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THE EFFECTS OF RESILIENCY TRAINING ON SELF-REPORTED COMPASSION FATIGUE AND COMPASSION SATISFACTION IN MENTAL HEALTH PROFESSIONALS AND COUNSELORS-IN-TRAINING

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FATIGUE AND COMPASSION SATISFACTION IN MENTAL HEALTH PROFESSIONALS

AND COUNSELORS-IN-TRAINING

By

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Abstract

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The Effects of Resiliency Training on Self-Reported Compassion Fatigue and Compassion Satisfaction in Mental Health Professionals and Counselors-In-Training

Chairperson: Veronica Johnson

Compassion fatigue (CF) is a pervasive problem in all caring professions, including counseling. The combination of secondary traumatic stress (STS) and burnout (BO) can lead to an overabundance of negative symptoms decreasing both professional and personal quality of life, perhaps resulting in career attrition. However, this does not have to be the case. CF experiences have been shown to be malleable to interventions like those offered through the Accelerated Recovery Program (ARP) and subsequent resiliency workshops. While yielding non-statistically significant results, this quasi-experimental control time series design found support for the reduction of self-reported CF in the short term and increased compassion satisfaction (CS) for mental health professionals and counselors-in-training who participated in the intervention. The significance of this study is the yielding of valuable longitudinal information about CF to help thwart symptoms before they become problematic. Furthermore, counselor educators can employ the information gained in this study as they seek to prepare their students to be competent and resilient counselors.

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CHAPTER ONE: INTRODUCTION

Facilitating hope, well-being and health are some of the primary jobs of mental health professionals. Counselors, specifically, often choose to enter the profession out of a deep longing to help make a positive impact in others' lives. These caring professionals are metaphorical candles, offering light (i.e. hope, healing, etc.) for those who find themselves stuck in pain and darkness. Such positive aspects of a counseling career are freely discussed and often praised by society. However, there is another, darker side to the job of helping that is seldom revealed. Frankl (1959) warns of the danger of helping when he states, "That which is to give light must endure burning" (p.129). Frankl suggests that helping comes at a price. Figley (1995), a pioneer in studying the phenomenon of wounded healers, succinctly agrees, "There is a cost to caring" (p. 1). Sitting with others who are hurting is demanding work that can take a toll on the helper.

The emotional pain associated with counseling and other helping professions has been a problem for as long as there have been healers. This pain has become known in the literature by several designations (Turgoose & Maddox, 2017): countertransference (Figley, 1995; Ponton & Sauerheber, 2014; Rothschild, 2006), burnout (Fruedenberger, 1974; Maslach & Goldberg, 1998), secondary traumatic stress (Figley, 1995; Stamm, 1999), vicarious traumatization (Saakvitne & Pearlman, 1996), empathy fatigue (Stebnicki, 2007), and compassion fatigue (Figley, 1995). For the purposes of this study, compassion fatigue (Figley, 1995) will be utilized to embody the cost of caring.

Compassion fatigue (CF) can exhibit itself through an assortment of physical, psychological and emotional, spiritual and professional symptoms (Figley, 1995; Figley, 1999; Figley, 2002; Gentry et al., 2002; Turgoose & Maddox, 2017). Physical symptoms include

fatigue, difficulty sleeping, feeling ill, and heightened autonomic nervous system arousal (Figley, 1995; Gentry et al., 2002; Merriman, 2015). Psychological and emotional symptoms of CF are thought to be inclusive of increased cynicism and pessimism, intrusive thoughts or images about client material, nightmares, startle responses, decreased sense of safety, decreased trust, loss of interest and/or enjoyment in activities, avoidance of reminders of client materials, loss of intimacy, irritability, anger, decreased empathy, hopelessness, as well as flat or depressed mood (Figley, 1995; Gentry et al., 2002; Mathieu, 2012; Merriman, 2015). Gentry and Monson (2017) describe a loss of connection to spiritual or religious beliefs and practices to be an integral part of CF symptomology. Loss of confidence, decreased work-related performance and productivity, diminished communication skills, disruption of frame of reference, lack of work satisfaction, as well as wanting to quit one's job or questioning career choices are all aspects of how CF symptoms can show up professionally (Figley, 1995; Gentry et al., 2002, Gentry & Monson, 2017; Merriman, 2015). Symptoms of CF can manifest in a diminished work and life balance.

CF takes a toll on professionals and systems alike. Burnout (BO), an element of CF, and CF are predictors for turnover intention, absenteeism, and career attrition in caring professions (Deary, Watson, & Hogston, 2003; Greenham, Harris, Hollett, & Harris, 2019; Potter, Pion, & Gentry, 2015; Rank, Zaparanick & Gentry, 2009; Volpe et al., 2014). Other negative outcomes of CF include: decreased work performance, an increase of work-related mistakes, decreased patient and staff satisfaction, substance abuse problems, depersonalization and poor coworker support (Potter et al., 2015). Ultimately, the complex convergence of CF symptoms often has global and devastating consequences for an individual, their relationships, their career as well as for the organizations in which they work.

CF is widespread. Gentry, Baranowsky and Dunning (2002) proclaim that the majority of professional caregivers suffer from CF at a minimum of one point during their career. Mathieu (2012) estimates lifetime occurrence rates to be as high as 40% to 85%. In their study, Lyndall and Bicknell (2001) reported that 46% of participating counselors exhibited moderate levels of CF. Correspondingly, a sample of 106 counselors reported moderate levels of CF in a different study (Sheehy Carmel & Friedlander, 2009). In both of these studies, novice counselors appeared to be at greater risk of CF (Lyndall & Bicknell, 2001; Sheehy Carmel & Friedlander, 2009). Similarly, Siebert (2006) studied the prevalence rates of burnout and CF among social workers and found a lifetime rate of 75% further suggesting the pervasiveness of this problem. CF affects those in the mental health profession as well as professionals in the medical, education, nonhuman caring professionals, law enforcement and clerical fields (Figley, 1995; Rank et al., 2009). Turgoose and Maddox (2017) reported finding CF literature for nurses, physicians, social workers, chaplains, and emergency professionals.

Interacting with people who are suffering as well as exposure to traumatic material, either primary or secondary in nature, are at the core of developing CF. CF can result from compassionate and energetic care for those who have experienced trauma (Potter et al., 2015). This empathic witnessing of others' trauma can result in an activated sympathetic nervous system causing a series of cognitive and physiological reactions (Craigie et al., 2016; Figley, 2002). If not adaptively managed, these cognitive and physiological changes can ultimately manifest net negative emotional and physical symptoms of CF (Craigie et al., 2016; Figley, 2002). Additionally, organizational factors or work environment conditions are also recognized as part of the development of CF (Thompson et al., 2014).

Further, Rothschild (2006) suggests that "emotions are contagious" (p. 9). Interacting in close proximity with people who are experiencing strong emotion(s), which is inherent in mental health professions, can make one susceptible to "catch" that same emotion (Rothschild, 2006; Gentry & Monson, 2017) like catching a cold or flu virus. The phenomenon applies to all emotions (Rothschild, 2006). Rothschild explains,

> as helping professionals, our emotions are also vulnerable to provocation through infection with our clients' feelings. Sometimes this is an advantage, helping us to feel inside their worlds. At other times, it is not advantageous to be infected by a client's state (2006, p. 10).

Empathy, in particular, can be a double-edged sword. It is a powerful change agent in counseling (Rogers, 1957; Lambert & Cattani-Thompson, 1996; Sommers-Flanagan, 2015) and empathy also places us at risk for experiencing the darker aspects of the profession (Figley, 1999; Rothschild, 2006; Stamm, 1999; Turgoose & Maddox, 2017). Given the importance of empathic understanding in counseling relationships as well as the capacity for CF to reduce empathy in the provider, further understanding of CF, and how to fight the "emotional contagion" is deemed imperative (Gentry & Monson, 2017; Turgoose & Maddox, 2017).

Generally speaking, most people who gravitate to caring professions are comfortable with and often identify with supportive roles. This altruistic attribute commonly serves them well. However, this very character trait can hinder those same individuals from seeking support when they are the ones hurting because of their work. Gentry et al. (2002) elaborate on this unique challenge associated with CF: "fear of judgment, reprisal, or ridicule; fear of exposing oneself; illusions of omnipotence and difficulty trusting other professionals seem to contribute to the silencing response and often prevent us from reaching out for the help we need" (p. 125). This

"silencing response," the unconscious avoidance of work-related emotional pain, precipitates the problem (Baranowsky, 2002). In theory, helpers are supposed to offer hope, healing and support to others; they are not supposed to experience hurt and pain. Yet, inevitably, they do. Avoidance of traumatic material is a natural visceral response. Other common responses to such emotional pain in caregivers are to hide, bury, or feel shame; making it harder and harder to seek support. Remen dispels this powerful myth: "The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet" (1996, p. 52).

A common predictive factor for CF is one's personal exposure to trauma (Killian, 2008; Turgoose & Maddox, 2017). For mental health professionals, higher CF scores appear to be related to experiences of personal trauma (Deighton, Gurris, & Traue, 2007; Killian, 2008; MacRitchie & Leibowitz, 2010; Nelson-Gardell & Harris, 2003; Rossi, Cetrano, Pertile, Rabbi, Donisi, Grigoletti, & Amaddeo, 2012, Thomas & Otis, 2010). Primary exposure to trauma coupled with exposure to their clients' traumatic material create fertile breeding grounds for STS and CF. As such, adverse child experiences (ACE) scores could serve as a predictor of a CF.

The blend of risk factors, including empathy, exposure to traumatic material, high prevalence rates, and the silencing response, culminate in making CF perplexing and problematic for counselors and counselors-in-training (CITs) in particular. Figley (1995) describes CF as a natural side effect of engaging in empathic work, like counseling. Yet, developing CF symptoms and suffering in silence does not have to be an inevitable cost of empathic work. We as counselors and CITs can be proactive about healing from CF and even preventing such symptoms from taking root in the first place (Gentry, Baranowsky & Dunning, 1997; Gentry et al., 2002; Gentry & Monson, 2017).

Statement of the Problem

Despite the uptick in the interest of CF in the last several decades (Figley, 2002; Stamm, 1999), gaps and limitations within CF literature still remain. Merriman (2011) and Turgoose and Maddox (2017) report that a majority of CF studies simply report prevalence rates and/or risk factors of CF. The majority of the studies that they examined rarely included comparison groups and were largely cross-sectional in nature (Craigie et al., 2016; Turgoose & Maddox, 2017). Similarly, there are few studies that examine CF in CITs and new professionals (Craig & Sprang, 2010; Merriman, 2011), few longitudinal CF studies (Turgoose & Maddox, 2017), and few studies that include preventative models for reducing CF (Alkema, Linton, & Davies, 2008; Figley, 1995, 2002; Gentry, 2002; Merriman, 2011; Rank et al., 2009; Sprang, Clark & Whitt-Woosley, 2007). Data gained from this study fills these CF literature gaps.

The emotional pain of sitting with others who are hurting deserves to be honored and acknowledged. The more CF is talked about, the less power "the silencing response" has and the less entrenched CF symptoms become. Discourse about self-care, a phrase used to talk about attending to one's own needs, in isolation from other areas that help facilitate more global well-being and resiliency is insufficient for equipping counselors to be resilient professionals (Gentry et al., 1997; Gentry et al., 2002). There is a need to offer specific preparation through trainings, workshops as well as discussions embedded within supervision and consultation and other courses to help thwart counselors' chances of developing CF symptoms throughout the course of their careers. Workshops, like the Accelerated Recovery Program (ARP), have been shown to reduce and prevent CF symptoms for a multitude of helping professionals (Baranowsky, Gentry, & Baggerly, 2005; Craigie et al., 2016; Flarity et al., 2013; Flarity et al., 2016; Flarity et al., 2016b; Gentry, Baggerly, & Baranowsky, 2004; Gentry, 2002; Potter et al., 2015; Rank et al.,

2009). Using the foundations of the ARP workshops specifically for professional counselors and CITs could produce similar results. Many authors (Alkema et al., 2008; Craig & Sprang, 2010; Figley, 1995; Merriman, 2011, 2015; Musa & Hamid, 2008; Thompson et al., 2014; Turgoose & Maddox, 2017) assert the importance of providing CITs with psychoeducation about CF as well as supplying them with knowledge and skills to combat symptomology. Figley (1995) believes that it is imperative that CITs and new professionals be warned that they are at risk of developing CF symptomology. He emphasizes that,

> We as practicing professionals have a special obligation to our students and trainees to prepare them for these hazards. A place to start is to incorporate stress, burnout, and compassion fatigue into our curriculum, and especially our supervision in practica (Figley, 1995, p. 17).

In summation, emotional well-being is essential for counselors and CITs. Equipping counseling students with resiliency skills and encouraging reflection on experiences with CF is essential for their development and ultimate success in the counseling field. A well-rounded approach to wellness in counselor training programs should include CF education and prevention (Merriman, 2011, 2015). CF education and prevention is a necessary component for preparing CITs to sit empathically with clients day after day and not become "infected" with their clients' emotions.

Purpose of the Study

The purpose of this quasi-experimental control time series design study was to assess how participation in resiliency training affects mental health professionals' and CITs' self-reported rating of CF over time. Collecting data over time assisted in understanding the longitudinal prevalence of CF symptoms in mental health professionals and CITs as well as

understanding how the resiliency training impacts CF symptoms over time. Currently, the lack of longitudinal studies about CF and related constructs is a gap in the literature (Turgoose & Maddox, 2017). By using longitudinal data, this study yields valuable information about CF, and can help inform treatment and prevention efforts. A richer understanding of CF and how it manifests over time should ultimately assist clinicians in learning how to manage and eliminate CF indicators before symptoms become problematic. The results of this study are used to corroborate the need for and impact of resiliency training interventions within counselor education programs. Through this research, the following research question was posed.

Research Question

Research Question:

How does participating in resiliency training affect self-reported STS, BO and CS scores (as measured by the Pro-QOL) over time?

Hypothesis:

Participants in the resiliency training will report significantly lower STS, BO symptoms and higher CS scores over time as compared to participants who did not participate in the resiliency training (control group).

Null Hypothesis:

There will be no difference in self-reported STS, BO or CS scores over time between the experimental and control groups.

Definition of Terms

There are several key terms that appear in this study. The definitions of such terms, as well as the descriptions of how they were utilized in this study follows.

Trauma. Trauma is often a subjective experience of adverse and painful events, including sexual, physical, and emotional abuse, natural disasters, as well as forms of discrimination (APA, 2013). These adverse events can be experienced throughout the lifespan.

Resiliency. Resiliency is commonly referenced as bouncing back after experiencing an aversive event. In this study, however, the term resiliency follows Soenke, O'Connor and Greenberg's (2015) broader conceptualization of the phenomenon that encompasses not only well-being following a difficulty (aka post-traumatic growth), but also includes positive affect, and motivation to approach adversity.

Compassion fatigue. In this study, Figley's (1995) definition of CF is used: a state of tension and preoccupation with the individual or cumulative trauma of clients as manifested in one or more ways: re-experiencing traumatic events, avoidance/numbing of reminders of the traumatic event, persistent arousal, combined with the added effects of cumulative stress (burnout) (p. 11).

CF symptoms can be categorized into two separate variables: secondary traumatic stress (STS) and burnout (Figley, 1995). STS is similar to Posttraumatic Stress Disorder (PTSD): both involve the presence of arousal, avoidance, and intrusive symptoms (APA, 2013; Gentry & Monson, 2017). The difference is how the traumatization occurs. STS gradually results from witnessing another's trauma(s) and pain (Figley, 1995; Gentry & Monson, 2017; Stamm, 1999). It is viewed as a natural response to witnessing the pain of others (Figley, 1995). BO is more than just stress (Maslach & Goldberg, 1988; Figley, 1999). The seminal definition of BO, as offered by Maslach and Goldberg (1988), is "a psychological syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment" (p. 64). An alternative definition of BO is the chronic state of exhaustion that happens when the perception of demands outweighs

the perception of resources to manage the demands (Gentry & Baranowsky, 1998). The importance of this different way of looking at BO is a key to the reduction of symptoms and is discussed further in Chapter Two.

      Helpers. Helpers is a term that is used to broadly refer to people who are in caring and direct service professions. Such careers include: counselors, psychologists, social workers, educators, law enforcement, as well as medical professionals.

      Mental health professionals. Mental health professionals is used to designate professional counselors (i.e. Licensed Clinical Professional Counselor, LCPC), school counselors, school psychologists, social workers (Licensed Clinical Social Worker, LCSW), psychologists and psychiatrists.

      Therapist. Therapist is often used in the literature to designate a mental health professional. As such, the terms therapist and mental health professional may be used interchangeably in this study.

      Counselors-in-training (CITs). Counselors-in-training (CITs) is a narrower term that is used to describe masters' level students enrolled in counseling programs. The term CITs includes students at all levels of their masters' level education (i.e. includes pre-practicum, practicum-level and internship-level students) and counseling students enrolled in either mental health counseling or school counseling tracks of study.

      Professional Quality of Life (Pro-QOL). Professional Quality of Life (Pro-QOL) is a construct as well as the main assessment instrument of this study. Created by Stamm (2010), the Pro-QOL breaks down the measurement CF symptoms into STS and BO subscales following Figley's (1995) definition of CF. Additionally, the Pro-QOL has a subscale that measures

compassion satisfaction (CS), "the good stuff" that helpers get from participating in their helping roles. The Pro-QOL is explained more in depth in the Instrumentation section in Chapter 3.

Adverse Childhood Experiences (ACE). The ACE questionnaire (Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards, Koss, & Marks, 1998) will be the primary assessment tool used to measure childhood traumatic experiences of participants. The ACE is explained more in depth in the Instrumentation section in Chapter 3.

Delimitations

This study explored self-reported CF symptoms among CITs and post degree mental health professionals. The treatment group consisted of resiliency training participants. This sample consisted of students (CITs) enrolled in masters' level counseling courses in The Department of Counseling at the University of Montana as well as several mental health professionals (i.e. licensed mental health professionals (i.e. Licensed Clinical Professional Counselors (LCPCs), Licensed Clinical Social Workers (LCSWs) residing and practicing in the state of Montana. The nonequivalent control group consisted of additional CITs from The Department of Counseling and mental health professionals who did not attend the resiliency training (i.e. do not receive the intervention). Information collected from these two samples included demographics, personal trauma history (including ACE scores), data about their clinical experiences and practices, the impact that the COVID-19 pandemic has had on their personal and professional lives as well as their self-reported CF symptoms and CS as measured by the Profession Quality of Life Scale (Pro-QOL) developed by Stamm (2009).

Limitations

This study has multiple limitations including limitations associated with the sample, the design of the study, as well as with the researcher. There are key limitations associated with this

study's sample. First, a limitation of this particular study has to do with sample size. The sample size for the experimental group of this study was based on the number of participants who took the resiliency training. Therefore, the exact number of participants was unknown until the actual study took place. The sample size was small (n= 15), thus lack of generalizability of the results was a threat to the external validity of this study. Also, generalizability could be threatened because many of the participants in the experimental group were taken from just one counselor education program that has its own unique culture and student population. Caution is taken to generalize the results to all counseling programs and mental health professions. Workshop marketing and recruitment efforts to minimize the risk of a small sample size were done. That said, there could be systematic differences, or selection differences, between the experimental and control groups (Privitera, 2017). It is possible that mental health professionals and CITs who are already oriented to protecting themselves from CF registered for the workshop, while those more susceptible may not. Similarly, participants chose to take part in the survey. Those who volunteered may have different characteristics, values and/or levels of CF than those who chose not to. There was no way to ensure that the groups were equivalent in nature, and caution was taken in comparing groups; to aid in adjusting the differences between groups due to the lack of random assignment appropriate statistical analyses was part of this study's design.

This study has additional limitations associated with the study's quasi-experimental control time series design. With this design, cause and effect cannot be ascertained; results can only inform about differences between the treatment and control group (Privitera, 2017). An additional limitation of this study related to this study's design is the accuracy of measurement. The design of this study relies on self-report. Participants may not have been entirely forthright in their responses, either by under or over reporting their experiences with CF or not accurately

completing the survey. Furthermore, the data collected could have measured the participants' expectancy of change as opposed to the effect(s) of the intervention. Similar to the placebo effect, expectancy could have been the active ingredient of workshop instead of the workshop itself. Similarly, the longitudinal nature of this study could have impacted the validity of self-reported CF symptoms. Life circumstances may have changed significantly, or not at all, for participants in between data collection points. Notably, the COVID-19 pandemic occurred during the course of this study. These circumstances may have impacted how participants rated their CF experiences over time. High attrition rates were also problematic due to the longitudinal design of this study.

Furthermore, other limitations of this study are researcher bias and dual relationships. This researcher functioned as both the facilitator of the resiliency training as well as the primary investigator in this study. Also, the study was conducted in the same counselor education program that this researcher attends. Many of the participants know the researcher in another roles (i.e. supervisor, doctoral student, licensed counselor in the community, etc.). This issue of dual roles was an integral part of the informed consent process and study participants had the option to volunteer for the research study, or not, at their discretion. The researcher knew some of the participants in the control group from as well. Despite these limitations, the value in learning about the longitudinal effects of a resiliency training on CF symptoms outweighed the limitations of this study.

Significance of the Study

CF is a common and painful experience associated with caring professions (Figley, 1995). Shedding light on the issue can help eradicate the "silencing response" that Baranowsky (2002) and Gentry et al. (2002) name as a challenging part of CF. The chief significance of this

study was bolstering our existing understanding of the phenomenon so that we can assist CITs and other mental health professions to guard against it. There are relatively few studies that examine how to reduce and/or treat compassion fatigue (Merriman, 2011; Turgoose & Maddox, 2017). Of those that exist, several studies examine how mindfulness impacts CF (Constantine Brown et al., 2017; Thompson et al., 2014; Turgoose & Maddox, 2017) yet there are few preventative models for equipping CITs for a career in the mental health field (Merriman, 2011, 2015). Additionally, to date, there is a lack of longitudinal CF studies and a lack of comparison groups used in existing CF studies (Turgoose & Maddox, 2017). This longitudinal study used treatment and control groups to examine how CF progressed over time and helps the refinement efforts of CF prevention models.

