5-2011

The Professional Quality of Life of Counselors in the U.S. Gulf State of Mississippi Following Multiple Traumatic Events

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To the Graduate Council:

I am submitting herewith a dissertation written by Deirdre Juanita Anderson-White entitled "The Professional Quality of Life of Counselors in the U.S. Gulf State of Mississippi Following Multiple Traumatic Events." I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Counselor Education.

Marianne Woodside, Major Professor

We have read this dissertation and recommend its acceptance:

Tricia McClam, Gary J. Skolits, Joy T. DeSensi

Accepted for the Council:
Dixie L. Thompson

Vice Provost and Dean of the Graduate School

(Original signatures are on file with official student records.)

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The Professional Quality of Life of Counselors in the U.S. Gulf State of Mississippi Following Multiple Traumatic Events

A Dissertation Presented
for the
Doctor of Philosophy
Degree
The University of Tennessee, Knoxville

Deirdre Juanita Anderson-White
May 2011

Dedication

I dedicate this dissertation to the memory of a few dear individuals who are unable to be here to celebrate this accomplishment. The experiences I shared with these people shaped me and I am forever grateful for their support of my dreams and me. Simply, I can not thank these individuals enough for their contributions. The acquisition of formal education was keenly important to each of them and I hope that my efforts related to this accomplishment made them proud.

First, I dedicate this dissertation to my father, Napoleon Cleveland Anderson, who was born in Mississippi in the 1920's. He was a Marine Corp World War II Veteran, a retired educator and administrator, and most importantly, my role model. My father was the kind of man who could be described as a provider, a source of strength, and a visionary. He was caring, serious minded, and filled with integrity.

Next, my best friend and cousin, Dawnyel "Nicky" Freeman, my college roommate. Nicky was a graduating senior at the University of Southern Mississippi who returned home to Chicago, IL for the Christmas Holidays and was tragically killed at the age of twenty-two. She was my confidant.

Next, a wonderful lady who served as my grandmother, Essie "Ms. Essie" Anderson. Ms. Essie was born in Mississippi in the 1910's, never missed an opportunity to teach me, encourage me, and entice me to think about matters from a different perspective, all while we had a good time. She was my Sunday School teacher and a constant encourager.

Lastly, my mother-in-law, Mrs. Josephine White. Mrs. White made her entrance later in my life but offered significant impressions in a short time frame. She welcomed me into her family with open loving arms and came to my defense when needed (smile). She always provided a listening ear and Christian encouragement regarding this academic journey.

Acknowledgements

At this time, I would like to express sincere gratitude for my committee members for their guidance, suggestions, sacrifice, and contributions for this research study. Dr. Marianne Woodside, Dr. Tricia McClam, Dr. Gary Skolits, and Dr. Joy DeSensi, thank you. Additionally, Dr. DeSensi thank you for your time, feedback, and contribution to my work. Dr. Skolits thank your for sharing your statistical expertise and your accessibility even during Spring Break. Dr. McClam thank you for all of your support and every teaching opportunity, I can not thank you adequately for the opportunities, evaluations, and the encouragement you provided. Dr. Woodside thank you for being my chair and providing me with support over the years, in the fall of 2006, you told me that this degree could open doors for me and I believed you. As my chair, I am especially grateful for your thoughtful leadership, feedback, encouragement, and accessibility, because of your efforts I felt less isolated in the dissertation process.

I owe a huge debt to the participants of this research study, the counselors of the U. S. Gulf State of Mississippi. The 60th Annual Mississippi Counseling Conference was a privilege to attend to collect data. Thank You! Also, a number of colleagues have been influential. I extend gratitude for the editorial efforts of Deidre Garriott and the statistical consultation of Cary Springer.

Next, I would like to express my sincere gratitude to my family who supported me, encouraged me, believed in me, and advised me through some challenging periods. My mother, Juanita Anderson, a retired educator has been a constant presence of stability and support in my life. Without a doubt, my mother is one of my most valuable resources. She is compassionate, peaceful, calming, and an encourager of my dreams. Next, my sister, LTC Cheryl Anderson. Cheryl, who at the time I write this acknowledgment is serving our country in Afghanistan, has served so many roles in my life, my sister, my friend, a guardian, my protector, and my counselor. Next, my sister, Stephanie Williamson. Stephanie has been a school counselor for the past 15 years and encouraged me to study counselors. She is my supporter and encourager, who always

made me laugh and helped me find humor within many of my frustrating experiences. To each of these ladies, thank you for listening to late night phone calls about frustrations. Also, thank you for making suggestions for the classroom, your love, your generosity, emotional support and for putting me back on track and not allowing me to give up. Additionally, my whole family has been a wonderful support team including my cousin Carl and my Aunt Nettie. Also, my dear friends Velma, Lori, and Dawn, thank you for your thoughts and prayers.

Saving the best for last, few people know that from 2006-2010, my husband and I lived apart in an effort to complete this degree. I lived in Chattanooga and Knoxville, Tennessee while my husband lived in Hinesville, Georgia. So, I would like to say "THANK YOU" to my husband, Henry White, Jr., first for your patience, love, and generosity. Without your cooking, cleaning, driving, and support this degree would not have been possible. Thank you for every sacrifice and all the love that you provided. It is over and I look forward to our life together, again!

Most importantly, I can not close this acknowledgement without giving all the glory, honor, and praise to my Lord and Savior Jesus Christ. Lord, Thank You for your grace, every traveling mercy, every protection, every blessing, and all the provisions that only You made possible. Thank You for allowing the completion of this task. In closing, I am reminded of a verse from a favorite gospel hymn, "For every mountain you brought me over, For every trial you brought me though, For every blessing, Hallelujah, For this I give you praise". Thank You, Lord.

Abstract

This dissertation was an exploratory research study using a cross-sectional survey design to examine the impact of ecological, environmental, psychological, and financial hardship on counselors of the U.S. Gulf Region. Since 2005, the U.S. Gulf Region, unlike any other region of the United States, has faced multiple disasters including Hurricanes Katrina, Rita, Ike and Gustav (Walsh, 2010), the Great Recession (Conant, 2010), and the largest ecological disaster in the history of the United States, the BP Oil Spill (Gray, 2010). The purpose of this study was to explore the attitudes and characteristics of counselors in one U.S. Gulf State, specifically Mississippi, to obtain valuable information about compassion fatigue and compassion satisfaction of counselors as measured by the Professional Quality of Life (ProQOL) (Stamm, 2009). The researcher used a demographic survey and the ProQOL (Stamm) for analyses. The researcher collected the ProQOL (Stamm) sub-scale scores of 282 Mississippi counselors who attended the 60th Annual Mississippi Counseling Conference. The counselors recorded high compassion satisfaction scores, low burnout scores and low secondary traumatic stress scores. Additionally, the researcher used one-way MANOVAs to examine the main effects of counselor characteristics such as educational level, gender, geographic location, self-care methods, and years of experience on the ProQOL (Stamm) sub-scale means of compassion satisfaction, burnout, and secondary traumatic stress. The researcher found two statistically significant differences in gender and years of experience. Male participants' burnout and secondary traumatic stress scores were significantly less than female participants' burnout and secondary traumatic stress scores.

Participants with 1-10 years of experience recorded statistically significant higher burnout scores and lower compassion satisfaction scores than participants with less than one year of experience, 10-20 years of experience, and more than 20 years of experience. In contrast to assumptions related to the ecological, environmental, psychological, and financial hardship present in this region, high levels of satisfaction was found in counselors who serve this region. The researcher found that despite the impact of these multiple traumatic events these counselors were satisfied with their work.

Keywords: compassion fatigue, U. S. Gulf Region counselors, multiple traumatic events

Table of Contents

List of Tables

List of Figures

Chapter 1

Introduction

Chapter Overview

Since 2005, the U.S. Gulf Region, unlike any other region of the United States, has faced multiple disasters including Hurricanes Katrina, Rita, Ike and Gustav (Walsh, 2010), the Great Recession (Conant, 2010), and the largest ecological disaster in the history of the United States, the BP Oil Spill (Gray, 2010). These events created a unique environment to explore the attitudes and characteristics of the counselors in the U.S. Gulf Region. This chapter introduces the concept of "disaster", especially as it related to the U. S. Gulf Region and describes the context for studying the phenomenon of compassion fatigue of counselors in this area of the United States. In addition, the chapter details the mental health implications for individuals, families, and groups experiencing disasters and the roles and experiences of counselors in a disaster area. Finally, a problem statement, explanation of the significance of the study, research questions, description of the theoretical framework, definition of terms, and discussion of delimitations and limitations define the parameters of the study.

Disasters and the U.S. Gulf Region

The "stars are evil" or "against the stars" are Latin meanings of the word disaster. "Dis" means against and "aster" means stars (Farber, 1967). A disaster is defined as anything that causes great harm or danger, a calamity (Merriam-Webster, 2010). The International Federation of Red Cross (2002) defined a disaster as "a calamitous event which suddenly and seriously inhibits the functioning of a community resulting in

human, environmental, and economic losses which exceed the communities' resources" (introduction section).

For the purpose of this study, disasters were classified as natural disasters, technological disasters, and human-made disasters (Johnsen, 2008a). Natural disasters are catastrophic events that occur in nature (Halpern & Tramontin, 2007) and include events such as floods, hurricanes, wild fires, and tornados. Technological disasters represent human-made yet unintentional catastrophic events such as the Gulf of Mexico oil spill (Johnsen). The last classification, mass violence, encompasses human made disasters, but this category included the intent by the involved party to create the event, such as the September 11, 2001 World Trade Center Disaster (Tuck, 2009). The universal theme present in each disaster classification is the short and long-term effects that disasters have on individuals and communities (Kahn, 2005; Norris, Friedman, & Watson, 2002).

Multiple Traumas for the U.S. Gulf Region

In recent years, residents of the U.S. Gulf Region endured multiple disasters and economic challenges. According to Walsh (2010), the residents of the U.S. Gulf Region may suffer from promnesia or recurring experiences of disasters. Promnesia describes the scientific phenomenon of déjà vu (Merriam-Webster, 2010). Residents experienced Hurricanes Katrina and Rita in 2005, Hurricanes Ike and Gustav in 2008, the U.S. Recession in 2008, and the 2010 BP Oil Spill. A significant imprint from these events remains with the U.S. Gulf Region residents and the counselors who support them (Dass-Brailsford, 2010; Levine, 2010).

Walsh (2010) concluded that the people of the U. S. Gulf Region are innately linked to a particular way of life and this is the only lifestyle many of them know. This way of life connects the Gulf of Mexico with the U.S. Gulf residents through culture, vocations, and lifestyles. In regard to careers, the Gulf of Mexico sustains several vocational industries. Lifelong fisherman and shrimpers support the commercial fishing industry. Employees of casinos, hotels, restaurants, and entertainment maintain the tourism and hospitality industries. Off-shore workers support oil refineries and oil and gas production units, support the oil and energy industries (Adams, Hernandez, & Cato, 2004). From April 20 through July 16, 2010, many people watched the 24-hour video feed providing continuous viewing of 200 million gallons of oil pouring into the Gulf of Mexico (Gray, 2010). Since the BP Oil Spill, reports of conditions related to anxiety, stress, and depression increased due to the loss of revenue, loss of jobs, and loss of livelihoods of U.S. Gulf residents (Byrd, 2010; Chavkin, 2010).

Historically, following disasters many survivors report an elevated intensity regarding trauma (Farber, 1967). The psychological effects related to trauma include conditions such as anxiety, depression, and Post Traumatic Stress Disorder (PTSD). Experts expect the symptoms associated with these conditions to continue into the first year following the disaster (Norris et al., 2002). After Hurricane Katrina, additional hurricanes Rita, Ike, and Gustav (Walsh, 2010), the Great Recession (Conant, 2010), and the largest ecological disaster in the history of the United States, the BP Oil Spill (Gray, 2010) exacerbated its devastating effects. In other words, the residents experienced the

effects of multiple disasters and economic challenges with little reprieve from the emotions and symptoms related to psychological traumas.

Economic Challenges for the U.S. Gulf Region

In addition to these multiple disasters, national and state economic challenges limited the support for the region. Walsh (2010) reported an increased need for counseling services in the U.S. Gulf Region related to increased alcohol consumption and domestic violence. Rather than finding adequate financial support, most of the U. S. Gulf States experienced budget deficits resulting in the reduction of funding for many human services programs. For example, with regard to the BP Oil Spill, the U. S. Gulf States of Alabama, Florida, Louisiana, and Mississippi filed financial requests to BP for mental health programs, but received limited support (Byrd, 2010; Chavkin, 2010). However, in a recent effort to provide financial support for the region, British Petroleum announced an intention to provide $52 million dollars for the mental health needs of U.S. Gulf Coast residents and its unemployed workers (Sebelius, 2010).

The number of disasters occurring also influenced funding available for the U.S. Gulf Region. The Center for Research on the Epidemiology of Disasters analyzed the number of disasters from 2000 through 2007 in the world and reported an increase in the number of deaths and economic losses associated with disasters (CRED, 2008). Reportedly, a disaster occurs around the world every day (Norris et al., 2002) reflecting an increase in the probability of individuals' exposure to disasters. During disasters, the budgets of humanitarian agencies, such as the International Federation of Red Cross, grew to support individuals and communities (Kahn, 2005). However, agency budgets

are less likely to grow during this current economic downturn (Belasco et al., 2010), thus jeopardizing the ability of agencies to adequately respond to the needs of trauma survivors.

Federal decisions also influenced budget constraints. On May 6, 2010, Congress reviewed the proposed 2011-2012 budgets of the Federal Emergency Management Agency (FEMA) and Economic Development Administration (EDA). FEMA provides assistance for post-disaster aid to individuals, states, and communities. EDA provides aid to economically distressed areas including disaster areas. During Congressional budget hearings, members of Congress noted that because of the Great Recession, these programs and agencies must limit responses to disasters (Belasco et al., 2010). For example, although some portions of the 2010-2011 FEMA budget for debris removal increased, FEMA suspended or reduced other projects related to post-disaster aid. Another example is the reduction of EDA's budget by $6.8 million. This loss reduces the EDA's ability to provide long-term recovery with grants and aid in restoration of the economic infrastructure of disaster areas (Belasco et al.).

In summary, disasters especially in the Gulf Region of the United States including Hurricanes Katrina, Rita, Ike, Gustav, the Great Recession, and the 2010 British Petroleum (BP) Oil Spill contributed to economic and psychological hardships to residents. Decreases in humanitarian and federal funding and limited financial support from BP contributed to a slowed recovery from trauma. The following section describes the U.S. Gulf Region in more detail.

The Context of the U. S. Gulf Region

This study explores the influence of multiple disasters and economic challenges, described in the previous section. These events influence the functioning of individuals of the U.S. Gulf Region and the counselors who support them. It is important to understand the context of the U.S. Gulf Region created by federal and state economic challenges, the differences between Northern and Southern contexts within the United States, and poverty in this region.

Federal and State Economic Challenges

In December 2008, the National Bureau of Economic Research (NBER) formally announced that the United States was in a recession. The United States experienced a historic economic downfall comparable only to the Great Depression, creating the "Great Recession" (Baker, 2010). Millions of Americans experienced unemployment or reduced salaries and hours, losing their homes, witnessing the reduction in their home value and dwindling retirement accounts and delaying their retirement. The far-reaching impact of the United States recession included decreased revenue for state governments (Drehle, 2010). Consequently, states have less revenue to provide state government services.

State Government during the "Great Recession"

The national recession created reductions in state revenues because monies generated from individual income, family income, and sales tax diminished (Drehle, 2010). According to the National Governors Association (NGA), since 2008, state spending decreased for two consecutive years. As a result, state governments made drastic cuts in the 2010-2011 fiscal year to fundamental programs such as K-12

education, Medicaid, prisons, and higher education (Johnson, Nicholas, & Pennington, 2009). Many state agencies cut their overall operating budgets by 3 - 6% because state constitutions require a balanced budget for states to operate. Yet, in the 2009 fiscal year as many as 22 states operated with a deficit (Conant, 2010).

To prevent further drastic cuts, many states used the revenue provided by the Recovery Act and 30 states have initiated tax increases (Johnson et al., 2009). Despite these efforts, these interventions of budget cuts coupled with tax increases are not sufficient. The Center for Economic and Policy Research reported that a total of 45 states reduced public services to education, health services, and assistance to the elderly and disabled (Johnson, Oliff, & Williams, 2010) despite the increasing demand for services. Other state cost-cutting methods included reducing the number of state employees and restricting individual access to health and mental health care programs (Johnson et al.). Needless to say, these cost-cutting measures place at-risk individuals in greater jeopardy (Woodside & McClam, 2012).

Recognizing the unfortunate timing in the reduction of health services, especially mental health services, experts raise concerns about government action (Collier, 2009). Current trends in unemployment, debt, and poverty cause tremendous stress (EurActiv, 2009) and will increase the number of service recipients. The states face a difficult challenge to balance fiscal responsibility and maintain programs that support at-risk individuals. It is worthy to note that the impact of these state budget cuts will be more profound in some regions of the country than others because some regions of the country have more resources than others.

Southern United States and Poverty

A growing body of literature indicates the fundamental differences that exist between the northern and the southern regions are as old as their origins (Tindall & Shi, 2006). Often, the stark differences between these two regions of the United States contribute to the perception of them functioning as two separate nations. In regard to geographic location and climate, scholars describe the North as rocky terrain with harsh winters, while characterizing the South by its rich Black Belt soil and warm weather (Washington, 1901). Philosophically, the North supported the concept of nationalism that illustrated a pursuit of a national state that emphasized urbanization, mechanization, and industrialization developing a national economy. Meanwhile, the South preferred a sectionalism approach that emphasized free trade and an agricultural economy susceptible to risks associated with the climate and supported by free labor through slavery (Tindall & Shi).

Mitchell (1998) reported that as early as 1860, the North was industrialized and produced 97% of the firearms, 94% of the cloth, 93% of pig iron, and 90% of footwear for the United States. Meanwhile, the South remained characterized as the agrarian leader providing tobacco, rice, sugar cane, and cotton. Essentially, the north used urban areas to develop a workforce and technology to develop machinery to increase productivity for industrialization. While the South provided raw material to the North, the South continued to maintain a heavy dependency on agriculture (Tindall & Shi, 2006).

As a result of fundamental and philosophical conflicts between the North and the South, the Civil War ensued from 1861 to 1865. Following the North's victory in the Civil War, the nation moved toward industrialization and mechanization (Tindall & Shi, 2006). Hyland, Register, and Gunther (1991) described the concept of underdeveloped regions of industrialized countries and identified the South as an underdeveloped region of the United States. The South continued to develop the agricultural economy, developed a low wage, and expanded into an impoverished region (Wright, 1987). Essentially, the low wages generated in the primarily agricultural south is one of the contributing factors allowing the South to continue to be the poorest region in the country.

The United States Department of Agriculture (USDA, 2004) defined poverty as the condition in which any person needs to procure basic needs such as food, shelter, clothing, and other fundamental materials with insufficient resources. According to the USDA, the southern region of the United States contains the highest and most persistent poverty rates. The Economic Research Service defined persistent poverty as a county in which more than 20% of the county population has been poor for at least three decades. The United States has 386 persistent poverty counties and 280 of these persistent poverty counties are located in the South. None of these counties are located in the Northeast. According to the U.S. Census Bureau (2000), 35% of poor Americans live in the South. Additionally, this region contains many low educated counties. A low educated county is defined as a county in which one of four adults from the ages of 25 to 64 do not have a

high school diploma (U.S. Census Bureau). Critical factors related to poverty and education challenge the South.

Womack (2007) noted the relationship between the South and poverty is significant and suggested that the reconstruction of the tattered U.S. Gulf Region must not be ignored. Simply, comparisons with the North reveal the South is poverty stricken. As a result of the recession, state operating budgets have been reduced and the financial reduction will likely have greater impact in the southern region of the country (Womack). In recent years, the South encountered multiple events that altered the lives of Southerners and their communities.

The United States has five southern states located on the Gulf of Mexico composing the U.S. Gulf Region: Alabama, Florida, Louisiana, Mississippi, and Texas. As noted earlier, the U.S. Gulf States and its residents experienced significant destruction from historic Hurricanes Katrina, Rita, Ike, and Gustav (Walsh, 2010), the Great Recession (Conant, 2010), and the largest ecological disaster in the history of the United States, the BP Oil Spill (Gray, 2010). These challenges occurred within the context of southern poverty. One result of these multiple disasters is the increased need for mental health services (Collier, 2009; Walsh, 2010).

Mental Health Implications

In 2007-2008, United Health Group, Inc., one of the largest health care insurers in the United States, reported a 10% increase of psychiatric admissions (Collier, 2009), and a Gallup poll suggested that 67% of Americans increased alcohol consumption (Morrissey, 2010). During the recession, the American public faced economic

difficulties that included a recession, a housing crisis, and massive job losses (Morrissey; Drehle, 2010). The individuals who were treated exhibited symptoms such as substance abuse, panic disorders, depression, and anxiety disorders. Many individuals reported the primary complaint related to economic concerns in their lives (Collier). It is important to recognize the timing of the 2008 announcement of a recession, the sharp increase in the access to mental health services, and the challenges faced by many American mental health professionals who have reported an increase of services in emergency rooms, hotlines, and clinics (Waters & Olmos, 2008).

Despite these needs, state agencies enforced budget cuts. The budget cuts detrimentally impacted the service delivery of U.S. Gulf Region counselors who have reported increases in anxiety, depression, grief, substance abuse, and suicide ideation in the U.S. Gulf residents (Levine, 2010). The multiple challenges faced by residents of the U.S. Gulf Region influenced the mental health needs of U.S. Gulf residents (Levine). In addition, those providing mental health services may also be at-risk for the development of conditions such as compassion fatigue (Dass-Brailsford, 2010; Morrissette, 2004).

The Role and Experience of Counselors

According to the U.S. Department of Homeland Security (2004), the American Red Cross should provide mental health services under the U.S. National Response Plan. The U.S. National Response Plan was established to manage domestic disasters. During disasters, the American Red Cross uses licensed mental health professionals to provide mental health services. Counselors consist of 40% of the American Red Cross Mental Health Response Team who provide services to the survivors of disasters (American Red

Cross, 2000). Many survivors of disasters have experienced trauma and counselors listen to the traumatic stories of survivors (Levy, 2008).

One primary counseling tool is the core competency skill of reflective listening (Parker, Everly, Barnett, & Links, 2006). Counselors use reflective listening to gather content, feelings, and hidden messages from another person, then communicate understanding to the person ensuring that they were heard. Reflective listening provides the foundation for basic counseling skills such as paraphrasing, reflections of feeling, reflections of meaning (Young, 2009), and empathic responses (Egan, 2010). Scholars confirmed the innate vulnerability that exists within reflective listening, especially when using empathic skills while listening to traumatic stories (Larson & Bush, 2006). Counselors can develop conditions such as compassion fatigue (Figley, 1995; Stamm, 2009), burnout (Maslach, 1982), secondary traumatic stress (Figley; Stamm), and vicarious traumatization (Pearlman & Saakvine, 1995) when they listen to traumatic stories. Compassion fatigue, a form of burnout, manifests itself as physical, emotional, and spiritual exhaustion (Pfifferling & Gilley, 2000). Vicarious traumatization refers to the exposure to secondary traumatic material created from listening to another individual (Bickenell-Hentges & Lynch, 2009). Secondary traumatic stress is a negative feeling driven by the exposure of the trauma of another person (Stamm, 2009). Maslach and Jackson (1981) defined burnout as "a syndrome of emotional exhaustion and cynicism that frequently occurs with people who do people work" (p. 99). The symptoms related to these conditions can have devastating effects on counselors (Figley, 1995; Pealman & Saakvine, 1995; Stamm, 2009).

Feelings of fear, difficulty sleeping, intrusive thoughts, and avoiding situations that are similar to the traumatic event (Trippany, White, Kress, & Wilcoxon, 2004) are symptoms related to compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization. Symptoms include a sense of hopelessness and feelings of ineffectiveness in counselors (Stamm, 2009). Additionally, they influence the delivery of quality counseling services. Although, these conditions do not develop in all counselors who listen to traumatic stories (Deighton, Gurris, & Traue, 2007), according to Figley (1995), counselors with higher levels of empathy for their clients make the best counselors and are subsequently vulnerable to the development of these conditions. Empathy creates strengths and weaknesses for a counselor (Larson & Bush, 2006). The formation of empathic therapeutic relationships with their clients place counselors at greater risk for developing compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization (Figley).

