CP counterparts. An independent samples t-test revealed that there was no significant difference between the frequency of self-care behaviors of CP ($M= 19.46$, $SD= 3.04$) and CMHC students ($M= 21.07$, $SD= 2.88$), $t(35)= 1.62$, $p= .12$, two-tailed (see Table 4). Although not originally hypothesized, there was a significant difference between CP ($M= 39.61$, $SD= 20.47$) and CMHC ($M= 26.53$, $SD= 11.53$) students' level of work-related burnout, and the size of the effect was moderate to large, $t(35)= 2.17$, $p= .04$, $d= .79$, two-tailed (see Table 6). There was also a significant difference between the CP ($M= 27.27$, $SD= 17.38$) and CMHC ($M= 14.58$, $SD= 11.76$) students' level of client-related burnout, and the size of the effect was large, $t(35)= 2.40$, $p= .02$, $d= .86$, two-tailed (see Table 5). Due to the fact that these are post-hoc, exploratory tests, a Bonferroni correction is required to reduce the type I error rate and preserve statistical power. This correction would reduce the alpha level to $p= .02$, rendering the results nonsignificant; however, a larger sample size

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would likely find a significant difference. This would be a consideration in prospective

studies. Although in the present study, the results are suggestive but not conclusive.

Discussion

The fundamental objective of the present study was to advance the current parochial

understanding of the role of self-care in relation to professional quality of life and

typologies of burnout. Consistent with predictions and previous research (Dorociak et al.,

2017; Goncher et al., 2013), engagement in self-care was related to both compassion

satisfaction and burnout. Notably, more frequent self-care was related to increased

compassion satisfaction and decreased burnout among trainees. Secondary traumatic stress,

however, was not related to self-care behaviors. This finding in particular does not align

with conclusions drawn from samples of health care providers, which implicate self-care in

the mitigation of CF (Sinclair et al., 2017; Sorenson et al., 2016).

Interpreting these findings in the context of Stamm's theoretical framework of

professional quality of life provides some insight into the underlying processes that may be

at play. Participants' mean scores for compassion satisfaction (M= 41.89; SD= 6.48) were

in the average to high range, indicating that they find their work as helping professionals to

be rewarding (Stamm, 2010). The mean scores for burnout (M= 20.19; SD= 6.21) and

secondary traumatic stress (M= 18.46; SD= 5.66) signified a low risk for CF. This is

conceptually sound, given that compassion satisfaction (the positive dimension of helping)

can lower vulnerability to CF (the negative dimension of helping) (Stamm, 2010).

According to Stamm (2010), this the most favorable profile that can emerge, characteristic

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of helping professionals who are fueled by optimism, who are effective in their work, and who have the capacity for professional growth. Bearing this in mind, the present findings may be extended to conclude that self-care behaviors promote such a positive profile among trainees. An alternative interpretation may be that graduate students are in the preliminary stages of their training and professional experiences, minimizing their exposure to client suffering, stressful events, and consequently, CF.

It is conceivable that, consistent with Kovach Clark and colleagues' (2009) interpretations, graduate students in the fields of counseling and psychology possess more adaptive tendencies, which in turn, reduce their risk for CF. They may also have a distinct sense of purpose, which is reinforced by virtue of their training. This sense of purpose may serve as a protective factor against the development of CF. Conversely, despite its extensive use among helping professionals, Stamm's (2010) conceptual framework for professional quality of life may not accurately assess the negative dimensions of helping among trainees. It is tenable that this population's experience of compassion fatigue may have unique manifestations, requiring distinct scales of measurement. Master's level students may exhibit burnout in distinct forms and rates than doctoral students who score high on burnout (Dorociak et al., 2017; Swords & Ellis, 2017). Participants' low scores on the burnout and secondary traumatic stress scales in the present study may reflect the scale's limited scope for use with novice helping professionals. Nevertheless, these results are consistent with previous research suggesting that helping professionals experience relatively low levels of burnout (Lee et al., 2010). Furthermore, questions on the secondary