CHAPTER TWO: LITERATURE REVIEW

The negative effects of helping others have had a presence in academic literature beginning with Freudenberger's (1974) formative study on BO among care providers. Research directed towards examining this phenomenon has grown within the last several decades and has informed the progression of thinking about the phenomenon of the cost of caring (Figley, 2002; Stamm, 1999; Turgoose & Maddox, 2017). Turgoose and Maddox (2017) found 477 quantitative studies on the topic; many of which used distinct, but overlapping terms. The nebulous web of distinct terms with overlapping definitions makes research in this field challenging.

This chapter first inspects the definitions, strengths and weaknesses of web of terms related to the negative pathogenic experiences of helping that have developed as understanding of this phenomenon has grown. Seminal works are primarily used in this exploration of terms. This section culminates by making the case for use of CF as the best term to embody the cost of caring. The second half of this chapter discusses the various attempts to identify protective factors that guard against CF as well as the existing preventative and intervention strategies. Participating in resiliency-based trainings, the CF intervention used in this study, is examined in depth. From this basis of understanding, the rationale for and structure of the current study emerges.

Cost of Caring Nomenclature

There is significant overlap between the various constructs used to encapsulate the cost of caring. The use of multiple terms that have analogous constructs often muddy the waters with their similarities (Figley, 1995; Ivicic & Motta, 2017; Lerias & Byrne, 2003; Merriman, 2011; Merriman, 2015; Ray et al., 2013; Stamm, 1999; Stebnicki, 2007; Turgoose & Maddox, 2017).

This lack of clarity and continuity creates challenges for both researchers and practitioners alike (Stamm, 1999; Turgoose & Maddox, 2017). It is thought that CF as a distinct construct offers the most all-encompassing way to define the phenomenon of the cost of caring. Figure 1 illustrates the overlap between the existing constructs and demonstrates that CF is currently the most inclusive term in the field. Term definitions are explained in this chapter.
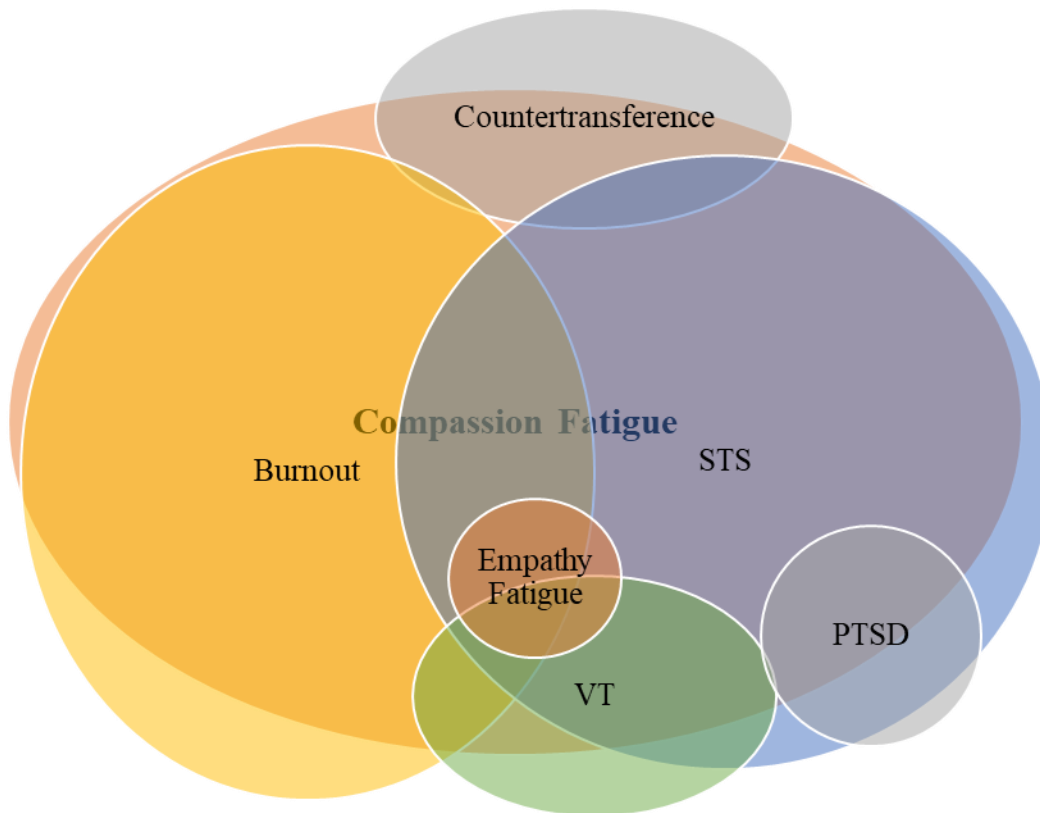
Figure 1. Cost of Caring Nomenclature Construct Overlap

(VT= Vicarious trauma; STS= Secondary traumatic stress; PTSD= Posttraumatic stress disorder)

A case for using CF as the term to embody the negative pathogenic experiences associated with helping others will be made through the examination of the literature. Common terms that are used to conceptualize and outline the cost of caring are: countertransference (CT), posttraumatic stress disorder (PTSD), burnout (BO), secondary traumatic stress (STS), compassion fatigue (CF), vicarious trauma (VT), and empathy fatigue. Except for CF, these terms are presented in a chronological manner following the timeline of terms presented in Figure 2. The constructs, strengths, weaknesses, and functionality of each term will be presented. This examination culminates with a description of CF and a thorough examination of the risk factors associated with it.
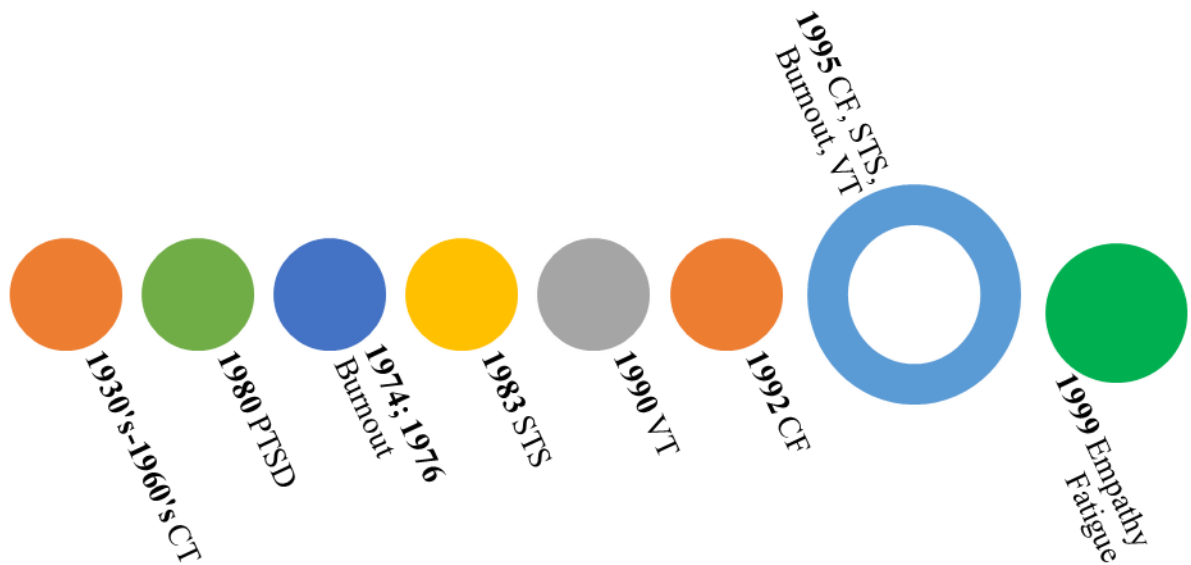
Figure 2. Timeline of Introduction and Prevalence of Cost of Caring Nomenclature

Countertransference (CT). Countertransference (CT) terminology has its roots in psychodynamic theory and is a term used to describe the emotional reactions therapists have to their clients (Figley, 1995; Ponton and Sauerheber, 2014; Rothschild, 2006). Transference, also

a psychoanalytic term, describes interactions in which the client "transfers" or projects their feelings from the past onto the psychoanalyst (Rothschild, 2006). CT, then, are the feelings that the therapist projects back onto the client. Transference and CT can be thought of as the volleying back of feelings between client and therapist at a largely unconscious level. Freud (1959) refers to CT as the distortion of a therapist's judgment that is connected with his or her unconscious, neurotic reaction to the client's transference. The historical richness in the literature associated with CT reflects "the therapist's unconscious, conflict-based reactions to the client's transference" (Ponton & Sauerheber, 2014, p. 255). A fundamental characteristic of CT is that it refers to the unresolved challenges of the therapist (McCann & Pearlman, 1990; Ponton & Sauerheber, 2014). These unresolved issues are projected onto one's client and can cause a helper to over identify with or distance themselves from the client (Figley, 1995; Haans & Balke, 2018). Another distinct feature of CT is that the term largely refers to the inner experience of the therapist (Ponton & Sauerheber, 2014). These inner experiences of therapists can encompass a wide array of reactions from sexual attraction to boredom to rage or even disgust (Ponton & Sauerheber, 2014). CT is temporary and is based on specific events or challenges that arise in therapy or within the "therapist's inner or external life as it interacts with the therapy" (Saakvitne & Pearlman, 1996, p. 47). CT is thus seen as an immediate, transitory reaction within a therapeutic relationship based on the therapists' history.

Within the cost of caring literature, CT as a distinctive term has an advantage. Its utility involves having a common way to conceptualize a therapist's (or other helping professional's) reactions (including negative ones) to their clients. All human interactions are collisions of each individual's personal histories, experiences, values, beliefs, feelings, thoughts, education, and

social and cultural influences all happening at both conscious and unconscious levels. CT has long been used to discuss these reactions within a therapeutic context.

The utility of CT as a term to encompass the cost of caring has several weaknesses. First, as explained above, CT is thought to occur within therapeutic contexts. Figley concurs, stating "it is assumed that countertransference happens only within the context of psychotherapy" (1999, p. 14). This aspect of the working definition of CT could be confounding for a helper if their negative responses to their clients and work persist beyond the office walls. Next, over the years there have been several variations on the conceptualization of CT that have led to confusion about its definition and have muddied (weakened) its utility as a construct (Norcross, 2001; Ponton & Sauerheber, 2014). They observe, "such a broad totalistic understanding of CT can be so unwieldy and broad as to be helpful" (Ponton & Sauerheber, 2014, p. 255). Rothschild concurs, "there are widely varying definitions of the term, as well as wildly divergent strategies for managing it" (2006, p. 16). Additionally, because CT largely refers to the internal experiences a therapist has in response to a client (Ponton & Sauerheber, 2014; Rothschild, 2006), it can often be difficult to identify, measure, study, and ultimately, manage. We know CT exists and occurs; yet, each therapist's experiences with CT is unique (Rothschild, 2006). There is no definitive set of CT symptoms and CT reactions to clients can range from sexual attraction to boredom to anger or hatred (Ponton & Sauerheber, 2014). Thus, the nebulousness of the term persists.

CT normalizes the experiences of reactions and responses to clients; where there are therapeutic relationships, CT will occur. The chief utility of CT as a term, however, is its underscoring of the importance of a helper's continual expansion of his or her awareness about how they perceive and interact with others both overtly and covertly. Courtois explains the value

of CT within a supervision context: "Countertransference sheds light on unconscious processes and can thus deepen the work by helping supervisees become aware of the implicit material (in the same way the supervisee hopes to do with the client)" (2018, p. 55). The more one knows, the more intentional one can be about his or her thoughts, feelings and behaviors. However, as a standalone term, CT does not encompass the extent of the negative experiences a helper can have as a result of working with those who are traumatized or suffering.

Posttraumatic Stress Disorder (PTSD). The evolution of the field of traumatology is extensive. People have long documented traumatic symptomology within literature and popular culture dating back to the first Egyptian writings on medicine (Figley, 1988). However, traumatology was not recognized as a specific field of study until the 1980s. One of the defining benchmarks for the development of the field was the addition of posttraumatic stress disorder (PTSD) to the DSM-III published in 1980. Before the establishment of PTSD, there were numerous observations of similar symptoms like combat stress, abuse, sexual violence, shell shock, etc. (Figley, 1988). Figley explains the impact of PTSD's unifying origin; "Certainly the DSM-III's inclusion of PTSD has dramatically facilitated the growth of the field of traumatic stress. It did this, among other ways, by establishing it as a psychiatric disorder along with a measure list of criterion symptoms" (1988, p. 9). Researchers and providers finally had a systematic way of assessing and talking about symptoms related to trauma. The field of traumatology has flourished ever since.

"Simply put, PTSD is an understandable response to an extremely stressful situation that results in chronic anxiety" (Seligman & Reichenberg, 2012, p. 221). The Diagnostic and Statistical Manual of Mental Disorders, 5th edition (APA, 2013) outlines the diagnostic criteria for PTSD through the following benchmarks: (a) the individual directly experiences or witnesses

a traumatic event or learns about the traumatic experiences of a close friend or family member or experiences repeated exposure to traumatic material; (b) presence of intrusive symptoms linked to the trauma event; (c) presence of avoidance symptoms of trauma material; (d) negative alterations of cognitions or mood following the traumatic event; (e) hyperarousal and/or reactivity following the trauma; (f) symptoms persist longer than 1 month; (g) clinically significant distress or impairment; (h) distress is not due to other issues or a medical condition (APA, 2013, p. 271-272). Criterion A recognizes that an individual does not need to directly experience the trauma themselves in order to develop trauma symptoms. Under this criterion then, a helping professional can be diagnosed with PTSD if all of the other criteria are met according to the standards outlined in the DSM-5. Thus, a diagnosis of PTSD could be an appropriate billable diagnosis for a caring professional exhibiting STS. Multiple authors (Figley, 1995; Gentry & Baranowsky, 1998; Gentry & Monson, 2017; Hyatt-Burkhart, 2014; Pearlman & Saakvitne, 1995; Saakvitne & Pearlman, 1996; Stamm, 1999) cite the link between helpers working with trauma-affected clients and these helpers developing trauma symptoms themselves. There has thus been a highlighting of the necessity for trauma-informed practices to include the helper's monitoring of their trauma as they engage in trauma work (Jordan, 2018; Knight, 2018).

Mental health diagnoses, including PTSD, are helpful in providing a common understanding of cluster symptoms and offering a helpful language with which both professionals and lay people can communicate about emotional challenges (Sommers-Flanagan & Sommers-Flanagan, 2007). Receiving a PTSD diagnosis can often be a helpful place from which to start therapeutic interventions. The recent boom in the field of traumatology has increased the various treatment options for working with trauma-affected clients including eye movement desensitization and reprocessing (EMDR; Shapiro, 2001), cognitive processing

therapy (Seligman & Reichenberg, 2012), and exposure therapy (Seligman & Reichenberg, 2012).

Despite the above described benefits of a PTSD diagnosis, receiving such a label can be detrimental in some instances. Sommers-Flanagan and Sommers-Flanagan outline the danger by succinctly stating, "diagnosis is problem or pathology driven" (2007, p. 204) and focuses on what is going wrong. Also, diagnostic labels become part of one's medical record and can potentially have deleterious consequences. For example, employment options may become limited and medical professionals may interact in a biased way with someone who carries a PTSD diagnosis. The term itself can be pathologizing. If PTSD is the term used to describe the cost of caring, this can be especially devastating for those who work in the mental health field.

PTSD is a commonly accepted term used within Western cultures to talk about the negative effects of experiencing trauma. The unified definition and criteria for PTSD have led to systematic ways to assist clients in managing and alleviating symptoms, like trauma-informed treatments. However, if PTSD was the term used to encompass the negative effects of caring, confusion might result for those not intimately familiar with the diagnostic criteria outlined in the DSM-5. Perhaps there is an alternate term that can be used for the explicit purpose of distinguishing the cost of caring from PTSD.

Burnout (BO). BO is a commonly used word that has an intuitive meaning. The concept of BO as it relates to job stress surfaced in academic literature in the 1970s according to Maslach and Goldberg (1998). Fruedenberger (1974) was the first to use the term BO. Seminal authors, Maslach and Goldberg define BO as "a psychological syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment" (1998, p. 64). People who are burned out commonly experience a lack of energy, interpersonal detachment and have low

self-efficacy or low work production (Maslach & Goldberg, 1998). BO is thought of as prolonged exposure to the combination of chronically high work demands and workplace conflict. The BO cycle is explained;

> Too much work combined with too much conflict is exhausting. People distance
> themselves from personal involvement at work in order to cope. Being left out of
> important decisions and having little control over the work bring about feelings of
> ineffectiveness (Maslach & Goldberg, 1998, p. 64).

The impact of the workplace environment is highlighted as the largest contributing factor in BO experiences (Fruedenberger, 1974; Maslach & Goldberg, 1998). As such, the social, cultural, economic and political influences of the workplace environment are also seen as underwriting factors of BO (Maslach & Goldberg, 1998). For example, the chronic lack of federal funding and budget cuts for mental health resources create systematic strains on those who work within those systems. To meet ever growing demands for service, these employees often find themselves seeing more clients, staying late, working through their lunch breaks, etc. and these additional tasks can eventually accumulate and lead to BO.

BO is more than just stress (Figley, 1999; Maslach & Goldberg, 1998). According to seminal authors, Maslach and Goldberg (1998), BO research has repeatedly found that situational variables (i.e. workplace conflict, lack of resources, high job demands, etc.) are more predictive of BO symptoms than are interpersonal factors. McCann and Pearlman explain, "the literature on burnout parallels the focus on characteristics of the stressor in that it suggests that the therapist is distressed because of the nature of the external event (isolation, difficult client populations, and so forth)" (1990, p. 135). This emphasis on job environment as a causal factor of BO can be helpful in fighting the myth that some helpers experience; if they are burned out,

then they are weak (Gentry & Monson, 2017; Maslach & Goldberg, 1998). This myth leads to hiding BO symptoms and is a prime ingredient for self-defeating thoughts; leaving these helpers less likely to seek help (Maslach & Goldberg, 1998).

There is also a contrasting but equally painful narrative that helpers may tell themselves about being burned out. This perspective views BO as resulting from virtuous and noble work of helping "above and beyond the call of duty" (Maslach & Goldberg, 1998). For example, a counselor with this maladaptive view of BO might have the following narrative, "I stay at the office later than all the other counselors and I see 5 more clients a week than everyone else does. I read extra articles related to my clients' challenges and am always available to them. I am a better counselor than everyone else is; it does not matter that I am drained." Indeed, there is a danger for helpers who tend to be empathic and self-sacrificing by nature, to have their ego worth tied up in BO symptoms. Additionally, there generally is positive external feedback (i.e. cultural, social and economic) that praises helpers for working beyond their limits to care for others. "Sadly, such a 'gift' to others can come with a high price tag" (Maslach & Goldberg, 1998, p. 63).

BO symptoms include: pessimism, defensiveness, overwhelming exhaustion, disconnectedness, and being emotionally absent (Gentry & Monson, 2017). Maslach and Goldberg (1998) add that people who experience BO also feel as though they are ineffective or are failures. For instance, experiencing BO is like being a hamster running on its wheel; working hard but not getting anywhere. Frustration and anger are also common emotional responses to BO according to Maslach and Goldberg (1998). Impairments of both personal and relational functioning result from these symptoms (Gentry & Monson, 2017; Maslach & Goldberg, 1998). BO, as reported by Kahill (1988), encompasses physical, emotional, behavioral, work-related,

and interpersonal symptoms, including: exhaustion, somatic complaints, helplessness, defensiveness, aggression, work performance difficulty and interpersonal relationship distress. Gentry and Monson (2017) equate BO to "professional learned helplessness" (p. 47), or feeling powerless to change one's situation. Feeling ineffectual over a period of time can result in burnout (Gentry & Monson, 2017).

A strength of the term BO is that the majority of people have some level of understanding of what it means intuitively. Also, BO is the normalization of feelings of exhaustion, detachment and inadequacy while working in a high demanding job field, like mental health care. This normalization increases the likelihood of help seeking behaviors to alleviate BO symptoms. Since its identification and appearance in academic literature, the portrait of BO has largely remained the same (Maslach & Goldberg, 1998). This consistency of symptomology makes BO easy to conceptualize, measure, research and ultimately prevent.

The common use of the term BO can also be considered a weakness. There is a potential danger that BO's academic definition might be diluted and misconstrued through everyday use. Next, a weakness of BO is its emphasis on situational contributing factors. When exhausted employees hear that their distress is largely due to a chronic maladaptive work environment, it may be easy to point the finger of blame decreasing their sense of personal responsibility for their distress if, "after all, it is all not my fault." Relatedly, the research places weight on the work environment being responsible for BO symptoms and could reinforce a sense of victimization, elaborating that "this mentally keeps people victims of their work" (Gentry & Monson, 2017, p. 46). Victimization is the opposite of empowerment and directly opposes Frankl's (1959) assertion that it is the perception of one's environment that causes suffering or contentment (Gentry & Baranowsky, 1998; Gentry et al., 2002). This painful cognition of

victimhood and a decreased internal locus of control led Gentry and Baranowsky (1998) to an alternative definition of BO: the perception of demands outweighing the perceived resources available to manage them. This alternative definition of BO is an adaptive perceptual shift and is an integral part of interventions that have been helpful to eliminate burnout symptoms (Gentry & Dietz, 2020).

BO can exist in all work environments and is not just limited to the helping professions (D. Hyatt-Burkhart & E. Owens, personal communication, March 31, 2019). BO literature provides helpful context for understanding how situational and personal factors can interact negatively with one another. BO is a well-researched term within the cost of caring literature. The consistency of the definition has largely remained constant since the 1970's. This consistency has spurred burnout preventative research and treatment models (Maslach & Goldberg, 1998; Maslach & Leiter, 2016). For example, fostering engagement, the antidote to BO (Maslach & Goldberg, 1998; Maslach & Leiter, 2016) and focusing on cognitive reframing of maladaptive perceptions (Gentry & Monson, 2017) may be helpful to many in assuaging their BO symptoms. While the causes of BO seem to center around working conditions and mostly external factors, the cure seems to be, as Frankl suggested, perspective and attitude adjustment, and factors within one's control. BO will emerge later as one part of what we now consider CF; the other factor, STS, is discussed below.