The effects of compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization are far reaching for individuals, agencies, and clients. In fact, qualitative researchers Arnold, Calhoun, Tedeschi, and Cann (2005) reported that 90% of counselors who supported trauma survivors described experiencing intrusive thoughts. The research of Palm, Polusny, and Follette (2004) reflected a similar finding that permanent change occurred in counselors who worked with survivors of traumatic events. Many counselors find themselves permanently altered by the experience of supporting trauma survivors (Black & Weinreich, 2001). Hazards related to affective, cognitive, and behavioral changes in clinicians result from counselor exposure to trauma (Bride, Radey,

& Figley, 2007). In summary, listening to the retelling of traumatic events threaten the ability of some counselors to continue to provide support to those in need.

Furthermore, counselors are not exempt from their own personal experiences of the ecological, environmental, psychological, and financial challenges within their communities. Counselors and specific to this study, counselors of the U.S. Gulf Region faced the same multiple traumatic events that affected their communities. According to Ayalon (2006), when helpers and clients are exposed to the same traumatic events, helpers reported a weakened ability to establish and maintain boundaries with their clients. This vulnerability may further increase the risk for the development of phenomena such as, compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization (Dass-Brailsford, 2010).

Some regions of the country recovered from more traumatic events than others. Multiple disasters such as Hurricanes Katrina, Rita, Ike, and Gustav (Walsh, 2010), the Great Recession (Conant, 2010), and the largest ecological disaster in the history of the United States, the BP Oil Spill (Gray, 2010) challenged the U.S. Gulf States of Alabama, Florida, Louisiana, Florida, Mississippi, and Texas. In an effort to explore how serving individuals who experience multiple disasters affect counselors, this study assesses compassion fatigue and compassion satisfaction as measured by the Professional Quality of Life (ProQOL) (Stamm, 2009) of counselors in the U.S. Gulf Region, specifically the U.S. Gulf State of Mississippi.

Summary

In summary, the exploration of mental health implications and the role and experiences of counselors in the U.S. Gulf Region is important because it emphasizes the need to increase the knowledge about the phenomenon of compassion fatigue as measured by the Professional Quality of Life (ProQOL) (Stamm, 2009) with individuals who experienced multiple traumatic events. Currently, counselors of the U.S. Gulf Region are listening to traumatic stories related to the multiple disasters of the region. Additionally, many of the U.S. Gulf Region counselors live in the region and personally endured these same ecological, environmental, psychological, and financial hardships. Listening to traumatic stories may contribute to the development of conditions such as compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization in some counselors. Since compassion fatigue negatively influences counselors personally and decreases their ability to help others, it is important to assess compassion fatigue, as measured by the Professional Quality of Life (ProQOL) (Stamm) of counselors in the U.S. Gulf Region.

Theoretical Framework

This study used the professional quality of life (ProQOL) theory as a theoretical framework (Stamm, 2009). The professional quality of life theory underscores the value of the helping experience by integrating positive and negative concepts. Essentially, the theory analyzes the comprehensive impact of helping including the therapeutic factor of altruism. Compassion satisfaction is the positive concept within the theory and represents altruism. The negative concept of compassion fatigue is composed of two

elements burnout and secondary traumatic stress. Stamm described a presence of fear within the phenomenon of compassion fatigue. Secondary traumatic stress incorporates a helpers' fear related to enduring similar trauma as their clients. Burnout does not include fear but feelings of inefficiency, frustration, and anger. Secondary traumatic stress and burnout were identified to negatively influence the helping process (Stamm).

The following diagram illustrates the professional quality of life (Stamm, 2009) theory emphasizing three environments: work environment, client environment, and person environment (Stamm). Stamm outlined the components of the professional quality of life theory. The positive concept of compassion satisfaction and the negative concept of compassion fatigue are presented in the center of the diagram. The environmental factors of work, client, and person can influence compassion fatigue and compassion satisfaction. For example, an unfavorable work environment may influence the development of compassion fatigue. In contrast, that same unfavorable work environment may influence the development of compassion satisfaction. For example, a helper feels fulfillment for the assistance they provided, in spite of the conditions of the work environment.

Stamm (2009) outlined the components of the professional quality of life theory. The positive concept of compassion satisfaction and the negative concept of compassion fatigue represent the center of the diagram. According to Stamm, the diagram illustrated a theoretical evaluation of positive and negative outcomes for those exposed to indirect trauma.

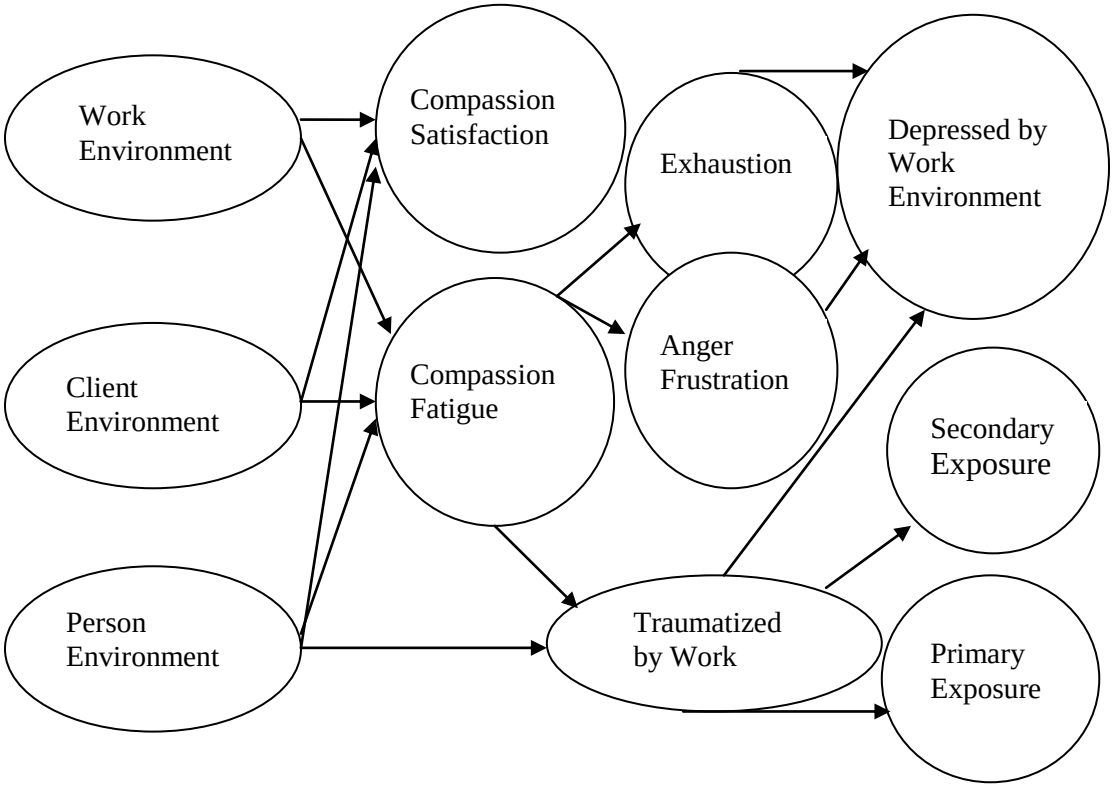

Figure 1: Theoretical Path Analysis (Stamm, 2009)

Instruments Used in This Study

This study used two self-report instruments to gather data. The first instrument was adapted from the Individual Information Form (Sweeney, Hohenshil, & Fortune, 2002) (See Appendix A). This instrument collected demographic information from the participants.

The second instrument utilized for this study was the Professional Quality of Life (ProQOL) (Stamm, 2009) (See Appendix A). The Professional Quality of Life assesses compassion fatigue and compassion satisfaction (Stamm, 2009). Initially, Charles Figley (1995) developed the Compassion Fatigue Scale. B. Hudnall Stamm (1997-2009) later

revised the instrument. In 2009, Stamm developed the current instrument with Figley supporting her continued development of a compassion fatigue measurement. The instrument is a psychometric measure assessing compassion fatigue and compassion satisfaction using a 30-item survey composed of three subscales: compassion satisfaction, burnout, and secondary traumatic stress. The following diagram illustrates the Professional Quality of Life (ProQOL) (Stamm, 2009).

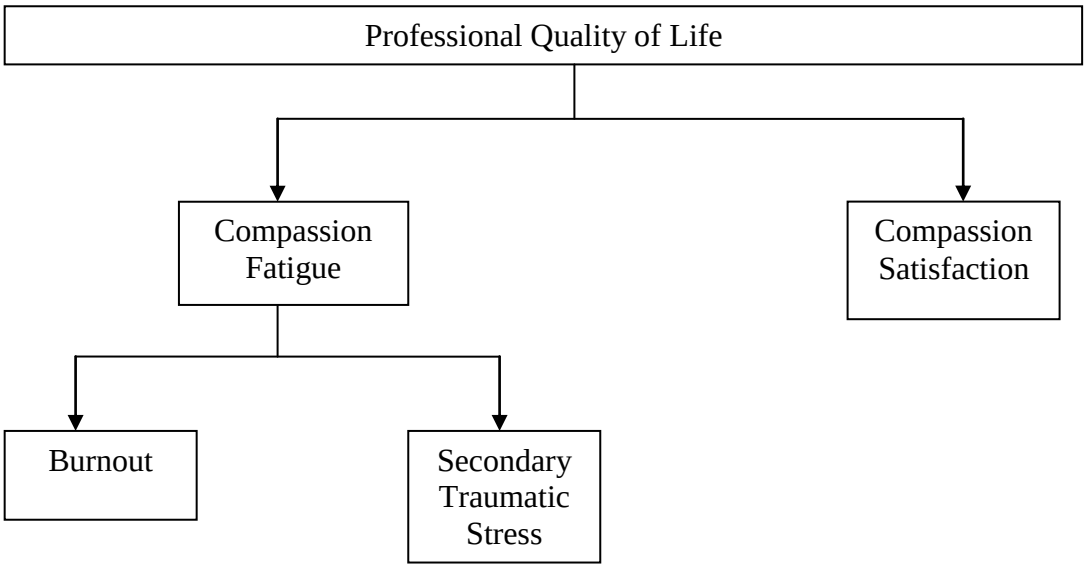

Figure 2: Diagram for Professional Quality of Life (Stamm, 2009)

The instrument uses items such as "My work makes me feel satisfied" or "I feel worn out because of my work as a counselor" to assess the compassion fatigue and compassion satisfaction of a helper in their current work situation over the past 30 days. Participants provided specific scoring to items by ratings items with one of the following responses 1=Never, 2=Rarely, 3=Sometimes, 4=Often, and 5=Very Often. The Professional Quality of Life (ProQOL) (Stamm) is discussed in detail in Chapter 3.

Problem Statement

Trauma is an emotional shock, often having a lasting psychic effect (Merriam-Webster, 2008). We live in a world where trauma more commonly occurs and there is an increasing probability for individual exposure to traumatic events (Palm et al., 2004). In 1992, the National Comorbidity Survey (NCS) found that trauma is a frequent occurrence. In fact, 61% of men and 51% of women reported at least one traumatic event during their lives. Recent studies suggest an increased possibility relating childhood trauma to the development of symptomology (Palm et al., 2004). Johnsen (2008b) reported that adults are likely to experience one event in their lifetime that will involve intense feelings related to alarm and vulnerability to harm. This also increases the probability that counselors will interact with individuals who have had traumatic experiences (Norris et al., 2002). In focusing on traumatic events, we must not lose sight of the frequency of traumatic incidents and the implications on counselor development and professional longevity.

As a result of these interactions, these mental health professionals are indirectly exposed to the effects of traumatic events (Killian, 2008). Counseling researchers Heppner, Kivlighan, and Wampold (1999) postulated that interventions can be developed to help counselors by identifying and understanding phenomena. It is worthy to learn about the experiences of counselors responding to multiple traumatic events to understand and develop interventions to reduce the development of conditions such as compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization.

Purpose Statement

The purpose of this study was to explore the attitudes and characteristics of counselors in one of the U.S. Gulf States, specifically Mississippi to obtain valuable information about compassion fatigue and compassion satisfaction as measured by the Professional Quality of Life (ProQOL) (Stamm, 2009). The Professional Quality of Life (ProQOL) (Stamm) sub-scale scores of counselors who participated in a state counseling conference provided insight into the effects of the provision of counseling services in a unique environment recovering from multiple traumatic events such as Hurricanes Katrina, Rita, Ike, and Gustav (Walsh, 2010), the Great Recession (Conant, 2010), and the largest ecological disaster in the history of the United States, the BP Oil Spill (Gray, 2010). The significance of the study is discussed next.

Significance of the Study

The significance of this study included the provision of beneficial information for counselors and other mental health professionals about factors related to the support of survivors of traumatic events. The Professional Quality of Life (ProQOL) (Stamm, 2009) of these counselors can provide useful information about compassion fatigue for counselors-in-training, as well as state and private counseling agencies that provide services in this region. Additionally, state and private mental health agencies responding to disasters can review this material to monitor counselors for compassion fatigue. Moreover, the results of this study will expand the literature related to compassion fatigue.

In particular, the researcher reviewed numerous studies that examined compassion fatigue in counselors. However, database searches conducted in the summer of 2010 and the fall of 2010 provided no empirical studies that examined compassion fatigue in counselors of the U.S. Gulf Region. This gap in the literature justified the need for this research study. This research study provides an examination of compassion fatigue and compassion satisfaction as measured by the Professional Quality of Life (ProQOL) (Stamm, 2009) in one of the U. S. Gulf States, specifically Mississippi challenged by the significant environmental, ecological, and financial destruction in recent years (Conant, 2010; Gray, 2010; Walsh, 2010). The U.S. Gulf Region provides a unique setting to explore the phenomenon of compassion fatigue for counselors because of the repeated exposure to traumatic events. In addition, it is important to examine the counselors' attitudes and characteristics providing counseling supports in this region to broaden the body of knowledge related to compassion fatigue.

Research Questions

This research study attempted to answer the questions significant to compassion fatigue of counselors in one state of the U.S. Gulf Region. The research questions addressed the purpose of this investigation.

1. What are the counselors' Professional Quality of Life (ProQOL) (Stamm, 2009) sub-scale scores of compassion satisfaction, burnout, and secondary traumatic stress from Mississippi, one state in the U.S. Gulf Region, and how are these scores distributed across respondents?

2. What are the differences among the Professional Quality of Life (ProQOL) (Stamm, 2009) sub-scales of compassion satisfaction, burnout, and secondary traumatic stress scores on each participant characteristic of educational level, gender, geographic location, self-care methods, and years of experience?

Definition of Terms

Burnout - According to the Professional Quality of Life (ProQOL) (Stamm, 2009) manual, burnout is one of the negative components of compassion fatigue relating to ineffectiveness, frustration, and anger that impede the helping process (Stamm). Additionally, burnout is one of the sub-scales of the Professional Quality of Life (ProQOL) (Stamm) contributing to the measure of compassion fatigue. Maslach and Jackson (1981) defined burnout as "a syndrome of emotional exhaustion and cynicism that frequently occurs with people who do people work" (p. 99).

Compassion Fatigue - The Professional Quality of Life (ProQOL) (Stamm, 2009) manual defined compassion fatigue as a phenomenon created by burnout and secondary traumatic stress (Stamm). Compassion is defined as a feeling of deep sympathy for the pain, anguish, and hardship of another person. Compassion stress describes the strain or pressure related to feelings of compassion. Compassion stress evolves into compassion fatigue when a counselor feels overwhelmed by the state of trauma experienced by clients of mental health professionals (Figley, 1995).

Compassion Satisfaction - The Professional Quality of Life (ProQOL) (Stamm, 2009) manual defined compassion satisfaction as a positive component of the Professional Quality of Life (ProQOL) theory relating to altruism (Stamm). Additionally,

compassion satisfaction is one of the sub-scales of the Professional Quality of Life (ProQOL) (Stamm) contributing to the measurement of compassion fatigue.

Counselors - Counselors who attend a state counseling conference in one of the Gulf States of Alabama, Florida, Louisiana, Mississippi, or Texas. The state of Mississippi was selected to conduct this study. Counselors are those who attended the 60th Annual Mississippi Counseling Association in the fall of 2010.

Educational level – The term describes the educational level of a counselor, such as Bachelors degree, Master's degree, Specialists degree, or doctorate degree. This data obtains information about the personal characteristics of the participants in this study (Creswell, 2005).

Gender - The term used when referring to women and men as social groups (APA, 2010). This data obtains information about the personal characteristics of the participants of this study (Creswell, 2005).

Geographic location - The location of a person, place, or thing (Merriam-Webster, 2008). The self-identified geographic location of the counselor within the state and this data obtains information about the personal characteristics of the participants of this study (Creswell, 2005). For purposes of this research study, the state of Mississippi was selected and the state was divided into four regions, Region 1 = north Mississippi, Region 2 = central Mississippi, Region 3 = south Mississippi, and Region 4 = Mississippi Gulf Coast.

Secondary Traumatic Stress - According to the Professional Quality of Life (ProQOL) (Stamm, 2009) manual, secondary traumatic stress is one of the two

components of compassion fatigue describing negative feelings created by the exposure to another person's trauma (Stamm). Additionally, secondary traumatic stress is one of the sub-scales of the Professional Quality of Life (ProQOL) (Stamm) contributing to the measurement of compassion fatigue.

Self-Care - Methods used to reduce stress and burnout in counselors by addressing personal and professional growth (Newsome, Christopher, Dahlen, & Christopher, 2006). For example, mindfulness practices such as yoga and meditation. This data obtains information about the behavior of the participants in this study (Creswell, 2005).

State Counseling Conference - Each of the Gulf States of Alabama, Florida, Louisiana, Mississippi, and Texas sponsor an annual American Counseling Association conference for the education and training of counselors. The annual state counseling conference is conducted in the fall of the year. For purposes of this research study, the state of Mississippi was selected to attend the 60th Annual Mississippi Counseling Association for data collection.

Vicarious Traumatization - Vicarious traumatization describes an occupational hazard, developed through the use of empathic engagement to listen to traumatic stories of clients (Canefield, 2005). Vicarious traumatization relates to secondary traumatic stress (Stamm, 2009).

U.S. Gulf Region - The United States has five southern states located on the Gulf of Mexico composing the Gulf Region: Alabama, Florida, Louisiana, Mississippi, and

Texas. Additionally, these states are located in the poorest region of the country (USDA, 2004).

Years of Experience - The number of years of employment as a counselor. This data obtains information about the personal characteristics of the participants in this study (Creswell, 2005).

Delimitations

The following delimitations reflect the utilization of a cross-sectional research study design and survey research. First, the study focused on the measure of compassion fatigue and compassion satisfaction as measured by the Professional Quality of Life (ProQOL) (Stamm, 2009). The scores of self-identified counselors who attended a state counseling conference at one state conference in the U.S. Gulf Region was measured. The study was limited to one organizational unit (Kaplan, 2004), a 2010 state counseling conference conducted in the U.S. Gulf Region. Therefore, other factors that may influence the Professional Quality of Life (Stamm) scores of these counselors were not examined. These factors were beyond the stated purpose of this research.

Limitations

One limitation of this study included the exclusive use of self-reporting data. Therefore, participants may provide misleading responses to items on the Professional Quality of Life (ProQOL) (Stamm, 2009) through intentional deception or lack of insight. The researcher conducted no observations or interviews to gather additional information. Also, the researcher conducted no follow-up data collection beyond the completion of the Professional Quality of Life (ProQOL) (Stamm) instrument and a demographic survey.

Future research should expand beyond the exclusive usage of self-reporting data with follow-up interviews and observations.

Organization of the Study

This chapter provided a comprehensive overview of the research study. Chapter Two reviews the pertinent literature related to concepts such as burnout, compassion fatigue, secondary traumatic stress, and vicarious traumatization. Chapter Three describes the methods of this research study. The data analysis and results will be outlined in Chapter Four. The discussion, conclusion, and implications for future studies will be presented in Chapter Five.

Chapter 2

Literature Review

Introduction

This chapter provides the framework and background for the examination of compassion fatigue in the U.S. Gulf Region counselors. Multiple disasters such as Hurricanes Katrina, Rita, Ike, and Gustav (Walsh, 2010), the Great Recession (Conant, 2010), and the largest ecological disaster in the history of the United States, the BP Oil Spill (Gray, 2010), challenged the U.S. Gulf States of Alabama, Florida, Louisiana, Florida, Mississippi, and Texas. Since serving individuals who experience multiple disasters affects counselors (Morrissette, 2004), this study assesses the compassion fatigue and compassion satisfaction as measured by the Professional Quality of Life (ProQOL) (Stamm, 2009) of counselors in the U.S. Gulf Region, specifically the state of Mississippi. In this comprehensive analysis of literature related to compassion fatigue, the following topics were narrowed to the empirical research and secondary literature relevant to compassion fatigue.

Chapter Overview

This literature review focuses on compassion fatigue and includes empirical research articles and secondary literature published from 1948 to 2010. Four sections comprise this review. The first section provides an overview of compassion fatigue and closely related terms. This section includes a brief history, definitions, list of symptoms, and review of salient empirical literature of the phenomena of compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization. The second section

introduces background literature related to populations at-risk for the development of compassion fatigue and examines concepts such as listening, stress, and empathy reviewing their roles in forming compassion fatigue in counselors. The third section focuses on methods and techniques related to the prevention of compassion fatigue. The final section provides a comprehensive overview of the review of the literature.

Often, researchers use the terms compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization interchangeably. To examine these phenomena, this chapter provides a review for each concept including a definition, symptoms related to the concept, and salient literature. The next section will review the literature concerning compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization.

Compassion Fatigue and Related Terms

This section addresses compassion fatigue and presents central terms helpful in understanding the concept. The literature related to compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization represent vast amounts of literature. Scholars disagreed about compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization. Several scholars (Arvay, 2001; Devilly, Wright, & Varker, 2009; Stamm, 2009) acknowledged very fine distinctions among these four phenomena. In short, there are inconsistencies in the literature related to compassion fatigue, some scholars report that compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization are the same, while other scholars report that compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization are unique and different.

Burnout

Initially, the term burnout referred to a negative effect of chronic drug abuse, but Freudenberger (1977) changed the meaning of burnout to describe a psychological state. As early as 1975, Freudenberger defined the concept of burnout as "a failure, wearing out, or exhaustion from the demands of the organization on a person's strength, energy, and resources" (p.26). Now, over 30 years later, researchers continue to study burnout and its implications, especially for helping professionals.

Freudenberger's (1975) study (as cited in Freudenberger, 1977) identified the syndrome of burnout in staff members of a psychological clinic. Freudenberger explored his personal experience with burnout after working a high number of hours at a free mental health clinic in New York City. Freudenberger's research contributed to the development of terms related to burnout such as employee commitment, job demands, job satisfaction, and environmental factors. Following that early empirical research of 1975, burnout continues to be a widely researched subject matter. Researchers noted inconsistent conclusions and findings with empirical research related to burnout (Evans et al., 2006; Maslach & Jackson, 1981; Pines, 2004; Rupert & Morgan, 2005; Shirom, Nirel, & Vinokur, 2006).

As a result of the inconsistencies, two of the above mentioned researchers created instruments to provide standardized measures of burnout. Maslach and Jackson (1981) created the Maslach Burnout Inventory (MBI), while Pines and Aronson created the Burnout Measure (as cited in Pines, 2004) to measure the phenomenon of burnout. The

wide usage of these two instruments had enormous influence on the research conducted on the subject of burnout.

Burnout was described as a factor focusing on the work environment. Maslach and Jackson's definition of burnout related to the social environment involving work with people and clarified the topic. Maslach defined the term as "a syndrome of emotional exhaustion and cynicism that frequently occurs with people who do people work" (Maslach & Jackson, 1981, p. 99). Four of the six quantitative research studies reviewed utilized either the Maslach Burnout Inventory or the Burnout Measure to measure burnout.