traumatic stress scale are trauma-focused, a potential shortcoming of the ProQOL scale (Stamm, 2010). The construct of CF as operationalized by this scale may not be sensitive to identifying manifestations of CF that result from exposure to client suffering as opposed to client trauma. Contextual predictors of burnout (Kaeding et al., 2017; Kovach Clark et al., 2009; Lanham et al., 2012; Lim et al., 2010) and risk factors for CF (Dorociak et al., 2017; Merriman, 2015; Turgoose & Maddox, 2017) may better account for trainee predisposition to CF.

Although participants' level of work-related ($M= 34.52$; $SD= 18.51$) and client-related burnout ($M= 22.34$; $SD= 16.49$) were relatively low, self-care was inversely related to these variables. These conclusions were drawn from an atheoretical, exploratory hypothesis, which aimed to establish whether engagement in self-care had an effect on the type of burnout participants experienced, as assessed by subdimensions of the CBI (Kristensen et al., 2005). The findings were consistent with conceptualizations of burnout as a multidimensional construct (Lee et al., 2010; Lim et al., 2010), as well as literature indicating that mindfulness is correlated with diminished levels of burnout (Christopher & Maris, 2010). Personal burnout as measured by the CBI (Kristensen et al., 2005) is not conceptually related to occupation, given that by definition, it measures universal experiences of fatigue and exhaustion. The nonsignificant findings that emerged in relation to mindful self-care as a predictor of personal burnout align with this conceptualization. Self-care significantly predicted lower levels of work-related and client-related burnout, indicating that in accordance with the extant literature, it is particularly effective in

mitigating occupational-related burnout (Browning et al., 2019; Dorociak et al., 2017; Puig et al., 2012). Moreover, the low levels of burnout across participants are consistent with Lee and colleagues' (2010) findings that manifestations of burnout among counselors tend to be minimal. These may be normative patterns of burnout characteristic of individuals who choose to pursue helping professions, as they may possess internal strengths which increase their resistance to burnout. Alternatively, these individuals may have learned to cultivate inner strength and resilience throughout their training. Nevertheless, there may be a more accurate way to measure and conceptualize burnout among trainees in particular.

The exploration of differences in the engagement of self-care between the clinical psychology and clinical mental health counseling students yielded no significant results. Despite the fact that wellness is more often emphasized and promoted in counseling programs (Blount, Bjornsen, & Moore, 2018; Keller-Dupree et al., 2017; Wolf et al., 2012; Wolf et al., 2014), clinical psychology students had comparable levels of engagement in self-care. These results may be representative of this particular sample, given that students enrolled in either program have overlapping courses and professors. This may also reflect an ongoing effort on the part of the institution to promote and reinforce self-care strategies among all trainees. Moreover, those who have a predilection to pursue helping professions may be aware of the inherent occupational risks and thus, accept the notion of self-care as a precondition to maintaining professional quality of life. It appears as though studies to date have not investigated whether there are programmatic differences in self-care utilization among clinical psychology and clinical mental health counseling Master's-level trainees.

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Significant findings did, however, emerge from analyses not associated with the *a priori* hypothesis regarding the type of burnout experienced between programs. Clinical psychology trainees endorsed higher levels of both work-related and client-related burnout than their clinical mental health counseling counterparts. This may be explained by the distinct concentrations of each program, as clinical psychology is more diagnostic and centered on psychopathology. This is in contrast to counseling's strength-based, holistic approach (Bamonti et al., 2014). It is possible that treating clients with pathological symptoms and presenting problems may magnify the experience of burnout among trainees. Researchers have suggested that counseling programs have been shifting towards emphasizing wellness (Wolf, Thompson, & Smith-Adcock, 2012; Wolf, Thompson, Thompson, & Smith-Adcock, 2014). Albeit Barnett and Cooper (2009) advocate for similar standards and ameliorated self-care within the field of psychology, the existing literature did not highlight wellness in clinical psychology programs. This may signify that the overarching emphases of these programs contribute to the appreciable levels of burnout among clinical psychology trainees.