Secondary Traumatic Stress (STS). Another term related to the cost of caring grew out of observations of supporting the families of those who were affected by trauma (Figley, 1983) and noting how traumatic material influences other individuals, including caring professionals, at an indirect level (Stamm, 1995, 1999). Figley (1983) found that family members caring for the traumatized often exhibited similar trauma symptomology themselves. He observed that

emotional contagion often resulted from empathic engagement with hurting others (Figley, 1995). Stamm emphasizes the difficulty of such caring by offering, "if we are not engaged with others sufficiently to understand their pain and their experiences, then how could we truly be with them? But, when we do engage with them empathically, it seems that there are grave risks" (1999, p. xxxiv). Figley (1995) coined the phrase secondary traumatic stress syndrome to explain this occurrence. As research surrounding this phenomenon progressed, the terms secondary traumatic stress (STS) and secondary traumatic stress disorder (STSD) emerged (Figley, 1995; Figley, 1999; Stamm, 1995; Stamm, 1999). STS is defined as "the natural, consequent behaviors and emotions resulting from knowledge about a traumatizing event experienced by a significant other. It is the stress resulting from helping or wanting to help a traumatized or suffering person" (Figley, 1999, p. 10).

STS, as described by Valent (1995), is a maladaptive response (p. 31) that occurs "when a person is secondarily influenced by the stress response of another person" (p. 29). STS is similar to posttraumatic stress disorder (PTSD): both involve the presence of arousal, avoidance, and intrusive symptoms (Figley, 1995; Figley, 1999; Gentry & Monson, 2017; Stamm, 1999). The difference is how the traumatization occurs. Unlike PTSD, STS develops following exposure to trauma at an ancillary level (Figley, 1999; Stamm, 1999). STS results from witnessing another's trauma(s) and pain (Figley, 1995; Figley, 1999; & Gentry & Monson, 2017, Stamm, 1999). STS can be a more rapid and sudden process, as contrasted with the gradual progression of burnout (Figley, 1999).

Rothschild (2006) asserts that caregivers become victimized "by becoming overwhelmed" (p. 14) by what they witness as a result of working with someone who is traumatized. Gentry (personal communication, April 18, 2014) offers a list of additional

secondary traumatic stress indicators including: fear, anxiety, obsessive thoughts, impulsivity,

weight loss/gain, somatization, immune system difficulties, irritability/easily angered,

procrastination, depression, self-medicating, relational difficulties, isolation, blame, dread,

hopelessness, constriction, diminished self-care activities, rumination, entitlement, increased

perceived threats and chronic fatigue. Figley (1995) also identifies that STS experiences often

include helplessness and confusion. The rapid onset of STS is also linked to a quicker recovery

rate, as opposed to burnout (Figley, 1995).

The definition of STS is adaptively used to describe negative symptoms of arousal,

intrusion and avoidance associated with empathically engaging with a hurting person. Its

similarity to PTSD provides breadth to its definition and constructs. In fact, the DSM-5 (APA,

2013) includes STS in the criteria for PTSD. Criterion A names repeated exposure to traumatic

material and learning about the traumatic experiences of others as part of the diagnostic criteria

(APA, 2013). For helpers, this repeated exposure to trauma via STS could be considered a

pathway to the development of PTSD (Gentry & Dietz, 2020). For example, a counselor who

experiences sudden and intrusive imagery related to a client's traumatic experience would

obviously be alarmed. However, being able to identify that this might be a manifestation of STS

could be normalizing and anxiety reducing for that counselor. Another strength of STS as a term

is that it can account for abrupt traumatic symptoms that a helper may experience. Figley's

(1995, 1999) definition of rapid onset of STS helps distinguish STS as a construct apart from

burnout.

STS, as a cost of caring term, also has a weakness in that it does not include exhaustion

or decreased self-efficacy like burnout does. STS and burnout are closely linked and share

common symptoms such as: detachment or avoidance as well as helpless and hopeless feelings.

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STS also does not explicitly name changes in cognitive schema or spiritual beliefs like VT and empathy fatigue do. Additionally, its similarity to PTSD may also be a weakness as well as a strength. Their similarities may cause misunderstandings between the two as distinct terms. Relatedly, the debate regarding classification of STS as a disorder remains (Stamm, 1999). This breeds some confusion regarding the utility of the construct. Stamm expounds on the difficulty of fully understanding STS and trauma when she states, "the complete spectrum of traumatic stress continues to elude our best efforts to understand it as a holistic phenomenon. Likewise, secondary traumatic stress eludes us" (1999, p. xxiv).

STS's strength and weakness as a term to embody the cost of caring both come out of its parallel with PTSD criteria. It is both helpful and confusing that the terms share similar symptoms. However, the very name is explanatory in deciphering between the two constructs as it implies that STS symptoms occur at an ancillary level. As a standalone term, however, STS does not account for the influence of a negative work environment the way that burnout does. CF, discussed later, is the term that encompasses both burnout and STS, and that best embodies the cost of caring.

Vicarious Trauma (VT). Another popular term used describe the cost of caring is vicarious trauma (VT). VT is seen as the combination of a desire to help coupled with engaging empathically with traumatized clients (Saakvitne & Pearlman, 1996). Saakvitne and Pearlman define VT as "a transformation of the helper's inner experience, resulting from empathic engagement with client's trauma material" (1996, p. 40). VT does not just happen; it is seen as the accumulation of experiences of working with hurting others (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Saakvitne & Pearlman, 1996). VT is seen as a natural but pervasive occupational hazard (McCann & Pearlman, 1990), a "human consequence of knowing,

caring, and facing the reality of trauma" (Saakvitne & Pearlman, 1996, p. 25). VT is a term somewhat distinct from STS because it represents the compounding effects of working with traumatized individuals on a helper's worldview, whereas, STS does not include this aspect. However, a negatively distorted sense of self, resulting from exposure to trauma aligns with Criterion D of PTSD (APA, 2013). This schema change of VT is discussed further below.

As the definition implies, empathy is a critical component to the etiology of VT. Empathy is all about connection. Jordan describes empathic engagement as "listening, often repeatedly, to the explicit details of the trauma-affected client's experiences, bearing witness to the cruelties of one human being to another: abuse, rape, torture, injuries, death, and destruction" (Jordan, 2018, p. 128). This level of deep empathic connection with another's intense pain requires the helper to be vulnerable to experience those same emotions (Saakvitne & Pearlman, 1996). Over time and without adaptive expression, overwhelming empathic pain can lead to the development of VT (Saakvitne & Pearlman, 1996).

Saakvitine and Pearlman (1996) report that VT has two separate contributing factors that influence each other: situational factors and individual factors. The theoretical model of constructivist self-development theory (CSDT) was developed to aid in understanding these two psychological responses to victimization (McCann & Pearlman, 1990). First, contributing situational factors of VT include the nature of the work and clients that a helper works with; these factors are particularly salient for those clinicians who engage in trauma recovery work (Saakvitine & Pearlman, 1996). Trauma work is difficult; it is challenging to see others in the midst of intense emotional distress client after client, day after day, week after week, year after year. It is this consistent and cumulative exposure to trauma that contributes to VT (Saakvitine & Pearlman, 1996). Saakvitine and Pearlman explain, "trauma work assaults our self-protective

beliefs about safety, control, predictability, and protection" (1996, p. 26). Additionally, trauma recovery is often slow and tedious. This slow progress can lead to demoralization and the loss of hope for both the traumatized client and the clinician (Saakvitine & Pearlman, 1996).

Individual factors of VT include aspects that the clinician brings into the therapy with them. Saakvitne and Pearlman (1996) list these individual factors as: personal history, personality, coping mechanisms, as well as current life situations and context. Educational, professional and supervision factors are also described as being features of individual clinicians that may contribute to developing VT symptoms (Saakvitne & Pearlman, 1996). There are also individual factors that may protect against developing VT symptoms. For example, if a clinician has no personal trauma background, is at a relatively stable stage in life (i.e. has stable job, housing, relationships, etc.) along with an established practice of using healthy coping skills, they may be less susceptible to VT than a clinician who has a trauma history, less stability, and maladaptive coping skills.

Symptoms of VT present differently for different people, as CSDT infers that individuals have their own history and experiences that impact how VT manifests. However, there are several common core symptoms of VT including: decreased energy, disconnection and withdrawal from others, cynicism, generalized despair and hopelessness, intrusive nightmares as well as increased sensitivities (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Saakvitne & Pearlman, 1996). VT can also influence the helper's sense of self, basic needs and mental schema about issues such as safety, world view, trust, identity, decreased self-efficacy and resources, as well as alterations in sensory memory and sensory experiences (Pearlman & Saakvitine, 1995; Saakvitine & Pearlman, 1996). These transformative alterations of sense of self are at the core of VT.

The CSDT foundation of VT emphasizes that the helper's personal reactions to clients are influenced by situational and individual factors. "Constructivist self-development theory is interactive in that it views the therapist's unique responses to client material as shaped by both characteristics of the situation and the therapist's unique psychological needs and cognitive schemas" (McCann & Pearlman, 1990, p. 136). By focusing on both the situational and individual distressing contributions, VT is thus more descriptive than just burnout or CT alone. "Our notion of vicarious traumatization is somewhat broader than countertransference, as it implies that much of the therapist's cognitive world will be altered by hearing traumatic client material" (McCann & Pearlman, 1990, p. 136). Saakvitine and Pearlman (1996) published a workbook outlining their work and suggestions on how VT symptoms can be adaptively managed. Perhaps the biggest strength that VT brings to understanding the cost of caring is its emphasis on how the very foundation and core of trauma workers are affected by the work that they do. "Vicarious trauma involves a profound change in the helper's core sense of self" (D. Hyatt-Burkhart & E. Owens, personal communication, March 31, 2019).

As a distinct term of the cost of caring, however, VT does have some challenges. Specifically, there are some VT constructs that overlap with CF, STS and PTSD. Intrusive thoughts and imagery (i.e. nightmares) are hallmarks of both STS and PTSD and are also included within the construct of VT. Similarly, the negative alterations of sense of self that are part of VT mimic Criterion D for PTSD (APA, 2013). Another conceptual weakness of VT is that the effects of VT are "likely permanent, even if worked through completely" (McCann & Pearlman, 1990, p. 136). The underlying assumption that VT endures despite being addressed is disheartening. However, it is important to note that VT symptoms can be alleviated through vicarious posttraumatic growth, a parallel process to the posttraumatic growth that traumatized

clients also go through to heal from trauma (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Saakvitne & Pearlman, 1996; Hyatt-Burkhart, 2014). It is ultimately confusing that VT is described as being both permanent and transient at the same time.

VT is a way to understand how one's cognitive schemas and core sense of self are challenged and/or altered as a result of sitting with others experiencing pain. "Simply put, when we open our hearts to hear someone's story of devastation or betrayal, our cherished beliefs are challenged and we are challenged" (Saakvitine & Pearlman, 1996, p. 25). VT normalizes the cost of caring and the various changes to the self that often go hand-in-hand with empathetic work. VT also has recognized treatment activities for adaptive management of symptoms. Yet, there are some constructional components that remain confusing within VT literature and burnout symptoms largely appear to be separate experiences from VT.

Empathy Fatigue. The newest addition to the cost of caring nomenclature is empathy fatigue. Stebnicki (2007) coined the term empathy fatigue to describe the parallel process that emerges from emphatic engagement with hurting others. "The experience of empathy fatigue hinders counselors' opportunities for personal growth, professional development, and overall mental, physical, and spiritual well-being" (Stebnicki, 2007, p. 319). The foundation of the term "empathy fatigue" originated out of differences between the words compassion and empathy (Stebnicki, 2007). The Dalai Lama stated that "empathy is really what we are describing when we talk about compassion fatigue" (Berger, 2006, p.1, as cited in Stebnicki, 2007). Stebnicki (2007) argues that empathy can be taught and cultivated, while compassion cannot. Empathy is a concept that is infused into helping professions, like counseling, and is described as one of the most important parts of a helping relationship (Rogers, 1957).

Stebnicki (2007) argues that empathy fatigue is an entity separate from compassion

fatigue, STS and VT. The outline of his (Stebnicki, 2007, p. 319) argument is as follows:

(a) Empathy fatigue is thought of as a counselor's impairment due to interactions

between personality, coping abilities, age and developmental level, systems of support,

"and the interrelationship between the person's mind, body, and spiritual development"

(b) Empathy fatigue symptoms can go unrecognized

(c) Empathy fatigue "has both acute and cumulative onset of emotional, physical, and

spiritual effects which does not follow a predictable linear path to STS reactions"

(d) Empathy fatigue is conceptualized as a "highly individualized experience"

These contextual factors of empathy fatigue often result in a reduced capacity to

continue engaging in empathic work as well as symptoms associated with anxiety, depression,

loss and burnout (Stebnicki, 2007).

Stebnicki's (2007) conceptualization of empathy fatigue emphasizes a holistic (i.e. mind,

body, soul, spirit) shift in describing the negative effects of caring. The nod to spiritualism is a

strength of empathy fatigue. Other terms mention that one's spirituality (beliefs and expressions

of) can be impacted by empathic work, but spirituality appears to be deeply rooted in the concept

of empathy fatigue. Stebnicki conceptualizes empathy fatigue in his discussion of the practices

of healers in other cultures and times (Stebnicki, 2007). Additionally, Stebnicki (2007) makes

the distinction that empathy fatigue can result from working with non-traumatized clients as

opposed to the emphasis that STS, CF and VT have on being a result of working with

traumatized clients.

Stebnicki (2000; 2007) clearly tries to differentiate empathy fatigue from CF, VT STS

and burnout, yet the multitudinous overlaps between the symptoms and constructs make it

difficult to tease apart as a unique construct. If the similarities make the term difficult to distinguish from others, why the new name? Empathy fatigue is a comparatively newer term that is used to aid in understanding the cost of caring. Its roots of understanding the impact of caring from ancient and spiritual healing practices and its emphasis on work impacting the whole helper are strengths. Yet, it is thought that the majority of the components of empathy fatigue are too similar in nature to other terms used within the cost of caring literature, such as CF, discussed next.

Compassion Fatigue (CF). The term compassion fatigue was coined by Joinson (1992) in nursing literature and continued to gain momentum as STS and BO were researched. For instance, as Figley (1995; 1999) continued to work with traumatized families, he also noted that these family members exhibited not only STS symptoms but some had additional symptomology. Families reported feeling like they could never do enough as well as physical, mental and emotional exhaustion (1995). Figley began to feel that the term secondary traumatic stress syndrome did not quite encompass all of the unique symptoms exhibited by this population. Figley (1995) broadened the definition of what he (and others) were actually observing to include BO symptoms; hence the more inclusive term compassion fatigue.

Figley's (1995) definition of compassion fatigue, as stated earlier, is:

a state of tension and preoccupation with the individual or cumulative trauma of clients as manifested in one or more ways: re-experiencing traumatic events, avoidance/numbing of reminders of the traumatic event, persistent arousal, combined with the added effects of cumulative stress (burnout) (p. 11).

These symptoms mirror PTSD with the addition of the exhaustive and "depletion of the ability to cope with one's everyday environment" indicators (Gentry, Baranoswky & Dunning, 2002, p.

124). Symptoms of CF, as provided by Gentry, Baranowsky and Dunning, include: amplified

arousal, intrusive thoughts or images of client's negative experiences/traumas, challenges with

deciphering between work and personal life, low frustration tolerance, increased outbursts of

anger, dread of working with a certain client, increased countertransference issues, depressive

symptoms, disturbances in world view, not feeling safe, unproductive or destructive self-

soothing behaviors (i.e. using substances to cope), hypervigilance, reduced sense of

accomplishment, diminished sense of purpose, decreased ego-functioning, lowered global

functioning (i.e. in non-professional settings), and loss of hope (2002, p. 126). Individual CF

experiences can include any combination of or all of the above items (Figley, 1995; Figley,

1999; Gentry et al., 2002).

Empathic engagement with others who are hurting and exposure to traumatic material

are at the heart of CF (Figley, 1995). Empathy, again, is a vital ingredient in the process of

therapy and walking with someone who is suffering (Rogers, 1957). Empathy can be described

as "to sense the client's private world as if it was your own….without getting bound up in it"

(Rogers, 1957, p. 99). The key aspect of empathy as it relates to CF is the separation between

the client's affectual state and the helper's. "The process of empathizing with a traumatized

person helps us to understand the person's experience of being traumatized, but, in the process,

we may be traumatized as well" (Figley, 1995, p. 15). Recognizing and being sensitive to

another's emotions while being able to maintain emotional regulation has long been an inherent

challenge for helping professionals and is an integral part of CF. Next, repeated and cumulative

exposure to suffering, traumatic material and stress are part of CF (Figley, 1995, Gentry, et al.,

2002). Whether its origin is primary or secondary in nature, immersion in pain can take its toll

on a person. Past experiences of personal trauma may increase the likelihood of individuals

developing CF (Deighton et al., 2007; Figley, 1995; Gentry, et al., 2002; Killian, 2008; MacRitchie & Leibowitz, 2010; Nelson-Gardell & Harris, 2003; Rossi et al., 2012; Thomas & Otis, 2010) and is a well-established risk factor for CF. CF can be summarized as the "convergence of primary traumatic stress, secondary traumatic stress and cumulative stress/burnout in the lives of helping professionals and other care providers" (Gentry et al. 2002, p. 124).

CF as a term has several significant assets. First, CF is a well-established term for the cost of caring. CF has existed in academic literature for nearly thirty years. It is a largely documented and well researched phenomena. As stated previously, there are hundreds of quantitative studies on the topic (Turgoose & Maddox, 2017). Secondly, CF is thought to be a comprehensive term because it accounts for both STS and BO within its definition and symptomology. As such, CF as a term, gains the strength and breadth of research related to both STS and BO. STS's relation to the established diagnostic criteria of PTSD and BO's relatively stable three-pronged construction are enfolded into CF. It is also thought that the majority of VT and empathy fatigue constructs are also found within the CF paradigm. Another strength of CF as a term is its system of measurement that was developed in collaboration with multiple researchers.

Stamm's (2010) The Professional Quality of Life (Pro-QOL) inventory is a culmination of that work. The Pro-QOL measures CF, as defined by both STS and BO, and has discrete subscales to quantify the concepts separately. In Stamm's (2010) comprehensive bibliography, 1035 studies are listed that have used the Pro-QOL. The Pro-QOL remains the most psychometrically robust and well-used way that CF symptoms are assessed in the literature (Stamm, 2010). Importantly, Stamm offers that CF as a term has a "more palatable nature"

(1999, p. xx) than STS does. Finally, a strength of CF as a term is that there are well-established

CF treatments available. Gentry et al.'s (1997; 2002) Accelerated Recovery Program (ARP) for

the treatment of compassion fatigue and subsequent trainings, including Gentry's *Professional*

Resilience and Optimization workshops (Gentry & Monson, 2017) are all aimed at stopping the

proliferation of CF among caring professionals and have had positive impacts on thousands of

participants over the last twenty years (Gentry & Monson, 2017).

CF is not without its flaws. The emergence of the term from STS can be

confusing at first glance. For example, the very title of the first book on the topic, *Compassion*

Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the

Traumatized, has another construct, STS, in its name. This could lead the casual reader to the

erroneous assumption that the two terms are one and the same. Also, some researchers vacillate

between using CF and STS. Stamm (1999) notes that she has avoided using CF during a period

of time in the late 1990s because of how media used the term to describe public apathy towards

homelessness. Also, as a concept CF nods to the changes in cognitive schema and worldview

that VT does, but not to the same level of depth and severity. Although there is much overlap

between the two, in this way VT has a marked distinction.

CF embraces both STS and BO into its construction. The emphasis on the empathic

transmission of CF also adds to the strength of CF as a term for the cost of caring. Figley (1995),

Newell, Gardell, and MacNeil (2016), and Stamm (2010), as cited in Turgoose and Maddox

(2017), assert that the designation of compassion fatigue is a "useful and more general term to

describe the emotional and physical fatigue experienced by professionals due to their chronic use

of empathy in helping others in distress" (p.173). CF has a well-established way of measurement

(the Pro-QOL) as well as established treatment modalities like the ARP and the *Professional Resilience and Optimization* workshop.

Based on the etiology, definitions, symptoms, constructs, strengths and weaknesses of the various existing terms, it is thought that CF is the most appropriate term to use in this research study. The following reasons outline this argument:

- CF includes both STS and BO. As such, CF encompasses the majority of the other terms being used to describe the cost of caring.

- CF's core includes empathic interactions with others who are hurting as well as exposure to painful material

- CF has a well-used, psychometrically robust assessment tool, the Pro-QOL.

- CF has existing and effective treatment interventions, like the ARP and *Professional Resiliency and Optimization* workshops.

- CF as a unifying term is supported by multiple seminal authors in the field (Figley, 1995; Gentry, et al., 1999; Gentry et al., 2002; Stamm, 2010; & Turgoose & Maddox, 2017).

The term CF appears to be the most inclusive, to date, providing a theory from which a field of study surrounding the cost of caring can be created around. For these reasons, the term CF was used and examined in this study.

Cost of Caring: Factors Influencing CF

Caring does not happen in a vacuum. There are a plethora of factors that influence one's experiences of being a source of hope and healing for others. There are aspects that increase one's susceptibility towards experiencing the negative aspects of caring (i.e. risk factors) as well as character traits, practices, and interventions that aid in reinforcing one's resiliency and

defending against the deleterious effects of caring. Prevalent risk factors of CF as well as protective and preventative factors for CF will be outlined below. This section of the literature review will culminate with treatment approaches used to treat CF.