Empirical Research. For the purpose of this review of literature, this study examined the empirical research related to burnout (Evans et al., 2006; Maslach & Jackson, 1981; Pines, 2004; Rupert & Morgan, 2005; Shirom et al., 2006). These studies described the most salient literature related to burnout from 2002-2010. All of the empirical research used quantitative methodology to conduct survey research with large sample sizes. Evans et al. recruited 237 United Kingdom mental health workers and found high levels of stress and emotional exhaustion. Maslach and Jackson measured burnout in 427 human service workers to develop and validated the Maslach Burnout Inventory. Pines (2004) compared the burnout levels of 1,062 Israeli workers with American workers who primarily performed human services work and found that Americans had higher burnout scores. Rupert and Morgan conducted the largest assessment of burnout in psychologist with a sample size of 571 and found that psychologist were at-risk for emotional exhaustion. Shirom et al. measured burnout in

890 physicians and found emotional exhaustion. All of the research used survey methods to examine the concept of burnout.

Symptoms. Pines (as cited by Morrisette, 2004) provided symptomology related to burnout. Pines categorized these symptoms into four dimensions: emotional, cognitive, physical, and behavioral. Emotional symptoms included depression, hopelessness, anger, and frustration. Cognitive symptoms included negativity, sense of aloneness, and feeling of limitations. Physical symptoms included headaches, lack of sleep, nightmares, and increased pre-existing medical conditions. Behavioral symptoms included the demonstration of high risk behaviors, tardiness, and lack of trust. In summary, researchers noted the negative aspects of providing services to individuals (Evans et al., 2006; Maslach & Jackson, 1981; Pines, 2004; Rupert & Morgan, 2005; Shirom et al., 2006).

Summary. This section of literature related to burnout included the review of salient empirical literature from 1981-2010 including the prominent research of scholar Christina Maslach (1981) and research used to measure burnout with various populations. This section includes definitions of burnout, symptomology and the review of empirical research related to burnout. The following table provides a summary of the empirical research studies used to review the literature related to burnout.

Table 1: Empirical Research Related to Burnout

Authors	Research Method	Sample Size	Measure	Main Findings	Quote
Evans et al. (2006)	Quantitative Survey Design	237 Mental Health Social Workers	Maslach Burnout Inventory (MBI) (burnout) General Health Questionnaire (GHQ-12) (stress)	The researchers reported high levels of stress and emotional exhaustion. Contributing factors included high number of hours worked and insufficient autonomy.	"81% of UK authorities reported problems recruiting and retaining mental health workers."
Maslach & Jackson (1981)	Quantitative Survey Design	420 Human Service Professionals	Maslach Burnout Inventory (burnout)	The researchers devised a highly reliable instrument rating two dimensions: intensity and frequency. The 25 item tool measured emotional exhaustion, depersonalization and personal accomplishment.	"Burnout is likely to occur within the first few years of one's career. If people have difficulty coping they may leave the profession entirely."
Pines (2004)	Quantitative Survey	1,062 American and Israeli nurses, teachers, and doctors	Burnout Measure (burnout)	The researchers expressed statistical significance. In all three cases, the Americans had higher burnout scores when compared with Israeli helpers.	"Burnout is a response to stress."

Table 1: Empirical Research Related to Burnout Continued

Authors	Research Method	Sample Size	Measure	Main Findings	Quote
Rupert & Morgan (2005)	Quantitative Survey Design	571 Psychologists	Rate Satisfaction and Stress Psychologist Burnout Inventory (burnout) Maslach Burnout Inventory (burnout)	The greatest risk for participants was emotional exhaustion. The work setting impacted different levels of burnout.	"A consistent finding is the relationship between the work setting and burnout."
Shirom et al. (2006)	Quantitative Survey Design	890 Physicians	Objective Workload, Overload, Autonomy, Burnout and Quality of Care	The researcher predicted negative quality of care as a result of emotional exhaustion and cognitive weariness.	"Perceived overload is a predictor of burnout and reduces the quality of care."

Compassion Fatigue

Nursing literature introduced the term compassion fatigue (Joinson, 1992) and used it to identify the unique stressor that affected people in care giving professions. Figley (1995) defined compassion as a feeling of deep sympathy for the pain, anguish, and hardship of another person. Compassion stress is strain or pressure related to feelings of caring. Compassion fatigue evolves from compassion stress that develops from feeling overwhelmed by the trauma experienced by clients. This fatigue relates to the indirect exposure to trauma (Figley).

Definition. Many researchers including Joinson (1992) suggested that compassion fatigue is a type of burnout (Bicknell-Hentges & Lynch, 2009; Figley, 1995; Pfifferling & Gilley, 2000). Bicknell-Henteges and Lynch reported that compassion fatigue may be a component of burnout. Pfifferling and Gilley (2000) identified compassion fatigue as a form of burnout that observed various types of exhaustion, such as physiological, affective, and spiritual. One of the central differences of compassion fatigue and burnout related to the onset and recovery of the two conditions. Reportedly, compassion fatigue has a quicker onset and recovery than burnout (Bicknell-Hentges & Lynch, 2009).

Compassion fatigue is described as the build-up of emotions related to the care of clients (Lamendola, 1996). Mathieu (2007) reported "Compassion fatigue was defined as the emotional experience described as physical and emotion exhaustion related to the cost of caring for others in emotional and physical pain" (p. 8). Additional definitions described compassion fatigue as a condition similar to Post Traumatic Stress Disorder (Campbell, 2007).

Empirical Research. Compassion fatigue is a relatively new concept in the empirical literature relating to helping. Of the six studies reviewed (Adams, Boscarino, & Figley, 2006; Adams, Figley, & Boscarino, 2008; Boscarino, Figley, & Adams, 2004; Deighton et al., 2007; Killian, 2008; Sprang, Clark & Whitt-Woolsey, 2006) four were authored by Charles Figley, renowned traumatologist and the scholar responsible for the development of the concept compassion fatigue.

Through 2004-2008, Figley was involved with three research studies measuring compassion fatigue with social workers who responded to the World Trade Center disaster for the National Institute of Health (Adams et al., 2006; Adams et al., 2008; Boscarino et al., 2004). Adams et al. (2006) conducted a validation study with 274 social workers who responded to the World Trade Disaster by examining the psychometric properties of the Compassion Fatigue Scale and found the scale was valid and had good concurrent and predictive validity. Next, Adams et al. (2008) measured compassion fatigue and psychological distress in social workers and found that social workers had increased levels of secondary traumatic stress but no job burnout. In other words, the work with traumatized clients was related to secondary traumatic stress but not to burnout. Finally, Boscarino et al. examined secondary trauma in 274 social workers who responded to the World Trade Disaster and found that working with trauma survivors placed clinicians at-risk for compassion fatigue.

The body of literature related to compassion fatigue focused on the negative aspects of providing supports for trauma survivors. The Professional Quality of Life (hereafter referred to as the ProQOL) (Stamm, 2009) incorporates the positive factor of compassion satisfaction into the measurement of compassion fatigue. The following research studies utilized the ProQOL (Stamm) to measure compassion fatigue as well as other measures. Deighton et al. (2007) measured burnout and compassion fatigue in German psychotherapists who supported survivors of torture. The researchers measured the concept of working through trauma, burnout, compassion fatigue, and psychological distress and found that the development of conditions such as compassion fatigue were

individualized responses to indirect trauma. In fact, the researchers concluded that the indirect exposure was not critical, yet the counselor's response to indirect trauma contributed to the development of compassion fatigue.

Sprang et al. (2007) also utilized the ProQOL (Stamm, 2009) to assess compassion fatigue in 1,121 rural mental health professionals and found a gender difference with a higher risk of compassion fatigue and burnout for women. Secondly, the researchers found that the work environment did not influence the development of compassion fatigue. Next, the symptoms related to compassion fatigue will be reviewed.

Symptoms. The literature fully documented the comprehensive effects of compassion fatigue on helpers. Killian (2008) reported that compassion fatigue is a by product of Post Traumatic Stress Disorder (PTSD) and these conditions stem from PTSD and PTSD stress- related disorders. Emotional distress is a natural and understandable outcome of working with those who have survived shocking events. Several researchers (Johnsen, 2008; Kataoka et al., 2009; Showalter, 2010) suggested that if these conditions are not addressed, then they may progress into psychopathology. Recent epidemiological literature postulated that the increased risk of Post Traumatic Stress Disorder, substance abuse, depression, and poor health outcomes were the effects of traumatic life events (Johnsen). Deighton et al. (2007) suggested that symptoms similar to PTSD created unmanageable thought patterns, overwhelming and uncontrollable thoughts, heightened stimulation, anxiety, feelings of despair, and seclusion.

Summary. This section of literature related to compassion fatigue including salient empirical literature from 2007-2010. This literature focused on recent studies

conducted by renowned traumatologist, Charles Figley and research regarding the World Trade Center disaster. In addition, this section included definitions of compassion fatigue, compassion fatigue symptomology, and the review of empirical research related to compassion fatigue including research using the Professional Quality of Life (ProQOL) (Stamm, 2009) instrument including both positive and negative aspects of supporting survivors of trauma in its measurement of compassion fatigue. The following table provides a summary of the empirical research studies used to review the literature related to compassion fatigue.

Table 2: Empirical Research Related to Compassion Fatigue

Authors	Research Method	Sample Size	Measure	Main Findings	Quote
Adams et al. (2008)	Quantitative Survey Design	236 Social Workers	Compassion Fatigue Scale (compassion fatigue) General Health Questionnaire (GHQ-12) (psychological distress)	The direct exposure to clients traumatized by the World Trade Center disaster created secondary traumatic stress.	"Elevate the awareness of compassion fatigue and secondary trauma. Otherwise, we will lose clients and compassionate psychotherapists."
Adams et al. (2006)	Quantitative Survey Design	236 Social Workers	Compassion Fatigue Scale (compassion fatigue)	The validation study found good reliability, good concurrent and predictive validity.	"Compassion fatigue is bearing the suffering of clients".
Boscarino et al. (2004)	Quantitative Survey Design	236 Social Workers	Compassion Fatigue Scale (compassion fatigue) Job Burnout	The researchers found that mental health professions working with survivors of trauma are at greater risk for compassion fatigue.	"The idea that compassion fatigue is unique to mental health professionals is shortsighted."

Table 2: Empirical Research Related to Compassion Fatigue Continued

Authors	Research Method	Sample Size	Measure	Main Findings	Quote
Deighton et al. (2007)	Quantitative Survey Design	100 Trauma Psychotherapist	Maslach Burnout Inventory (burnout) Professional Quality of Life (ProQOL) (Compassion fatigue) Working Through Questionnaire. Distress questionnaire.	A low degree of working through was related to compassion fatigue, burnout, and distress.	"The indirect exposure to trauma is not the risk but what the therapist does with the exposure, contributes to the development of conditions such as compassion fatigue."
Sprang et al. (2006)	Quantitative Survey Design	1,121 Rural Southern Mental Health Providers	Demographic Survey Professional Quality of Life (ProQOL) (compassion fatigue)	The researchers found females had greater risk for compassion fatigue and burnout.	"Limited resources, geographical isolation, few colleagues, and high demanding caseloads created a perfect storm of burnout risk among rural clinicians".

Secondary Traumatic Stress

In 1995, Figley coined the phrase secondary traumatic stress and claimed that secondary traumatic stress and compassion fatigue described the same phenomenon. Additionally, researchers (Buchanan, Anderson, Uhlemann, & Horwitz, 2006; Jenkins & Baird, 2002; Figley, 1995; Simpson & Starkey, 2006) supported the theory that compassion fatigue and secondary traumatic stress were the same phenomenon. Secondary traumatic stress was defined as a natural reaction to the knowledge of a

traumatic event experienced by a significant other. Helping or desiring to help the traumatized or suffering person produces this stress (Figley).

According to Figley (1995), secondary traumatic stress is a condition with similar symptomology to Post Traumatic Stress Disorder. The differences between Post Traumatic Stress Disorder and secondary traumatic stress relate to the trauma exposure. In Post Traumatic Stress Disorder the trauma and the symptoms are related to the person who endured the trauma; while in secondary traumatic stress the knowledge of the traumatizing event creates the stress for the person who knows about the trauma, although, this person did not endure the stress.

Several researchers proposed that secondary traumatic stress is a form of Post Traumatic Stress Disorder caused by indirect exposure (Arvay, 2001; Bell, 2003; Buchanan et al., 2006; Shah, Garland, & Katz, 2007). Buchanan et al. (2006) found that mental health professionals who worked with high caseloads including trauma survivors experienced distress. The researchers conducted quantitative research measuring distress and compassion fatigue in 280 participants. Additionally, the researchers concluded that their research findings supported previous findings that estimated more than one-third of mental health professionals had encountered childhood trauma. This exposure increased the likelihood of mental health professionals developing a condition such as compassion fatigue, burnout, secondary traumatic stress, or vicarious traumatization.

The following literature related secondary traumatic stress and Post Traumatic Stress Disorder. Bell (2003) conducted quantitative research to measure secondary traumatic stress in 30 family violence counselors, using a strengths-based model and

found that 40% of trauma workers described their work as positive. Arvay (2001) conducted a literature review and reported that secondary traumatic stress and vicarious traumatization were the same phenomenon. Shah (2007) conducted quantitative research measuring secondary traumatic stress in 76 humanitarian workers and found that 100% of workers, who provided support following civil unrest, met the criteria for at least one secondary traumatic stress symptom and six workers met the criteria for one symptom of Post Traumatic Stress Disorder.

Finally, Jenkins and Baird (2002) conducted a validation study measuring secondary traumatic stress and vicarious traumatization with sexual assault and domestic violence counselors. The researchers used five instruments to measure compassion fatigue, traumatic beliefs, burnout, distress, and traumatic history and found that participants experienced secondary traumatic stress/compassion fatigue on an individualized level. For example, traumatic stories affected some counselors, while other counselors were not affected by traumatic stories.

Symptoms. Figley (as cited in Morrisette, 2004) provided symptomology related to secondary traumatic stress and reported it is the same symptomology related to compassion fatigue because they are the same phenomenon. Figley categorized the four dimensions: emotional, cognitive, physical, and behavior. Emotional symptoms included avoidance, reduced affect, and irritability. Cognitive symptoms included recalling the traumatic person, reminders of traumatic events, challenges in cognitive ability such as concentration. Physical symptoms included insomnia, physical reactions to triggers, and dreams of the event or the traumatized person. Behavioral symptoms included

avoidance, reduced interest in activities, detachment from others, and hyper advocacy for traumatized individuals.

Summary. This section of the literature review regarding secondary traumatic stress included salient empirical literature from 2003-2010. This literature focused on recent studies conducted by renowned traumatologist, Charles Figley, and this section included definitions of secondary traumatic stress that linked secondary traumatic stress disorder with Post Traumatic Stress Disorder, a review of secondary traumatic stress symptomology, and the review of empirical research related to secondary traumatic stress. The following table provides a summary of the empirical research studies (Bell, 2003; Buchanan et al., 2006; Jenkins & Baird, 2002; Shah et al., 2007) used to review the literature related to secondary traumatic stress.

Table3: Empirical Research Related to Secondary Traumatic Stress

Authors	Research Design	Sample Size	Measurement	Main Findings	Quote
Bell (2003)	Qualitative Research	30 Family Violence Counselors	Interviews focusing on strengths and allowance of the participants to be experts	The findings indicated 40% of counselors felt that their trauma work had positive affects on them, 10% felt that their work had a negative affect on them.	"The strength of counselors included having a sense of competence about coping and maintaining an objective motivation."
Buchanan et al. (2006)	Quantitative Research Survey Design	280 Certified clinical counselors, psychologist, psychiatrists, social workers, community agency counselors, and others identified as trauma counselors	The Impact of Event Scale-Revised (trauma exposure) Compassion Fatigue Self Test (Compassion Fatigue)	The researchers reported that mental health professionals working with high caseloads of traumatized adults were distressed.	"These results are consistent with previous research that more than one third of all mental health professionals had experienced childhood trauma."

Table3: Empirical Research Related to Secondary Traumatic Stress Continued

Authors	Research Design	Sample Size	Measurement	Main Findings	Quote
Jenkins & Baird (2002)	Quantitative Survey Design	99 Sexual Assault and Domestic Violence Counselors	Compassion Fatigue Self-Test (compassion fatigue) TSI Belief Scale, Revision (vicarious trauma) MBI (burnout) Symptom Checklist 90 (psychological distress) TSI Life Events Checklist (trauma exposure)	Workers with more exposure did not show more secondary traumatic stress, vicarious traumatization, stress, burnout, or distress. More educated counselors reported less vicarious trauma.	"Good stress represents demanding jobs before the excess leads to burnout."
Shah et al. (2007)	Quantitative Survey Design	76 Humanitarian Workers	Secondary Traumatic Stress Scale (STSS)	100% of the participants illustrated at least one STS symptom. Six individuals met the criteria for PTSD.	"People who come to the aid of others experience negative consequences as a result of their work."

Vicarious Traumatization

Vicarious traumatization is another body of literature that reinforces the importance of assessing individuals who support survivors of trauma. "Vicarious traumatization was defined as the reconstruction of the therapist's experience. The reconstruction occurs as a result of the empathic engagement with the client's trauma" (Pearlman & Saakvitne, 1995, p. 31). Bicknell-Henteges and Lynch (2009) wrote that vicarious traumatization is the experience of listening, examining, and involving oneself with the traumatic material of another person.

Essentially, the body of literature regarding vicarious traumatization identified it as a complicated, multifaceted concept (Pearlman & MacIan, 1995) created by the work-related risk of listening to traumatic stories (Dunkley & Whelan, 2006). Furthermore, vicarious traumatization is not a reflection of inadequacy or pathology of the therapist or dysfunction of the client. Rather, the use of empathic skills with trauma survivors contributes to the development of vicarious traumatization (Bicknell-Henteges & Lynch, 2009). As a result of the use of empathy, a change may occur in the therapist's view of self, others, and the world. According to McCann and Pearlman (1990), trauma may disrupt the counselor's schemata (schemes) in the areas of safety, trust, esteem, control, and intimacy. For example, a therapist's worldview may include that man is good; however, following his/her work with trauma that was intentionally conducted, such as genocide, the therapist's worldview about the innate goodness of man may change.

Empirical Studies. This review of compassion fatigue literature included reviews of empirical research of vicarious traumatization (Arnold, Calhoun, Tedeschi, & Cann,

2005; Devilly et al., 2009; Pearlman & MacIan, 1995). Pearlman and MacIan measured vicarious traumatization in 188 self-identified trauma therapists by using four instruments to measure traumatic beliefs, Post Traumatic Stress Disorder symptoms, distress levels, and the need for approval. The findings suggested the highest levels of distress were in new therapists who often left the field. This reaction is consistent with burnout literature.

Devilly et al. (2009) used seven instruments to measure demographics, work-related variables, previous exposure to trauma, affective distress, burnout, and secondary traumatic stress, disruptions in beliefs that result from trauma, empathy, and perceived social supports. The study population included in 152 Australian mental health professionals. The researchers found that secondary traumatic stress, vicarious traumatization, and burnout are essentially the same phenomenon. Lastly, Arnold et al. (2005) used qualitative research to assess vicarious traumatization with 21 psychotherapists. The researchers found that 90% of the participants reported intrusive thoughts as a result of working with client trauma and 71% of the psychotherapist reported feelings of negative emotional responses following sessions with survivors of trauma.

Symptoms. Saakvitne and Pearlman (1996) (as cited in Morrissette, 2004) provided symptomology related to vicarious traumatization. The symptomology was categorized into four dimensions: emotional, cognitive, physical, and behavioral. Emotional symptoms included being overwhelmed, emotional numbness, sadness, anger, and exhaustion. Cognitive symptoms included unworthiness, cynicism, emotions related to poor value. Physical symptoms included feeling an exposure to danger and intrusive

thoughts. Behavioral symptoms consisted of social disconnection, crying episodes, harshness, and emotional distance.

Summary. This section of literature relates to vicarious traumatization included salient empirical literature from 1995-2009. This section included definitions of vicarious traumatization, the association of empathy with survivors of trauma and the development of vicarious traumatization, vicarious traumatization symptomology, and the review of empirical research related to vicarious traumatization. The following table provides a summary of the empirical research studies used to review the literature related to vicarious traumatization.

Table 4: Empirical Research Related to Vicarious Traumatization

Authors	Research Design & Methods	Sample Size	Measures	Main Findings	Quote
Arnold et al. (2005)	Qualitative	21 Psychotherapist who support trauma survivors	Vicarious Traumatization	The findings included the following data: 90% reported intrusive thoughts, 20% reported emotional detachment, 29% doubted their effectiveness.	"It is impossible to be in the presence of someone struggling to cope with trauma and not be affected spiritually."
Devilly et al. (2009)	Quantitative Survey Design	152 Mental Health Professionals	Victimatization history Copenhagen Burnout Inventory (burnout) Secondary Traumatic Stress Scale (secondary traumatic stress) TSI Belief Scale (Traumatic Beliefs) Interpersonal Reactivity Index (Empathy) Interpersonal Support Evaluation List	The researchers found vicarious traumatization and burnout contributed significantly to the prediction of affective distress.	"It was found that secondary traumatic stress, vicarious traumatization measure the same phenomena"

Table 4: Empirical Research Related to Vicarious Traumatization Continued

Authors	Research Design & Methods	Sample Size	Measures	Main Findings	Quote
Pearlman & MacIan (1995)	Quantitative Survey Design	188 Self selected trauma therapist recruited at conferences, seminars, and training programs	TSI (Traumatic Stress Institute) Belief Scale (beliefs about trauma) Impact of Event Scale (IES), Symptom (trauma exposure) Checklist -90 (stress levels) Social Desirability	The findings suggested the highest level of distress in new therapist, who often left the field.	"Vicarious traumatization is a work related risk for those who work with trauma survivors."

This section reviewed the literature related to compassion fatigue and related terms of burnout, secondary traumatic stress, and vicarious traumatization. Each concept was considered in terms of definition, symptoms related to the phenomenon, and salient empirical research. In conclusion, several researchers noted the similarities and differences among compassion fatigue and the related terms of burnout, secondary traumatic stress, and vicarious traumatization. Figley (1995) noted that compassion fatigue and secondary traumatic stress are the same phenomenon. Meanwhile, Devilly et al. (2009) concluded that secondary traumatic stress, vicarious traumatization, and burnout are essentially the same phenomenon. Arvay (2001) reported that secondary traumatic stress and vicarious traumatization are the same phenomenon. Stamm (2009) reported similar definitions of each phenomenon noting fine distinctions. Yet, the

phenomena of compassion fatigue, secondary traumatic stress, and vicarious traumatization are the same concepts (Stamm).

The next section will review background literature related to compassion fatigue. Additionally, literature related to at-risk populations for the development of conditions related to compassion fatigue will be reviewed. Finally, concepts such as listening, stress, and empathy will be reviewed to examine their relationship in the development of concepts such as compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization.

Background Literature

Since 1900 B.C., human beings have recorded their responses to traumatic events (Figley, 1995). Trauma is defined as emotional shock, often having a lasting psychic effect (Merriam-Webster, 2010). According to Morrisette (2004) traumatology studies human reactions to traumatic events, there are two aspects of traumatology literature. The first focuses on the individuals who experience the trauma. The second focuses on the review of literature associated with individuals who provide assistance to trauma survivors.

At-Risk Populations

The account that follows reflects a personal experience from the researcher. The researcher selected the topic of compassion fatigue as a result of witnessing the impact of conditions such a compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization. During the 2008-2009 academic year, the researcher experienced the following scenario. Devon is a pseudonym used for this client.

A school counselor referred Devon, a 3rd grade, 9-year-old African-American male to a grief outreach group. As a result of Hurricane Katrina, Devon's family evacuated from New Orleans and relocated to another southern state. Since the relocation, the medical conditions of Devon's mother and uncle deteriorated. One year following the move, Devon's uncle passed away. Two years following the move, Devon's mother fell into a diabetic coma. As a result of the coma, Devon's mother was involved in a car accident after taking Devon to school, and died. Devon, who was eight years old, at the time, never had the opportunity to tell his mother good-bye.

One day following a group session, Devon stayed to speak with the group facilitator. He told the facilitator that he missed his mother and began to cry. He sat on the lap of the group leader and wept. After this event, the group leader continued to process this event thinking about the care of Devon, who was now living with his aunt and cousins.

Following this incident, the group facilitator, who was a doctoral student, continued to have intrusive thoughts regarding Devon's circumstances. Later, the group facilitator was in class when the professor commented that the group facilitator was distant. The group facilitator briefly described the circumstances from the group and expressed that she was thinking about the circumstances of young children who lost a parent. This account illustrates the origins of compassion fatigue. Compassion fatigue originates from listening to traumatic stories that leave a lasting imprint on the listener (Figley, 1995).