Conversely, differences in burnout between the two programs may be attributed to the variable work experience and client contact of the participants. It is possible that the clinical mental health counseling students in the sample were still in the initial stages of training, with fewer hours of practical experience, rendering them less susceptible to burnout. An alternative interpretation may reflect the occupational goals of the trainees in each program. Qualitative evaluations indicated that the majority of clinical psychology

students planned to pursue a doctorate degree, whereas the majority of clinical mental health counseling students intended to provide psychotherapeutic services following graduation. This may be indicative of the increased workload and additional tasks of clinical psychology trainees who may be working as research assistants or teaching assistants in the interest of becoming more competitive doctoral candidates. These auxiliary demands may compound the stress of psychology trainees, predisposing them to burnout. It is also plausible that students who choose to pursue doctorates are more research-oriented than counseling-oriented, rendering practical experience increasingly taxing on them. Counseling students may be better equipped for high client contact, shielding them from the effects of burnout. A comparison of counseling and clinical psychology doctoral students on these variables can provide further insight into these programmatic differences.

Implications

Taken together, these findings underscore the significance of engagement in self-care among counseling and clinical psychology trainees. Professional quality of life is critical to the competence of practitioners (Barnett, Baker, Elman, & Schoener, 2007), and when neglected, can compromise their ability to uphold their ethical responsibilities towards their clients (ACA, 2014; APA, 2017). Barnett and Cooper (2009) assert that graduate training molds professional identity, laying the groundwork for establishing effective self-care practices. There is a requisite balance between personal needs and professional responsibilities, which must be cultivated throughout training. Quantitative

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and qualitative data alike indicate that graduate students have an expressed need for the reinforcement of self-care behaviors by means of open dialogue, psychoeducation, and increased prominence attributed to self-care within programs (Rummell, 2015).

Bamonti and colleagues (2014) reviewed the departmental handbooks available to students across 136 clinical psychology doctoral programs for references to self-care and related constructs, including "work-life balance, stress, burnout, impairment, mental health, and psychotherapy" (p. 255). Their analysis revealed that clinical psychology programs referenced self-care in their graduate handbooks more frequently than general departmental handbooks. However, self-care content primarily pertained to therapeutic services that sought to address student impairment. The authors posit that the paucity of material related to managing stress and burnout, as well as balancing personal and occupational demands denote the marked lack of prevention efforts throughout training. They further purport that current efforts are "reactive rather than proactive" (Bamonti et al., 2014, p. 258). In light of the present study's findings, graduate programs would benefit from framing self-care as an exigency and a protective factor rather than addressing it in the context of professional impairment.

Tertiary prevention efforts aimed at impairment are not constructive or efficacious, as graduate students are often hesitant to seek help at this stage (El Ghoroury, Galper, Sawaqdeh, & Bufka, 2012; Rummell, 2015). Consistent with Rummell's (2015) research, El-Ghoroury and co-investigators (2012) found that therapeutic services were related to pronounced stigma among psychology graduate students, while financial and time

limitations minimized their feasibility. Rummell (2015) postulates that seeking mental

health services may not be an option for graduate students in counseling and clinical

psychology programs, given that students are employed at agencies in their community.

This issue gives rise to concerns related to their professional identities and the risk of dual

relationships. Nevertheless, therapeutic intervention may be a means by which trainees in

counseling and psychology programs can discuss and monitor personal efforts toward self-

care and the prevention of burnout (Barnett & Cooper, 2009; Yager & Tovar-Blank, 2007)

if it is promoted effectively throughout training.