Risk factors of CF. There are several theories surrounding the risk factors for developing CF. Figure 3 outlines the various risk factors associated with CF in the literature.
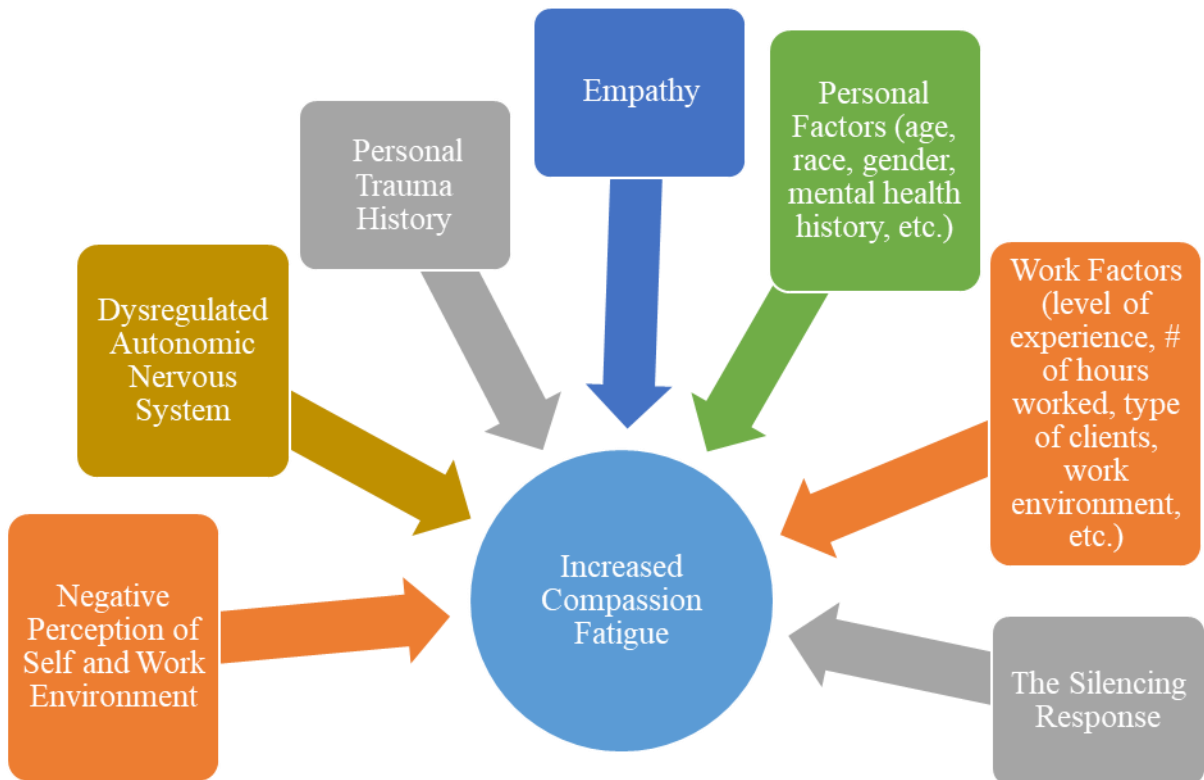
Figure 3. Outline of Risk Factors Influencing CF

Figley (1995) found that empathy plays a key role in one's ability to develop symptoms. Specifically, he describes an individual's ability to empathize with another's pain to be the vehicle of transmission (Figley, 1995). Since individuals drawn to the helping professions generally exhibit high levels of empathy, they have a heightened risk for acquiring CF symptoms

(Figley, 1995; Rothschild, 2006; Turgoose & Maddox, 2017). Stamm (1999) summarizes Figley's (1999) postulation by declaring "the capacity for compassion and empathy seems to be at the core of our ability to do the work and at the core of our ability to be wounded by the work" (p. xv). In their review of 32 CF studies, Turgoose and Maddox (2017) found evidence that supports Figley's (2002) empathy contagion theory as a developmental risk factor for CF. Indeed, "the tendency to feel distress in response to that of others is important to the development of compassion fatigue" (Turgoose & Maddox, 2017, p. 178).

Another prevalent etiological risk factor is the professional's own history with emotional pain and exposure to direct or indirect trauma (Figley, 1995; Gentry et al., 2002; Harris, 2002; Lerias & Byrne, 2003; Ray et al., 2013; Turgoose & Maddox, 2017). The most widespread factor associated with CF was participants' personal trauma history (Turgoose & Maddox, 2017). In their study of VT, a related construct to CF, Williams, Helm and Clemens (2012) found that having a trauma history increased counselor's vulnerability to develop VT. A difficulty associated with a trauma history is that it can strain regulating efforts after a critical incident(s) (Lerias & Bryne, 2003).

Similarly, there appears to be a positive relationship between professionals working with clients who have experienced trauma and CF symptoms (Lerias & Bryne, 2003; Ivicic & Motta, 2016; Stamm, 2010; Thompson, et al., 2014; Turgoose & Maddox, 2017). This theme continued to be evident in a recent literature review done by Turgoose and Maddox (2017). They (Turgoose & Maddox, 2017) uncovered a positive correlation with CF and the amount of time spent engaging in work with the traumatized in some studies. Indeed, helpers who work with those who have had traumatic experiences are particularly vulnerable to the negative effects of caring. "Trauma care comes at a price for those who provide it" (Hyatt-Burkhart, 2014, p. 452).

Other predictors of CF include personal characteristics of race, culture, and interpersonal competence, and may also contribute to one's susceptibility to secondary traumatic stress, a key component of CF (Harris, 2002). Gender also appears to be related to CF (Ivicic & Motta, 2016; Lerias & Byrne, 2003; Thompson et al., 2014). Females exhibit higher levels of CF than their male counterparts (Ivicic & Motta, 2016; Lerias & Byrne, 2003). Turgoose and Maddox (2017) found mixed support for the factors of age, caseload and level of clinical experience in contributing to CF symptoms among mental health professionals. Several studies reported that increased age and professional experience (i.e. the higher the case load and more experience one had) often yielded higher levels of CF; yet, other studies found opposite results (Turgoose & Maddox, 2017). Thus, experience and age can both be considered risk factors and protective factors for CF.

Employment setting also appears to impact symptoms of CF (Stamm, 2010). Craig and Sprang (2010) reported that therapists who work in inpatient and community mental health centers had higher levels of CF as opposed to clinicians in private practice. Thompson et al. (2014) also offer that "private practice practitioners may have less risk of burnout than counselors working in community settings, perhaps due to the greater autonomy and fewer contextual or systemic stressors" (p. 59). It appears that there are a multitude of risk factors that can culminate in CF symptoms for counselors. However, the summary of principle risk factors includes:

> Those factors where a high proportion of studies found significant relationships include trauma history, certain types of empathy, and a high caseload. These could therefore be considered as the main "risk factors" for compassion fatigue in mental health professionals (Turgoose & Maddox, 2017, p. 180).

By the very nature of their job, all counselors are subject to CF. For counselors who have all of the risk factors, the danger of developing CF compounds. Yet, CF does not have to be an inevitable part of a counseling career. The literature surrounding CF also includes information about protective factors and prevention methods. This study sought to understand how protective and preventative factors for CF can be intentionally bolstered.

Protective and preventative factors of CF. Just as there are certain things that make us more vulnerable to CF, there are also certain things that can help shield us from becoming symptomatic to vicarious pathogenic experiences like CF (Constantine Brown et al., 2017; Figley, 1995, Gentry et al., 2002; Gentry & Monson, 2017; Merriman, 2011; Merriman, 2015; Ray et al., 2013; Skovholt, 2001; Stamm, 1999; Stamm, 2000; Thompson et al., 2014; Turgoose & Maddox, 2017). Thompson et al. (2014) report that social support from peers and supervisors, self-care practices, mindfulness practices, active problem-solving, positive perceptions of the working environment, and compassion satisfaction all appear to be beneficial personal resources that safeguard against CF. Training programs/workshops that aim to prevent CF from taking root in professional counselors should incorporate these various aspects that will be explored in more detail below. Factors that moderate CF symptomology are presented in Figure 4.
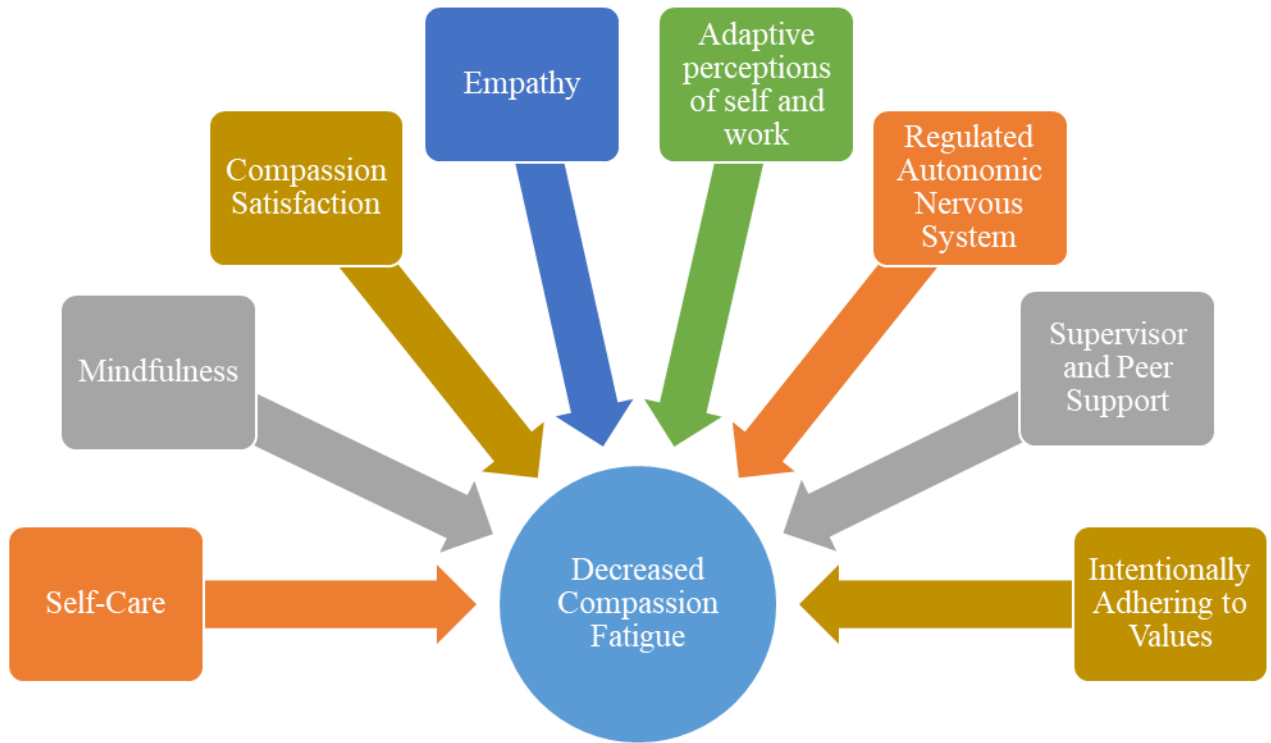
Figure 4. Outline of Protective and Preventative Factors of CF

Self-care. Self-care is a broad concept that is used throughout helping professions as a call to engage "in behaviors that balance the effects of emotional and physical stressors" (Gentry & Monson, 2017, p. 92). There are a plethora of ways that humans engage in self-care including (but not limited to): vacations, spiritual practices, investing in relationships, mindfulness, exercise, learning, relaxation, etc. Self-care has long been associated with wellness (Wolf et al., 2014). It is thought that self-care strategies honor various aspects of humanity (i.e. relational, cognitive, physical, spiritual, emotional) and that a well-rounded self-care plan includes activities and/or investment in all of these realms (Wolf et al., 2014). Engaging in self-care practices appears to mitigate CF symptoms (Thompson et al., 2014; Wolf et al., 2014).

Mindfulness. Mindfulness is defined as "the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of the

experience moment by moment" (Kabat-Zinn, 2003, p. 145). Mindfulness can be viewed as a

self-care practice (Brown, Ong, Mathers & Decker, 2017). There are several studies that support

the hypothesis that mindfulness may also be a protective and preventative factor against CF

(Brown et al., 2017; Craigie et al., 2016; Merriman, 2011; Thompson et al., 2014; Turgoose &

Maddox, 2017). Turgoose and Maddox (2017) identified several studies that reported that higher

levels of mindfulness were linked to lower levels of self-reported CF symptoms. In their study

of Master's level social work students and other mental health professionals looking at the

relationship between CF and mindfulness, Brown et al. (2017) also found an inverse relationship

with these two variables. Cultivating a mindful practice continues to emerge in the literature as a

way to lower emotional distress making it a relevant way to guard against CF symptomology.

Compassion satisfaction (CS). Compassion satisfaction (CS), the gratification one

receives from their work as a caregiver, is a well-documented protective factor that guards

against developing CF (Craigie et al., 2016; Merriman, 2011; Ray et al., 2013; Stamm, 1999;

Stamm, 2010). Reporting higher levels of CS appears to be related to lower levels of CF in a

multitude of studies (Merriman, 2011; Ray et al., 2013; Stamm, 1999; Stamm, 2010; Thompson

et al., 2014; Turgoose & Maddox, 2017). It is logical that those who report positive aspects of

their work as helpers would report lower levels of psychological distress and perceived stress of

that work (Thompson et al., 2014; Turgoose & Maddox, 2017). Indeed, the way that one thinks

about their work and themselves matters greatly.

Empathy. Empathy is tricky; it leaves a helper vulnerable to CF and it can also be a

protective factor safeguarding against CF (Figley, 1995; Rothschild, 2006; Stamm, 1999;

Thompson et al., 2014; Turgoose & Maddox, 2017). In an examination of the relationship

between empathy and CF, Turgoose and Maddox summarize "not only that participant's level of

compassion fatigue increased as level of empathy increased, but that empathy also moderated the relationship between compassion fatigue and previous trauma" (2017, p. 178). Empathy is associated with cultivating rich emotional bonds between humans (Rothschild, 2016); such human bonds are also associated with the healing power of supportive relationships (Gentry & Monson, 2017).

Discussed above are well-documented risk factors that can culminate in the development of CF and well-documented protective factors that guard against it. There are also several interventions that have shown evidence of effectiveness in bolstering resiliency and warding off CF symptoms. The evolution and format of the ARP and PRO interventions, the treatment in this study, is elaborated on below.

Interventions for CF

In 1997 Gentry et al. developed a manualized treatment, called the Accelerated Recovery Program (ARP), for individuals who were exhibiting CF symptoms. The initial study of the ARP yielded statistically significant and clinically significant effective treatment of CF in Gentry's unpublished dissertation (as cited in Gentry, 2002). During the preliminary trials of the ARP,

> It became apparent that CF was responsive to intervention and may even be the incentive
> that leads to the enhancement of professional skills and personal life enrichment in the
> same way that a crisis may precipitate change and growth in a patient or client's lives.
> (Gentry et al., 2002, p. 128)

Posttraumatic growth, in addition to symptom reduction, appeared to be a part of participants' experiences during the ARP. The ARP model continued to undergo revisions and morphed into several different types of treatment options including training-as-treatment models as well as

large and small group workshop and retreat models (Gentry, 2002; Gentry et al., 2002). The

overall purpose of all ARP models "was to provide participants with the raw materials to begin

to develop resiliency and prevention skills from CF" (Gentry et al., 2002, p. 128). Gentry et al.

(2002) describe that the ARP models were purposefully designed to be collaborative, engaging

and highly introspective in nature with the intent of inviting participants toward intentionality

and responsiveness in their professional and personal lives.

The training-as-treatment model yielded statistically significant results (p < .001) when

pre-training and post-training measures of CF were compared (Gentry, 2002). The ARP, and/or

training-as-treatment model, has since assisted thousands of professional caregivers to manage

their CF symptoms, bolster their resiliency, and rekindle their professional purpose (Gentry &

Monson, 2017). A multitude of studies support the effectiveness of this treatment model in

decreasing CF symptoms (Baranpwsky, Gentry, & Baggerly, 2005; Craigie et al., 2016; Flarity et

al., 2013; Flarity et al., 2016; Flarity et al., 2016b; Gentry, Baggerly, & Baranowsky, 2004;

Gentry, 2002; Potter et al., 2015; Rank et al., 2009). The current version of the ARP is Gentry's

Professional Resilience and Optimization (PRO) workshop (Gentry & Monson, 2017).

Outline of PRO workshop

A myriad of individual and group dynamics as well as purposeful interventions are part

of what make the PRO workshop effective in the reduction and prevention of CF. The operative

structural components of the ARP include: developing a therapeutic alliance, quantitative and

qualitative self-assessment of CF symptoms, anxiety reduction, developing and sharing

secondary trauma narratives, using exposure techniques to resolve STS symptoms, cognitive

restructuring as well as equipping participants with resiliency skills (Gentry et al., 2002, p. 129-

131). Additionally, normalizing the experience of CF and fostering a safe and supportive group

environment for participants are also integral parts of all ARP models (J. E. Gentry, personal communication, May 27, 2017).

The chronological order of workshop material is deliberate and cumulative. Preliminary information and activities function as building blocks for subsequent material and interventions. Eliciting participant buy-in and personal identification of their own CF symptomology are key beginning components (Gentry & Monson, 2017). Also, the use of psychoeducational and experiential means to lay a foundation for understanding CF, including how the perception of threat leads to physiological reactions in our autonomic nervous systems, are pivotal introductory intervention mechanisms for lasting CF symptom reduction (Gentry & Dietz, 2020; Gentry & Monson, 2017). The later portions of the workshop outline five skills that have been found to stimulate professional resiliency when used in deliberate and regular practice (Gentry et al., 2002; Gentry & Monson, 2017). The five resiliency skills are: self-regulation, intentionality, perceptual maturation, social support and self-care (Gentry & Dietz, 2020; Gentry & Monson, 2017). The resiliency skills are often referred to as the "antibodies of CF" in accordance to the "emotional contagion theory" postulated by Figley (1995) and Rothschild (2006). The use of these "antibodies" can bolster one's emotional immune system to effectively fight off symptoms of CF. The information and resiliency skills build on each other and are presented in the following chronological order.

Psychoeducation and experiential activities on the topic of threat perception and the autonomic nervous system (ANS) occur first. When humans are confronted with a threat, the ANS is activated creating a chain of physiological changes to help keep us safe from the threat. However, humans do not actually need to be confronted with a real threat for these physiological changes to occur; we can often simply perceive a threat. This perception of threat is stress and

often functions beneath our awareness (Gentry & Dietz, 2020). Recognizing and learning to interrupt this threat response is pivotal to CF reduction and prevention.

The first resiliency skill is self-regulation. "Self-regulation is the ability to intentionally control the activity of our autonomic nervous system (ANS)" (Gentry & Monson, 2017, p. 54). Specifically, it involves engaging in body awareness (i.e. interoception) and relaxing the body's muscles while in the context of perceived threats (Gentry & Dietz, 2019; Gentry & Monson, 2017). This acute muscle relaxation practice interrupts our threat-response system by shifting out of sympathetic nervous system arousal, thus decreasing distress levels (Gentry & Dietz, 2019). The habitual practice of ANS arousal modulation through self-regulation can assist with controlling the body's use of energy, increasing bodily comfort as well as optimizing cognitive and motor functioning (Gentry & Dietz, 2019). Practical ways to practice self-regulation include: noticing and relaxing tense muscles in the body (i.e. "wet noodle"), diaphragmatic breathing, pelvic floor muscle relaxation and expanding the visual field to include the periphery (i.e. "peripheral vision") (Gentry & Monson, 2017). When cognitive functioning is restored via self-regulation, it is physiologically easier to think and act purposefully. Thus, self-regulation provides a foundation for building the other resiliency skills.

The next resiliency skill that has been found helpful in eliminating CF is intentionality (Gentry & Dietz, 2020; Gentry & Monson, 2017). Intentionality is the ability to choose responses (vs. emotionally reacting) that align with our personal values and principles (Potter et al., 2015). Following trauma, sympathetic nervous system arousal creates biological changes that inhibit our ability to think logically and engage in intentional behavior (Gentry, 2016; Gentry & Dietz, 2019). These dysregulated behaviors are "breaches in our integrity" (Gentry & Dietz, 2019, p. 96) and can culminate in the creation of moral wounds (Gentry, 2016).

Accompanied by self-regulation, intentionality can be accomplished no matter what the circumstances might be (Frankl, 1959; Gentry & Monson, 2017). Intentionality involves being explicit about what values one holds dear as well as adhering to one's individual moral compass. Crafting a Mission Statement is an activity that fosters intentionality (Gentry & Monson, 2017).

Positive shifts in perceptions of self and work as well as the ability to actively engage in problem solving coping strategies appear to be CF protective factors (Potter et al., 2015; Thompson et al., 2014). Perceptual maturation is the next resiliency skill, and involves shifting cognitions and perceptions in adaptive and mature ways (Gentry & Monson, 2017). This concept of resiliency is reminiscent of Cognitive Behavioral Therapy that largely involves being able to change maladaptive thoughts and behaviors (J. E. Gentry, April 18, 2014, personal communication). Gentry (2002) asserts the importance of softening coercive and negative self-talk towards self-acceptance and compassion as part of healing wounds associated with CF. Feeling like a victim of a toxic work environment and resulting diminished internal locus of control are integral to burnout development. As such, a perceptual shift to the definition of burnout to the perception of demands outweighing the perceived resources (Gentry & Baranoswky, 1998) can help restore internal locus of control, reducing burnout. Several other examples of cognitive shifts that decrease CF symptoms include: Choice vs. Demand, Acceptance of Anxious Systems/System Demands and Personal Best vs. Outcome Oriented as outlined by Gentry and Monson (2017). Choice vs. Demand involves choosing to engage in tasks instead of perceiving that tasks are being demanded of them. Acceptance of Anxious Systems/System Demands embraces the understanding that systems will ask more of employees than they are likely able to give. Personal Best vs. Outcome Orientated encompasses striving for positive outcomes while being secure in performing at one's personal best.

Another critical aspect of resiliency is social support. Positive emotional and social connections, for instance receiving support from supervisors and colleagues, can decrease or prevent CF and/or burnout (Greenham et al., 2019; Thompson et al., 2014). Social support empowers helpers to challenge their negative thought patterns as well as admit and confront breaches in their integrity. These adaptive shifts assist in decreasing burnout symptoms (Gentry & Monson, 2017). Providing accountability and offering a safe place for the sharing of STS trauma narratives (Gentry, 2002; Gentry & Monson, 2017) also falls under the notion of social support.

The last resiliency skill emphasized in the workshop is self-care. Self-care is more than just engaging in comforting activities (i.e. a hot bath). Adaptive self-care involves engaging in activities and tasks that will ultimately yield health, wellness, joy, contentment and vitality (Gentry & Monson, 2017). The concept of self-care can be broken down into facets of caring for our physical, emotional, intellectual, spiritual and relational selves (Wolf et al., 2014). Evaluation of existing self-care strategies and creating a plan to improve self-care are part of the workshop (Gentry & Dietz, 2020; Gentry & Monson, 2017).