Many individuals are at-risk for the development of compassion fatigue; in fact, every caregiver has the potential to develop compassion fatigue (Bush, 2009). Caregivers that listen to traumatic events are vulnerable to develop the negative conditions of compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization (Stamm, 2009). An increased likelihood to develop compassion fatigue exists for those vulnerable listeners indirectly exposed to stress and traumatic events. For example, media personnel (Palm, Polusny, & Follette, 2004), disaster workers (Cronin, Ryan, & Brier, 2007), volunteers (Clukey, 2010), nurses (Alexander, 2006; Showalter, 2010), counselors (Kataoka et al., 2009; Trippany, Kress, & Wilcoxon, 2004), humanitarian workers (Shah et al., 2007), law enforcement (Tuck, 2009), social workers (Alexander, 2006; Boscarino et al., 2006), chaplains (Flannelly, Roberts, & Waver, 2005), and physicians (Bilal, Rana, Rahim, & Ali, 2007). Despite the diversity that exist among these various occupations, compassion fatigue and its related terms such as burnout, secondary traumatic stress, and vicarious traumatization developed into an authentic phenomena (Showalter; Tuck).

Why does compassion fatigue develop for these professionals? The literature suggested inherent flaws within foundational counseling skills related to listening (Arnold et al., 2005; Deighton et al., 2007; Dunkley & Whelan, 2006), empathy (Bober, Regehr, & Zhou, 2006; Bridges, 2006; Canefield, 2005; Figley, 1995; Siebert, 2004), and stress (Berceli & Napoli, 2006; Cronin et al., 2007; Figley, 1995; Tuck, 2009) may contribute to the development of compassion fatigue and its related terms (Adams et al.,

2006; Evans et al., 2006; Figley, 2006). The literature related to listening, empathy, and stress and compassion fatigue follows.

Listening

Reik (1948) introduced the concept of the third ear in psychological literature. The third ear describes the assessment and evaluation of counseling sessions (Lothane, 1981) and primarily uses listening as a tool for gaining information. Feist (2005) wrote that therapeutic listening is a skill that is difficult to manage. Essentially, following a session, when does a counselor stop the assessment and evaluation of the counseling session? For some counselors, the inability to stop processing and incorporate boundaries may contribute to the development of conditions such as compassion fatigue (Everall & Paulson, 2004). Yet, researchers (Egan, 2010; Johnsen, 2008; Levy, 2008) suggested that listening is a fundamental skill within the field of counseling and essential when responding to trauma survivors. Arnold et al. (2005) conducted qualitative research in which 90% of trauma counselors reported experiencing intrusive thoughts and concluded that listening to traumatic events can contribute to the development of compassion fatigue. Thus, listening is a key tool for helping, especially in a time of crisis and places counselors at-risk by listening to clients' traumatic stories (Arnold et al., 2005).

As stated earlier, listening is linked to conditions such as compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization (Buchanan et al., 2006; Smith, Kleihn, & Trijsburg, 2007). The primary method used to assist clients is listening to their compelling stories and helping them create new meaning and interpretations of

these events (Mendenhall & Berge, 2010). Hence, this fundamental method of helping may place the counselor in a vulnerable position. Another tool related to helping others is empathy. The next section reviews literature related to empathy and compassion fatigue.

Empathy

In the 1950's, Rogerian psychologists reinvigorated the concept of empathy in psychology. Young (2009) defined empathy as the skill to express understanding of another's feelings and worldview. This skill is demonstrated through the ability to take hold of the critical elements of another person's story and communicate comprehension. Previously, Young, Eisenberg and Strayer (1987) defined empathy as an affective reaction with another person's emotional circumstances. In regard to supporting trauma survivors, it is important to note the difference between sympathy and empathy. Eisenberg and Strayer defined the term sympathy as feelings of grief, distress, and sadness for another. Essentially, empathy is feeling the emotions with another person, while sympathy was characterized as feeling for another person (Egan, 2010).

The counselor literature reports the importance of empathy in the helping process (Corey, 2005; Egan, 2010; Young, 2009). Figley (1995) recognized that empathy contributes to the establishment of the therapeutic relationship developed between client and counselor. Empathy is critical to the helping process and some scholars suggested that the capacity to be empathic should be a qualification to be an effective helper (Zellmer, 2010). Several researchers (Bober et al., 2006; Bridges, 2006; Canefield, 2005; Cronin et al., 2007; Figley, 1995; Siebert, 2004) provided literature related to empathy as

it relates to compassion fatigue. For example, Cronin et al. (2007) conducted a literature review on empathy and further emphasized the importance of using empathic skills with trauma survivors. Reportedly, trauma survivors may have preconceived and stereotypical beliefs that trauma services are charity or welfare, and may demonstrate resistance to accept services (Cronin et al.). Therefore, following a traumatic event, it is imperative that counselors who respond to trauma survivors' needs provide trustworthy and non-judgmental supports by using empathic skills to relate and connect with their clients.

Meanwhile, the literature related to the negative aspects of empathy contains inconsistencies. Some of the literature depicted limitations and risks associated with the use of empathy. According to Figley (1995), the best counselors are at-risk because of their care, concern, and level of empathy. Larson and Bush (2006) described empathy as a vulnerability created when listening to traumatic stories (Larson & Bush). Bober et al. (2006) conducted quantitative research measuring the coping strategies of trauma counselors and found that the empathic connection influenced the development of compassion fatigue. Hook et al. (2008) also conducted quantitative research with child-care workers and found that the child-care workers who identified helping as their passion were more likely to exhibit empathy, trustworthiness, and genuineness to establish therapeutic bonds with their clients and subsequently expose themselves to conditions such as compassion fatigue. Depending on the severity of compassion fatigue, indirect exposure to trauma can alter counselors' worldviews (Hook et al.).

Pearlman and Saakvitne (1995) used quantitative research with trauma therapists and found two types of empathic connections, cognitive and affective. Counselors

demonstrated the cognitive empathic connection when counselors attempted to understand the thoughts of an individual. Counselors demonstrated the affective empathic connection when counselors attempted to understand the person's experience on an emotional level. The scholars found a link with counselors' levels of empathy and risk for compassion fatigue. Just as listening and empathy places counselors working with trauma survivors in a vulnerable position, stress exacerbates their vulnerability. Next, the literature related to stress and compassion fatigue will be reviewed.

Stress

Mental health literature has examined the issue of stress for twenty-five years (Canefield, 2005). Selye (1956) was credited with the acknowledgement of the biological concept of stress, utilized patient observations to develop the General Adaptation Syndrome (GAS). GAS is a physiological reaction to stress which was noted in several patients with different diagnosis. Selye's work noted the effects of extended exposure to stress on the body. Since 1956, the literature related to stress has broadened significantly (Morrisette, 2004). However, the basic concept of stress is linked to work-related burnout and compassion fatigue (Tuck, 2009). The literature noted that providing counseling supports to trauma survivors is stressful (Morrisette, 2004). Two scholars noted the link of stress to the development of compassion fatigue (Cronin et al., 2007; Tuck, 2009). One literature review regarding stressful occupations validated the phenomenon of compassion fatigue and related terms (Tuck). Another literature

review linked stress with disaster responsiveness (Cronin et al.). Both literature reviews emphasized the role of stress as a critical component in the development of conditions related to compassion fatigue.

According to the literature, the stress of professionals who respond to trauma is well documented (Bicknell-Henteges & Lynch, 2009; Cronin et al., 2007; Inbar & Ganor, 2003; Palm et al., 2004; Tuck, 2009). Often, these individuals experience Post Traumatic Stress Disorder or emotional burnout (Inbar & Ganor). Bicknell-Henteges and Lynch developed a technical resource guide for the biological aspects and responses to trauma which included material related to the treatment of trauma, the treatment of trauma in children and adolescents, and the effects of trauma on counselors. Although distress is a common response with traumatic events, the extended exposure to trauma may contribute to heightened reactions to stress in individuals (Bicknell-Henteges & Lynch). Emotional distress likely develops as a result of working with trauma survivors (Palm et al.).

The literature related to the impact of stress as it relates to the development of compassion fatigue illustrated contradictions. While most of the literature presented the negative aspects or risk related to the concept of stress, not all scholars agreed with this assessment. In contrast, Pines (2004) reported that stress may not contribute to burnout and its related conditions of compassion fatigue, secondary traumatic stress, or vicarious traumatization. In fact, some helpers may thrive in a stressful environment that provides meaningful work (Pines). Additionally, the Professional Quality of Life (ProQOL) theory included both positive and negative aspects of helping regardless of the stress that may be present for the helper (Stamm, 2009). Stamm postulated that an unfavorable work

environment may contribute to the development of compassion fatigue. In contrast, that same unfavorable work environment may influence the development of compassion satisfaction, a positive feature to helping. The concept of compassion satisfaction is related to altruism (Stamm).

In summary, the literature linked the foundational elements of listening, empathy, and stress to the development of compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization. Counselors use empathic skills to listen to the traumatic events of trauma survivors. In some counselors, listening to these traumatic events can cause the development of stress for the counselor. Indirect exposure to traumatic events may produce stress and can further develop into phenomena such as compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization (Cronin et al., 2007; Tuck, 2009). Several researchers (Johnsen, 2008; Kataoka et al., 2009; Showalter, 2010) suggested that these unresolved conditions can develop into psychopathology. Recent epidemiological literature postulated the increased risk of Post Traumatic Stress Disorder and other anxiety related disorders are related to the direct exposure to trauma (Farber, 1967; Norris, Friedman, & Watson, 2002).

The Diagnostic and Statistical Manual of Mental Disorders (2000) defined Post Traumatic Stress Disorder as

> the development of characteristic exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity or witnessing an event that involves death, injury, or a threat to the physical integrity

> of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (p.424).

To understand the development of conditions such as compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization, it is important to acknowledge the severe outcomes related to trauma. This definition describes conditions related to trauma exposure. Additionally, the definition links the experience of indirect exposure to trauma and Post Traumatic Stress Disorder.

The next section will review concepts related to the prevention of negative aspects related to providing services to trauma survivors. Moreover, there are inconsistencies in the utilization and availability of prevention methods to reduce the development of compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization. The literature suggested several methods of prevention. The information related to prevention supports the ethical obligation of counseling professionals and counselor educators (Sommer, 2008) to provide methods and strategies to reduce the development of conditions such as compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization in counselors who support survivors of trauma.

Methods of Prevention

The following section reviews literature related to the prevention of compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization. This section primarily reviews three methods of prevention: training programs, individual methods of prevention, and prevention techniques. The training program information addresses

educational strategies for counseling students and recent changes in accreditation standards. The material related to prevention methods includes individual methods of prevention such as self-care and self-awareness. Lastly, the literature outlined prevention techniques such as debriefing, supervision, and working in teams.

Counselor Training

According to the National Institute of Mental Health (2002), mental health professionals must be prepared to provide services to individuals and communities that encounter catastrophic events created by nature or by humans. As a result of that charge, agencies and organizations involved with the delivery of mental health services to survivors of trauma have implemented changes to provide education and training to meet this mandate and provide quality services (Bolnik & Brock, 2005).

Currently, many social science disciplines have increased responsibilities regarding the training of future helpers by modifying their educational standards to include crisis intervention training. Otherwise, these mental health professionals would lack the technical knowledge necessary to support survivors of disasters. For example, the Council for the Accreditation of Counseling and Related Educational Programs (hereafter referred to as CACREP) accredits and monitors the educational programs for counselors. CACREP (2009) modified its standards to include crisis training interventions such as Critical Incident Stress Debriefing (CISD), Psychological Triage, Psychological Debriefing, and Defusing.

There is a need to link the authentic demands of future counseling vocational needs to academic counseling training (Sommer, 2008). Sommer wrote that counselor

educators have an ethical obligation to provide fully trained counselors. The failure to provide fully trained counselors increases the likelihood that counselors will develop conditions such as compassion fatigue because they are unprepared. Campbell (2007) suggested that education and training should include the use of assessments such as the ProQOL (Stamm, 2009) to provide in-depth discussions with students related to the history and current understanding of conditions such as compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization.

According to CACREP Standards (2009), counselor educators are ethically responsible to provide education and training regarding trauma and disasters. Providing training to support trauma survivors properly and methods to provide self-care can benefit counselors-in-training. While, some students may have limited experience, others may be at-risk for the development of compassion fatigue because of previous exposure to trauma (Buchanan et al., 2006). Still, all students can benefit from the indirect exposure to trauma while in a protected and supported environment. Cunningham (2004) recommended the use of case vignettes, simulations, and role plays to present educational and training material in the safety of the classroom to prepare students for future challenges.

Additionally, it is important to note the previous history of counselors. For instance, counselors who have been previously exposed to trauma are more likely to develop symptoms related to compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization (Buchanan et al., 2006). Students should be aware of the potential impact these conditions may have on their ability to support others (Sexton,

1999). Buchanan et al. found that an estimated one-third of mental health professionals had encountered childhood trauma. Thus, students who have a history of trauma may benefit from classroom instruction that provides prevention methods within the classroom. The purpose of this type of instruction is related to the education and training of counselors who support survivors of trauma and help students understand and manage reactions to trauma (Sommer, 2008). Next, individual methods of prevention will be discussed.

Individual Methods of Prevention

Self-Awareness. One critical element in the prevention of compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization involves the concept of self awareness. Nelson-Jones (2009) defined self-awareness as an awareness of one's significant thoughts, feelings, and experiences and the impact that one makes on others. Vast amounts of literature discuss the importance of the topic of self-awareness (Corey, 2005; Egan, 2010; Young, 2009). Counselor educators should teach students to be aware of the warning signs related to compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization so students can increase their consciousness about this topic (Zellmer, 2005).

The first crucial step begins with self-awareness. In general, counselors are reluctant to identify the warning signs of conditions such as burnout, compassion fatigue, secondary traumatic stress, and vicarious traumatization (White, 2001) because some counselors may feel guilty and refute these feelings. Many counselors with conditions such as compassion fatigue ignore warning signs and place themselves and clients at-risk

by creating ethical dilemmas. Recently, counselor training programs have addressed an ethical responsibility to prepare counselors for these conditions. In preventing these conditions, it is important for counseling programs to stress self-awareness and self-care and develop counseling program cultures that value these concepts (Everall & Paulson, 2004).

Bicknell-Hentges and Lynch (2009) reported that using self-awareness to know one's tendencies as a counselor may minimize the development of compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization. For example, through one's self-awareness, a person may become aware of a lack of boundaries (Devilly et al., 2009) and balance (Edwards, 2006) in therapeutic relations. Essentially, these symptoms of compassion fatigue and related conditions could exacerbate the development of decision-making impairments related to blurred judgments and the removal of boundaries with a therapist's clients. Nonetheless, authors (Egan, 2010; Nelson-Jones, 2009; Young, 2009) have stressed the importance and value for the concept of self-awareness in counselor development. Everall and Paulson (2004) addressed ethical behaviors of counselors in a literature review and encouraged self-awareness to prevent the development of compassion fatigue.

Self-Care. Self-care methods are used to reduce stress and burnout in counselors by addressing personal and professional growth (Newsome, Christopher, Dahlen, & Christopher, 2006). For example, mindfulness practices such as yoga, meditation, or journaling. Several researchers (Bober et al., 2006; Bicknell-Hentges &Lynch, 2009; Killian, 2008; Pfifferling & Gilley, 2000) conducted research related to the use of self-

care to reduce or prevent conditions such as compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization. Pfifferling and Gilley (2000) provided a resource guide for physicians to reduce and manage the symptoms related to compassion fatigue. The scholars encouraged the development of self-care plans that were similar to a plan of care. This plan outlined the use of interventions such as quiet time alone to recharge and engagement in meaningful conversation to counter the effects of compassion fatigue and similar conditions. Additionally, individuals with symptoms were encouraged to refrain from the use of substances, making important decisions, blaming others, and complaining. Finally, the authors encouraged individuals to simply say "no" to additional requests.

Bober et al. (2006) used quantitative research to assess coping strategies for 259 trauma counselors. The researchers found that counselors believed that activities of leisure, self-care, and supervision would reduce the symptoms related to vicarious traumatization. Additionally, Bicknell-Hentges and Lynch (2009) suggested that counselors' coping styles may be an area that assists in the defense of the development of symptoms related to compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization.

Killian (2008) endorsed the concept of self-care and requested a paradigm shift of agencies and organizations to invest in mental health benefits for their workers to alter workloads to reduce turnover, increase morale, and increase the quality of the services delivered to clients (Killian). Counselors must learn to increase self-care to prevent the development of impairments such as burnout, compassion fatigue, secondary traumatic

stress, and vicarious traumatization (Palm et al., 2004; Pearlman & MacIan, 1995). Bicknell-Hentges and Lynch (2009) reported the use of self-care methods were vital for the prevention of conditions such as burnout, compassion fatigue, secondary traumatic stress, and vicarious traumatization after providing supports to survivors of trauma. Some researchers (Hesse, 2002; Ortlepp & Friedman, 2002; Regehr & Cadell, 1999) postulated the acquisition of support systems and the development of outside interests as essential components for successful self-care methods and the reduction of compassion fatigue and related conditions. Next, specific techniques consisting of debriefing, supervision, and clinical teams will be reviewed.

Techniques

The literature supported the use of prevention methods such as debriefing, supervision, and clinical teams to reduce the development of conditions such as compassion fatigue. Several empirical studies reported debriefing as an effective prevention method. Despite, this recommendation, some agencies and organizations that provide services for trauma survivors do not provide debriefing sessions for helpers (Adams et al., 2006; Shah et al., 2007). Studies identified supervision as a useful method to assist counselors in the support of trauma survivors (Bernard & Goodyear, 2009; Figley, 2006; Levy, 2008). However, supervision is difficult to manage as workers reported that often the rules related to post-trauma environments can be confusing, fragmented, bureaucratic systems that impede the delivery of services and create frustration. Moreover, supervision may not be a support that is available, due to the limited number of supervisors (Cluckey, 2010). Teaming is a method that illustrated

benefit by distributing service responsibilities from an individual to a group. Adams et al. (2006) supported the use of this method as a beneficial technique used with social workers who supported trauma survivors after the World Trade Center disaster.

Debriefing. Three researchers (Adams et al., 2008; Clukey, 2010; Shah et al., 2007) urged the use of methods such as debriefing with individuals who provide support to trauma survivors. Shah et al. conducted quantitative research with humanitarian workers and found levels of secondary traumatic stress and Post Traumatic Stress Disorder symptoms. Adams et al. conducted quantitative research with social workers following the World Trade Disaster and supported the use of methods such as debriefing. Debriefing can assist in the reduction of symptoms for individuals who respond to trauma (Adams et al., 2008; Shah et al., 2007).

Supervision. Supervision is critically important for counselors (Bernard & Goodyear, 2009; Hayes, Corey, & Moulton, 2003). However, the provision of supervision for counselors who provide supports for survivors of trauma can be challenging. Mendenhall and Berge (2010) reported some of the challenges related to supervision in post-trauma sites. During field deployments, boundaries are inhibited as supervisors and supervisees may share personal spaces used for bathing and sleeping. Members of the same team may exhibit symptoms such as insomnia and face the ethical dilemma of a team member prescribing a medication. Therefore, factors related to boundaries may influence the supervisory relationship in the delivery of supports following a traumatic event.

Also, Pearlman and MacIan (1995) reported the availability of supervision for counselors who support survivors of trauma may be limited. Pearlman and MacIan noted the lack of supervision provided for therapists who supported trauma survivors. Counselors have an ethical responsibility to ensure that their peers are not harmed while performing work related to helping. One method to reduce the development of conditions such as compassion fatigue includes supervision (Edwards, 2006). Next, the concept of teams will be discussed as it related to the prevention of compassion fatigue.

Teams. Several researchers (Adams et al., 2006; Bicknell-Hentges & Lynch, 2009) addressed benefits linked to the use of teams in the support of trauma survivors. Essentially, the job and subsequent responsibility to support trauma survivors is not placed with an individual counselor but divided among a team of counselors. Bicknell-Hentges and Lynch noted the vulnerability of working in isolation increases the risk of the development of compassion fatigue. Adams et al. reported that teams created working alliances that offset the dynamics created by working alone with trauma survivors and proposed the use of working with teams as a method to reduce the development of concepts such as compassion fatigue.

Summary. The existing literature suggested that counselor education and training, individualized methods such as self-awareness and self-care, and prevention techniques may reduce the development of conditions such as compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization. The counseling literature stressed the importance of self-awareness and self-care. Counseling programs should introduce and stress the importance of self-awareness in counseling programs because

self-care methods have been linked to the reduction of concepts such as compassion fatigue. Devising a self-care plan to create and track progress for the reduction of symptoms should be encouraged (Killian, 2008). Finally, research studies advised implementing techniques such as debriefing (Adams et al., 2006; Clukey, 2010; Shah et al., 2007), supervision (Mendenhall & Berge, 2010; Pearlman & MacIan, 1995), and clinical teams (Adams et al., 2006) to reduce the development of conditions related to compassion fatigue.

Conclusion

The purpose of this literature review was to evaluate the existing literature related to compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization. This conclusion outlines the salient literature related to compassion fatigue and related terms, identifies gaps in the literature, especially as they relate to ethics, multicultural considerations, and geographic locations, and provides suggestions regarding future research considerations.

The literature related to burnout included the review of empirical literature from 1981-2010 including the prominent research of scholar Christina Maslach (1981) and research used to measure burnout with various populations. Essentially, burnout was an introductory concept related to working with people and emotional exhaustion. Later, burnout contributed to the development of compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization. The section of literature regarding compassion fatigue reviewed studies conducted by renowned traumatologist, Charles Figley and research using the Professional Quality of Life (ProQOL) (Stamm, 2009)

instrument. The ProQOL (Stamm) instrument assessed positive and negative aspects of supporting survivors of trauma in its measurement of compassion fatigue. The literature regarding secondary traumatic stress linked secondary traumatic stress and Post Traumatic Stress Disorder. The literature related to vicarious traumatization associated the use of empathy with survivors of trauma and the development of vicarious traumatization.

Additionally, the literature reviewed at-risk populations and identified that all helpers are at-risk for the development of compassion fatigue. The examination of concepts such as listening, stress, and empathy were linked to the development of compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization. Furthermore, the literature identified prevention methods as education and training programs, individual methods of prevention such as self-care and self-awareness, and prevention techniques such as debriefing, supervision, and working in teams.

Gaps in the Literature

Several studies failed to examine concepts such as ethical issues, multicultural considerations, and geographic location. Furthermore, there is limited empirical research related to how these concepts relate to the development of compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization. Therefore, literature related to ethics, multicultural considerations, and geographic locations were identified as gaps in this review of literature.

Ethical Issues. Ethics in counseling is important and critical to the delivery of services to clients (Remley & Herlihy, 2009; Welfel, 2006). According to Everall and

Paulson (2004) counseling is demanding and counselors have an ethical responsibility to maintain professional competencies to provide quality services to their clients. Mental health professionals make ethical decisions everyday, yet providing ethically sound support to trauma survivors may be a challenge because of the flawed and limited environment that these counselors operate in following a traumatic event. Most ethical conflicts are attributed to opposing needs that exist among individuals, employers, or professional codes. During the time period following a traumatic event, normal operating systems may be absent, but services are provided.

An additional ethical implication relates to the effects of the unresolved symptomology of compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization that lead to questionable behavior in counselors (Palm et al., 2004). The ACA Code of Ethics (2005) preamble supports the ethical principle of benevolence, do no harm. Yet, a counselor who lacks self-awareness and is unaware of the effects of the indirect exposure of trauma could indiscriminately demonstrate unethical behavior while providing services (Palm et al.).

Multicultural Considerations. Several multicultural authors (McGoldrick, Giodrano, & Garcia-Preto, 2005; Ho, Rasheed, & Rasheed, 2004; Sue & Sue, 2008) reported counselors are not adequately trained to provide the multicultural needs of their clients and many minority clients leave counseling prematurely. Due to the prevalence and location of traumatic events, counselors require multicultural sensitivity. It is important that counselors are prepared (Sommer, 2008) to sufficiently respond to a diverse population of clients. Western culture stresses the liberating practice of talking as

a solution (Feist, 2005). In the treatment of trauma, retelling the story may have curative factors for some trauma survivors (Bicknell-Hentges & Lynch, 2009). Yet, the implementation of this method with every person and every culture may not be successful. Counselors must be mindful of the cultural differences and best practices related to multicultural competencies of mental health services in the midst of trauma. The likelihood of counselors to interface with individuals who are survivors of trauma is very likely. Therefore, it is necessary to provide thorough multicultural training for counselors.