Proactive efforts towards the implementation of self-care are a prerequisite for the

proficiency of trainees. Investigations revealing that psychology and counseling faculty

were less inclined to demonstrate concern and compassion with regard to the onerous

challenge of striking an appropriate work-life balance (Barnet & Cooper, 2009; Rummell,

2015) are troubling provided that graduate students are habitually overwhelmed by the

competing demands of their academic training, practical experience, and personal needs

(Goncher et al., 2010). Lim and colleagues (2010) advise that striking an equilibrium

between achievement and well-being will safeguard mental health providers against

impairment. The authors note that supportive mentors within the occupational context are

paramount to well-being.

Researchers advocate for a paradigm shift, which serves to engender academic and

training environments that are conducive to wellness (Bamonti et al., 2014; Barnett et al.,

2007; Wolf et al., 2012; Wolf et al., 2014). One way to ensure this is by encouraging

programs to establish official declarations and competencies regarding self-care (Bamonti et al., 2014). Institutional approaches and changes in academic policies can serve to foster a climate that facilitates self-care among this vulnerable population. Several authors highlight the importance of modeling from faculty members (Barnett & Cooper, 2009; Barnett et al., 2007; Colman et al., 2016), while Goncher and co-investigators propound that formal self-care training be offered throughout graduate school. El-Ghoroury and colleagues (2012) recommend best practices for self-care; namely, the integration of self-care strategies and discussion into academic curricula, as well as embedded within organizational and departmental policies. This can promote the development of adaptive tendencies that future professionals can exercise throughout the trajectory of their careers.

Rummell (2015) recommends establishing interventions during the first or second year of graduate studies in virtue of the increased workload and distress that is definitive of this period. Lanham and colleagues (2012) recommend the use of evidence-based interventions, which can foster gratitude and presumably prevent burnout, including gratitude journaling and letter-writing. They also stress the importance of modeling these virtues in mentor and supervisory relationships, as they can be protective, inoculating factors against burnout. Merriman (2015) asserts that conceptualizing and modeling self-care within the supervisory relationship will promote practice and engagement among trainees and interns (Merriman, 2015). Yager and Tovar-Blank's (2007) recommendation for wellness in counselor education programs echoes the importance of mentoring,

modeling, and framing the concept of wellness as a continual process. Creative approaches to self-care may also enhance outcomes (Bradley, Whisenhunt, Adamson, & Kress, 2013).

In sum, the findings of the present study call for individual (mentor and supervisory relationships), organizational (professional competencies outlined by the ACA and the APA), and institutional (academic declarations and policies) action to enhance the self-care and professional quality of trainees. The promotion of self-care as a primary initiative cannot be overstated. The substantial role of training programs is highlighted, as graduate students are establishing enduring standards of practice. Advocacy efforts from professionals in the fields of counseling and clinical psychology are essential. The ethical codes of conduct of professionals in both fields mandate engagement in self-care and call for the awareness of professional impairment (ACA, 2014; APA, 2017); however, self-care and professional quality of life should be core competencies which are addressed throughout graduate training to ensure the optimal functioning of trainees. These principles must be embedded into the ethos of training programs to prevent the glaring occupational hazards that have been discussed and to provide a foundation that will be preserved throughout professional development. The above recommendations proposed by various researchers can facilitate such changes, creating a climate that fosters self-care and professional quality of life in counseling and clinical psychology graduate programs.

Limitations

Methodological limitations continue to undermine research on self-care and professional quality of life. The examination of these constructs relies heavily on self-

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report measures and is thus, subject to respondent biases. Voluntary participants and convenience sampling pose the continued dilemma of excluding those most vulnerable to stress, burnout, and compassion fatigue, given the likelihood that these individuals are unable to contend with additional tasks or demands (Lee et al., 2010; Puig et al., 2012, Rummell, 2015). The present study was not exempt from these limitations. Additionally, the construct of CF is confounded with related terms and concepts, such as vicarious traumatization and secondary traumatic stress (Craig & Sprang, 2010). This research was not trauma-focused and thus, compassion fatigue was operationally defined in terms of the general exposure of trainees to client stressors and suffering. Other researchers may not agree with this conceptualization.