The last stage of the workshop is providing participants with an opportunity to put together a Self-Directed Resiliency Plan (Gentry & Dietz, 2020; Gentry & Monson, 2017). The purpose of the Self-Directed Resiliency Plan is to foster explicit intentions for the utilization of the resiliency skills (Gentry & Monson, 2017). Ultimately, solidifying a plan to use all of the resiliency factors will aid in cementing the learning from the workshop and improving the overall effectiveness of participants' efforts to cultivate lifelong resiliency habits (Gentry & Monson, 2017). This opportunity to reflect and plan is followed by a closing ritual that includes

the expression of gratitude. The intervention used in the current study will be an adaptation of the PRO workshop; facilitated with permission.

In summation of the literature, CF is the most all-encompassing term that embodies the cost of caring when compared to other terms like: CT, VT, empathy fatigue or STS and BO as standalone terms. There is no existing longitudinal research on the treatment and prevention of CF in mental health professionals and CITs using a treatment and control group. It is hypothesized that following the PRO outline of training could continue to be effective for decreasing CF in mental health professionals and CITs; thus, was used as the treatment in this study. This study included both a longitudinal design and a control group. Chapter Three will outline the research methods proposed for this study.

CHAPTER THREE: METHODS

This study aimed to understand how a resiliency based training impacted CF symptoms over time compared to a nonequivalent control group who did not participate in the training.

Participants

The target population in this research study was Masters' level CITs enrolled in counselor education programs and mental health professionals in the state of Montana. This study used a nonprobability convenience sample of these nonequivalent target populations and participants were not randomly assigned.

A total of 43 CITs and mental health professionals consented to take part in this study (treatment group n = 15; control group n = 28). Three control group participants did not finish their pretest survey and were therefore omitted from the sample. Interestingly, there was an unequal distribution of CITs and mental health professionals between the treatment and control groups; the treatment group was comprised primarily of CITs whereas the control group was comprised primarily of professionals. Table 1 presents the total number of participants for each group and their participation at each data collection times. The total sample size for this study was 19 participants who completed assessments at all three times.

Table 1.
Breakdown of study participants

Data Collection Times	Treatment Group			Control Group		
	CITs	MHPs	Total	CITs	MHPs	Total
Pretest	12	3	15	3	22	25
Time 1	5	0	5	2	15	17
Time 2	8	2	10	3	19	22
All 3 Data Collection Times	5	0	5	1	13	14

Demographics are reported for all participants who completed any part of the study, whereas some of the analyses below will only include participants who completed all three test administrations as well as those who completed only pretest and Time 2 test administrations. Participants' ages ranged from 23 years to 71 years with the mean age of 44 years. The majority of the participants identified as Caucasian (n = 35), followed by multiracial (n = 3), American Indian (n = 1), and Other (n = 1). Seven participants identified their gender as male and 30 identified as female, two participants reported identifying with multiple genders (one as transgendered and male; one as female and non-binary) and one participant did not complete the gender question. Thirty-five participants reported experiencing trauma as a child, as measured by the ACE, (88.4%) and 31 as an adult (72.1%). (For details on collection methodology also see Demographic survey in Instrumentation section below.)

Four treatment group participants, all CITs, also participated in a 7-week resiliency group after the resiliency training workshop in the Spring of 2020. The purpose of this group was to bolster the utilization of resiliency skills and was based on the Forward-Facing Trauma Therapy (FFTT) group protocol (Gentry, 2016). This group may have functioned as a "booster" for participants.

Variables in the Study

This was a quasi-experimental control time series study design with two independent variables and three dependent variables. The variables assessed in this study are elaborated on below.

Independent variables. The independent variables in this study were: 1) participation in a resiliency training based on the ARP model, and 2) time. Participation in the resiliency training was a categorical variable; participants either attended the resiliency training and

volunteered to be in the experimental group or they volunteered to be in the control group. Time

represented the second independent variable, as participants were assessed at three time periods

throughout the course of the study- at baseline (during the training), at 3-month follow-up (Time

1), and at 6-month follow-up (Time 2).

Dependent variables.

Secondary traumatic stress (STS). STS, as described by Valent (1995), is a maladaptive

response (p. 31) that occurs "when a person is secondarily influenced by the stress response of

another person" (p. 29). Figley (1999) offers a similar definition: "we define secondary

traumatic stress as the natural, consequent behaviors and emotions resulting from *knowledge*

about a traumatizing event experienced by a significant other. It is the stress resulting from

helping or wanting to help a traumatized or suffering person" (p.10). Rothschild (2006) asserts

that caregivers become victimized "by becoming overwhelmed" (p. 14) by what they witness as

a result of working with someone who is traumatized. Notably, STS is distinct from

Posttraumatic Stress Disorder (PTSD) in that it develops following exposure to trauma at an

ancillary level (Figley, 1999). In this study STS was measured by participant responses to the

secondary traumatic stress subscale of the Professional Quality of Life (Pro-QOL) self-

assessment tool.

Burnout (BO). BO, the second element of CF, is defined by Maslach and Goldberg

(1998) as "a psychological syndrome of emotional exhaustion, depersonalization, and reduced

personal accomplishment" (p. 64). An alternate definition of BO is the perception of demands

outweighing the perceived ability to manage them (Gentry & Baranowsky, 1998). Figley (2006)

labels BO as a gradual process of job stress, loss of idealism and sense of accomplishment and

intense exposure to clients. BO, as reported by Kahill (1988), encompasses physical, emotional,

behavioral, work-related, and interpersonal symptoms. Several of such symptoms include: exhaustion, somatic complaints, helplessness, defensiveness, aggression, work performance difficulty and interpersonal relationship distress (Kahill, 1988). BO was measured using the Pro-QOL BO subscale.

Compassion satisfaction (CS). The final quantitative dependent variable that the Pro-QOL measures is CS. This scale measures the amount of affirmation that one experiences from their work (Stamm, 2010). It is defined as "the positive feelings about people's ability to help" (Stamm, 2010, p. 8). CS is an important protective factor against contracting symptoms of CF (Stamm, 2010). The higher the scores on this variable, the more likely a person is to be engaged in their work, feel like they are making a valuable contribution and enjoy the work that they do (Stamm, 2010). CS was measured by the Pro-QOL CS subscale.

Instrumentation

Professional quality of life (Pro-QOL). The dependent variables were measured by participant responses to the Professional Quality of Life (Pro-QOL) self-assessment tool (Stamm, 2010). This assessment tool was chosen for this study because it is widely used in research studies on the topic with various helping professions, including mental health professionals (Stamm, 2010). Furthermore, the Pro-QOL's categories of CF coincide with the definition of CF (Figley, 1995) that was used in this study. The Pro-QOL is a self-assessment screening tool that breaks down CF into STS and BO symptoms providing measures of each scale (Stamm, 2010). The Pro-QOL has been used to assess CF and CS in a variety of cultures (Stamm, 2010). The Pro-QOL can be found in Appendix A. The Pro-QOL STS subscale statements are presented in

Table 2; the Pro-QOL BO subscale statements are presented in Table 3; and the Pro-QOL CS

subscale statements are presented in Table 4.

Table 2
Secondary Traumatic Stress Pro-QOL Items

Secondary Traumatic Stress Items
I am preoccupied with more than one person I help.
I jump or am startled by unexpected sounds.
I find it difficult to separate my personal life from my life as a helper.
I think that I might have been affected by the traumatic stress of those I help.
Because of my helping, I have felt "on edge" about various things.
I feel depressed because of the traumatic experiences of the people I help.
I fell as thought I am experiencing the trauma of someone I have helped.
I avoid certain activities or situations because they remind me of frightening experiences of the people I help.
As a result of my helping, I have intrusive, frightening thoughts.
I can't recall important parts of my work with trauma victims.

Note. Adapted from "Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL)" by B. H. Stamm, 2010. www.proqol.org. This test may be freely copied as long as (a) author is credited, (b) no changes are made, and (c) it is not sold.

Table 3
Burnout Pro-QOL Items

Burnout Items
I am happy.*
I feel connected to others.*
I am not as productive at work because I am losing sleep over traumatic experiences of a person I help.
I feel trapped by my job as a helper.
I have beliefs that sustain me.*
I am the person I always wanted to be.*
I feel worn out because of my work as a helper.
I feel overwhelmed because of my case [work] load seems endless.
I feel "bogged down" by the system.
I am a very caring person.*

Note. Adapted from "Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL)" by B. H. Stamm, 2010. www.proqol.org. This test may be freely copied as long as (a) author is credited, (b) no changes are made, and (c) it is not sold.
*reverse scored items

Table 4

Compassion Satisfaction Pro-QOL Items

Compassion Satisfaction Items
I get satisfaction from being able to help people.
I feel invigorated after work with those I help.
I like my work as a helper.
I am pleased with how I am able to keep up with helping techniques and protocols.
My work makes me feel satisfied.
I have happy thoughts and feelings about those I help and how I could help them.
I believe I can make a difference through my work.
I am proud of what I can do to help.
I have thoughts that I am a "success" as a helper.
I am happy that I chose to do this work.

Note. Adapted from "Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL)" by B. H. Stamm, 2010. www.proqol.org. This test may be freely copied as long as (a) author is credited, (b) no changes are made, and (c) it is not sold.

The Pro-QOL utilizes a Likert scale for each question; asking participants to rate how often they have experienced the various statements within the last thirty days (1=Never, 2=Rarely, 3=Sometimes, 4=Often, 5=Very Often) (Stamm, 2009). This Likert scale yields ordinal (non-continuous) level data (Kero & Lee, 2016). The 30-question instrument is broken into the three variables (STS, BO and CS) and the item scores are summed to get a raw score for each variable. There is no cumulative CF score. The raw scores are reported as continuous (ratio) variables. Raw scores are then converted into t-scores and reported at the interval level. Finally, a nominal description of low, average, or high (Stamm, 2010) is provided for a quick interpretation of scores.

A multitude of published works have reported that the Pro-QOL has evidence of good construct validity (Stamm, 2010). Stamm (2009) reported that the Pro-QOL subscales measure different constructs as a result of a multi-trait, multi-method approach to convergent and discriminant validity; however, further specific validity data is not available. Reliability of the Pro-QOL scales are reported separately. The STS scale has an average score of 50 (SD 10; alpha

scale reliability 0.81) (Stamm, 2010). The BO scale average score is 50 (SD 10; alpha scale

reliability 0.75) (Stamm, 2010). Stamm (2010) reports that CS scale yields average scores of 50

(SD 10; alpha scale reliability 0.88).

There is some shared variance between the Pro-QOL subscales according to Stamm

(2010). Inter-scale correlations between subscales revealed a 34% shared variance ($r = .58$; co-σ

= 34%; n = 1187) between STS and BO subscales, a 5% shared variance ($r = -.23$; co-σ = 5%; n

= 1187) between STS and CS subscales and a 2% shared variance ($r = -.14$; co-σ = 2%; n =

1187) between BO and CS (Stamm, 2010). Detectible mathematical and logistical errors in the

Pro-QOL Manual (Stamm, 2010) have been corrected here.

Adverse Childhood Experiences (ACE). The ACE is a 10-item forced choice (yes, no)

questionnaire that assesses the presence of traumatic or adverse childhood experiences. It came

out of the well-known ACE study (Felitti et al., 1998) that demonstrated a strong relationship

between a myriad of risk factors attributed to leading causes of death in adults and exposure to

adverse childhood experiences. The questions on the ACE are either related to childhood abuse

or exposure to dysfunction in the household during childhood (Dong, Giles, Felitti, Dube,

Willimas, Chapman & Anda, 2006; Dube, Williamson, Thompson, Felitti, & Anda, 2004; Felitti

et al., 1998). There are three categories of childhood abuse: physical abuse, sexual abuse, and

psychological abuse (Dube et al., 2004; Dong et al., 2006; & Felitti et al., 1998). The categories

of household dysfunction include questions related to exposure to mental illness, violent

treatment of another, substance abuse or criminal behavior (Dong et al., 2006; Felitti et al.,

1998). One point is given for each item answered in the affirmative ("yes") and zero points are

given for each "no" response for a total of ten (10) possible points. Felitti et al. (1998) report

that roughly 70% of adults living in the United States report having an ACE score of at least one. A copy of the ACE questionnaire can be found in Appendix C.

There is limited information about the reliability and validity of the ACE questionnaire and yet it is a well-used research tool to examine the existence of childhood trauma retrospectively. In a response bias analysis (i.e. attributing health concerns to adverse childhood experiences), no evidence was found to support participant response biases (Dong et al., 2006). Results of a multivariate logistic regression yielded no evidence of collinearity between demographic factors (i.e. age, race, sex, education) and ACE scores of participants (Dong et al., 2006). An additional analysis of test-retest reliability of adults reporting the retrospective reports of adverse childhood experiences yielded kappa coefficients in the good agreement to the moderate to substantial range for each individual ACE question as well as for the overall ACE score (Dube et al., 2004). In terms of validity, the ACE questionnaire is thought to possess good face validity for measuring childhood experiences that could be interpreted as traumatic in nature.

Demographic survey. Study participants also completed a brief demographic survey as part of this study. Items measured in this survey were drawn from similar demographic surveys; collecting data about age, race, sex, gender, professional development information, etc. Participants were also asked if they have ever participated in a resiliency workshop before in this survey. Additionally, optional item(s) assessing adult trauma were included. Trauma classifications (i.e. physical abuse, emotional abuse, sexual abuse, neglect, discrimination, historical trauma, racism, traumatic event(s), homophobia, sexism, other) were gleaned from a panel of experts and trauma literature. A copy of the demographic survey can be found in Appendix B.

COVID-19 pandemic impact questions. The COVID-19 pandemic began generating large scale changes to our world beginning March 2020. After the baseline data collection, IRB approval was sought and granted for the inclusion of questions measuring the pandemic's influence on participants due to the importance of capturing this history effect as a potential confounding variable. The following questions were added to the Time 1 and Time 2 data collection times:

Please indicate how the COVID-19 pandemic has impacted your work life (check all that apply):

   a) Transitioned to virtual delivery of counseling services

   b) Lost clients

   c) Gained clients

   d) Loss of job (no longer practicing counseling at this time)

   e) No changes to delivery of counseling services

   f) Other: (please describe)

Please indicate how the COIVD-19 pandemic has impacted your personal life (check all that apply):

   a) Social isolation as a result of social distancing

   b) Increased sadness

   c) Increased anxiety

   d) Trauma responses have been triggered

   e) Financial strain

   f) Increased happiness

   g) Increased connection to supportive others

h) No changes to personal life

i) Other (please describe):

Resiliency skills usage survey (RSUS). A resiliency skills usage survey was developed to assess the treatment group participants' ongoing practice of the resiliency skills learned post-training. This survey used a Likert scale (1 = never use; 2 = use once a month; 3 = use once a week; 4 = use daily) to yield ordinal level data. This survey produced a sum score of resiliency skill usage ranging from 14 (min) to 56 (max). Also, this survey assessed which, if any, of the resiliency skills treatment group participants may have practiced prior to the workshop. Treatment group participants were asked to complete this survey as part of their posttest Time 1 (3 month) and Time 2 (6 month) data collection points. A copy of the resiliency skills usage survey can be found in Appendix D.

Research Procedures

This study was a quasi-experimental control time series design. The benefit of this quantitative research design was that scores before and after a treatment could be compared between a treatment group and a nonequivalent control group (Privitera, 2017). This design attempted to answer the research question: How does attending a resiliency training affect self-reported STS, BO and CS scores (as measured by the Pro-QOL) over time?

Data collection procedures. Participants in the experimental group attended a two-day resiliency training based off of Gentry's *Professional Resilience and Optimization* workshop (Gentry & Deitz, 2020; Gentry & Monson, 2017) in February 2020. Experimental group participants registered for either academic credit (1 credit) or for continuing education credit (13 hours) for training attendance. During the training, participants were invited to participate in the research study. Informed consent was obtained, both orally and in writing. Only workshop

participants consenting to participate in the study were included in this research. An individual

numerical code was assigned to each participant on their Informed Consent form; this code was

used to both track their Pro-QOL scores over time and to add another layer of privacy protection.

Participants in the experimental group completed the Pro-QOL, ACE Questionnaire and

demographic survey during the course of the resiliency training. Participants left their hardcopy

of their Pro-QOL and ACE Questionnaire overnight for the researcher to copy. Their original

Pro-QOL and ACE Questionnaire were returned to participants on Day 2 of the workshop for

their own progress monitoring purposes, and the researcher retained a copy in a secure location.

Accuracy of experimental group pretest Pro-QOL self-scoring was double checked by the

researcher. If necessary, appropriate scoring changes were made before data entry. The

remainder of Pro-QOL scoring was automatically calculated by Qualtrics. Participants then

received a Qualtrics survey link via their provided email address to access the 3-month posttest

assessments (Pro-QOL, RSUS, COVID-19 impact questions) in May 2020. Identical 6-month

posttest assessments (Pro-QOL, RSUS, COVID-19 impact questions) were sent out in the same

manner in August 2020. Both posttest surveys included an initial question querying if the

participant has experienced any significant changes in life and/or work in the last 3 months. If

endorsed, the participant were directed to complete the demographic survey again before

completing the Pro-QOL. If denied, the participant was directed to the Pro-QOL and RSUS.

The purpose of the inclusion of this question was to account for potential confounding variables.

Control group participants did not attend the resiliency workshop (the treatment). They

received a link via email to access the pre-test assessment battery consisting of: the Pro-QOL,

ACE Questionnaire and demographic survey. The 3 and 6 month posttest assessment battery

(Pro-QOL, COVID-19 questions, and, if appropriate, the demographic survey again) were emailed to control group participants in May and August, respectively.

Assessment scores for both the experimental and control groups were automatically calculated by Qualtrics. The data was then analyzed using SPSS. Figure 5 outlines the data collection timeline.

Data Collection Phase 1: Pretest
- Experimental Group:
  - Participated in 2-day resiliency workshop
  - Collected: Pro-QOL, ACE, Demographic Survey
- Control Group:
  - Did not participate in resiliency workshop
  - Collected: Pro-QOL, ACE, Demographic Survey

Data Collection Phase 2: 3 month posttest
- Experimental Group:
  - Collected: Pro-QOL, RSUS, COVID-19 impact questions
- Control Group:
  - Collected: Pro-QOL, COVID-19 impact questions

Data Collection Phase 3: 6 month posttest
- Experimental Group:
  - Collected: Pro-QOL, RSUS, COVID-19 impact questions
- Control Group:
  - Collected: Pro-QOL, COVID-19 impact questions

Figure 5. Data Collection Outline

Data Analysis

There was a substantial amount of missing data (91.18% of all variables) over the course of this study; a common challenge in longitudinal studies. All participants had some missing values. Some of the missing values were built into the demographic survey; CITs for example, were not asked to complete the demographic questions that were not applicable to them. For the main analysis, the trimming method of dealing with missing values was used. If a participant did not complete all three data collection points, then their results were removed from the main analysis. Trimming did result in a substantial reduction in sample size, particularly for the treatment group (treatment group n = 5; control group n = 14), and is a major limitation of this study.

Baseline, Time 1 (3-month posttest), and Time 2 (6-month posttest) Pro-QOL results for both the treatment and control group were gathered. Specifically, each participant's baseline and Time 1 and Time 2 Pro-QOL subscales of STS, BO and CS were compared by computing differences in scores between the time point administrations of the Pro-QOL.

Three two-way mixed ANOVAs, one per each dependent variable, were used to determine how attending a resiliency training affected STS and BO symptoms and CS over time between the experimental and control group. The two-way mixed ANOVAs examined the individual and joint effect of the two independent variables (experimental or control group and pretest, Time 1 and Time 2) on each dependent variable, the three Pro-QOL subscales of STS, BO, and CS (Pallant, 2013). The null hypothesis was that there would be no difference in adjusted means of the Pro-QOL subscales over time. Said another way, self-reported professional quality of life scores would not vary over time between the experimental and control groups. A priori assumptions included setting α at 0.05.

There are several assumptions of the two-way mixed ANOVA (Pallant, 2013;

www.statistics.laerd.com):

- One continuous dependent variable

    o This study had three dependent variables: the STS, BO, and CS subscales of the

      Pro-QOL. Thus, three two-way mixed ANOVAs were conducted, one per

      dependent variable.

- One categorical between-subjects factor (i.e. independent variable) that consisted of two

  or more categories

    o Two groups: Experimental or control group

- One categorical within-subjects factor (i.e. independent variable) that consisted of two or

  more categories

    o Three levels of time points: pretest, Time 1, Time 2

- No significant outliers

- Approximately normal distribution

- Variances of differences between all combinations of levels must be approximately equal

  (i.e. sphericity)

Inferential statistical analyses of this study should be interpreted with caution due to the small

sample size after trimming. Descriptive statistics may be a more informative way of looking at

this study's data and will also be provided in Chapter Four.

CHAPTER FOUR: RESULTS

The main hypothesis predicted a difference between CF (BO and STS subscales) and CS scores over time between the treatment and control group. The main analysis included three two-way mixed ANOVAs (one per dependent variable) for participants who completed the survey at all three data collection times. A priori assumptions included setting the adjusted α level at 0.05 for statistical analyses.

Secondary Traumatic Stress (STS) Pro-QOL Subscale

It was hypothesized that STS scores would decrease after workshop attendance for the treatment group compared to the control group over time. Data from participants who completed assessments at all three data collection times were used to answer this hypothesis. Table 5 provides the Pro-QOL STS subscale mean scores over time. Figure 5 overlays the Pro-QOL STS mean scores on individual participants' scores in both groups over time showing the non-significant pattern of STS score variation.