Geographic Location. Additionally, the concept of geographic location represents a gap in the compassion fatigue literature. Existing literature does not include research measuring compassion fatigue levels of the U.S. Gulf Region counselors. No literature related to compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization addressed the influence that geographic location may have on counselors. For example, counselors who are closer to the devastated areas may have higher compassion fatigue. Based on limited data, the researcher speculates that geographic location may be linked to compassion fatigue.

Many types of events may cause individuals stress and trauma. Examples of these incidents include violence, catastrophes, military combat, and terrorism. Cornin et al. (2007) suggested that jobs related to the support of trauma survivors will become more intense. Therefore, more research is needed to reduce the effects of the indirect exposure to traumatic events, often created through the provision of mental health services by counselors (Palm et al., 2004).

According to Bicknell-Hentges and Lynch (2009) more research is needed to determine who is more vulnerable to develop the symptoms of compassion fatigue. Additionally, there is partial understanding of the development of compassion fatigue. Researchers postulated that factors such as gender and education (Sprang et al., 2007), geographic location, years of experience (Arvay 2001; Cunningham, 2004; Dunkley & Whelan, 2006; Flannelly et al., 2005), and self-care (Kataoka et al., 2009; Killian, 2008; Pearlman & MacIan, 1995) may place counselors at-risk. These findings from the literature suggest the importance of further examination of these factors. Therefore, these factors of gender, geographic location, educational level, years of experience, and use of self-care will be measured in this research study.

Chapter Summary

This review of the literature documents the vulnerability of counselors, especially those helping individuals in trauma, to compassion fatigue. As stated in Chapter One, counselors in the U.S. Gulf Region are particularly at-risk. For the past five years, these counselors have helped individuals who have been exposed to multiple traumatic events. The individuals of the U.S. Gulf Region have been challenged by the significant environmental, ecological, and financial destruction in recent years (Conant, 2010; Gray, 2010; Walsh, 2010). The literature suggests an ethical obligation to help counselors with compassion fatigue. A first step in helping is to identify the nature of and the severity of the compassion fatigue of these individuals.

As described in Chapter One this exploratory research study examined compassion fatigue and compassion satisfaction as measured by the Professional Quality

of Life (Stamm, 2009) of counselors in one of the U.S. Gulf States, specifically Mississippi. It is important to examine the counselors who provide counseling support in this region and broaden the body of knowledge related to compassion fatigue. In addition, the U.S. Gulf Region provides a unique setting to explore the phenomenon of compassion fatigue for counselors. Chapter 3 reviews the methodology used in this study.

Chapter 3

Methodology

This chapter describes the methodology used to explore the self-reports of the U.S. Gulf Region, specifically Mississippi counselors, from the perspective of attitudes and characteristics. The counselors in the U.S. Gulf State of Mississippi provided valuable information about their compassion fatigue and compassion satisfaction as measured by the Professional Quality of Life (ProQOL) (Stamm, 2009) instrument. The chapter is organized into the following sections: research design, research questions, population, instrumentation, procedures, data analysis, and chapter summary.

Research Design

The research design of this study utilized a cross-sectional survey design. The rationale for this methodology is consistent with the purpose of the study as outlined by Creswell (2008). In this type of research, either the entire population or a subset is selected to be studied at one point in time. Quantitative data are collected from these individuals to learn about the respondents and describe their attitudes and characteristics. The data are statistically analyzed to delineate patterns related to the responses to survey items to provide evidence to support research questions (Creswell, 2005). The dependent variables in this study were the sub-scales scores, compassion satisfaction, burnout, and secondary traumatic stress, as measured by the Professional Quality of Life (ProQOL) (Stamm, 2009). The independent variables in this study included the counselors' educational level, gender, geographic location, self-care methods, and years of experience.

Research Questions

This research study attempted to answer the questions significant to the Professional Quality of Life (ProQOL) (Stamm, 2009) of counselors in one state of the U. S. Gulf Region, specifically Mississippi. The research questions addressed the purpose of this investigation.

1. What are the counselors' Professional Quality of Life (ProQOL) (Stamm, 2009) sub-scale scores of compassion satisfaction, burnout, and secondary traumatic stress from Mississippi, one state in the U.S. Gulf Region, and how these scores are distributed across respondents?
2. What are the differences among the Professional Quality of Life (ProQOL) (Stamm, 2009) sub-scales scores of compassion satisfaction, burnout, and secondary traumatic stress scores on each participant characteristic of educational level, gender, geographic location, self-care methods, and years of experience?

Participants

The U. S. Gulf State of Mississippi hosts an annual state counseling conference each fall, sponsored by the state counseling association for the education and training of Mississippi counselors. The state of Mississippi was selected for data collection for this research study; Mississippi is a state in the U.S. Gulf Region. Counselors who attended the 60th Annual Mississippi Counseling Conference in Jackson, Mississippi were recruited to participate in this study (See Appendix B). The researcher secured and operated an exhibit booth that opened one hour prior to the opening session and closed

one hour prior to the closing session of the conference. The researcher staffed the booth during conference hours. Additionally, the researcher actively sought conference attendees to participate in the study as they attended conference break-out sessions. For example, the researcher disseminated survey packets to potential participants while conference attendees were walking to conference sessions. Participants returned the survey packets to the researcher or to the exhibit booth. The exhibit booth contained survey packets consisting of the informed consent, demographic survey, and ProQOL (Stamm, 2009) (Appendix A), raffle tickets (Appendix C), a raffle box to collect raffle tickets, and a box to collect completed survey packets.

Participants in this study were individuals attending the annual state conference who agreed to the terms of the informed consent, completed the demographic survey, the Professional Quality of Life (ProQOL) (Stamm, 2009), and submitted both instruments to the researcher during the conference. The researcher included all completed survey packets in the data analysis; the researcher anticipated 100 to 150 participants. Participants completing the survey packet received a raffle ticket and were eligible to participate in drawings for five $50 Wal-Mart gift cards. Participants could withdraw from the study at any time without penalty and without loss of benefits.

Instrumentation

This study used two self-report instruments to gather data. The study adapted the first instrument from the Individual Information Form (Sweeney, Hohenshil, & Fortune, 2002) (See Appendix A) to collect demographic information. This study also used the Professional Quality of Life (Stamm, 2009) as a second instrument (See Appendix A).

Two criteria guided the selection of these instruments: their value in answering the research questions and their psychometric properties.

Demographic Survey

The survey collected demographic information related to age, gender, race, education, training, licensure, certification, career planning, years of experience, use of technology, self-care methods, and geographic location. As stated earlier, educational level, gender, geographic location, self-care methods, and years of experience also represented independent variables in this study. These items were selected based on factors affecting compassion fatigue outcomes as identified in the compassion fatigue literature. However, the item related to geographic location represented a gap in the compassion fatigue literature. No literature related to compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization addressed the influence that geographic location may have on counselors. For example, counselors who are closer to the devastated areas may have higher scores on burnout and secondary traumatic stress sub-scales and subsequently higher compassion fatigue scores.

The Professional Quality of Life (ProQOL)(Stamm, 2009)

Background. The Professional Quality of Life instrument assesses compassion fatigue (Stamm, 2009). Initially, Charles Figley developed the Compassion Fatigue Scale (1995). B. Hudnall Stamm revised the Compassion Fatigue Scale (1997-2009). In 2009, Stamm (2009) developed the current revision of the instrument. Figley, the original developer of the compassion fatigue measurement supported Stamm's continued

development of a compassion fatigue measurement. Essentially, the instrument is an updated version of the Compassion Fatigue Self Test (Figley, 1995).

Stamm (2009) designed the instrument to measure psychometric properties of compassion fatigue by using a 30-item instrument composed of three sub-scales: compassion satisfaction, burnout, and secondary traumatic stress. The compassion satisfaction sub-scale measures the gratification produced from effectively completing work. The burnout sub-scale measures feelings of discouragement and challenges related with a person's ability to work. The secondary traumatic stress sub-scale measures work related indirect exposure to trauma. Overall, the instrument integrates positive and negative concepts related to helping.

The Professional Quality of Life (ProQOL) (Stamm, 2009) analyzes the comprehensive impact of helping including the therapeutic factor of altruism with occupational challenges (Stamm). Compassion satisfaction describes the positive concept within the theory and represents altruism. The negative concept of compassion fatigue represents two elements, burnout and secondary trauma. Secondary traumatic stress incorporates a helper's fear related to enduring similar trauma as his/her clients. In summary, the ProQOL (Stamm, 2009) uses the factors found in the compassion fatigue literature: compassion satisfaction, burnout, and secondary traumatic stress (Stamm, 2009). The three constructs described above and the Professional Quality of Life theory forms the foundations for item construction (Stamm).

Description of Instrument. The ProQOL uses 30-items to assess compassion fatigue (e.g. "My work makes me feel satisfied," "I feel worn out because of my work as

a counselor" etc.) (Stamm, 2009). Participants rate each item with the following response 1=Never, 2=Rarely, 3=Sometimes, 4=Often, and 5=Very Often (Stamm, 2009). According to the ProQOL (Stamm) manual, the most stressful scores reflect high secondary traumatic stress and high burnout with low compassion satisfaction. The person is both overwhelmed and ineffective in the workplace (Stamm). According to Stamm, individuals with this score should consider another type of work.

Compassion satisfaction refers to 10 items on the ProQOL (Stamm, 2009) and is defined as "the pleasure you derived from being able to do your work well" (p. 12). Meanwhile, Stamm defined burnout as "feelings of hopelessness and difficulties dealing with work or in doing your job effectively" (p.13) and refers to 10 items on the ProQOL (Stamm). Finally, secondary traumatic stress refers to 10 items on the ProQOL (Stamm) and is defined as "work-related, secondary exposure to people who have experienced extremely or traumatically stressful events (Stamm, p. 13).

Validity. According to the ProQOL test manual, Stamm confirms construct validity for the ProQOL (Stamm, 2009).

> There is good construct validity with over 200 published papers. There are also more than 100,000 articles on the internet. Of the 100 published research papers on compassion fatigue, secondary traumatic stress, and vicarious traumatization, nearly half have utilized the ProQOL or one of its earlier versions. The three scales measure separate constructs. The Compassion Fatigue scale is distinct. The inter-scale correlations show 2% shared variance (r=-.23; co--=5%, n=1187) with secondary traumatic stress and 5% shared variance (r=-.14; co--

> =n=1187) with burnout. While there is shared variance between burnout and secondary traumatic stress the two scales measure different constructs with the shared variance likely reflecting the distress that is common to both conditions. The shared variance between the two scales is 34% (r=-.58; co-o=34%; n=1187). The scales both measure negative affect but are clearly different; the burnout scale does not address fear while the secondary traumatic stress scale does. (Stamm, 2009, p. 14)

Reliability. According to the ProQOL test manual, Stamm confirms reliability for the ProQOL (Stamm, 2009).

> The alpha reliability for the compassion satisfaction scale is a = .88 (n=1130); the alpha reliability for burnout is a=.75 (n=976) and compassion fatigue is a = .81 (n=1135). The measure has good item-to-scale properties with no single item adding or subtracting from the overall scale quality. The standard errors of the measure are quite small, and are as follows: compassion satisfaction .22, burnout .21, and secondary traumatic stress .20 these small standard errors indicate that the test typically has small error interference, improving the potential measureable effect size. (Stamm, 2009, p. 14)

Procedures

Permission to use the Professional Quality of Life (ProQOL) (Stamm, 2009) is provided on the footer of the instrument. Permission to conduct the study was granted by human subjects Institutional Review Board. The researcher secured a vendors booth at the 60th Annual Mississippi Counseling Association Conference in Jackson, Mississippi

and participants were recruited by flyers (Appendix B). The researcher completed an application to secure an exhibit booth that included a draped table and chairs. The exhibit booth opened one hour prior to the opening session and closed one hour prior to the closing session of the conference. The researcher staffed the booth during conference hours. The exhibit booth contained the instrument packets consisting of the informed consent, demographic survey, and ProQOL (Stamm, 2009) (Appendix A), raffle tickets (Appendix C), a raffle box to collect raffle tickets, and a box to collect completed survey packets. After participants completed the survey packet, they tore off a raffle ticket attached to the survey packet and placed the completed raffle ticket into the raffle box. The raffle tickets collected information such as name, address, and telephone number, so the presence of prize winners was not required to receive their raffle prize. The gift cards were sent to the winners by mail. To ensure the anonymity of the participants, the raffle tickets and survey packets were not coded to link raffle tickets and survey packets.

Counselors completed the survey packet within approximately 10 - 20 minutes. The researcher was available to respond to questions related to the survey packet and the research study. As indicated earlier, the researcher provided an incentive to participate in the study. Participants who completed and submitted the survey packet were eligible to participate in drawings for five $50 Wal-Mart gift cards. Individuals were not required to participate in the research study to be eligible for the raffle drawing. Participants were aware of ethical considerations including privacy, confidentiality, and the purpose of the study via informed consent (Appendix A) and the University of Tennessee Institutional

Review Board Human Subjects' Research approval. Completion of the instruments also indicated consent.

Data Analysis

In regard to scoring the demographic survey, a codebook was developed assigning scores to participants' responses. The researcher scored the ProQOL (Stamm, 2009) and obtained a raw score for each of the participants' responses to 30 items. The individual raw scores were used to compile sub-scale scores. The results from the instruments were imported into the Statistical Package for the Social Sciences (SPSS) version 17. The researcher used the statistical software package to analyze the dataset. The following tables review the statistical analyses utilized in this study.

Table 5 illustrates the level of measurement and statistical analysis used with each of the independent variables of educational level, gender, geographic location, self-care methods, and years of experience in conjunction with each dependent variable sub-scale measured at the interval level of measurement. The independent variable of educational level is considered categorical naming four categories of education (Coladarci, Cobb, Minium, & Clarke, 2004). For example, 1=2 Year or Bachelors degree, 2=Masters degree, 3=Specialists degree, 4=Doctorate degree. The independent variable of gender is considered categorical and was coded to reflect two categories: male and females. For example, 1=Male, 2=Female. The independent variable of geographic location was considered categorical and coded to name four regions of the state of Mississippi. For example, 1= North Mississippi, 2= Central Mississippi, 3= South Mississippi, and 4= Mississippi Gulf Coast. The independent variable of self-care was considered categorical

and coded to provide categories of self-care methods. For example, 1=exercise/yoga, 2= meditation, 3=personal counseling, 4=socializing, 5= supervision, and 6=other. The independent variable of years of experience was considered categorical and coded to reflect categories of vocational experience (Coladarci, Cobb, Minium, & Clarke, 2004). For example, 1 = less than 1 year, 2 = 1-10 years, 3 = 10-20 years, and 4 = 20+ years of experience.

According to Creswell (2005) nominal scales of measurement are considered categorical. All of the independent variables were considered nominal scales of measurement and called categorical data. Categorical data provides response options where participants check one or more categories that describe traits, attributes, or characteristics (Creswell, 2005).

One-Way MANOVA

One-way multivariate analysis of variance (MANOVAs) was performed to analyze the data set. One-way MANOVAs examined the main effect of independent variables such as educational level (2 Year or Bachelors degree, Masters degree, Specialists degree, Doctorate degree), gender (male and female), geographic location (Region 1, Region 2, Region 3, Region 4), self-care methods (exercise/yoga, meditation, personal counseling, socializing, supervision, or other methods), and years of experience (less than 1 year, 1-10 years, 10-20 years, and 20+ years) on the sub-scale scores of the Professional Quality of Life (ProQOL) (Stamm, 2009) compassion satisfaction, burnout, and secondary traumatic stress.

A one-way multivariate analysis of variance (MANOVA) is used to test the main effects of one or more independent variables on more than one dependent variable (Borg & Gall, 1989; Vogt, 1999). Overall, a one-way MANOVA emphasizes mean differences and statistical significance of differences among different groups (Tabachnick & Fidell, 2007). Essentially, the basic question a one-way MANOVA answers relates to whether or not there is a difference in the scores on the dependent variable attributable to one of the independent variables (Salkind, 2000). For example, consider this research study testing five counselor characteristics of educational level, gender, geographic location, self-care methods, and years of experience on the counselors' ProQOL sub-scale scores of compassion satisfaction, burnout, and secondary traumatic stress (Stamm, 2009).

The following outlines the steps used to conduct a one-way MANOVA. A one-way MANOVA can be used to test the assumption of the equality of group dispersions (Heiman, 1998). Next, test the statistical significance of the difference between group means, commonly using a *Wilks' lambda*, which produces a *F* ratio that examines statistical significance. The assumption of equality of group dispersion is satisfied, if a nonsignificant *F* is obtained, the analysis stops. However, if a significant one-way MANOVA *F* is obtained, an analysis of variance (ANOVA) is used to determine the influence of the independent variable on each dependent variable (Heiman, 1998).

Tabachnick and Fidell (2007) provided assumptions of a one-way MANOVA including multivariate normality, absence of outliers, and independence of observations. The first assumption of a one-way MANOVA is multivariate normality. Multivariate normality assumes that all of the independent variables must be distributed normally, any

linear combination of the dependent variables must be distributed normally, and any subsets of the variables must have a multivariate normal distribution (Tabachnick & Fidell). The second assumption of a one-way MANOVA is the absence of outliers. A one-way MANOVA is sensitive to outliers and outliers should be assessed to prevent either Type I or Type II errors (Tabachnick & Fidell). A third assumption of one-way MANOVA is the independence of observations. The participants' scores should not be influenced by or related to the scores of other participants (Tabachnick & Fidell).

Salkind (2007) supported the use of one-way MANOVA instead of multiple ANOVAs or multiple *t*-tests. The author suggested that measuring several dependent variables instead of one dependent variable increases the chance to determine what factor causes change. Another reason to use a one-way MANOVA instead of multiple ANOVAs or multiple *t*-tests involve reducing a Type I error due to multiple testing. Lastly, another reason to use a one-way MANOVA relates to finding significance that was not detectable in using a single ANOVA or *t*-test.

The following tables illustrate the level of measurement for the three dependent variables of compassion satisfaction, burnout, and secondary traumatic stress. All of these dependent (sub-scales) were measured on the interval level of measurement.

Table 5: Independent Variables, Level of Measurement, and Proposed Statistical Analysis with Each Dependent Variable

Independent Variable	Level of Measurement	Statistical Analysis
Educational Level	Nominal	One-Way MANOVA
Gender	Nominal	One-Way MANOVA
Geographic Location	Nominal	One-Way MANOVA
Self-Care	Nominal	One-Way MANOVA
Years of Experience	Nominal	One-Way MANOVA

Table 6: Dependent Variables and Level of Measurement

Dependent Variables	
Compassion Satisfaction	Interval
Burnout	Interval
Secondary Traumatic Stress	Interval

Chapter Summary

In conclusion, this study examined the Professional Quality of Life (ProQOL) (Stamm, 2009) of counselors from one of the U.S. Gulf States, specifically Mississippi. A demographic questionnaire and the ProQOL (Stamm) instrument were used to assess these counselors. Data analyses included the use of one-way multivariate analysis of variance (MANOVA). Chapter Four discusses the results from the data analyses. Chapter Five presents a discussion of the results, implications for counseling and counselor education, and recommendations for future research.

Chapter 4

Results

Chapter Introduction

Chapter Four presents a description of responses to a cross-sectional research study and statistical analyses of survey data. Self-reports provided the analyzed data from Mississippi counselors who attended a state counseling conference. The chapter provides descriptive data focusing on demographic information about these participants. In addition, the chapter includes statistical analyses to explore research questions related to the Professional Quality of Life (ProQOL) (Stamm, 2009) of counselors in one state of the U. S. Gulf Region, specifically Mississippi. The organization of this chapter includes the following sections: chapter introduction, data entry and analyses, participants, description of the findings, overall results, and chapter summary. The following research questions focused the study:

1. What are the counselors' Professional Quality of Life (ProQOL) (Stamm, 2009) sub-scales of compassion satisfaction, burnout, and secondary traumatic stress scores from Mississippi, one state in the U.S. Gulf Region, and how are these scores distributed across respondents?
2. What are the differences among the Professional Quality of Life (ProQOL) (Stamm, 2009) sub-scales of compassion satisfaction, burnout, and secondary traumatic stress scores on each participant characteristic of educational level, gender, geographic location, self-care methods, and years of experience?

The purpose of the present exploratory research study is to explore the attitudes and characteristics of counselors in the U. S. Gulf State of Mississippi to obtain valuable information about the Professional Quality of Life (ProQOL) (Stamm, 2009) of counselors. The Professional Quality of Life (Stamm) scores of counselors participating in a state counseling conference provided insight into the provision of counseling services in a unique environment recovering from multiple traumatic events such as hurricanes Katrina, Rita, Ike, and Gustav (Walsh, 2010), the Great Recession (Conant, 2010), and the largest ecological disaster in the history of the United States, the BP Oil Spill (Gray, 2010). Previous chapters presented the rationale of this study, the review of the literature, and the study's methodology. The results from this quantitative study will be presented in this chapter.

Data Entry and Analyses

The researcher entered survey responses into a computerized database file and analyzed them using the Statistical Package for the Social Sciences (SPSS) version 17. Data were checked for errors. Descriptive statistics were computed on all survey instrument items, and open-ended comment responses were excluded from statistical analyses. Descriptive statistics including frequencies and percentages provided a profile for all item responses.

Participants

On November 3-5, 2010, the researcher attended the 60th Annual Mississippi Counseling Association Conference conducted in Jackson, Mississippi. The researcher obtained an exhibit booth to disseminate and collect survey packets from the 801

conference attendees. Five hundred fifty-eight survey packets were distributed and 282 participants completed them. The return rate for this study was 50.5%. According to Creswell (2005), the response rate is calculated by dividing the number of completed surveys (282) by the number of participants contacted (558) equaling .505 multiplied by 100 to determine the response rate of 50.5%. A high response rate ensures the survey results are representative of the survey population (Salkind, 2000).

A response rate of 70% or higher is acceptable to ensure that the sample is representative of the population (Johnson & Christensen, 2012). However, a high response rate does not ensure a true representation of the population because of biases in the sample (Johnson & Christensen). Reportedly, the type of people who participate in the study may be different from the type of people who did not participate in the study.

Those who completed the survey packet comprised the final sample of 282. The survey packet consisted of an informed consent and two self-report instruments. The study used an instrument adapted from the Individual Information Form (Sweeney, Hohenshil, & Fortune, 2002) (See Appendix A) to collect demographic information. This study also used the Professional Quality of Life (Stamm, 2009) as a second instrument (See Appendix A). Participants completing the survey packet received a raffle ticket to participate in drawings for one of five $50 Wal-Mart gift cards. Participants could withdraw from the study at any time without penalty and without a loss of benefits.

Demographic Information

The first instrument from the survey packet provided demographic information about the participants. Participants provided information regarding age, gender,

ethnicity, educational level, certification, licensure, work setting, work location, use of technology, years of employment, satisfaction, planned departure from the profession of counseling, experience with a traumatic event, and self-care methods. Lastly, participants identified the specific Mississippi Region that they considered as home.

The following table provides the demographic information related to the participants' age, ethnicity, educational level, educational training, certification, and licensure. Ninety-six participants (34%) reported their age as 30-40. The majority of the participants identified themselves as female; 243 participants (86.2 %). Additionally, the majority of participants, 48.6 % identified themselves as Caucasian. Other ethnicities represented included African American 48.2%, Asian 2.1%, and Hispanic .7%. One hundred and seventy-four participants (61.7%) reported the completion of a Master's degree, while 58 participants (20.6%) reported a Specialist's degree, and 30 participants (10.6%) reported the completion of a doctoral degree. In regard to educational training, 162 participants (54.5%) reported educational training from a Council for Accreditation of Counseling and Related Educational Programs (CACREP) program, 49 participants (16.4%) reported educational training from a psychology program and other participants listed training from programs not listed on the survey such as marriage and family therapy and theology. Lastly, 11 participants (3.7%) reported educational training from a social work program. In regard to certification, 105 participants (37.2%) reported they held a National Certified Counselor (NCC) certification. Forty participants (14.1%) reported certification as a trauma counselor. Lastly, 95 participants (33.6%) reported no certification, while 75 participants (26.5%) reported another type of certification not

listed on the survey. Nineteen participants reported to hold a national certification as a school counselor and three participants reported certification as mental health therapist. Additional certifications included eye movement desensitization and reprocessing certification (EMDR), assessment, and critical incident stress management (CISM). In regard to licensure, 205 participants (72.7%) reported to hold a counseling license, while, 54 participants (19.1 %) reported no license. Additionally, participants reported licenses from other disciplines such as social work and psychology. Four participants (1.4%) reported a social work license, six participants (2.1%) reported a psychology license, and 16 participants (5.6%) reported holding a license in another field not identified on the survey such as teaching.