There are considerable limitations with regards to the measures employed in the present study. The scale utilized to measure CF (ProQOL; Stamm, 2010) includes a number of trauma-focused questions to assess the potential risk of developing CF rather than its presence. This scale was utilized due to its psychometric properties and validation as a measure of CF (Stamm, 2010); however, the conception of a unique measure for the purpose of this study may have improved construct validity. The Mindful Self-Care scale (MSCS; Cook-Cottone & Guyker, 2018) measures mindfulness solely on the basis of one subscale (mindful awareness), potentially conflating the construct with traditional self-care. This construct's convergent and divergent validity should be assessed in order to address this shortcoming. Furthermore, despite the fact that the low levels of burnout within the sample may have been normative, there is a possibility that the burnout measure (CBI;

Kristensen et al., 2005) failed to accurately detect burnout among trainees with minimal experience and exposure to clients.

Results of this study should be interpreted with caution owing to the small sample size and the fact that graduate students from multiple institutions were not represented in the sample. Moreover, there was an overrepresentation of females within the sample, which may be characteristic of the demographic variations in the fields of counseling and psychology; nonetheless, this may limit the generalizability of results. The methodology of the present study and the statistical analyses employed rule out any inferences of causation and did not take into account confounding variables. It can be argued that the low rates of burnout and secondary traumatic stress within the present study could have been controlled for by means of client contact hours and work experience. Although these variables were measured in the questionnaire via open-ended items, they were not accounted for within the analyses due to the variable response formats. These variables may have improved accuracy if they were entered as additional predictors in the regression model.

Additionally, the lack of uniformity among measures that quantify the constructs of self-care and compassion fatigue continue to be problematic in this line of research. Researchers tend to create unique measures for the purpose of examining these constructs (O'Brien & Haaga, 2015; Dorociak et al., 2017), thus the absence of standardization across measures continues to compromise reliability and validity, as well as the replicability of results. Lastly, due to the dearth of studies on self-care and professional quality of life

within the disciplines of counseling and psychology, a proportion of the cited literature is dated and may rely on interdisciplinary findings.

Future Directions

A number of considerations must be addressed in order to improve this area of research. Primary endeavours should be aimed toward defining compassion fatigue and establishing whether it is conceptually distinct from burnout and related constructs. Moreover, the construct of mindful self-care should be refined, leading to improved operationalization. Such efforts can facilitate the development of standardized measures, which are both valid and reliable. The development of a measure for compassion fatigue that is in line with conceptualizations grounded in exposure to client suffering rather than client trauma could serve to enhance current understandings. Prospective studies should seek to further insights into the relationship between self-care and professional quality of life, determining whether causality exists via experimental methods. Additionally, longitudinal studies should be undertaken with the objective of examining the evolution of professional quality of life among counseling and psychology trainees vis-à-vis self-care. Qualitative data may also inform this area of research. Future investigations could assess the developmental trajectory of self-care and professional quality of life among mental health practitioners, assessing whether critical periods emerge.

Further consideration should be given to the dynamic ways that these constructs influence one another. Studies should continue to examine the effects of mindfulness on burnout, compassion fatigue, and overall well-being in the interest of informing prevention

efforts. Path analyses can be employed to establish whether self-care is a protective factor and to assess whether mediating variables emerge. The construct of mindful self-care must be effectively measured in future studies so that comparative analyses can be undertaken in order to determine whether it is more or less effective than traditional self-care. Furthermore, to discern the underlying processes in the relationship between self-care and professional quality of life, programmatic differences should be examined further. This will help tailor intervention efforts to particular programs and individuals, thereby enhancing their efficacy.