Table 5
Pro-QOL STS subscale mean scores over time

	Pretest Mean	Time 1 Mean	Time 2 Mean
Treatment Group (n = 5)	23.6	20.8	22
	(SD = 5.41)	(SD = 4.75)	(SD = 5.79)
Control Group (n= 14)	22.07	22.71	20.79
	(SD = 3.58)	(SD = 3.56)	(SD = 3.62)
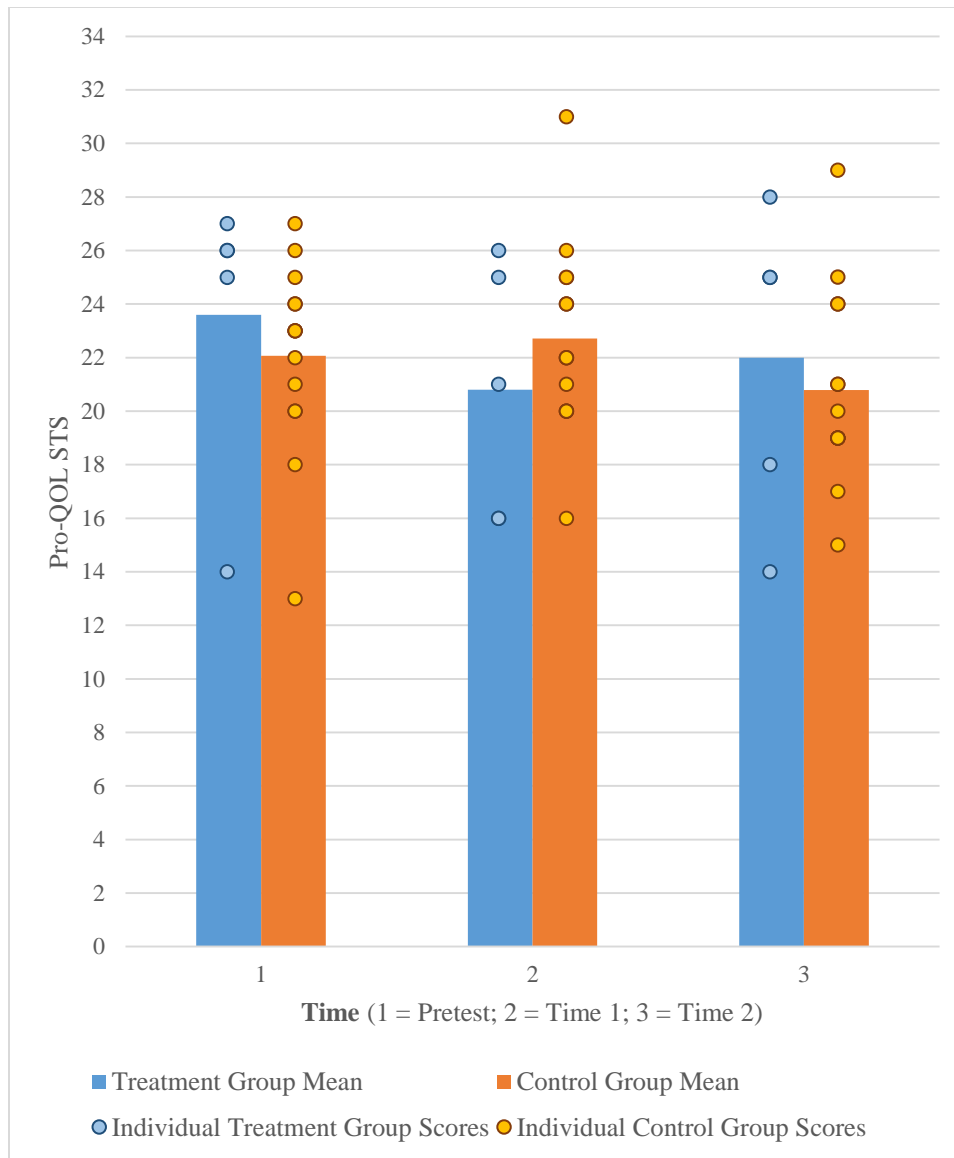
Figure 5. Overlay of Pro-QOL STS subscale mean and individual participant scores over time. There were some identical individual Pro-QOL STS scores; thus the number of individual scores shown may be less than the *n*s.

Treatment group STS mean scores did decrease from Pretest to Time 1 (Table 5; Figure 5); however, this symptom reduction was not maintained over time as the treatment group STS mean increased between Time 1 and Time 2 (Table 5; Figure 5). Control group Pro-QOL mean scores were relatively stable over time (Table 5; Figure 5). Stable control group STS mean score results were consistent with the hypothesis.

An inspection of a boxplot found two outliers; these outliers were retained to keep the integrity of sample size intact. The majority of Pro-QOL STS scores were normally distributed, as assessed by Shapiro-Wilks' test ($p > .05$). However, the assumption of normal distribution was violated for the treatment group pretest Pro-QOL STS scores, as assessed by Shapiro-Wilks' test, $p = .005$. It was decided to continue the analysis as the rest of the scores met this assumption and because ANOVAs are fairly resistant to deviations of normality (www.statistics.laerd.com). There was homogeneity of variance, as assessed by Levene's Test, $p > .05$. Mauchly's test of sphericity was met for the two-way interaction, $x^2(2) = 3.886$, $p = .143$. A non-statistically significant interaction was found between the treatment and time on Pro-QOL STS scores, $F(2, 34) = 2.713$, $p = .081$, partial $\eta^2 = .138$. The main effect of time yielded a non-statistically significant difference in mean Pro-QOL STS scores at different time points, $F(2, 34) = 1.686$, $p = .200$, partial $\eta^2 = .090$. The main effect of group yielded a non-statistically significant difference in mean Pro-QOL STS scores between the treatment and control groups, $F(1, 17) = .021$, $p = .886$, partial $\eta^2 = .001$. The result of this analysis is a failure to reject the null hypothesis that there is no statistically significant difference between Pro-QOL STS scores between the treatment and control groups. No additional analyses were run on the data collected at all three time administrations as no significant interactions were found. A post hoc analyzing data collected at pretest and Time 2 administrations is included below. Table 6 depicts the two-way mixed ANOVA analysis for participants who completed all three data collection times (total $n = 19$; treatment group $n = 5$; control group $n = 14$).

Table 6
ANOVA for Pro-QOL STS at all three time points

Source	df	F	p	η^2
Time	2	1.686	0.2	0.09

Group	1	0.021	0.886	0.001
Time*Group	2	2.713	0.081	0.138

A post hoc two-way mixed ANOVA was conducted to determine whether there were differences in Pro-QOL STS mean scores between the treatment and control group from pretest and Time 2 posttest. This analysis was conducted to capture a larger sample size that included all participants who completed assessments at pretest and Time 2. The total sample size for this post hoc analysis was 30 (treatment group n = 10; control group n = 20). Table 7 provides the Pro-QOL STS subscale mean scores at pretest and Time 2. Figure 6 overlays the Pro-QOL STS mean scores on individual participants' scores in both groups at pretest and Time 2 showing the non-significant pattern of STS score variation.

Table 7
Pro-QOL STS subscale mean scores at pretest and Time 2

|	Pretest Mean	Time 2 Mean
Treatment Group (n = 10)	24 (SD = 5.40)	23 (SD = 6.31)
Control Group (n = 20)	21.85 (SD = 3.18)	21.5 (SD = 4.01)

Figure 6. Overlay of Pro-QOL STS subscale mean and individual participant scores at pretest and Time 2. There were some identical individual Pro-QOL STS scores; thus the number of individual scores shown may be less than the *n*s.

Treatment group STS mean scores did decrease from Pretest to Time 2 (Table 7; Figure 6); consistent with the hypothesis. Control group Pro-QOL STS mean scores were relatively stable between pretest and Time 2 (Table 7; Figure 6); consistent with the hypothesis. However, contrary to the hypothesis, control group Pro-QOL STS mean scores were lower than the treatment group at both pretest and Time 2 (Table 7; Figure 6).

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There were four non-extreme outliers in the dataset, as assessed by inspection of a boxplot for values greater than 1.5 box-lengths from the edge of the box. These outliers were retained in the analysis as they were not extreme and to retain the sample size integrity. Pro-QOL STS scores were generally normally distributed, as assessed by Shapio-Wilk's test ($p >$ .05); the treatment group pretest STS scores were not normally distributed ($p = $ .040). Data was retained, as ANOVAs are fairly resistant to violations of normality (www.statistics.laerd.com). Generally, there was homogeneity of variances, as assessed by Levene's test of homogeneity of variance ($p >$ .05). However, $p = $ .049 for STS scores at Time 1. Data was retained despite this violation in order to conduct the ANOVA; results should be interpreted with caution. There was homogeneity of covariances, as assessed by Box's test of equality of covariance matrices ($p >$ .05). There was a non-statistically significant interaction between the intervention and time on Pro-QOL STS scores $F(1, 28) = $ .182, $p = $ .673, partial $\eta^2 = $ .006. Testing the main effect of time yielded a non-statistically significant difference in mean Pro-QOL STS scores at different time points, $F(1, 28) = $ .786, $p = $ .383, partial $\eta^2 = $ .027. There was a non-statistically significant main effect for group, $F(1, 28) = $ 1.380, $p = $ .250, partial $\eta^2 = $ .047. In contrast to the hypothesis, participants in the control group reported non-significantly lower STS scores as compared with the treatment group. The result of this analysis is a failure to reject the null hypothesis that there is no statistically significant difference between Pro-QOL STS scores between the treatment and control group. No additional analyses were run as no significant interactions were found. Table 8 depicts the two-way mixed ANOVA analysis for participants who completed the pretest and Time 2 collection times (total n = 30; treatment group n = 10; control group n = 20).

Table 8
ANOVA for Pro-QOL STS at pretest and Time 2 time points

Source	df	F	p	η^2
Time	1	0.786	0.383	0.027
Group	1	1.38	0.25	0.047
Time*Group	1	0.182	0.673	0.006

Burnout (BO) Pro-QOL Subscale

It was hypothesized that BO scores would decrease after workshop attendance for the

treatment group compared to the control group over time. Data from participants who completed

assessments at all three data collection times were used to answer this hypothesis. Table 9

provides the Pro-QOL BO subscale mean scores over time. Figure 7 overlays the Pro-QOL BO

mean scores on individual participants' scores in both groups over time showing the pattern of

BO score variation.

Table 9
Pro-QOL BO subscale scores over time

	Pretest Mean	Time 1 Mean	Time 2 Mean
Treatment Group (n = 5)	23.2 (SD = 4.82)	20.8 (SD = 3.63)	23.8 (SD = 4.49)
Control Group (n = 14)	21.36 (SD = 4.40)	22.43 (SD = 5.09)	22 (SD = 5.05)
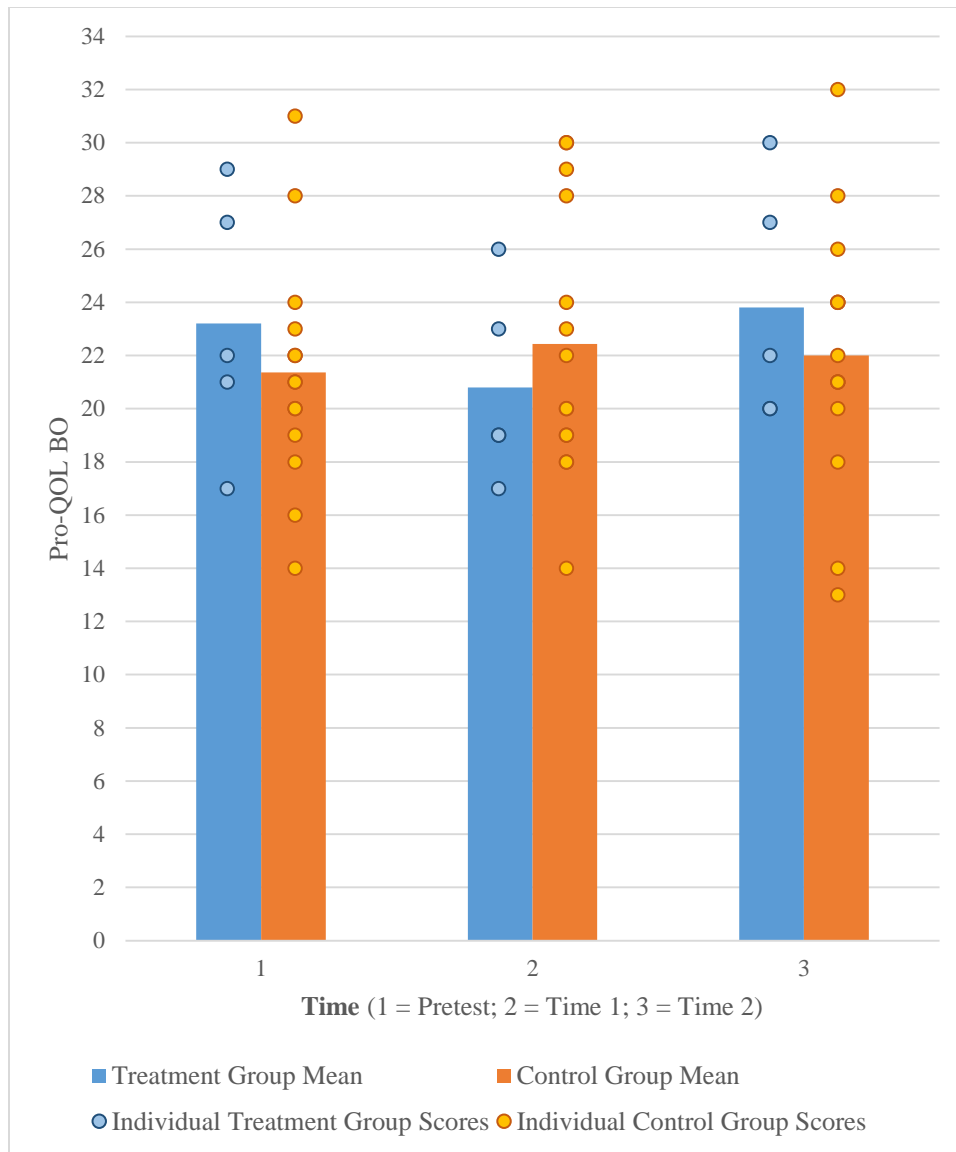
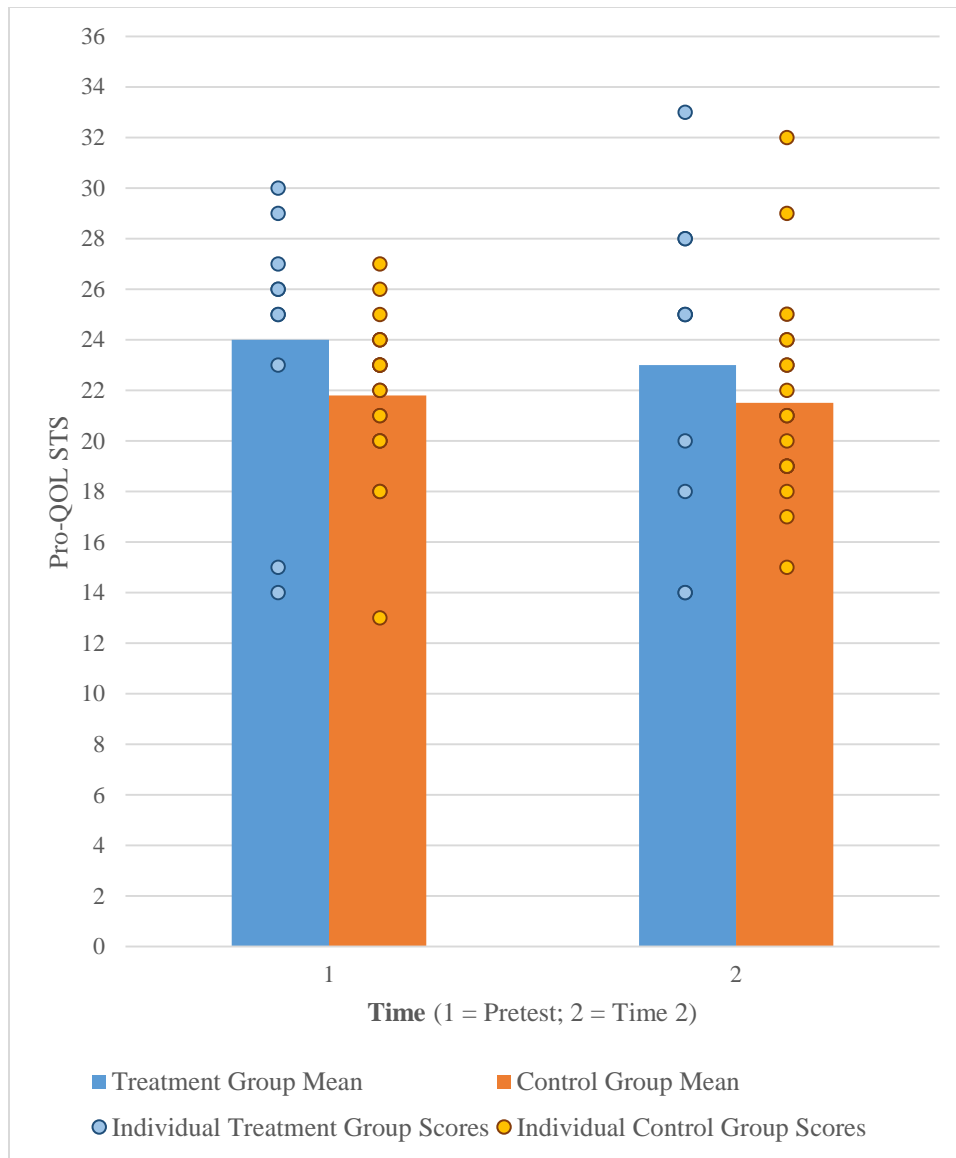*Figure 7.* Overlay of Pro-QOL BO subscale mean and individual participant scores over time. There were some identical individual Pro-QOL BO scores; thus the number of individual scores shown may be less than the *n*s.

Treatment group BO mean scores decreased from pretest to Time 1; (Table 9; Figure 7); however, this symptom reduction was not maintained over time as treatment group BO mean increased between Time 1 and Time 2 (Table 9; Figure 7). Control group BO mean scores were relatively stable over time.

An inspection of a boxplot found three outliers; these outliers were retained because they were not "extreme outliers" and therefore might not substantially affect the results as well as to keep the integrity of sample size intact. Pro-QOL BO scores were normally distributed, as assessed by Shapiro-Wilks' test ($p > .05$). There was homogeneity of variance, as assessed by Levene's Test, $p > .05$. Mauchly's test of sphericity indicated that the assumption of sphericity was violated for the two-way interaction, $x^2(2) = 11.09$, $p = .004$; therefore the Greenhouse-Geisser correction was used (Maxwell & Delaney, 2004). A non-statistically significant interaction was found between the treatment and time on Pro-QOL BO scores, $F(1.333, 22.669) = 1.878$, $p = .183$, partial $\eta^2 = .099$, $\varepsilon = .667$. The main effect of time yielded a non-statistically significant difference in mean Pro-QOL BO scores at different time points, $F(1.33, 22.669) = .783$, $p = .421$, partial $\eta^2 = .044$. The main effect of group yielded a non-statistically significant difference in mean Pro-QOL BO scores between the treatment and control groups, $F(1, 17) = .096$, $p = .760$, partial $\eta^2 = .006$. The result of this analysis is a failure to reject the null hypothesis that there is no statistically significant difference between Pro-QOL BO scores between the treatment and control group. No additional analyses were run on the data collected at all three time administrations as no significant interactions were found. A post hoc analyzing data collected at pretest and Time 2 administrations is included below. Table 10 depicts the results of the two-way mixed ANOVA for all three data collection times (total n = 19; treatment group n = 5; control group n = 14).

Table 10
ANOVA for Pro-QOL BO scores at all three time collection points

Source	df	F	p	η^2	ε
Time	1.33	0.783	0.421	0.044	
Group	1	0.096	0.76	0.006	

Time*Group   1.33   1.878   0.193   0.099   0.667

A post hoc two-way mixed ANOVA was conducted to determine whether there were differences in Pro-QOL BO mean scores between the treatment and control group between pretest and Time 2. This analysis was conducted to capture a larger sample size that includes all participants who completed assessments at pretest and Time 2. The total sample size for this post hoc analysis was 30 (treatment group n = 10; control group n = 20). Table 11 provides the Pro-QOL BO subscale mean scores at pretest and Time 2. Figure 8 overlays the Pro-QOL BO mean scores on individual participants' scores in both groups at pretest and Time 2 showing the pattern of BO score variation.

Table 11
Pro-QOL BO subscale mean scores at pretest and Time 2

|	Pretest Mean	Time 2 Mean
Treatment Group (n = 10)	25.5 (SD = 4.09)	24.6 (SD = 4.43)
Control Group (n = 20)	20.9 (SD = 3.97)	22.2 (SD = 4.51)

Figure 8. Overlay of Pro-QOL BO subscale mean and individual participant scores at pretest and Time 2. There were some identical individual Pro-QOL BO scores; thus the number of individual scores shown may be less than the *n*s.

Treatment group BO mean scores did decrease from Pretest to Time 2 (Table 11; Figure 8); consistent with the hypothesis. Control group Pro-QOL BO mean scores were relatively stable with a slight increase between pretest and Time 2 (Table 11; Figure 8); generally consistent with the hypothesis. However, contrary to the hypothesis, control group Pro-QOL BO mean scores were lower than the treatment group at both pretest and Time 2 (Table 11; Figure 8).

There were five non-extreme outliers in the control group data, as assessed by inspection of a boxplot for values greater than 1.5 box-lengths from the edge of the box. These outliers were retained in the analysis as they were not extreme and to retain sample size integrity. Pro-QOL BO scores were generally normally distributed, as assessed by Shapio-Wilk's test ($p > .05$); the treatment group pretest BO scores were not normally distributed ($p = .017$). Data was retained, as ANOVAs are fairly resistant to violations of normality (www.statistics.laerd.com). There was homogeneity of variances, as assessed by Levene's test of homogeneity of variance ($p > .05$). There was homogeneity of covariances, as assessed by Box's test of equality of covariance matrices ($p > .05$). There was a non-statistically significant interaction between the intervention and time on Pro-QOL BO scores $F(1, 28) = 3.125$, $p = .088$, partial $\eta^2 = .100$. Testing the main effect of time yielded a non-statistically significant difference in mean Pro-QOL BO scores at different time points, $F(1, 28) = .103$, $p = .750$, partial $\eta^2 = .004$. There was a statistically significant main effect for group, $F(1, 28) = 5.261$, $p = .030$, partial $\eta^2 = .158$. To ascertain where this difference was, additional analyses were run revealing a statistically significant difference in BO scores at pretest $F(1, 28) = 8.772$, $p = .006$, partial $\eta^2 = .239$. BO scores were statistically significantly greater in the treatment group (4.6 +/- 1.55, p = .006) compared to the control group. BO scores were not statistically significant at Time 2 (2.4 +/- 1.74, p = .178). Contrary to the hypothesis, participants in the control group reported a non-statistically significant lower mean Pro-QOL BO scores compared to the treatment group. The result of this analysis is a failure to reject the null hypothesis that there is no statistically significant difference between Pro-QOL BO scores between the treatment and control group. Table 12 depicts the results of the two-way mixed ANOVA for pretest and Time 2 (total n = 30; treatment group n = 10; control group n = 20).