Table 7: Demographic Information

Characteristic	**N**	**%**
AGE		
20-30	36	12.8
30-40	96	34.0
40-50	64	22.7
50-60	61	21.6
60+	25	8.9
GENDER		
Female	243	86.2
Male	39	13.8
ETHNICITY		
African-American	136	48.2
Asian	6	2.1
Caucasian	137	48.6
Hispanic	2	.7
EDUCATIONAL LEVEL		
2 Year and Bachelors degree	16	5.7
Masters degree	174	61.7
Specialists degree	58	20.6
Doctorate degree	30	10.6
EDUCATIONAL TRAINING		
CACREP Program	162	54.5
Social Work Program	11	3.7
Psychology Program	49	16.4
Other	75	25.2
CERTIFICATION		
NCC	105	37.2
Trauma Counselor	40	14.1
None	95	33.6
Other	75	26.5
LICENSURE		
Counseling	205	72.6
Social Work	4	1.4
Psychology	6	2.1
None	54	18.9
Other	16	5.6

The following table provides the demographic information related to the participants' work settings, work locations, the use of technology, years of experience, planned departure from the counseling field, and the experience of a traumatic event. One-hundred eighty three participants (62.6%) reported K-12 schools as a work setting, 41 participants (14.1%) reported university work settings, 26 participants (8.9%) reported state/federal agency work settings, and 25 participants (8.5%) reported private practice as their work setting. The reminder of participants included 8 participants (2.7%) who reported in-patient hospitals as a working setting. Lastly, 9 participants (3.0 %) reported a residential work setting. The majority of participants reported a rural work location, 151 participants (53.6%). Meanwhile, 79 participants (28%) worked in an urban work location and 42 participants (14.9%) reported working in a suburban work environment. In regard to the use of technology, 271 participants (96.1%) reported the work related use of technology, while 11 participants (3.9%) reported no work related use of technology. The majority of participants reported 1-10 years of counseling experience (42.6%), 92 participants (32.6%) reported 10-20 years of counseling experience, and 28 participants (9.9%) reported less than one year of counseling experience. Thirty-six participants (12.8%) noted more than 20 years of experience. In regard to a planned departure from the counseling profession, 241 participants (85.5%) did not plan to leave the counseling field, while 35 participants (12.4%) reported a planned departure from the counseling field. Furthermore, 143 participants (50.7%) had personally experienced a traumatic event, while 130 participants (46.1%) reported no personal experience with a traumatic event.

Table 8: Demographic Information

Characteristic	N	%
WORK SETTING		
College/University	41	14.0
Agency State/Federal	26	8.9
School K-12	183	62.6
In-Patient Hospital	8	2.7
Residential Setting	9	3.0
Private Practice	25	8.5
WORK LOCATION		
Urban	79	28
Suburban	42	14.9
Rural	151	53.6
USE OF TECHNOLOGY		
Yes	271	96.1
No	11	3.9
YEARS OF EXPERIENCE		
<1 year	28	9.9
1-10Years	120	42.6
10-20	92	32.6
20+ Years	36	12.8
PLANNED DEPARTURE		
Yes	35	12.4
No	241	85.5
PERSONAL EXPERIENCE WITH TRAUMA		
Yes	143	50.7
No	130	46.1

The following table contains the information related to Mississippi regions, self-care methods, and satisfaction. The participants provided the following regarding Mississippi regions. The majority of participants, 156 participants (55.3%) identified Region 2 Central Mississippi as their residence. Region 2 Central Mississippi includes cities such as Jackson and Meridian, Mississippi. Fifty-nine participants (20.9%) reported Region 3 as home. Region 3 identified as South Mississippi includes cities such as McComb and Hattiesburg, Mississippi. Fifty-one participants (18.1%) reported Region 1

as home; Region 1 North Mississippi contains cities such as Tupelo and Oxford, Mississippi. Lastly, 16 participants (5.7%) recognized Region 4 as home. Region 4 was identified as the Mississippi Gulf Coast containing cities such as Gulfport and Biloxi, Mississippi. In regard to self-care, 165 participants (58.5%) selected the self-care method of socializing, 149 participants (52.8%) selected exercise/yoga as a method of self-care, 93 participants (32.9%) reported meditation as a method of self-care, 68 participants (24.1 %) identified personal counseling as a method of self-care, 42 participants (14.8%) identified another type of self-care not listed on the survey such as fishing, shopping, and prayer, meanwhile 3 participants (1.0%) reported the use of no self-care methods. The majority of the participants 131 (46.5%) rated their satisfaction level as satisfied by noting a four out of a five point scale, 83 participants (29.4%) reported a very satisfied level by reporting satisfaction as five out of five, while 38 participants (13.5%) reported a neutral satisfaction rating, and 23 participants (8.2%) reported dissatisfaction with their current job. Two participants (.7%) reported a very dissatisfied rating.

Table 9: Demographic Information on Participants

Characteristic	N	%
MISSISSIPPI REGION		
Region 1 North MS	51	18.1
Region 2 Central MS	156	55.3
Region 3 South MS	59	20.9
Region 4 Gulf Coast	16	5.7
SELF-CARE METHODS		
Exercise/Yoga	149	52.4
Meditation	93	32.9
Counseling	68	23.4
Socialization	165	57.8
Supervision	28	9.9
Other	42	14.1
SATISFACTION		
Very Satisfied	83	29.4
Satisfied	131	46.5
Neutral	38	13.5
Dissatisfied	23	8.2
Very Dissatisfied	2	.7

Results of Open-Ended Survey Items

The participants provided an abundance of descriptive data including responses to open-ended survey items related to reasons for leaving the counseling field and comments related to the ability of participants to support survivors of trauma. The following summary includes data and direct statements obtained from participants' survey packets regarding reasons for leaving the counseling field and comments about supporting survivors of trauma.

Reasons for leaving the counseling field. Item #14 asked "Do you plan to leave the counseling field? Provide a reason." In response, nine participants (3.1%) reported retirement for a reason for leaving the counseling profession. Eight participants (2.8%)

reported pursuing an advance degree such as “educational administration, clinical psychology, or psychometrics” as a reason for leaving the counseling profession. Six participants (2.1%) reported the “emotional drain, being tired, and lack of fulfillment” as reasons to leave the counseling field. Two participants (.7%) reported challenges with school counseling as a reason for leaving the counseling field. For example, “Counseling in the educational (K-12) setting is very difficult due to differing perceptions of how counselors should be used effectively”; “leaving if educational counseling does not change” and “school counselors rarely provide counseling services to students.”

Comments related to the support of trauma survivors. Item #18 asked to “Please, report any comments related to your ability to support survivors of trauma (including disasters).” Twenty-four participants (8.5%) reported training as a factor in their ability to support survivors of trauma. For example, “Ten years of mental health counseling that included crisis counseling, participated in Red Cross Disaster Training”, “Have additional training in working with children who have experienced natural disasters” and “I was trained in eye movement desensitization and reprocessing (EMDR) after Hurricane Katrina.”

Twenty-two participants (7.8%) reported personal experience or job related experiences influenced their ability to support survivors of trauma. For example, “After going through Katrina in New Orleans, I became a reintegration counselor for evacuees in Mississippi.” “I believe I have compassion to help others through traumatic events along with the skills to help someone through it. When I experienced personal trauma I began to understand more and feel my counseling become better because I better

understood the depth of pain and loss from a traumatic event." "I have been deployed twice and have experience dealing with traumatic situations." "My life has included a car wreck, lost ability to speak due to crushed larynx, had Teflon injected into vocal cords, crushed right ankle, went through Katrina, fibromyalgia, raped at 16. I covered almost every area I see students and counsel for." and "We worked through Katrina. We had a lot of evacuees to enroll in our school."

The previous section reviewed demographic information regarding the counselors from the U.S. Gulf Region who completed a survey packet including a demographic survey and the Professional Quality of Life (ProQOL) (Stamm, 2009), and summarized the results from the demographic survey. The next section will review the statistical analyses used to explore the study's research questions.

Description of the Results

Prior to analysis, the researcher examined educational level, gender, geographic location, self-care methods, and years of experience through the Statistical Package for the Social Sciences (SPSS) version 17 frequency distributions for accuracy of data entry, missing values, and fit between their distributions. The researcher addressed missing values by providing no value. Results of the data analysis for each research question follows.

1. What are the counselors' Professional Quality of Life (ProQOL) (Stamm, 2009) sub-scales of compassion satisfaction, burnout, and secondary traumatic stress scores from Mississippi, one state in the U.S. Gulf Region, and how are these scores distributed across respondents?

Instrumentation

This study used the Professional Quality of Life (ProQOL) (Stamm, 2009) with counselors of the U.S. Gulf State of Mississippi. The survey is a self-report instrument that examines Professional Quality of Life (Stamm) by allowing the respondent to rate experiences. Stamm designed the instrument to measure psychometric properties of compassion fatigue by using a 30-item instrument composed of three subscales: compassion satisfaction, burnout, and secondary traumatic stress. The alpha reliabilities for the scales are the following: compassion satisfaction alpha = .88, burnout alpha= .75, and secondary traumatic stress alpha = .81 (Stamm).

Participants' ProQOL Sub-Scale Scores

Compassion satisfaction. The compassion satisfaction sub-scale measures the gratification produced from effectively completing work. The range of raw scores for the compassion satisfaction sub-scale is a minimum score of 10 and a maximum score of 50. High scores on this scale characterize an increased satisfaction associated with respondents' abilities to provide effective services on the job (Stamm, 2009). The compassion satisfaction subscale mean for the participants in this study was 41.9 (*SD*=5.05). According to the ProQOL (Stamm) manual, a score of 42 or more reflects a high level of compassion satisfaction. If the compassion satisfaction score is below 40, a counselor may find problems with his/her job (Stamm).

Burnout. The burnout sub-scale measures feelings of discouragement and challenges related with the ability of individuals to work. The range of raw scores for the burnout sub-scale is a minimum score of 10 and a maximum score of 50. High scores on

this scale characterize a greater risk for burnout (Stamm, 2009). The burnout sub-scale mean for the participants in this study was 20.5 (*SD*=4.60). According to the ProQOL (Stamm) manual, a score of 22 or less reflects a low level of burnout. A burnout score below 18 reflects positive feelings regarding a counselor's work and his/her ability to be effective (Stamm).

Secondary Traumatic Stress. The secondary traumatic stress sub-scale measures work related indirect exposure to trauma. The range of scores for the secondary traumatic stress sub-scale is a minimum score of 10 and a maximum score of 50. The secondary traumatic stress sub-scale mean was 19.9 (*SD*=4.84). According to the ProQOL (Stamm, 2009) manual, a secondary traumatic stress level of 22 or less reflects a low level of secondary traumatic stress. Individuals with high scores would indicate the exposure to work related trauma and the development of problems as a result of that exposure to the trauma of others (Stamm). However, this study did not indicate a risk for secondary traumatic stress in the sample population.

Raw Scores of the ProQOL Sub-Scales

The rating system of the Professional Quality of Life (ProQOL) (Stamm, 2009) was used to analyze the raw sub-scale mean scores. The Professional Quality of Life (ProQOL) (Stamm) is a self-report instrument that measures compassion fatigue by examining the sub-scales of compassion satisfaction, burnout, and secondary traumatic stress (Stamm) by allowing the respondent to rate experiences. Participants rated each item with the following response 1=Never, 2=Rarely, 3=Sometimes, 4=Often, and 5=Very Often (Stamm). Each subscale mean was compared to the rating system of the

Professional Quality of Life (ProQOL) (Stamm). When compared to the rating system of the instrument, the compassion satisfaction sub-scale mean 41.9 (SD = 5.05) suggested the sample in this study experienced feelings of satisfaction often. The sub-scale mean of 41.9 was divided by 10 (the number of sub-scale items) providing a 4.19. According to the rating system 4 represents often. When compared to the rating system of the instrument, the burnout sub-scale mean 20.5 (SD = 4.60) suggested the sample in this study experienced feelings of burnout rarely. The sub-scale mean of 20.5 was divided by 10 (the number of sub-scale items) providing a 2.05. According to the rating system 2 represents rarely. Lastly, when compared to the rating system of the instrument, the secondary traumatic stress sub-scale mean 19.9 (SD = 4.84) suggested the sample in this study experienced feelings of secondary traumatic stress never to rarely. The sub-scale mean of 19.9 was divided by 10 (the number of sub-scale items) providing a 1.99. According to the rating system 1 represents never and 2 represents rarely. Table 10 summarizes descriptive statistics for the instrument.

Table 10: Descriptive Statistics for ProQOL(Stamm, 2009) sub-scale raw scores

Instrument	Study	
	M	*SD*
ProQOL		
Compassion Satisfaction	41.95	5.05
Burnout	20.58	4.60
Secondary Traumatic Stress	19.99	4.84

Results

The researcher used the Statistical Package for the Social Sciences (SPSS) version 17 one-way MANOVAs for the analyses. According to Tabachnick & Fidell (2007) a one-way multivariate analysis of variance evaluates differences among means for a set of dependent variables, when there are two or more groups of independent variables. One-way MANOVAs highlight mean differences and statistical significant differences among groups. The remaining research question is as follows:

2. What are the differences among the Professional Quality of Life (ProQOL) (Stamm, 2009) sub-scales of compassion satisfaction, burnout, and secondary traumatic stress scores on each participant characteristic of educational level, gender, geographic location, self-care methods, and years of experience?

The researcher performed individual one-way multivariate analysis of variance (MANOVAs) to analyze the data set. One-way MANOVAs examined the main effects of characteristics such as educational level (2 Year or Bachelors degree, Masters degree, Specialists degree, Doctorate degree), gender (male and female), geographic location (Region 1, Region 2, Region 3, Region 4), self-care methods (exercise/yoga, personal counseling, socializing, meditation, supervision, or other methods), and years of experience (less than 1 year, 1-10 years, 10-20 years, and 20+ years) on the Professional Quality of Life (ProQOL) (Stamm, 2009) sub-scale means of compassion satisfaction, burnout, and secondary traumatic stress.

The independent variable of educational level is considered categorical naming four categories of educational level (Coladarci, Cobb, Minium, & Clarke, 2004). The

researcher performed a one-way MANOVA to determine a difference in educational level (2 Year degree or Bachelors degree, Masters degree, Specialists degree, Doctorate degree) on the Professional Quality of Life (ProQOL) (Stamm, 2009) sub-scale means of compassion satisfaction, burnout, and secondary traumatic stress. Using the *Wilks' Lambda*, no significant effect was found $F(9,662) = .788$, $p=628$ (See Appendix D). There was no statistically significant influence of educational level on the ProQOL (Stamm) sub-scale means of compassion satisfaction, burnout, and secondary traumatic stress. Table 11 summarizes educational level and ProQOL (Stamm) sub-scales means.

Table 11: Summarizes educational level and ProQOL (Stamm) sub-scale means

Educational Level	Compassion Satisfaction	Burnout	Secondary Traumatic Stress
2 Year or Bachelors Degree	40.687	22.313	21.625
Masters Degree	41.920	20.402	19.897
Specialists Degree	42.379	20.586	20.483
Doctorate Degree	42.200	20.600	18.967

The independent variable of gender is considered categorical and was coded providing two categories: male and females. The researcher performed a one-way MANOVA to determine a difference in gender (male and female) on the Professional Quality of Life (Professional Quality of Life) (ProQOL) (Stamm, 2009) sub-scale means of compassion satisfaction, burnout, and secondary traumatic stress. Using the *Wilks' Lambda*, a significant difference was found $F(3,278) = 2.690$, $p=.047$. Individual ANOVAs were used to determine which of the sub-scales differed by gender. The results

of the ANOVAs indicated a difference with burnout (p=.006) and secondary traumatic stress (p=.043) but not compassion satisfaction (p=.078) (See Appendix D). Male participants' burnout and secondary traumatic stress scores were significantly less than female participants' burnout and secondary traumatic stress scores. Table 12 summarizes gender and ProQOL (Stamm) sub-scale means.

Table 12: Summarizes gender and ProQOL (Stamm) sub-scale means

Gender	Compassion Satisfaction	Burnout*	Secondary Traumatic Stress*
Male	43.282	18.718	18.538
Female	41.745	20.889	20.230

*$p<.05$

The independent variable of geographic location is considered categorical and coded to name four regions of the state of Mississippi. For example, 1= North Mississippi, 2= Central Mississippi, 3= South Mississippi, and 4= Mississippi Gulf Coast. A one-way MANOVA was performed to determine a difference in geographic location (North Mississippi, Central Mississippi, South Mississippi, and the Mississippi Gulf Coast) on the Professional Quality of Life (ProQOL) (Stamm, 2009) sub-scale means of compassion satisfaction, burnout, and secondary traumatic stress. Using the *Wilks' Lambda*, no significant effect was found $F(9, 671) = .799$, $p=.618$ (See Appendix D). There was no statistically significant influence of geographic location on the sub-scale means of compassion satisfaction, burnout, and secondary traumatic stress. Table 13 summarizes geographic location and ProQOL (Stamm) sub-scale means.

Table 13: Summarizes geographic location and ProQOL (Stamm) sub-scale means

Geographical Location	Compassion Satisfaction	Burnout	Secondary Traumatic Stress
North Mississippi	41.137	21.529	20.627
Central Mississippi	42.128	20.436	20.013
South Mississippi	42.254	20.576	19.593
Mississippi Gulf Coast	41.813	19.125	19.313

The independent variable of self-care is considered categorical data and coded to group categories of self-care methods. For example, 1= exercise/yoga, 2= meditation, 3=personal counseling, 4=socializing, 5= supervision, and 6=other. A one-way MANOVA was performed to determine differences of self-care methods (exercise/yoga, meditation, personal counseling, socializing, supervision, or other self-care methods) on the Professional Quality of Life (ProQOL) (Stamm, 2009) sub-scale means of compassion satisfaction, burnout, and secondary traumatic stress. Using the *Wilks' Lambda*, no statistically significant difference was found $F(3,276) = 1.584$, $p = .193$ (See Appendix D). There was no statistically significant influence of self-care methods on the sub-scale means of compassion satisfaction, burnout, and secondary traumatic stress. Table 14 summarizes self-care methods and ProQOL (Stamm) sub-scale means.

Table 14: Summarizes self-care methods and ProQOL (Stamm) sub-scale means

Self-Care Methods	Compassion Satisfaction	Burnout	Secondary Traumatic Stress
Exercise	41.953	20.318	19.858
Meditation	42.022	20.591	20.656
Counseling	42.258	20.939	20.758
Socialization	41.773	20.871	20.215
Supervision	41.071	20.607	19.643
Other methods of self-care	42.200	19.750	19.425

The independent variable of years of experience was considered categorical and coded to reflect categories of vocational experience (Coladarci, Cobb, Minium, & Clarke, 2004). A one-way MANOVA was performed to determine differences in years of experience (less than one year, 1-10 years, 10-20 years, and more than 20 years) on the Professional Quality of Life (ProQOL) (Stamm, 2009) sub-scale means of compassion satisfaction, burnout, and secondary traumatic stress. Using the *Wilks' Lambda*, a significant effect was found $F(9,657) = 2.504$, $p = .008$. Individual ANOVAs indicated a difference in years of experience on the compassion satisfaction subscale $p=.046$ and the burnout subscale $p < .001$. No significant difference was found on the secondary traumatic stress subscale $p=.221$ (See Appendix D). Participants with 1-10 years of experience recorded statistically significant higher burnout scores and lower compassion satisfaction scores than individuals with less than one year of experience, 10-20 years,

and more than 20 years of experience. Table 15 summarizes years of experience and ProQOL (Stamm) sub-scales means.

Table 15: Summarizes years of experience and ProQOL (Stamm) sub-scale means

Years of Experience	Compassion Satisfaction*	Burnout*	Secondary Traumatic Stress
Less than 1 Year	43.250	18.714	19.464
1-10 Years	41.000	21.933	20.700
10-20 Years	42.478	20.120	19.457
20+ Years	42.750	19.083	19.472

*$p<.05$

Chapter Summary

The chapter reviewed the scoring of the Professional Quality of Life (ProQOL) (Stamm, 2009) and calculation of the sub-scales of compassion satisfaction, burnout, and secondary traumatic stress (Stamm). The compassion satisfaction subscale mean for the participants in this study was 41.9 (*SD*=5.05). A score of 42 or more reflects a high level of compassion satisfaction (Stamm). The burnout sub-scale mean for the participants in this study was 20.5 (*SD*=4.60). A score of 22 or less reflects a low level of burnout. The secondary traumatic stress sub-scale mean was 19.9 (*SD*=4.84). A secondary traumatic stress level of 22 or less reflects a low level of secondary traumatic stress.

In addition, the rating system of the Professional Quality of Life (ProQOL) (Stamm, 2009) was used to analyze the raw sub-scale mean scores. The sub-scale mean of 41.9 was divided by 10 (the number of sub-scale items) providing a 4.19 when compared to the rating system of the instrument, this sub-scale mean suggested the sample experienced feelings of satisfaction often. The sub-scale mean of 20.5 was

divided by 10 (the number of sub-scale items) providing a 2.05, when compared to the rating system of the instrument, this sub-scale mean suggested the sample experienced feelings of burnout rarely. The sub-scale mean of 19.9 was divided by 10 (the number of sub-scale items) providing a 1.99 when compared to the rating system of the instrument, this sub-scale mean suggested the sample experienced feelings of secondary traumatic stress never to rarely.

This chapter discussed results of the quantitative analyses. The analyses of this study examined the main effect of counselor characteristics such as educational level (2 Year or Bachelors degree, Masters degree, Specialists degree, Doctorate degree), gender (male and female), geographic location (Region 1, Region 2, Region 3, Region 4), self-care methods (exercise/yoga, meditation, personal counseling, socializing, supervision, or other), and years of experience (less than 1 year, 1-10 years, 10-20 years, and more than 20 years) on the Professional Quality of Life (ProQOL) (Stamm, 2009) sub-scale means of compassion satisfaction, burnout, and secondary traumatic stress.

Two significant differences were found. The researcher found significant gender differences on the Professional Quality of Life (ProQOL) (Stamm, 2009) sub-scale means of burnout and secondary traumatic stress. Male participants' burnout and secondary traumatic stress scores were significantly less than female participants' burnout and secondary traumatic stress scores. Also, the researcher found statistically significant differences in years of experience on the Professional Quality of Life (ProQOL) (Stamm) sub-scale means of compassion satisfaction and burnout. Participants with 1-10 years of experience recorded statistically significant higher burnout scores and lower compassion

satisfaction scores than participants with less than one year of experience, 10-20 years of experience, and more than 20 years of experience. Using the *Wilks' Lambda*, no statistically significant influence was found among educational level, geographic location, and self-care methods on the Professional Quality of Life (ProQOL) (Stamm) sub-scale means of compassion satisfaction, burnout, and secondary traumatic stress. A discussion of the results of this study will be presented in Chapter Five.

Chapter 5

Discussion and Implications

Chapter Five reviews the study's methodology, participants, and instruments. In addition, the chapter presents discussion, implications, conclusion, and recommendations for this quantitative exploratory research study.

Summary of Current Study

This research study explored the attitudes and characteristics of counselors in the U. S. Gulf State of Mississippi to obtain valuable information about the Professional Quality of Life (ProQOL) (Stamm, 2009) of counselors. The Professional Quality of Life (Stamm) scores of Mississippi counselors who participated in a state counseling conference provided insight into the provision of counseling services in a unique environment recovering from multiple traumatic events such as hurricanes Katrina, Rita, Ike, and Gustav (Walsh, 2010), the Great Recession (Conant, 2010), and the largest ecological disaster in the history of the United States, the BP Oil Spill (Gray, 2010).

Methodology

The present study used a cross-sectional survey research design. In cross-sectional research, either the entire population or a subset is selected to be studied at one point in time. Quantitative data are collected from these individuals to learn about the respondents and describe their attitudes and characteristics. The data are statistically analyzed and delineate patterns related to the responses to survey items to provide evidence to support research questions (Creswell, 2005). The dependent variables in this study included the Professional Quality of Life (ProQOL) (Stamm, 2009) sub-scale

scores of compassion satisfaction, burnout, and secondary traumatic stress. The independent variables in this study included participants' gender, geographic location, education, years of experience, and self-care methods.