Faculty engagement in self-care was not within the scope of the present study. A future area of exploration involves comparing the frequency of self-care behaviors among trainees in relation to their professors, mentors, supervisors, or advisors. The effect of faculty engagement on self-care may also be examined as a potential mediator in the relationship between the self-care behaviors and professional quality of life of trainees. These findings could conceivably promote the establishment of initiatives that encourage and foster self-care among counseling and clinical psychology graduate students. Future investigations can also examine the efficacy of various self-care interventions implemented in training programs. This can inform efforts toward primary prevention and the maintenance of professional quality of life. Advocacy efforts and initiatives that seek to promote self-care among this population are of vital importance, as self-care tends to be undervalued in spite of its virtues.

Conclusion

Professional well-being and impairment are dichotomous axioms addressed in the counseling and psychology codes of ethics (ACA, 2014; APA, 2017). The professional quality of life of graduate students is inextricably linked to the implementation of self-care strategies. The present study established directional relationships among the frequency of self-care behaviors and the professional quality of life of counseling and clinical psychology trainees. Although causation cannot be inferred, engagement in self-care may enhance professional quality of life, as characterized by increased levels of compassion satisfaction, reduced levels of compassion fatigue, as well as decreased levels of work-related and client-related burnout. Prospective studies should seek to examine the mechanisms and potential protective properties of mindful self-care in order to take proactive measures towards the promotion of professional quality of life and the prevention of compassion fatigue.

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Appendix A. Tables and Figures

Table 1. Participant Demographics.

Demographics	Categories	N	Percent	Valid Percent
Gender	Male	2	5.26	5.60
	Female	34	89.47	94.40
Age (in years)	20-25	17	37.00	48.70
	26-30	13	28.30	37.20
	31-35	2	4.30	5.70
	36 and older	3	6.60	8.70
Race	African American	1	2.20	2.80
	Caucasian	29	63.00	80.60
	Hispanic or Latino	4	8.70	11.10
	Middle Eastern	1	2.20	2.80
	Two or More Ethnicity	1	2.20	2.80

Table 2. Regression Analysis Summary for Self-Care Predicting ProQOL Subscales.

Variable	B	$SE(B)$	β	t	p	$adj.\ R^2$
Compassion Satisfaction	1.36	.28	.64	4.89	< .001	.39
Burnout	-1.37	.26	-.67	-5.35	< .001	.43
Secondary Traumatic Stress	-.44	.31	-.24	-1.44	.16	.03

Appendix A (Continued)

Table 3. Regression Analysis Summary for Self-Care Predicting CBI Subscales.

Variable	B	$SE(B)$	β	t	p	$adj.\ R^2$
Personal Burnout	-2.28	1.14	-.32	-1.99	.05	.07
Work-Related						
Burnout	-2.30	1.03	-.36	-2.22	.03	.10
Client-Related						
Burnout	-2.63	.88	-.46	-2.10	.01	.19

Table 4. Results of Independent Samples T-Test Comparing Self-Care Frequency Between

Programs.

	Program	N	*M*	*SD*	*Outcome*
Mindful Self-Care	Clinical Psychology	22	19.5	3.0	*t(35)=2.40*
	Clinical Mental Health Counseling	15	21.1	2.9	*p= .02*

Table 5. Results of Independent Samples T-Test Comparing Scores on CBI Subscales Between Programs.