Table 12

ANOVA for Pro-QOL BO at pretest and Time 2 time points

Source	df	F	p	η^2
Time	1	0.103	0.75	0.004
Group	1	5.261	0.03*	0.158
Time*Group	1	3.125	0.088	0.1

*Note. *$p < .05$.

Compassion Satisfaction (CS) Pro-QOL Subscale

It was hypothesized that Pro-QOL CS subscale scores for the treatment group would increase over time following workshop attendance compared to the control group's Pro-QOL CS subscale scores. Data from participants who completed assessments at all three data collection times were used to answer this hypothesis. Table 13 provides the Pro-QOL CS subscale mean scores over time. Figure 9 overlays the Pro-QOL CS mean scores on individual participants' scores in both groups over time showing the pattern of CS score variation.

Table 13

Pro-QOL CS subscale scores over time

	Pretest Mean	Time 1 Mean	Time 2 Mean
Treatment Group (n = 5)	34.4 (SD = 5.59)	36.8 (SD = 2.95)	35.2 (SD = 6.02)
Control Group (n = 14)	41.5 (SD = 6.11)	38.57 (SD = 5.43)	40.14 (SD = 6.22)
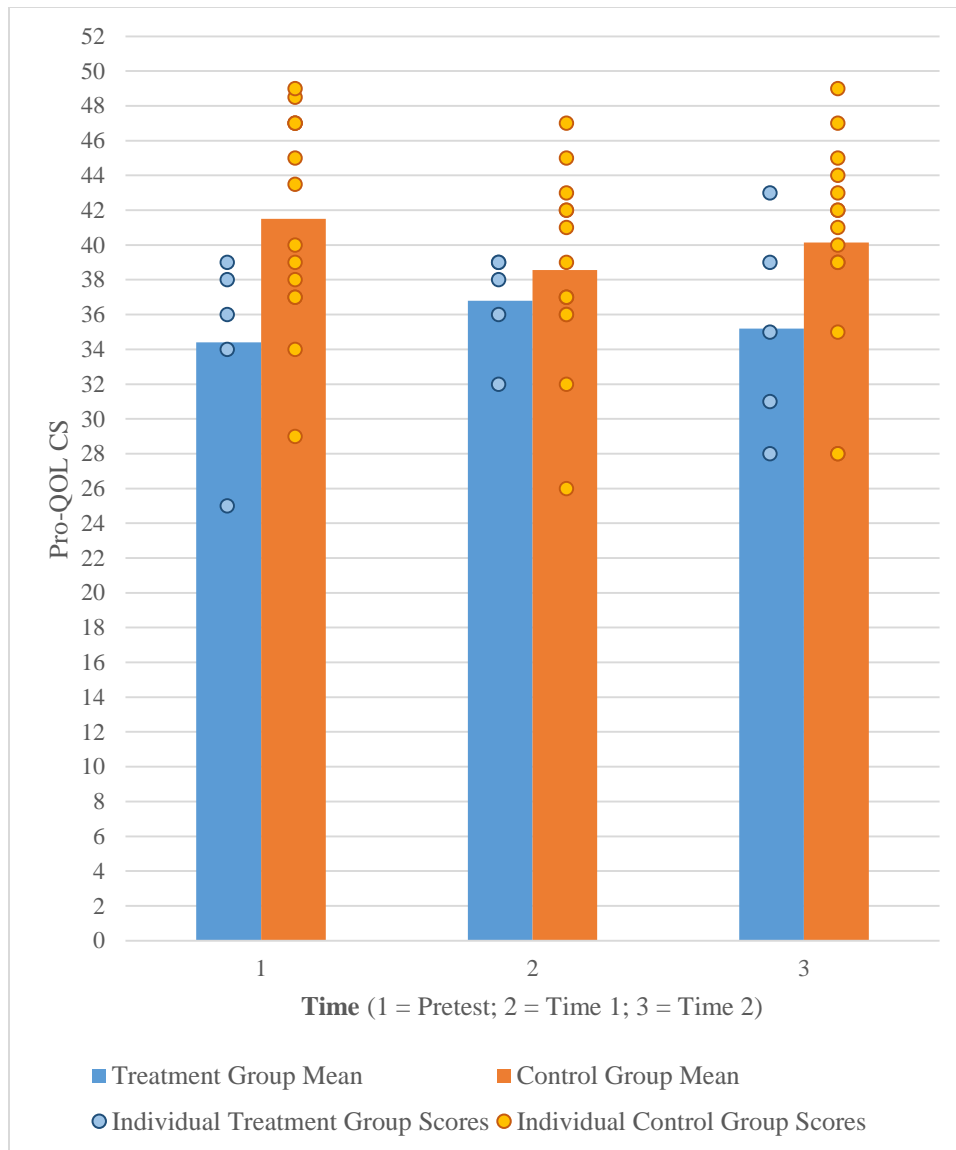
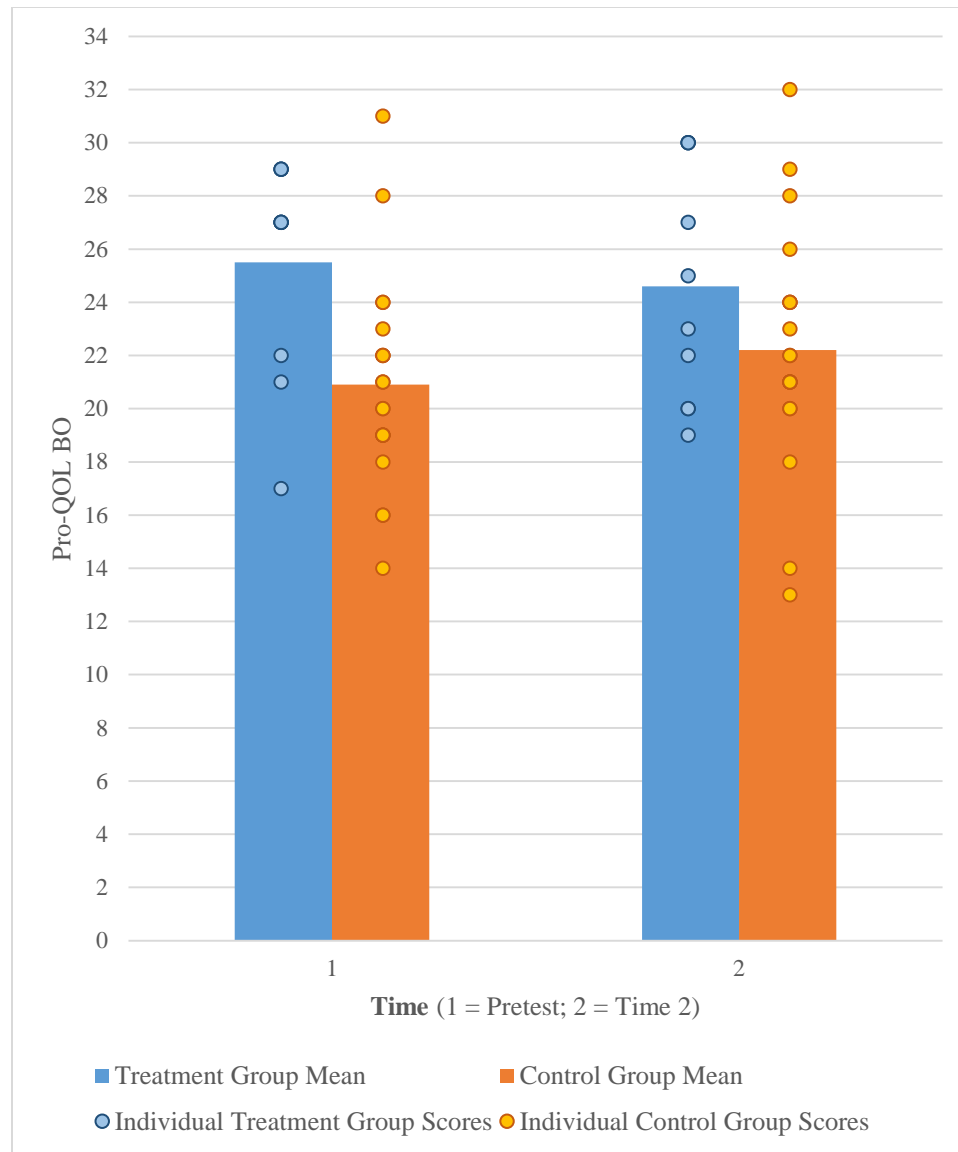*Figure 9.* Overlay of Pro-QOL CS subscale mean and individual participant scores over time. There were some identical individual Pro-QOL CS scores; thus the number of individual scores shown may be less than the *n*s.

Pro-QOL CS scores for the treatment group stayed relatively stable across time with slight variations. Specifically, treatment group CS means increased slightly between pretest and Time 1 and then decreased slightly between Time 1 and Time 2 (Table 13, Figure 9). Conversely, control group CS means decreased between pretest and Time 1 and then increased slightly between Time 1 and Time 2 (Table 13, Figure 9).

An inspection of a boxplot found four outliers; these outliers were retained because they were not "extreme outliers" and therefore might not substantially affect the results as well as to keep the integrity of sample size intact. Pro-QOL CS scores were normally distributed, as assessed by Shapiro-Wilks' test ($p > .05$). There was homogeneity of variance, as assessed by Levene's Test, $p > .05$. Mauchly's test of sphericity was met for the two-way interaction, $x^2(2) = 1.59$, $p = .451$. A non-statistically significant interaction was found between treatment and time on Pro-QOL CS scores, $F(2, 34) = 2.74$, $p = .07$, partial $\eta^2 = .139$. The main effect of time yielded a non-statistically significant difference in mean Pro-QOL CS scores at different time points, $F(2,34) = .04$, $p = .96$, partial $\eta^2 = .002$. The main effect of group yielded a non-statistically significant difference in mean Pro-QOL CS scores between the treatment and control groups, $F(1, 17) = 2.95$, $p = .104$, partial $\eta^2 = .148$. Contrary to the hypothesis, treatment group CS scores were always lower than the control group, although not significantly lower. The result of this analysis is a failure to reject the null hypothesis that there is no statistically significant difference between Pro-QOL CS scores between the treatment and control group. No additional analyses were run on data collected at all three time administrations as no significant interactions were found. A post hoc analyzing data collected at pretest and Time 2 administrations is included below. Table 14 depicts the two-way mixed ANOVA analysis results for participants who completed all three data collection times (total n = 19; treatment group n = 5; control group n = 14).

Table 14
ANOVA for Pro-QOL CS at all three time points

Source	df	F	p	η^2
Time	2	0.038	0.963	0.002
Group	1	2.95	0.104	0.148
Time*Group	2	2.74	0.079	0.139

A post hoc two-way mixed ANOVA was conducted to determine whether there were differences in Pro-QOL CS mean scores between the treatment and control group between pretest and Time 2. This analysis was conducted to capture a larger sample size that included all participants who completed assessments at pretest and Time 2. The total sample size for this post hoc analysis was 30 (treatment group n = 10; control group n = 20). Table 15 provides the Pro-QOL CS subscale mean scores at pretest and Time 2. Figure 10 overlays the Pro-QOL CS mean scores on individual participants' scores in both groups at pretest and Time 2 showing the pattern of CS score variation.

Table 15
Pro-QOL CS subscale mean scores at pretest and Time 2

|	Pretest Mean	Time 2 Mean
Treatment Group (n = 10)	34.7 (SD = 4.9)	35.9 (SD = 5.00)
Control Group (n = 20)	42.3 (SD = 5.38)	40.6 (SD = 5.45)
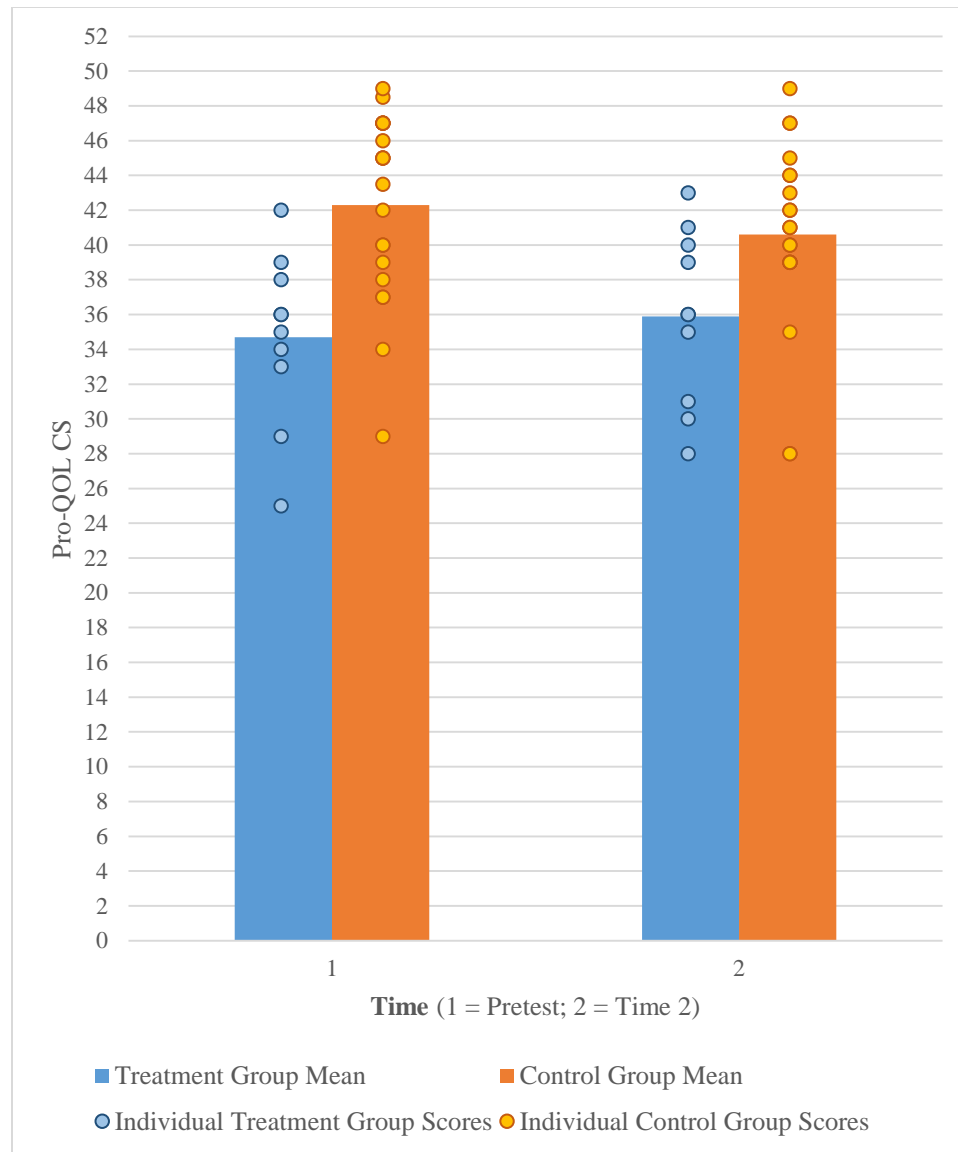
Figure 10. Overlay of Pro-QOL CS subscale mean and individual participant scores at pretest and Time 2. There were some identical individual Pro-QOL CS scores; thus the number of individual scores shown may be less than the *n*s.

Treatment group CS mean scores increased slightly from Pretest to Time 2 (Table 15; Figure 10); consistent with the hypothesis. Control group Pro-QOL CS mean scores decreased slightly between pretest and Time 2 (Table 15; Figure 10); generally consistent with the hypothesis. However, contrary to the hypothesis, control group Pro-QOL CS mean scores were higher than the treatment group at both pretest and Time 2 (Table 15; Figure 10).

There were three non-extreme outliers in the data, as assessed by inspection of a boxplot for values greater than 1.5 box-lengths from the edge of the box. These outliers were retained in the analysis as they were not extreme and to maintain sample size integrity. Pro-QOL CS scores were generally normally distributed, as assessed by Shapio-Wilk's test ($p > .05$); the control group Time 2 CS scores were not normally distributed ($p = .037$). Data was retained, as ANOVAs are fairly resistant to violations of normality (www.statistics.laerd.com). There was homogeneity of variances, as assessed by Levene's test of homogeneity of variance ($p > .05$). There was homogeneity of covariances, as assessed by Box's test of equality of covariance matrices ($p >.05$). There was a non-statistically significant interaction between the intervention and time on Pro-QOL CS scores $F(1, 28) = 2.620$, $p = .117$, partial $\eta^2 = .086$. Testing the main effect of time yielded a non-statistically significant difference in mean Pro-QOL CS scores at different time points, $F(1, 28) = .078$, $p = .782$, partial $\eta^2 = .003$. There was a statistically significant main effect for group, $F(1, 28) = 11.235$, $p = .002$, partial $\eta^2 = .286$. To ascertain where this difference was, additional analyses were run revealing a statistically significant difference in CS scores at pretest, $F(1,28) = 14.061$, $p = .001$, partial $\eta^2 = .334$. CS scores were statistically significantly greater in the control group ($7.6 +/- 2.03$, $p = .001$) compared to the treatment group. Additionally, a statistically significant difference in CS scores at Time 2 was found, $F(1, 28) = 147.267$, $p = .030$, partial $\eta^2 = .157$. CS scores were statistically significantly greater in the control group ($4.7 +/- 2.06$, $p = .03$) compared to the treatment group. Contrary to the hypothesis, participants in the control group reported a statistically significant higher mean Pro-QOL CS scores compared to the treatment group. The result of this analysis is a failure to reject the null hypothesis that there is no statistically significant difference between Pro-QOL CS scores between the treatment and control group. Table 16 displays the results of the two-way

mixed ANOVA for Pro-QOL CS for pretest and Time 2 (total n = 30; treatment group n = 10;

control group n = 20).

Table 16
ANOVA for Pro-QOL CS based off of pretest and Time 2 time points

Source	df	F	p	η²
Time	1	0.078	0.782	0.003
Group	1	11.235	0.002*	0.286
Time*Group	1	2.62	0.117	0.086

Note. * $p < .05$.

Resiliency Group

Four treatment group participants, all CITs, participated in a 7-week resiliency group post

workshop. Three Wilcoxson signed-rank tests were conducted to determine if there was a

median difference in their Pro-QOL scores at pretest and at Time 2. STS symptoms decreased

for three out of the four participants. Participation in this group yielded a non-statistically

significant median decrease in STS scores (-1.00) over time, z = -1.134, *p* = .257. BO symptoms

decreased for three out of the four participants. Participation in this group yielded a non-

statistically significant median decrease in BO scores (-1.50) over time, z = -.730, *p* = .465. Of

the four participants who participated in the resiliency group, two participants reported an

increase in CS, whereas one participant reported no change, and one participant reported a

decrease in CS over time. Participation in this group yielded a non-statistically significant

median increase in CS scores (.500) over time, z = .000, *p* = 1.00.

Resiliency Skills Usage Scale (RSUS)

An exact sign test was used to determine the median difference between the treatment

groups' use of resiliency skills (as measured by the RSUS) at Time 1 and Time 2. Of the five

treatment group participants who completed both Time 1 and Time 2, three reported using more

resiliency skills at Time 2, whereas two reported using more resiliency skills at Time 1. No statistically significant median difference in resiliency skill usage was detected between Time 1 and Time 2, $p = 1.00$.

At Time 1 and Time 2 three Spearman rank correlations (one for each Pro-QOL subscale) were used to determine the relationship, if any, between Pro-QOL scores and the reported use of resiliency skills at Time 1 and Time 2 for the treatment group. At Time 1, a moderate positive, yet non-significant, correlation between the use of resiliency skills and Pro-QOL STS subscale scores (rs = .677, p = .219) was found. This counters what was expected but may be explained by the reported breakdown of specific resiliency skill use presented below. A moderate, yet non-significant, negative correlation between the use of resiliency skills and Pro-QOL BO subscale scores (rs = -.616, p = .269). This negative correlation was expected; that BO scores could decrease as a result of using the resiliency skills taught in the workshop. A strong positive correlation, approaching significance, was found between the use of resiliency skills and the Pro-QOL CS subscale (rs = .872, p = .054) suggesting that as the use of resiliency skills increases so does the participants' reported enjoyment of clinical work. At Time 2, a moderate positive and non-significant correlation between the use of resiliency skills and Pro-QOL STS subscale scores (rs =.486, p = .154) was found. A minimal positive and non-significant correlation was found between resiliency skill usage and Pro-QOL BO (rs = .167, p = .645). These positive relationships between Pro-QOL BO and STS scores and the use of resiliency skills were not expected; however these results could be explained by the reported breakdown of specific resiliency skill use presented below. A small positive and non-significant correlation between the use of resiliency skills and Pro-QOL CS subscale scores (rs = .375, p = .286) was expected.

Table 17 details the type and frequency of responses on the RSUS. At both Time 1 and Time 2, participants reported most commonly using the self-regulation skill of diaphragmatic breathing as well as physical, spiritual and emotional self-care strategies. The least commonly reported resiliency skills at both Time 1 and Time 2 were the self-regulation skill of peripheral vision, the intentionality skill of utilizing mission statement, the social support skill of sharing STS narratives, and the self-care skill of professional self-care strategies. At Time 1 (n = 5), three participants reported already using select resiliency skills prior to workshop attendance (most commonly reported diaphragmatic breathing and self-care strategies; Table 17). At Time 2 (n = 10), half of participants reported already using resiliency skills prior to workshop attendance. Again, these participants most commonly reported using diaphragmatic breathing and self-care strategies (Table 17). Notably, participants reported using very few of the resiliency skills on a daily basis.