Participants

Participants for this quantitative research study were 282 conference attendees of the 60th Annual Mississippi Counseling Association. The researcher obtained an exhibit booth to disseminate and collect survey packets from 801 conference attendees. Five hundred fifty-eight survey packets were disseminated; 282 individuals returned the completed survey packet producing a 50.5% return rate for this study.

A response rate of 70% or higher is acceptable to ensure that the sample is representative of the population. As a result of sample biases, a high response rate does not ensure a true representation of the population (Johnson & Christensen, 2012). For example, the willingness to participate in this study may differentiate participants from nonparticipants.

U.S. Gulf Region counselors attending a state counseling conference provided the following descriptive information through self-reported survey data. The majority of participants (34%) reported the average age of 30 - 40. The majority of the participants (86.2%) were females. Most of the participants reported their ethnicity as Caucasian (48.6%) or African American (48.2%). The majority of the participants (92.9%) reported their educational level at the Masters degree or higher.

In regard to geographic location, the majority of participants (55.3%) identified Region 2 Central Mississippi as their home. Region 2 includes cities such as Jackson and

Meridian, Mississippi. Jackson, Mississippi is the state capital and most populated city in Mississippi with an estimated population of 625,000 residents. The majority of participants (42.6%) reported 10 - 20 years of experience in the counseling field. In regard to the use of self-care methods, the majority of participants (57.8%) reported the use of socialization as their preferred method of self-care followed by exercise/yoga (52.5%).

Data Collection: Instruments

This study used two self-report instruments to gather data described in detail in Chapter Four. The study adapted the first instrument from the Individual Information Form (Sweeney, Hohenshil, & Fortune, 2002) (See Appendix A) to collect demographic information. The researcher used an 18 item survey to gather demographic information. Demographic information related to age, gender, race, education, training, licensure, certification, career planning, years of experience, use of technology, use of self-care methods, geographic location, and comments relating to the support of survivors of trauma was collected through a demographic survey. Information about gender, geographic location, educational level, years of service and self-care represented independent variables in this study.

This study also used the Professional Quality of Life (Stamm, 2009) as a second instrument (See Appendix A). Stamm (2009) designed the instrument to measure psychometric properties of compassion fatigue by using a 30-item instrument composed of three sub-scales: compassion satisfaction, burnout, and secondary traumatic stress.

Discussion

The previous section provided a summary of the present research study. This section includes, major findings, the Professional Quality of Life (Stamm, 2009) of Mississippi counselors, and the differences of the participant characteristics and ProQOL (Stamm) sub-scale scores. In addition, a discussion of the findings related to the participant characteristics of educational level, gender, geographic location, self-care methods, and years of experience on the ProQOL (Stamm) sub-scale scores of compassion satisfaction, burnout, and secondary traumatic stress are presented.

Major Findings

This study used the professional quality of life (ProQOL) theory as a theoretical framework (Stamm, 2009). The professional quality of life theory underscores the value of the helping experience by integrating positive and negative concepts. Essentially, the theory analyzes the comprehensive impact of helping including the therapeutic factor of altruism. Overall, the findings of this study provide a perspective on the quality of life of helpers in Mississippi. Despite the impact of ecological, environmental, psychological, and financial hardship on the counselors of the U. S. Gulf Region, these counselors recorded high compassion satisfaction scores and low burnout and low secondary traumatic stress scores.

Professional Quality of Life (ProQOL) (Stamm, 2009) of Mississippi Counselors

The researcher used the rating system of the Professional Quality of Life (ProQOL) (Stamm, 2009) to interpret the sub-scale raw scores of the participants' in this study and found high scores of compassion satisfaction and low scores of burnout and

secondary traumatic stress with this group of counselors. The Professional Quality of Life (ProQOL) (Stamm) is a self-report instrument that measures compassion fatigue and compassion satisfaction by examining compassion satisfaction, burnout, and secondary traumatic stress (Stamm). Participants rated each item with the following response 1=Never, 2=Rarely, 3=Sometimes, 4=Often, and 5=Very Often (Stamm). Each subscale mean was compared to the rating system of the Professional Quality of Life (ProQOL) (Stamm). When compared to the rating system of the instrument, the compassion satisfaction sub-scale mean 41.9 (SD = 5.05) suggested the sample in this study experienced feelings of satisfaction often. The sub-scale mean of 41.9 was divided by 10 (the number of sub-scale items) providing a 4.19. According to the rating system 4 represents often. When compared to the rating system of the instrument, the burnout sub-scale mean 20.5 (SD = 4.60) suggested the sample in this study experienced feelings of burnout rarely. The sub-scale mean of 20.5 was divided by 10 (the number of sub-scale items) providing a 2.05. According to the rating system 2 represents rarely. Lastly, when compared to the rating system of the instrument, the secondary traumatic stress sub-scale mean 19.9 (SD = 4.84) suggested the sample in this study experienced feelings of secondary traumatic stress never to rarely. The sub-scale mean of 19.9 was divided by 10 (the number of sub-scale items) providing a 1.99. According to the rating system 1 represents never and 2 represents rarely.

Overall, the participants in this study reported high compassion satisfaction, low burnout and low secondary traumatic stress scores. According to the ProQOL manual (Stamm, 2009), there are three conclusions we may draw for individuals with the sub-

scale scores similar to the participants of this study. First, these sub-scale scores suggested the most positive results (Stamm). Secondly, these results suggested that participants were individuals who obtained positive work related feedback. They have no noteworthy concerns regarding feelings leading to ineffectiveness at work. Typically, these individuals have no significant fears related to work (Stamm). Lastly, the individuals who score in this range benefit from continuing education opportunities and professional development (Stamm).

Supporting the findings were participants responses to item #13 "Overall, how satisfied are you with your present position?" Participants used a 5 point Likert scale to rate their satisfaction 1=very dissatisfied, 2=dissatisfied, 3=neutral, 4=satisfied, 5=very satisfied. According to this measurement of satisfaction, the majority of participants 214 (75.9%) reported levels of satisfaction with their jobs as satisfied (4) or very satisfied (5). These results further strengthened the findings of this study that despite the recovery from multiple traumatic events such as hurricanes Katrina, Rita, Ike, and Gustav (Walsh, 2010), the Great Recession (Conant, 2010), and the largest ecological disaster in the history of the United States, the BP Oil Spill (Gray, 2010) the counselors of the U.S. Gulf State of Mississippi who attended the state counseling conference and participated in this research study recorded strong levels of satisfaction with their work.

The previous section reviewed the discussion of the study's methodology, participants, instruments, and results. In addition, this section included a review of central findings of this research study. The next section will review the findings related to the

influence of counselor characteristics on the ProQOL (Stamm, 2009) sub-scale means of compassions satisfaction, burnout, and secondary traumatic stress.

Participant Characteristics on ProQOL (Stamm, 2009) Scores

The findings provided from the statistical analyses and results are summarized in this section. The influence of each participant characteristic of educational level, gender, geographic location, self-care methods, and years of experience on the ProQOL (Stamm, 2009) sub-scale scores are discussed in terms of related literature.

The present findings failed to support a significant difference of participants' characteristics of educational level (2 Year or Bachelors degree, Masters degree, Specialists degree, Doctorate degree), geographic location (Region 1, Region 2, Region 3, Region 4), and self-care methods (exercise/yoga, meditation, personal counseling, socializing, supervision, or other methods) on the dependent variables the Professional Quality of Life (ProQOL) (Stamm, 2009) sub-scale mean scores of compassion satisfaction, burnout, and secondary traumatic stress.

The findings of the study included two significant differences with the participants' characteristics of gender (male and female) and years of experience (less than 1 year, 1-10 years, 10-20 years, and more than 20 years). Significant differences were found among gender and the Professional Quality of Life (ProQOL) (Stamm, 2009) sub-scale means of burnout and secondary traumatic stress. Male participants' burnout and secondary traumatic stress scores were significantly less than female participants' burnout and secondary traumatic stress scores. Also, significant differences were found among years of experience with the Professional Quality of Life (ProQOL) (Stamm) sub-

scale means of compassion satisfaction and burnout. Participants with 1-10 years of experience recorded significantly higher burnout scores and lower compassion satisfaction scores than participants with less than one year of experience, 10-20 years of experience, and more than 20 years of experience.

Educational level. Unlike previous studies (Abu-Bader, 2000; Spang et al., 2007), this study revealed no significant interaction with educational levels (2 Year or Bachelors degree, Masters degree, Specialists degree, Doctorate degree) on the ProQOL sub-scales of compassion satisfaction, burnout, and secondary traumatic stress. One explanation for this finding is that the researcher failed to adequately gather information regarding participants who identified their educational level as Two Year or Bachelors degree. This category may include the responses of graduate level counseling students prior to graduation as well as mental health agency case managers.

The researcher noted this group of participants (Two Year or Bachelors degree) recorded higher means on the burnout and secondary traumatic stress sub-scales than participants with a Masters degree, Specialists degree, or Doctorate degree. Additionally, participants who reported Two Year or Bachelors degree educational level recorded lower compassion satisfaction scores than participants with a Masters degree, Specialists degree, and Doctorate degree. Although this difference is not statistically significant, these findings are consistent with previous research that suggested higher educational levels reduced compassion fatigue and related conditions such as burnout, secondary traumatic stress, and vicarious traumatization (Sprang, 2007). For example, some research (Abu-Bader, 2000; Sprang et al.,) suggested education influences conditions

such as compassion fatigue and increase compassion satisfaction. One explanation for this inconsistency regarding educational level may be linked to the acquisition of education is a developmental process, because collectively individuals age while acquiring education. Previous research (Adams, Matto, & Harrington, 2001; Nelson-Gardell & Harris, 2003) postulated that as age increased the risk of developing conditions such as compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization decreased.

Gender. A review of literature regarding gender and compassion fatigue and related terms such as burnout, secondary traumatic stress, and vicarious traumatization reflected conflicted findings. Sprang et al. (2007) utilized the Professional Quality of Life (ProQOL) (Stamm, 2009) to assess compassion fatigue in 1,121 rural mental health professionals and found a gender difference with a higher risk of compassion fatigue and burnout for females. However, the Professional Quality of Life (ProQOL) (Stamm, 2009) manual reports no statistical differences observed across the gender demographic in the official data bank.

Consistent with previous research (Brady et al., 1999; Sprang et al. 2007), this study revealed a significant difference among gender on the Professional Quality of Life (ProQOL) (Stamm, 2009) sub-scale means of burnout and secondary traumatic stress. Male participants' burnout and secondary traumatic stress sub-scale scores were significantly less than female participants' burnout and secondary traumatic stress sub-scale scores. Another statistically significant difference between male and female

participants' compassion satisfaction scores may have been detected with a larger sample size, given the sub-scale compassion satisfaction *p* value of .078.

There are several reasons to carefully interpret these findings related to gender. First, the literature noting gender differences in research suggested the use of cautious interpretation for reasons relating to social context (Yonder & Kahn, 2003), theoretical world views (Hare-Mustin & Marecek, 1988), and gender dominated occupations (Bryant & Constantine, 2006; Reskin, 1988). For a number of years, authors encouraged researchers to include social context within the interpretation of gender differences in research (Yonder & Kahn). Yonder and Kahn conducted a literature review examining gender differences in psychological literature and found that many researchers failed to discuss the gender differences found in their research.

Another reason for thoughtful interpretation of these findings relate to the theoretical perspective of the two world views of alpha bias versus beta bias (Hare-Mustin & Marecek, 1988). These two flawed and vastly different theoretical world views present two polarizing positions. Alpha bias depicts large gender differences and beta bias depicts minimal differences (Hare-Mustin & Marecek). The primary differences of these worldviews relate to their implications, alpha bias ignores intra-group differences suggesting that men and women operate differently ignoring social context and promote male superiority and female inferiority. In contrast, beta bias minimizes gender differences supporting identical treatment (Hare-Mustin & Marecek). Additionally, these two world views fail to account for biological and sociological factors (Yonder & Kahn, 2003), researchers should carefully consider how gender differences will be interpreted.

Lastly, careful interpretation of the gender differences in this study relates to very distinctive experiences of men and women within the same occupation. Some occupations reported more representation from one gender than another, such as the military employing more males than females and the teaching profession employs more female than males. According to Reskin (1988) the practice of considering identical social context for men and women within a gender-skewed occupation is unsound. Several researchers (Bryant & Constantine, 2006; Reskin) identified the helping field as a gender–skewed occupation, employing more female than male helpers. For example, this study sample provided a small number of male participants (n= 39) 13.8%. Therefore, careful interpretations of these statistically significant findings are suggested.

Geographic location. The concept of geographic location represented a gap in the compassion fatigue literature. No literature related to compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization addressed the influence of geographic location on counselors. For example, counselors who are closer to the devastated areas may have higher levels of conditions such as compassion fatigue, burnout, secondary traumatic stress, or vicarious traumatization. Based on limited data, the researcher speculated that geographic location may be linked to compassion fatigue. In support of this belief, one of the participants from the Region 4, Mississippi Gulf Coast disclosed "I was working in community mental health when Hurricane Katrina hit. Less than two years later I transferred from mental health into school counseling." This statement suggested that the participant transferred from mental health counseling to

school counseling as a result of the demands related to the community recovering from the effects of Hurricane Katrina.

The present findings failed to provide evidence to support this speculation that geographic location provided a significant influence on the ProQOL (Stamm, 2009) sub-scales of compassion satisfaction, burnout, and secondary traumatic stress. Although these differences were not statistically significant, this study's participants from the Mississippi Gulf Coast recorded lower burnout scores and secondary traumatic stress scores than participants from north Mississippi, central Mississippi, and south Mississippi. Given the small number of participants from the Mississippi Gulf Coast (n=16) 5.7% of the entire sample, the researcher carefully interprets these findings.

An explanation for this finding may relate to factors related to stress. As previously reviewed in Chapter Two, while most of the literature presented the negative aspects or risk related to the concept of stress, not all scholars agreed with this assessment. In contrast, Pines (2004) reported that stress may not contribute to burnout and its related conditions of compassion fatigue, burnout, secondary traumatic stress, or vicarious traumatization. In fact, some helpers may thrive in a stressful environment that provides meaningful work (Pines).

Another reason for these lower burnout and secondary traumatic stress scores for the counselors of Region 4, the Mississippi Gulf Coast may relate to the Professional Quality of Life (ProQOL) (Stamm, 2009) theory. According to the Professional Quality of Life (ProQOL) theory negative and positive aspects of helping contribute to the development of altruism in helpers. In addition, the theory acknowledges that work

environments may influence the development of satisfaction. For example, a helper feels fulfillment for the assistance they provided, in spite of the devastating conditions of the work environment.

Most theories associated with disasters and traumatic events tend to discuss risk factors for the clients such as poverty (Anan, 1999; Curtis, Mills, & Leitner, 2007; Kahn, 2005), minorities (Anan; Curtis, Mills, & Leitner; Kahn), and gender (Curtis, Mills, & Leitner). Geography stress theory (Foster, 1979) used geography literature to postulate a geographical influence related to stress. Most of the authors studying this theory reported that geography increases risk to disasters and catastrophic events. Former United Nations Secretary General Annan reported a correlation with poverty and exposure to natural disasters. For example, limited resources influenced individuals' choices to live in hazard areas such as flood zones, earthquake fault lines, and over populated areas. Curtis, Mills, and Leitner studied the geography of Hurricanes Katrina and Rita and suggested that poverty, minority status, and gender influenced exposure to these hurricanes. Kahn studied economics and reported national resources, geographic location, and monetary resources represented three factors influencing the devastation of a catastrophic event. However, few studies have addressed the influence of geography on the helper.

Another idea that supports this finding relates to a reduction of the proximity between helpers and victims. Ayalon (2006) conducted research with post-tsunami helpers and acknowledged that during the provision of emergency services following a catastrophic event the neutral place created between helper and client can be eliminated.

This boundary was necessary for the helper to maintain a healthy balance. According to Ayalon, the removal of this boundary placed the helper in the same circle of vulnerability and circle of support as the clients. The concept of the circle of support may be the explanation for this research finding regarding low burnout and low secondary traumatic stress scores recorded from the Mississippi Gulf Coast counselors.

Self-care methods. Self-care methods reduce stress and burnout in counselors by addressing personal and professional growth (Newsome, Christopher, Dahlen, & Christopher, 2006). For example, yoga, meditation, or journaling are mindfulness activities practiced by counselors to reduce stress and burnout in counselors by addressing personal and professional growth (Newsome et al.). Several researchers (Bober et al., 2006; Bicknell-Hentges & Lynch, 2009; Killian, 2008; Pfifferling & Gilley, 2000) conducted studies related to the use of self-care to reduce or prevent conditions such as compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization.

The present findings failed to support a significant influence of self-care methods on the Professional Quality of Life (ProQOL) (Stamm, 2009) sub-scales of compassion satisfaction, burnout, and secondary traumatic stress. Although these differences were not statistically significant, participants who reported the use of an alternative self-care method recorded lower burnout scores and lower secondary traumatic stress scores than participants who used methods such as exercise/yoga, meditation, personal counseling, socializing, and supervision. However, the researcher failed to identify the specific types of alternative self-care methods. Some participants voluntarily identified these

alternative self-care methods as fishing, shopping, and praying. Given the lack of identification of these alternative self-care methods careful interpretation is suggested. In support of this finding, researchers (Hesse, 2002; Ortlepp & Friedman, 2002; Regehr & Cadell, 1999) postulated the acquisition of support systems and the development of outside interests were essential components for successful self-care methods and the reduction of compassion fatigue and related conditions.

Years of experience. A review of literature regarding years of experience and compassion fatigue and related terms such as burnout, secondary traumatic stress, and vicarious traumatization resulted in conflicting findings. The Professional Quality of Life (ProQOL) (Stamm, 2009) manual reported unpublished studies that contributed to the official data bank illustrated differences based on years of experience. The ProQOL manual suggested that more years in the field is related to lower scores (Stamm). Stamm postulated that individuals with increased exposure and low resiliency left the field, while those who remained were resilient. In contrast, the Professional Quality of Life (ProQOL) (Stamm, 2009) manual reports no statistical differences were observed across years of experience in the official data bank.

Consistent with previous research (Arvay 2001; Cunningham, 2004; Dunkley & Whelan, 2006; Flannelly et al., 2005; Pearlman & MacIan, 1995), this research study revealed a significant difference between years of experience on the Professional Quality of Life (ProQOL) (Stamm, 2009) sub-scale means of compassion satisfaction and burnout. Participants with 1-10 years of experience recorded statistically significant higher burnout scores and lower compassion satisfaction scores than participants with

less than one year of experience, 10-20 years of experience, and more than 20 years of experience. Additionally, while this finding was not statistically significant, this group of participants with 1-10 years of experience recorded higher secondary traumatic stress scores than participants with less than one year of experience, 10-20 years of experience, and more than 20 years of experience. Future studies should explore the years of experience and Professional Quality of Life (ProQOL) (Stamm, 2009) sub-scales of compassion satisfaction, burnout, and secondary traumatic stress.

One explanation for this finding relates to the positive psychology concept of happiness at work (Pryce-Jones, 2010). Happiness at work is defined as a mindset to make the best use of your resources to overcome challenges. Actively enjoying the highs and managing the lows will help to increase your overall performance (Pryce-Jones, 2010). Another possible explanation for this finding, may relate to the concept of resiliency. Glicken (2006) identified resiliency as a justification related to how some people cope with trauma better than others. Resiliency has been identified as the capacity to successfully adapt, positively function, or provide competence despite high risk, chronic stress, or prolonged exposure to severe trauma (Henry, 1999 p. 521). While most of the literature related to resiliency is connected to the client, some literature has linked the concept of resiliency to counselors. Wicks (2008) suggested that the development of resiliency is needed for the sustainability of clinicians and encouraged the use of methods such as self-care plans. Next the limitations of this research study will be discussed.

Limitations of the Study

There are several limitations of the present study. The findings of this study should be considered along with the limitations. Participants may have been predisposed to view their jobs as counselors in a positive light. First, participants were limited to those who remained in the counseling field after working in a state beset by trauma, in contrast to those who left the field during that period of time. Second, participants were those who attended a state professional conference, participation traditionally seen as an act of professional development, reinforcing their commitment to their work. A third, limitation was the small number of males participating in the study. However, this representation depicted an actual gender difference existing within the counseling field. The helping fields employ more females than males (Bryant & Constantine, 2006; Reskin, 1988). Despite this limitation, this study's results should be taken seriously since they confirm a statistically significant gender difference on the Professional Quality of Life (ProQOL) (Stamm, 2009) sub-scale means of burnout and secondary traumatic stress. Gender may influence the development of conditions such as compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization.

A fourth limitation of this study was the exclusive use of self-report data. Through the use of self-reporting data, participants may provide misleading responses to items on the demographic survey and the Professional Quality of Life (ProQOL) (Stamm, 2009) through intentional deception or lack of insight. In this research study, participants' self-reports were not verified through the use of observations or interviews. Additionally, the researcher conducted no interviews with supervisors and clients to

gather corroborating information. The researcher conducted no follow-up data collection beyond the completion of the demographic survey and the Professional Quality of Life (ProQOL) (Stamm). Future research should expand beyond the exclusive usage of self-report data to include methods such as follow-up interviews.

Lastly, this study maintained several characteristics of cross-sectional research. A cross-sectional study uses a snapshot method offering a short time span to conduct research with a low dropout rate. Also, this study design provided no evidence of change or direction of change in participants (Salkind, 2000). The next section reviews the implications of this study.

Implications

Previous sections reviewed the study's methodology, participants, instruments, and discussion. This section reviews the implications of this research study in three areas. The results of this study provide viable implications for the counseling practice, counselor education, and future research.

Counseling Practice

This section includes a discussion of quantitative findings related to the counseling practice. The study participants included practicing counselors who provide counseling supports in a variety of settings such as schools and universities, private and public mental health agencies, and private practice. The significant findings related to gender and years of experience. In addition, implications related to advocacy, self-awareness, and self-care methods are discussed.

Advocacy. This research examined the Professional Quality of Life (Stamm, 2009) of counselors in an environment recovering from multiple traumatic events. An additional implication for the counseling field relates to the role of advocacy and social justice for counselors providing services in similar environments and therefore are susceptible for the development of compassion fatigue and related conditions. Bryant and Constantine (2006) encouraged a commitment to advocacy and social justice by seeking out professional relationships with other professionals from different areas of the helping fields to increase dialogue, reduce competition, and create support. Additionally, organizations can organize and coordinate meeting places and times to conduct brown-bag sessions to cultivate partnerships (Bryant & Constantine, 2006) and contribute to the overall well being of the helpers who participate in these sessions. Next, counseling practice implications related to gender will be discussed.

Gender. Primarily, the quantitative findings of this study have implications for practicing counselors related to gender. Gender appeared to represent an important factor to explore for practicing counselors. Current research reflects the role of gender in a gender-skewed occupation (Bryant & Constantine, 2006; Reskin, 1988). This study supported the findings of Lee, Cho, Kissinger, and Ogle (2010) indicating counselors should be aware of the possible factors associated with the development of conditions related to compassion fatigue. As indicated in this study, females are more at risk than males. The researcher advises agencies and organizations to educate and monitor factors related to the development of compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization for prevention. The researcher supports prevention focus on

both male and female counselors. A balanced interpretation of research findings still need to be considered, especially in light of factors such as social context (Yonder & Kahn, 2003), gender theories (Hare-Mustin & Marecek, 1988), and gender-skewed occupations (Bryant & Constantine, 2006; Reskin, 1988). Next, counseling practice implications related to self-awareness will be discussed.

Self-Awareness. Counselors could benefit from knowing potential factors that contribute to the development of compassion fatigue because awareness can reveal individual and environmental factors (Lee et al., 2010). The continuing education of counselors regarding risk factors is important because this information may increase counselor self-awareness regarding the susceptibility to develop compassion fatigue and related conditions. Also, the early acknowledgement of factors such as compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization is helpful for healthy counselor development (Cunningham, 2004). The next section will review counseling practice implications related to self-care methods.