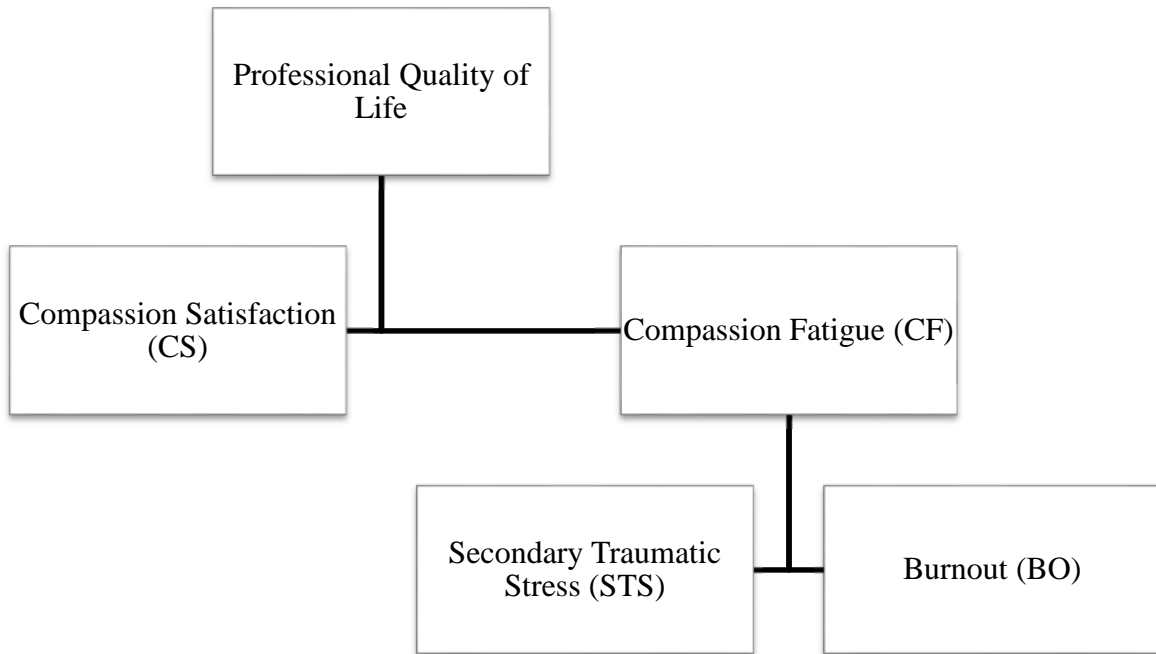| Program	CBI Subscales	N	*M*	*SD*	*Outcome*
Clinical Psychology	Personal Burnout	22	50.76	24.72	*t(35)*= .74, *p*= .46
	Work-Related Burnout	22	39.61	20.47	*t(34)*= 2.17, *p*= .04
	Client-Related Burnout	22	27.27	17.38	*t(34)*= 2.40, *p*= .02
Clinical Mental Health Counseling	Personal Burnout	15	45.28	17.46	*t(35)*= .74, p= .46
	Work-Related Burnout	14	26.53	11.53	*t(34)*= 2.17, *p*= .04
	Client-Related Burnout	14	14.58	11.76	*t(34)*= 2.40, *p*= .02

Figure 1. Stamm's (2010) Theoretical Model for Professional Quality of Life.

Appendix B. Questionnaires

Demographic Questions

1. Which program are you currently enrolled in?

☐ Clinical Psychology

☐ Clinical Mental Health Counseling

2. What semester of your program are you currently in? (You may count summers as a semester)

3. Which statement best describes your professional goals? Please check all that apply.

☐ Pursue a doctorate degree

☐ Work in an academic setting

☐ Work in a research setting

☐ Provide counseling and psychotherapy services

4. How many years [or hours] of work experience do you have in the field(s) of psychology and/or counseling?

5. What is your gender?

☐ Male

☐ Female

☐ Neither, I identify as:

6. How old are you?

7. What is your ethnicity?

☐ African American or Black

☐ Hispanic or Latino

☐ American Indian or Alaska Native

☐ Asian

☐ Hawaiian or Pacific Islander

☐ Caucasian

☐ Middle Eastern

☐ More than two race/ethnicities:

☐ None of the above, I identify as:

8. Do you identify as:

☐ Religious

☐ Spiritual

☐ Both

☐ None of the above

Mindful Self-Care Scale (MSCS; Cook-Cottone & Guyker, 2018)

Scoring: Responses were scored on a 5-point Likert-type scale (1= Never, 0 days; 5= Regularly, 6 to 7 days).

Mindful Relaxation (6 items)

I did something intellectual (using my mind) to help me relax (e.g., read a book, wrote)

I did something interpersonal to relax (e.g., connected with friends)

I did something creative to relax (e.g., drew, played instrument, wrote creatively, sang, organized)

I listened to relax (e.g., to music, a podcast, radio show, rainforest sounds)

I sought out images to relax (e.g., art, film, window shopping, nature)

I sought out smells to relax (lotions, nature, candles/incense, smells of baking)

Physical Care (8 items)

I drank at least 6 to 8 cups of water

I ate a variety of nutritious foods (e.g., vegetables, protein, fruits, and grains).

I planned my meals and snacks

I exercised at least 30 to 60 minutes.

I took part in sports, dance or other scheduled physical activities (e.g., sports teams, dance classes).

I did sedentary activities instead of exercising (e.g., watched tv, worked on

the computer) *reverse scored*

I planned/scheduled my exercise for the day

I practiced yoga or another mind/body practice (e.g., Tae Kwon Do, Tai Chi)

Self-Compassion and Purpose (6 items)

I kindly acknowledged my own challenges and difficulties

I engaged in supportive and comforting self-talk (e.g., "My effort is valuable

and meaningful")

I reminded myself that failure and challenge are part of the human experience

I gave myself permission to feel my feelings (e.g., allowed myself to cry)

I experienced meaning and/or a larger purpose in my work/school life (e.g.,

for a cause)

I experienced meaning and/or a larger purpose in my private/personal life

(e.g., for a cause)

Supportive Relationships (5 items)

I spent time with people who are good to me (e.g., support, encourage, and

believe in me)

I scheduled/planned time to be with people who are special to me

I felt supported by people in my life

I felt confident that people in my life would respect my choice if I said "no"

I felt that I had someone who would listen to me if I became upset (e.g., friend,

counselor, group)

Supportive Structure (4 items)

I maintained a manageable schedule

I kept my work/schoolwork area organized to support my work/school tasks

I maintained balance between the demands of others and what is important

to me

I maintained a comforting and pleasing living environment

Mindful Awareness (4 items)

I had a calm awareness of my thoughts

I had a calm awareness of my feelings

I had a calm awareness of my body

I carefully selected which of my thoughts and feelings I used to guide my actions

General (3 items – not to be averaged)

I engaged in a variety of self-care activities

I planned my self-care

I explored new ways to bring self-care into my life

Copenhagen Burnout Inventory (CBI; Kristensen et al., 2005)

Scoring: Responses were scored on a 5-point Likert-type scale (1= Always or to a very high

degree; 5= never/almost never or to a very low degree)

Personal Burnout

1. How often do you feel tired?

2. How often are you physically exhausted?

3. How often are you emotionally exhausted?

4. How often do you think: "I can't take it anymore"?

5. How often do you feel worn out?

6. How often do you feel weak and susceptible to illness?

Work-Related Burnout

1. Is your work emotionally exhausting?

2. Do you feel burnt out because of your work?

3. Does your work frustrate you?

4. Do you feel worn out at the end of the working day?

5. Are you exhausted in the morning at the thought of another day at work?

6. Do you feel that every working hour is tiring for you?

7. Do you have enough energy for family and friends during leisure time?

Client-Related Burnout

1. Do you find it hard to work with clients?

2. Do you find it frustrating to work with clients?

3. Does it drain your energy to work with clients?

4. Do you feel that you give more than you get back when you work with clients?

5. Are you tired of working with clients?

6. Do you sometimes wonder how long you will be able to continue working with clients?

Professional Quality of Life Scale Version 5 (ProQOL; Stamm, 2010)

Scoring: Responses were scored on a 5-point Likert-type scale (1= Never; 5= Very often).

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. 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.