Self-Care Methods. Self-care methods contribute to the sustainability of counselors. Numerous individuals are attracted to the counseling field, but many are unable to maintain longevity without good self-care skills (Young, 2009). Good self-care skills are related to effective helping (Wicks, 2008; Young, 2009). Self-care methods are typically used by practicing counselors, as illustrated by the participants of this study. It is worthy to note, that only 1% (n=3) of the participants of this study reported no use of self-care methods. Surprisingly, this research found that participants reported the use of alternative self-care methods such as fishing, shopping, and praying. According to

Courtois (1999), the development of personal and professional outlets are essential to maintain physical and mental health to obtain relief from the intensive and rewarding work of supporting people. In addition, self-care activities are expanding to include more diverse activities in addition to traditional self-care methods such as exercise/yoga, meditation, counseling, socialization, and supervision. The participants in this study listed a variety of self-care activities. Organizations should encourage and provide information about a variety of self-care methods for the benefit and success of counselors. The next section reviews counseling practice implications related to years of experience.

Years of Experience. Lastly, the quantitative findings of this study provided implications for counseling professionals with 1-10 years of experience. One to ten years of experience suggest another salient factor for counselors. Current counselors should be aware of the important factors associated with the development of conditions related to compassion fatigue (Lee et al., 2010). Many helpers experience a vocational journey leading from novice to expert (Skovholt & Ronnestad, 1995). Skovholt, Grier, and Hanson (2001) examined counselor development and reported an optimal professional development that took many years to acquire. According to Skovholt and Ronnestad, the progression from novice insecurity to expert competency can be an arduous and laborious path.

Individual counselors and counseling organizations should monitor this period in counselor development to focus on the needs of new counselors and expert counselors. Skovholt et al. suggested areas that new counselors may need assistance with as

insufficient supervision or mentoring, unrealistic expectations, questions regarding legal and ethical issues, and performance anxiety. While, expert counselors may be stressed by uncommitted clients, urgent life issues compromising their professional roles, and cases that challenge their competency. Regardless of their point in development, all of these helpers need additional support and oversight from the agencies and organizations that employ them to prevent the development of compassion fatigue and related conditions.

In conclusion, this section presented implications for the counseling practice. The researcher reviewed findings salient to the counseling practice related to compassion fatigue related to advocacy, gender, self-awareness, self-care, and years of experience. The next section will review implications for counselor educators.

Counselor Education

The counselor education implication section includes a discussion of quantitative findings related to counselor education. Primarily, these implications relate to self-awareness, self-care, and wellness. In addition, implications related to the practical usage of self-awareness, self-care, and wellness are discussed.

The quantitative analyses of this study provided implications for counselor education programs. As previously stated in Chapter Two, counselor training programs have an ethical responsibility to fully prepare counselors-in-training. In preventing the development of conditions such as compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization, it is important for counseling programs to emphasize self-awareness and self-care and develop counseling program cultures that value these concepts (Everall & Paulson, 2004). Current counselors-in-training may one day support

survivors of trauma or provide services in an area recovering from multiple traumatic events, therefore the following implications for counselor educators relating to self-awareness, self-care, and wellness are important.

Self-Awareness. Counseling programs should introduce and underscore the importance of self-awareness in counseling programs because self-care methods have been linked to the reduction of concepts such as compassion fatigue (Bober et al., 2006; Bicknell-Hentges & Lynch, 2009; Killian, 2008; Pfifferling & Gilley, 2000). Bicknell-Hentges and Lynch (2009) reported that using self-awareness to know one's tendencies as a counselor may minimize the development of compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization.

There are many methods counselor educators can incorporate material related to compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization into the classroom. Counselor educators should provide counselors-in-training with in-depth discussions about the history and current understanding of conditions such as compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization (Campbell, 2007). Cunningham (2004) recommended the use of case vignettes, simulations, and role play to present educational and training material in the safety of the classroom to prepare students for future challenges. Additionally, it maybe beneficial to use assessments such as the Professional Quality of Life (ProQOL) (Stamm, 2009) with students to offer an individual measurement of conditions such as compassion fatigue and compassion satisfaction for student learning. Also, developing an individual profile

could be used to discover contributing factors of conditions related to compassion fatigue (Lee, 2010).

Furthermore, counselor educators can reinforce self-awareness concepts by introducing possible risk factors associated with the conditions such as compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization. According to Buchanan et al. (2006) counselors who have been previously exposed to trauma are more likely to develop symptoms related to compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization (Buchanan et al.). Thus, students who have a history of trauma may benefit from classroom instruction that provides prevention methods in the classroom. The purpose of this type of instruction is related to the education and training of counselors who support survivors of trauma and help students understanding and manage reactions to trauma (Sommer, 2008) by providing assurance. Counselors-in-training should acknowledge their previous history and note the impact of any history related to trauma. This current study reported that 143 participants (50.7%) reported a previous experience with a traumatic event.

It is important to apply the findings of this present research study to the counselor education field because many counselor training programs influence the practice of counseling through education, training, mentoring, and through the practice of gate keeping. As stated in Chapter Two, counselor educators should teach students to be aware of the factors associated with compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization so students increase their consciousness about these topics (Zellmer, 2005). Counselors-in-training are likely to support trauma survivors;

therefore it is important for these future counselors to be educated about factors associated with the support of trauma survivors (Bolnik & Brock, 2005). Next, counselor education self-care implications will be discussed.

Self-Care. It is worthy to note, the findings of this research study reflected healthy counselors who reported high compassion satisfaction, low burnout, and low secondary traumatic stress scores. In addition, a very small number of these participants 3 (1.0%) reported no use of self-care methods. Counselor educators have the opportunity to explore the use of self-care methods for future counselors. In addition to exploring self-care methods, it is important that counselors-in-training can take a first step to introducing, developing, and implementing self-care methods. Counselor educators can further develop concepts such as self-care plans (Wicks, 2008). These plans are similar to the type of treatment plans devised with clients for effective measuring and monitoring. Counselor self-care is essential to the counseling field.

As stated in Chapter Two, the review of literature documented the vulnerability of counselors, especially those helping individuals in trauma, to develop compassion fatigue. It is important for counseling students to understand the factors identified in the literature that may increase susceptibility for the development of compassion satisfaction, burnout, secondary traumatic stress, and vicarious traumatization, while these students are in the supported educational environment. Next, the implications related to counselor education and wellness will be discussed.

Wellness. Counselor educators should include wellness related course work in their courses and help students demonstrate the elements of a wellness lifestyle. Wellness is defined as

> A way of life oriented toward optimal health and well being, in which mind, body, and spirit are integrated by the individual to live life more fully within the human and natural community. Ideally, it is the optimum state of health and well being that each individual is capable of achieving. (Myers, Sweeney, & Witmer, 2000, p. 252)

The wellness of counselors should be considered on six domains. According to O'Halloran and Linton (2000) counselors could benefit from the development of career and personal wellness plans emphasizing balance in the areas of vocation, physical, spiritual, social, emotional, and cognition. It is critical for counselor education programs to model and demonstrate the use of wellness concepts for students. Counseling students should be aware of the potential impact that wellness may have on their ability to support others (Sexton, 1999). The first crucial step begins with self-awareness. Many counselors with conditions such as compassion fatigue ignore warning signs and place themselves and clients at-risk by creating ethical dilemmas.

In conclusion, this section presented implications for counselor educators. The researcher reviewed counselor education implications related to self-awareness, self-care, and wellness to educate counselors-in-training about conditions such as compassion fatigue. The next section will review implications for future research.

Future Research

This quantitative research study findings provided several implications for future research studies. Primarily, the findings of this present research study identified gender, geographic location, and years of experience as salient factors. The findings encourage further investigation of these factors within counseling research.

Future research should consider the replication of this research study. The replication of this research study can increase the validity and reliability of the results (Rosenthal, 1990). Field (2006) reported that replication can decide the generaliziability of variables and further examine research results. For example, this current research study could be replicated by conducting this research study in another U.S. Gulf State of Texas, Louisiana, Alabama, or Florida.

Gender. Within the quantitative analyses of this study, the researcher found significant gender differences on the Professional Quality of Life (ProQOL) (Stamm, 2009) sub-scale means of burnout and secondary traumatic stress. As a result of the conflicting findings regarding empirical research that examined gender roles, in the development of conditions such as compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization, future research is recommended. Factors related to social context (Yonder & Kahn, 2003), theoretical world views (Hare-Mustin & Marecek, 1988), and gender dominated occupations (Bryant & Constantine, 2006; Reskin, 1988) should be considered in the development of future research studies. Also, it is suggested that future research use alternative research methods and designs such as mixed methods and longitudinal research studies that will examine development and measure changes in

participants. In addition, these future research studies should consider sampling methods to increase the number of male participants to better understand this subset of counselors and their experience of compassion fatigue, burnout, and secondary traumatic stress to expand the compassion fatigue knowledge base (Bryant & Constantine; Reskin).

Geographic location. As previously stated, the researcher identified a gap in the literature related to geographic location. As previously stated in Chapter Two, no literature related to compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization addressed the influence of geographic location on counselors. For example, counselors who are closer to the devastated areas may have higher compassion fatigue. While the researcher reported a statement from one of the participants regarding a vocational change from mental health counseling to school counseling following her involvement from Hurricane Katrina. The quantitative analyses suggested counselors who identified their home as Region 4, the Mississippi Gulf Coast reported higher, though not significant, compassion satisfaction and lower burnout and secondary traumatic stress than counselors from Region 1 (North Mississippi), Region 2 (Central Mississippi), and Region 3 (South Mississippi). Region 4 (Mississippi Gulf Coast) counselors were geographically closer to the multiple traumatic events including the ecological, environmental, psychological, and financial hardship than in counselors in the remaining regions. Additional research could further explore counselors in geographic locations impacted by multiple traumatic events.

Years of Experience. The researcher found statistically significant differences in years of experience on the Professional Quality of Life (ProQOL) (Stamm) sub-scale

means of compassion satisfaction and burnout. Existing literature reported conflicts in the findings of empirical research regarding years of experience. Future research could explore differences with years of experience and the development of conditions such as compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization by using developmental research methods such as longitudinal or follow-up studies (Salkind, 2000). Longitudinal research designs could be used to assess changes (Salkind) in counselor development focusing on counselors with 1-10 years of experience. Follow-up studies could be used to access participants from prior research to collect additional information and monitor counselors with 1-10 years of experience in counselors who have participated in previous research (Salkind). For example, future research could use a follow-up study with the participants of this research study by recruiting participants at the 2011 Annual Mississippi Counseling Conference and add to these existing findings.

In conclusion, this section presented implications for future research. The researcher reviewed implications related to gender, geographic location, and years of experience. The next section presents the chapter summary.

Chapter Summary

Chapter Five presented a discussion of the findings of this research study. The chapter also included a discussion of the methodology, participants, instruments, limitations, and implications. The conclusion follows with a concluding statement.

Conclusion

This section addresses conclusions that can be drawn from the study. The focus of the conclusion includes a review of the study, including any gaps in the literature, and an exploration of the study findings.

This study allowed a one-time snapshot of characteristics and attitudes of counselors who attended a state counseling conference in Mississippi, a state in the U.S. Gulf Region. The researcher conducted an assessment of the Professional Quality of Life (ProQOL) (Stamm, 2009) of the counselors of the U.S. Gulf Region. Two significant differences were found. The researcher found statistically significant gender differences on the Professional Quality of Life (ProQOL) (Stamm, 2009) sub-scale means of burnout and secondary traumatic stress. Also, the researcher found statistically significant differences in years of experience on the Professional Quality of Life (ProQOL) (Stamm) sub-scale means of compassion satisfaction and burnout. The study failed to support a significant difference of participants' characteristics of educational level (2 Year or Bachelors degree, Masters degree, Specialists degree, Doctorate degree), geographic location (Region 1, Region 2, Region 3, Region 4), and self-care methods (exercise/yoga, meditation, personal counseling, socializing, supervision, or other methods) on the Professional Quality of Life (ProQOL) (Stamm, 2009) sub-scale mean scores of compassion satisfaction, burnout, and secondary traumatic stress.

Essentially, this research provided an exploratory assessment of counselors from the U.S. Gulf Region, specifically Mississippi counselors finding measures of satisfaction with their work. In contrast to assumptions related to the ecological, environmental,

psychological, and financial hardship present in this region, satisfaction was found in counselors who serve this region. The researcher found that despite the impact of these multiple traumatic events these counselors were satisfied with their work.

A review of literature indicated that the concept of geographic location related to a gap in the literature of compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization. No literature related to compassion fatigue and related terms addressed the influence that geographic location may have on counselors. The results of the statistical analyses of this study failed to support a statistically significant influence of geographic location on the Professional Quality of Life (ProQOL) (Stamm, 2009) sub-scales of compassion satisfaction, burnout, and secondary traumatic stress. This researcher recommended future studies to examine the influence of geographic location and the conditions of compassion fatigue, burnout, secondary traumatic stress, and vicarious traumatization. The next section will present a concluding statement.

Concluding Statement

This study represented exploratory research with counselors in a very unique environment to expand the knowledge base about conditions that hinder the efforts of counselors and place them at risk. Essentially, this research study examined the impact of ecological, environmental, psychological, and financial hardship on the counselors in Mississippi, a U.S. Gulf Region state by measuring the Professional Quality of Life (ProQOL) (Stamm, 2009). The researcher concluded that, despite the impact of these multiple traumatic events counselors were satisfied with their work. The researcher confirmed counselor satisfaction using three measures: the comparison of the ProQOL

(Stamm) sub-scales of compassion satisfaction, burnout, and secondary traumatic stress, the interpretation of the raw ProQOL (Stamm) sub-scale scores with the instrument rating system, and the demographic survey satisfaction item.

It is fitting to close this study reiterating a comment from one of the 282 Mississippi counselors who took part this research project. The counselor worked in an environment impacted by multiple traumatic events including hurricanes Katrina, Rita, Ike and Gustav (Walsh, 2010), the Great Recession (Conant, 2010), and the largest ecological disaster in the history of the United States, the BP Oil Spill (Gray, 2010). The counselor disclosed "I believe I have compassion to help others through traumatic events along with the skills to help someone through it. When I experienced personal trauma I began to understand more and feel my counseling become better because I better understood the depth of pain and loss from a traumatic event."

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APPENDICES

The submission of multiple survey packets is prohibited. Please submit one survey packet.

Informed Consent

Principal Investigator: Deirdre Anderson-White
Faculty Advisor: Dr. Marianne Woodside

I. Purpose of this Research Project
The purpose of this research is to explore the experiences of counselors in one of the Gulf States of Louisiana, Mississippi, Alabama, or Florida. Exploring these experiences will provide useful information about compassion fatigue, compassion satisfaction, and burnout

II. Procedures
This study adopts quantitative methodology using a survey packet to explore the experiences of counselors in one of the Gulf States of Louisiana, Mississippi, Alabama, or Florida. The survey will be administered during a state counseling conference. The survey packet should be completed within 10-20 minutes.

III. Risks
The risks of harm anticipated in this proposed research are minimal. There are no physical risks, psychological risks, or sociological risks. As a safeguard, participants are free to withdraw at anytime. The only cost related to the participation in this research study, relates to the time taken to complete the survey instrument.

IV. Benefits
As an incentive, the participants of this study will participate in a drawing for participating in this study. One hour prior to the conclusion of the conference five tickets will be drawn from a raffle box. Five raffle tickets will be drawn for five $50 (Wal-Mart) gift cards.
Benefits of this study include the provision of useful information for counselors and other mental health professionals about factors related to compassion fatigue and burnout. Moreover, the results of this study will contribute to the literature related to compassion fatigue, burnout, and compassion satisfaction.

V. Anonymity and Confidentiality
The confidentiality of each participant will be carefully preserved. To ensure confidentiality, any information obtained from this study will be used for reporting purposes in aggregate form only. No reference will be made in oral or written reports which could link participants to the study

VI. Compensation
As an incentive, the participants of this study will participate in a drawing for participating in this study. One of four Gulf States Counseling Association Conferences will be the site of this study. The states considered and their conference dates are listed: Louisiana (September 19-22, 2010), Mississippi (November 3-6, 2010), Alabama (November 11-13, 2010) and Florida (October, 9-12, 2010). One hour prior to the conclusion of the conference five tickets will be drawn from a raffle box. Five raffle tickets will be drawn for five $50 (Wal-Mart) gift cards.

VII. Emergency Medical Treatment
There are no physical risks related to this research study. Yet, if physical injury is suffered in the course of this research, please notify the principal investigator. The University of Tennessee does not reimburse participants for medical claims automatically.

VIII. Participation
Your participation in this study is voluntary; you may decline to participate without penalty. If you decide to participate, you may withdraw from the study at anytime without penalty and without loss of benefits to which you are otherwise entitled. If you withdraw from the study before data collection is completed, your data will be destroyed.

Participant Initials _____
Date_____

IX. Subject's Responsibilities
I voluntarily agree to participate in this study. I will participate in the completion of a survey packet. I understand that survey responses will be used as the main source of data and will be used for research purposes. In addition, demographic responses will be used as data for purposes of this study. I further understand that any identifiers will be modified to protect confidentiality.

X. Subject's Permission
I have read the above information and hereby agree to participate in this study:

_____ _____
Participant's Signature **Date**

_____ _____
Investigator's Signature **Date**

Should you have any questions about this research project, contact the principal investigator, Deirdre Anderson-White (423) 834-6530. If you have questions about your rights as a participant, contact the Compliance Section of the Office of Research at (865) 974-3466.

Demographic Survey

Please answer each of the following items.

1. What is your age?	__20-30	__30-40	__40-50	__50-60	__60+	
2. Please, indicate your gender?	__Female	__Male				
3. What is your race?	__African American	__Asian	__ Caucasian	__ Hispanic	__ Other:	
4. What is your current degree?	__2 Year Diploma	__Bachelor's	__Master's	__Specialist	__ Doctor's	
5. I am a graduate of which of the following training programs: (Check all that apply)	__CACREP	__Social Work	__Psychology	__Other:		
6. Do you possess any counseling related certificates? (Check all that apply)	__NCC	__Trauma Counselor	__None	__Other:		
7. Do you possess a license in the following fields? (Check all that apply)	__Counseling	__Social Work	__Psychology	__None	__Other:	
8. Check the best description of your work setting:	__ College/University	__ Agency State/Federal	__School K-12	__ In-Patient Hospital	___Residential	__ Private Practice
9. Which best describes your work setting?	__Urban	___Suburban	__Rural			
10. Do you use technology such as computers in your job?	__Yes	__No				
11. How many years have you worked as a helper? (For example, employment in a non-counseling role)	__Less than One Year	__1-5 Years	__5-10 Years	__10-15 Years	__15-20 Years	__20+ Years
12. How many years have you worked as a counselor?	__Less then One Year	__1-5 Years	__5-10 Years	__10-15 Years	__15-20 Years	__20+Years
13. Overall, how satisfied are you with your present position?	__Very Satisfied	__Satisfied	__Neutral	__Dissatisfied	__Very Dissatisfied	
14. Do you plan to leave the counseling field?	__Yes	__No	Reason:			
15. Have you experienced a traumatic event?	__Yes	__No				
16. Please indicate which practice(s) you use for self-care? (Check all that apply)	__Exercise/Yoga	__Meditation	__Personal Counseling	__Socializing	__Supervision	__Other:

17. Please, list the Mississippi Region that you reside: **Region1**___ **Region 2**___**Region 3**____ **Region 4**___

North MS= Region 1
Central MS= Region 2
South MS= Region 3
MS Gulf Coast= Region 4

18. Please, report any comments related to your ability to support survivors of trauma (including disasters).

Adapted from Sweeny, A.P., Hohenshil, T.H., & Fortune, J.C. (2002). Job satisfaction among employee assistance professionals: A national study, Journal of Employment Counseling, 39, 50-60.

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 satisfied 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 loosing 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 that 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.

University of Tennessee
421 Philander P. Claxton Education Bldg.
1122 Volunteer Blvd.
Knoxville, TN 37996
Contact:
Deirdre Anderson-White (423) 834-6530

FIVE --$50 WAL-MART GIFTCARDS WILL BE RAFFLED
PARTICIPANTS ARE ELIGIBLE FOR THE DRAWING
November 3-5 2010
Jackson, MS

The Professional Quality of Life

Participate in an Important Counseling Research Study

Are you a Counselor in the U.S. Gulf Region?

Do you want to share your professional experiences?

If you answered yes, you may be eligible to participate in a research study. The purpose of this research is to explore the experiences of counselors in the U.S. Gulf Region. Exploring these experiences will provide valuable information about the professional quality of life for counselors.

University of Tennessee

The Professional Quality of Life Study

Participate in an Important Counseling Research Study

Are you a Counselor?

Do you want to share your professional counseling experiences?

If you answered yes, you may be eligible to participate in a research study.

The purpose of this research is to explore the experiences of counselors in the U.S. Gulf Region. Exploring these experiences will provide beneficial information about the professional quality of life for counselors.

FIVE--$50 WAL-MART GIFT CARDS WILL BE RAFFLED
Participants are eligible for the drawing
November 3-5, 2010
Jackson, MS

Please call Deirdre Anderson-White at 423-834-6530 for more information

WAL-MARTGIFT CARD RAFFLE TICKET

Name:_____

Address:_____

_____

Telephone Number:_____

DRAWING FOR GIFTCARDS WILL OCCUR November 3-5, 2010

Using the *Wilks' Lambda*, there was no statistically significant influence of educational level on the ProQOL (Stamm) sub-scale means of compassion satisfaction, burnout, and secondary traumatic stress (See Appendix D).

Multivariate Tests[c]

Effect		Value	F	Hypothesis df	Error df	Sig.
Educational Level	Wilks' Lambda	.974	.788	9.000	662.127	.628

Using the *Wilks' Lambda*, a significant difference was found $F(3,278) = 2.690$, $p=.047$. Individual ANOVAs were used to determine which of the sub-scales differed by gender. The results of the ANOVAs indicated a difference with burnout (p=.006) and secondary traumatic stress (p=.043) but not compassion satisfaction (p=.078) (See Appendix D).

Tests of Between-Subjects Effects

Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	F	Sig.
GENDER	Burnout	158.386	1	158.386	7.662	.006
	Secondary Traumatic Stress	96.209	1	96.209	4.141	.043
	Compassion Satisfaction	79.411	1	79.411	3.128	.078

Using the *Wilks' Lambda*, there was no statistically significant influence of geographic location on the ProQOL (Stamm) sub-scale means of compassion satisfaction, burnout, and secondary traumatic stress (See Appendix D).

Multivariate Tests[c]

Effect		Value	F	Hypothesis df	Error df	Sig.
MS Region	Wilks' Lambda	.974	.799	9.000	671.862	.618

Using the *Wilks' Lambda*, there was no statistically significant influence of self-care methods on the ProQOL (Stamm) sub-scale means of compassion satisfaction, burnout, and secondary traumatic stress (See Appendix D).

Multivariate Tests[b]

Effect		Value	F	Hypothesis df	Error df	Sig.
Self-Care	Wilks' Lambda	.983	1.584[a]	3.000	276.000	.193

Using the *Wilks' Lambda*, a significant effect was found $F(9,657) = 2.504$, $p = .008$. Individual ANOVAs indicated a difference in years of experience on the compassion satisfaction subscale $p=.046$ and the burnout subscale $p < .001$. No significant difference was found on the secondary traumatic stress subscale $p=.221$ (See Appendix D).

Tests of Between-Subjects Effects

Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	F	Sig.
YearsCounsel2	Burnout	416.689	3	138.896	7.010	.000
	Secondary Traumatic Stress	104.037	3	34.679	1.478	.221
	Compassion Satisfaction	204.333	3	68.111	2.705	.046

Vita

Deirdre Juanita Anderson-White was born in Centreville, Mississippi. She attended the University of Southern Mississippi, where she received her Bachelor's of Science in Psychology. After working in Mississippi public and private mental health agencies for three years, she returned to school, attending Mississippi State University, where she received her Master's of Science in Vocational Rehabilitation Counseling. Following the completion of her graduate degree, Deirdre was employed as a manager and administrator in private non-profit mental health agencies in Alabama and Tennessee for eight years, before pursuing the Doctorate of Philosophy in Counselor Education in 2006. While completing the doctoral degree, Deirdre served as a graduate research assistant, graduate teaching assistant, and graduate teaching associate. She is receiving a Doctor of Philosophy in Counselor Education with a Specialty in Higher Education Administration. She is presently living with her husband, Henry, in Hinesville, Georgia.