Table 17
Type and frequency responses for the RSUS

Category of Resiliency Skill	Resiliency Skill	Response	Time 1 Frequency of use (n = 5)	Time 2 Frequency of use (n = 10)
Self-Regulation:	Wet Noodle *(Scanning body for tense muscles and releasing them)*	never	2	1
		monthly	2	6
		weekly	1	3
		daily	0	0
	Peripheral Vision *(widening field of vision to include the periphery)*	never	4	7
		monthly	1	1
		weekly	0	2
		daily	0	0
	Diaphragmatic Breathing *(bringing*	never	0	1
		monthly	2	1

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	awareness to the breath)	weekly daily	1 2	4 4
	Pelvic Floor Muscle Relaxation *(relaxing the muscles of the pelvic floor)*	Never Monthly Weekly Daily	1 1 2 1	2 5 3 0
Intentionality:	Use of Core Values	Never Monthly Weekly Daily	0 2 2 1	1 4 3 2
	Use of Mission Statement	Never Monthly Weekly Daily	3 1 1 0	7 2 1 0
Perceptual Maturation:	Optimization Skills *(happiness, positive psychology, mindfulness, self-validation & gratitude)*	Never Monthly Weekly Daily	2 1 0 2	1 5 3 1
	Detoxifying Negative Attitudes *(recognizing and shifting negative thoughts about self & workplace)*	Never Monthly Weekly Daily	1 0 2 2	2 6 2 0
Social Support:	Social Support Accountability	Never Monthly Weekly Daily	2 1 2 0	3 4 3 0
	Sharing STS Narratives			

	Never	2	5
	Monthly	2	4
	Weekly	1	1
	Daily	0	0
Self-Care:			
Physical Self-Care	Never	0	0
	Monthly	0	1
	Weekly	2	5
	Daily	3	4
Spiritual Self-Care	Never	1	1
	Monthly	1	2
	Weekly	3	3
	Daily	0	4
Emotional Self-Care	Never	0	0
	Monthly	0	1
	Weekly	2	5
	Daily	3	4
Professional Self-Care	Never	1	2
	Monthly	2	6
	Weekly	2	2
	Daily	0	0

Exposure to Trauma

   ACE. Thirty-five out of 40 pretest participants reported experiencing an adverse

experience in childhood. ACE scores (min = 0; max = 10) ranged between 0 and 8 with a mean

score of 2.85 (SD = 2.37). A Mann-Whitney U test did not find a statistically significant

difference between ACE scores between the treatment and control group (mean rank = 18.07 and

21.96, respectively; $U = 224$, $p = .319$), suggesting that childhood traumatic experiences did not

appear to impact the desire to attend a resiliency-based workshop.

   Spearman's Rank correlations were used to investigate the relationships between reported

childhood traumatic experiences (ACE scores) and the three Pro-QOL subscale scores at pretest

for all participants. Preliminary analyses were performed to ensure no violations of assumptions of variable types and monotonic relationships. No relationship between Pro-QOL STS and ACE scores was detected (rs = -.042, p = .797). This result is inconsistent with CF risk factor literature that commonly reports positive relationships between personal traumatic experiences and STS symptoms; thus a correlation between these two variables was expected. No relationship between Pro-QOL BO and ACE scores was detected (rs = -.029, p = .858). No relationship between Pro-QOL CS and ACE scores was detected (rs = .004, p = .982).

Adult trauma. Thirty-one participants (n = 43) reported experiencing adult trauma (min = 0; max = 11) ranging from 0 to 4 with a mean score of 1.19 (SD = 1.12). Figure 11 details a breakdown of reported traumas measured at the pretest.
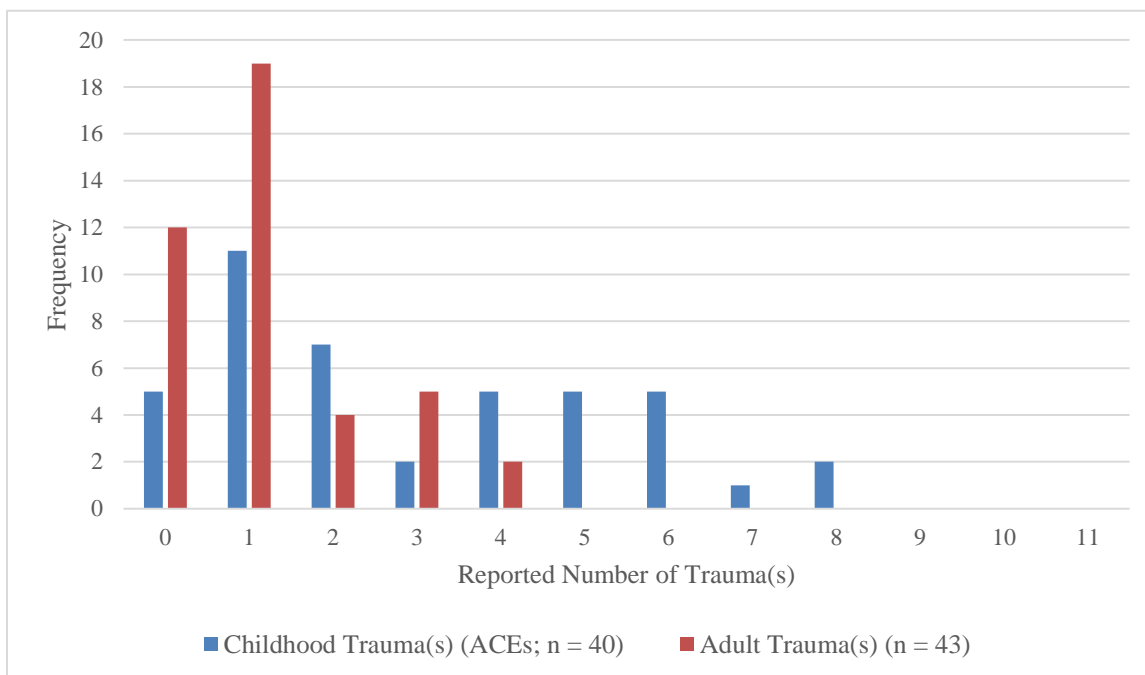
Figure 11. Reported Traumatic Experiences. Based off of non-trimmed data.

Spearman's Rank correlations were used to investigate the relationships between reported traumatic experiences in adulthood and the three Pro-QOL subscale scores at pretest for all participants. Preliminary analyses were performed to ensure no violation of assumptions of

variable types and monotonic relationships. No relationship was found between the sum of adult

trauma and Pro-QOL STS subscale ($rs = -.026$, $p = .873$); this result was unusual because

personal traumatic experiences are risk factors for experiencing STS; thus a correlation between

these two variables was expected. A small negative, yet non-significant correlation was found

between the sum of adult trauma and Pro-QOL BO subscale, $rs = -.297$, $p = .063$. Interestingly,

a statistically significant, medium positive correlation was found between the sum of adult

trauma and Pro-QOL CS subscale of the treatment group, $rs = .332$, $p = .037$.

COVID-19 Pandemic Impact Questions

The COVID-19 pandemic occurred during the course of this study and impacted

participants in a variety of ways, both personally and professionally. To gauge the impact of the

pandemic, a history effect of this study, participants were asked to select from a list the way(s) in

which their professional and personal lives have been influenced. Responses were tabulated at

Time 1 and at Time 2 data collection points. The majority of participants reported work related

and personal pandemic affects at both data collection points. Table 18 presents the frequency of

responses from these questions.

Table 18
Frequency of COVID-19 impacts at work and personal levels

	Time 1		Time 2	
	Treatment (n = 5)	Control (n = 17)	Treatment (n = 10)	Control (n = 22)
Pandemic Work Related Impacts				
Transitioned to telehealth	5	15	8	15
Lost clients	3	7	4	8
Gained clients	1	5	1	10
Loss of job	0	1	1	1
No changes	0	0	0	3
Other:	3	5	3	4
Pandemic Personal Impacts				
Social isolation	4	14	5	14

Increased sadness	0	5	5	9
Increased anxiety	4	9	7	11
Trauma responses triggered	0	2	3	4
Financial strain	2	2	2	2
Increased happiness	2	4	2	5
Increased connection to supportive others	0	6	4	6
No changes	0	1	0	0
Other:	2	4	2	4

Note. The sample sizes differ for each time point. Participants could select as many options as were applicable to them as well as type in responses in the "Other" category.

Participants reported a similar mean number of pandemic-related impacts at work at Time 1 ($m = 1.70$; SD = 0.88; n = 23) and Time 2 ($m = 1.78$; SD = 0.83; n = 32). The most commonly reported work change was the transition to telehealth services. Typed responses on the "Other" category included: online classes, new job, wear a mask, hours cut, lost consulting business, loss of consulting and training opportunities, Zoom fatigue and isolation from colleagues.

On a personal level, the majority of participants noted the pandemic had several effects on them at both Time 1 ($m = 2.35$; SD = 1.33; n = 23) and Time 2 ($m = 2.66$; SD = 1.31; n = 32). The most commonly reported personal changes were increased anxiety and social isolation. Typed responses on the "Other" category included: logistical challenges, cancelled big life events (i.e. wedding, baby shower), wanting a life change, weight gain, gained technology skills, introversion supported, stress with politicization of pandemic, view it as a challenge for change, loss of travel, and reflection on state of being and changes needed. Figure 12 demonstrates the breakdown of COVID-19 impacts.
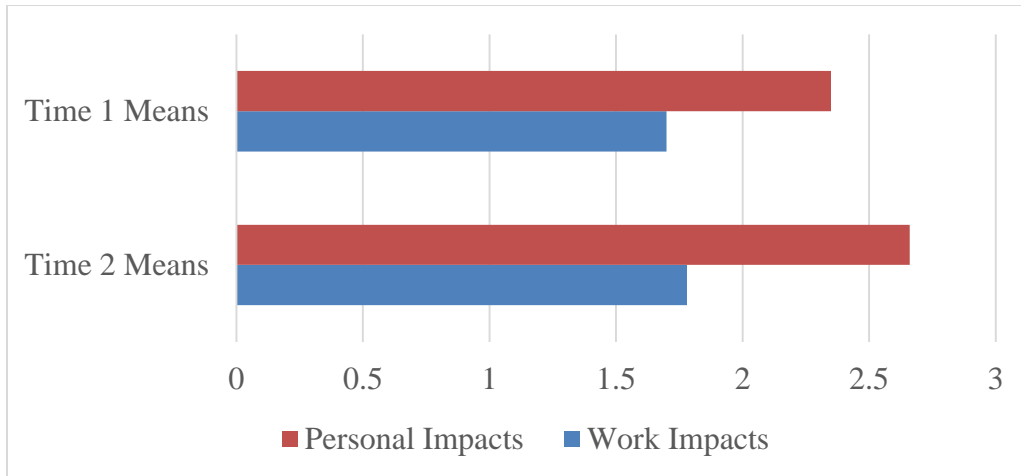
Figure 12. Reported impacts of the COVID-19 pandemic.

Summary

The results from the statistical analyses of this study generally yielded non-significant findings resulting in a failure to reject the null hypothesis that there are no statistically significant differences in Pro-QOL STS, BO and CS scores between the treatment and control group. Said another way, the results largely contradicted the hypothesis that the treatment group would report lower CF (i.e. STS and BO) symptoms and higher CS scores over time compared to the control group. However, trends that emerged in the data as well as possible explanations, limitations, implications and directions for future research are discussed in the following chapter.

CHAPTER FIVE: DISCUSSION

The hypothesis of this study was that participants in the resiliency training (treatment group) would report significantly lower STS and BO symptoms and higher CS scores over time as compared to participants who did not participate in the resiliency training (control group). The main statistical analyses of this study generated non-significant findings resulting in a failure to reject the null hypothesis that there are no statistically significant differences in Pro-QOL STS, BO and CS scores between the treatment and control group.

Treatment group participants reported a decrease in CF symptoms 3 months after the workshop. The control group's CF symptoms largely remained stable over time, while STS and BO symptoms for the treatment group decreased between Pretest and Time 1 (Figures 5 & 7). These results are consistent with symptom reduction in other studies examining the efficacy of treatments and trainings aimed at reducing CF (Cocker & Joss, 2016; Craigie et al., 2016; Baranowsky et al., 2005; Craigie et al., 2016; Flarity et al., 2013; Flarity et al., 2016; Flarity et al., 2016b; Gentry et al., 2004; Gentry, 2002; Gregory, 2015; Potter et al., 2013; Potter et al., 2015; Rank et al., 2009). Of note, these studies involved various types and lengths of CF treatments, participants from diverse helping professions, and measured follow-ups at various timeframes. Regardless of methodology, interventions that produced the most change in CF and CS were ones related to the ARP (Cocker & Joss, 2016). While not statistically significant, this study's results suggest that the ARP model could have played a role in CF symptom reduction for treatment group participants, at least in the short term.

Treatment group CF symptoms decreased between pretest and Time 1 but increased between Time 1 and Time 2 (Figures 5 and 7). This conflicts with Potter et al. (2013) in which a similar treatment for nurses yielded CF symptom reduction maintenance at a 6 month posttest.

Inherent differences between the populations (between nurses vs. CITs and mental health professionals) and the COVID-19 pandemic occurring during this study's timeline could have influenced these results.

The overall higher levels of BO as well as the specific pattern of increased BO symptoms between Time 1 and Time 2 by the treatment group (Figure 7 & 8), largely comprised of CITs, is congruent with other studies citing the presence of BO in both students and new professionals (Deary et al., 2003; Volpe et al., 2014). Deary et al. (2003) found that BO symptoms increased as nursing students progressed through their educational training and Volpe et al. (2014) found the presence of BO symptoms in new mental health professionals. As perceptions of the accumulation of demand and responsibility grow over the course of training, it makes sense that reported levels of BO would also increase. Defining BO as the perception of an overabundance of demands and responsibilities that can lead to BO symptoms (Gentry & Baranowsky, 2002), it follows that if students and new professionals are better equipped with skills to shift these perceptions about the demands they face in their educational programs and early job training, perhaps this could reduce their overall negative and stressful experiences of higher education and of the field in general.

Furthermore, adding resiliency training in education programs could reduce attrition rates both in educational programs as well as in mental health careers as the presences of BO symptoms are linked to attrition rates (Deary et al., 2003). Adding BO training into education programs could reduce the overall attrition rates in both educational programs, as well as for the helping fields in general. The results of this study appear to corroborate other study's findings (Deary et al., 2003; Volpe et al., 2014) that indicate the need for specific BO prevention in higher educational programs as well as early on in their career workplaces. ARP and related

trainings, like the treatment in this study, show promise in providing opportunities for this valuable shift in thinking.

Incorporating resiliency training early and often into programs could yield the best results. Suggestions for placement in counselor education programs include: introducing the concepts during a program orientation, as part of ethics courses, and embedding into clinical supervision (Figley, 1995; Merriman, 2015) at both practicum and internship levels. Additionally, offering a 1-credit course, like the treatment in this study, during the first semester of study followed by "boosters" each semester could also beneficial in reducing CF among CITs. Additional research is warranted to discover the most optimal placement(s) of CF interventions within counselor education programs. Intentional inclusion of CF education and prevention into counselor education programs could reduce CF levels in CITs, reduce both educational and career attrition rates, increase compassion satisfaction in the short and long term, and increase overall counselor well-being. Together these shifts could enhance client care and overall treatment outcomes for the counseling field.

Interestingly, control group participants generally reported lower levels of CF (both BO and STS Pro-QOL subscale scores) and higher levels of CS over time (Figures 5, 7 & 9). This could be explained by greater between group demographic differences than similarities. The proportion of experienced mental health professionals in the control group was higher relative to the treatment group, which had a disproportionate number of CIT participants. However, this pattern was not observed in the data collected at Time 1 where a rise in BO and STS for the control group were reported (Figure 6 & 8). Time 1 data was collected two months into the COVID-19 pandemic when initial changes and more acute distress could have been experienced by control group participants as they were in the midst of switching to telehealth delivery of

counseling and the other myriad of changes that the pandemic ushered in. Remarkably, a pattern

of higher levels of CS reported across time points by control group participants as compared to

treatment group participants was found (Figure 9). A statistically significant higher mean CS

score by 6.150 was observed when comparing groups at the pretest and Time 2 time points.

Many in the control group had years of experience in the field witnessing therapeutic growth of

clients, perhaps increasing the meaning, satisfaction and purpose of their work compared to CITs

who are just beginning their clinical work.

Participants reported higher prevalence rates of trauma compared to other studies.

Thirty-five participants (n = 40), or 88% of participants, reported an ACE score of at least one

compared to approximately 52% and 70% of study participants, respectively (Felitti et al., 1998;

Poole, Dobson & Pusch, 2018). Thirty-one participants (n = 43), or 72% of participants,

reported experiencing adult trauma at a slightly higher rate compared to two-thirds of the U.S.

population (Webber, 2017). These results correlate with Courtios (2018) suggesting that the

mental health field may draw those with a trauma history into its fold. Conversely, CITs and

mental health professionals could be more likely to report traumatic experiences than the average

lay person. Higher levels of self and trauma awareness could explain the elevated levels

personal trauma(s) reported by participants in this study. Further study of trauma prevalence

rates of mental health professionals is indicated.

No correlations were found between participants' ACE and Pro-QOL STS scores; this did

not support the assumption that relationships would have been detected. Similarly, no

relationship was found between the sum of reported adult traumatic experiences and the STS

subscale of the Pro-QOL. It was postulated that there would have been positive correlations

between the reporting of traumatic experiences and STS scores as experiencing trauma is a well-

documented risk factor for developing STS symptoms of CF (Lerias & Bryne, 2003; Turgoose & Maddox, 2017; Williams et al., 2012). These results do not provide evidence to support the creation of a PTSD subset outlining criteria specifically for STS as a stand-alone diagnosis or as part of CF (See the PTSD and STS sections of the nomenclature section of Chapter Two for more discussion about this issue). More research would be needed to support this idea; specifically asking questions like: Is there enough evidence for the inclusion of a STS diagnosis under the umbrella of PTSD? What would the benefits and consequences of such a diagnosis be? Could a STS diagnosis create more access to receive care for STS symptoms?

Conversely, a statistically significant, medium positive correlation between the sum of adult traumatic experiences and Pro-QOL CS subscale of the treatment group (rs = .332, p = .037) was detected. This was rather surprising but could indicate that those who have experienced trauma themselves possess "deep empathic attunement" (Courtios, 2018, p. 50) and experience great rewards from witnessing others experience posttraumatic growth as they have.

The resiliency skills taught in the treatment of this study are protective factors and have shown to insulate those in various caring professions from CF (Cocker & Joss, 2016; Craigie et al., 2016; Baranowsky et al., 2005; Craigie et al., 2016; Flarity et al., 2013; Flarity et al., 2016; Flarity et al., 2016b; Gentry et al., 2004; Gentry, 2002; Gregory, 2015; Potter et al., 2013; Potter et al., 2015; Rank et al., 2009). It was thought that use of these same skills, with regular deployment, might have provided the same protection for the treatment group of this study. Interestingly, participants in other studies with similar treatments report significant decreases in CF symptoms and describe using resiliency skills of self-regulation more often (Potter et al., 2015) as well as using the resiliency skills on a regular basis (Flarity et al., 2013). These results contrast somewhat with the type and amount of resiliency skill use reported in this study; besides

self-care, this study's participants report using less variety of resiliency skills, mostly on a weekly basis. Participants appeared to fall back into pre-existing patterns of coping following the workshop as many reported already engaging in self-care practices prior to workshop attendance. This could offer a partial explanation why CF symptom reduction was not sustained over time by this study's treatment group participants. More research is warranted to understand the relationships, if any, which exist between the use and type of resiliency skills and CF symptoms.

Treatment group participants in this study report that diaphragmatic breathing, a self-regulation skill, and self-care strategies are the resiliency skills that they utilize the most at both Time 1 and Time 2. Physical exercise appears to be a well-used self-care strategy, both as reported by this study as well as by Rank et al. (2009). At Time 1, a non-significant moderate negative correlation between overall resiliency skill use and BO symptoms as well as a non-significant strong positive correlation between overall resiliency skill use and CS were consistent with the notion that the more the skills are used, the less CF symptoms will be reported and that CS would increase. However, there was an unexpected non-significant moderate positive correlation found between the use of resiliency skills and reported STS symptoms. Upon examination, the specific resiliency skills related to decreasing STS symptoms (self-regulation and sharing STS narratives with supportive others) (Gentry & Dietz, 2020), were reportedly used minimally which could partially explain this pattern. It could be surmised that because participants in this study did not report using the resiliency skills needed to yield lower STS profiles, that their reported STS scores would reflect this. Nonetheless, many participants reported that access to supportive others was diminished because of the pandemic. The majority of participants transitioned to telehealth delivery of counseling services, often working alone

from home.   Indeed, several participants reported increased social isolation and restricted access to consultation groups due to the pandemic, as indicated by the COVID-19 impact questions. The option of virtually connecting with others to share STS narratives was likely available, however, this option may not have been appealing due to "screen time fatigue" or "Zoom fatigue."

Additionally, for BO symptoms to remain diminished, continued use of perceptual shifts, specifically to internal locus of control, are necessary (Gentry & Dietz, 2020). Treatment group participants did not report using perceptual maturation resiliency skills frequently, thus it is not surprising the BO symptoms did not remain at lower levels. Importantly, evidence of perceptual maturation skills from control group participants was found in several of their responses to the COVID-19 impact questions. The responses of "gained technology skills," time for reflection, increased connection, and happiness are all examples of positive reframing, even in the midst of a pandemic. These perceptual maturation skills are, perhaps, inherent to the field of mental health.

The learning and implementation of new skills does not happen overnight; thus workshop attendance alone is not likely to yield a reduction in CF symptoms. Lasting CF reduction is likely to occur through the diligent and disciplined use of all of the resiliency skills and principles covered in the treatment (Gentry & Dietz, 2020). When initially confronted with stressors, we tend to fall back into our existing ways of coping. Participants reported these "tried and true" coping strategies as physical self-care activities and diaphragmatic breathing. As stressors increase, like living in the midst of a pandemic for months on end, it becomes even harder to utilize coping skills at all, let alone novel skills. Thus, treatment "boosters" may be

indicated to aid in the solidification of resiliency skill usage, particularly during times of increased stress.

Moreover, the patterns of CF symptom changes over time in this study could suggest that participation in the resiliency-based workshop may be helpful in creating shorter term reductions in CF symptoms, and that "boosters" may be helpful in creating sustained CF symptom reduction over longer periods of time. Studies examining the effects of CF treatments that involve multiple interventions or "treatment doses" tend to yield greater reduction in CF symptoms than treatments that occur at one time period (Cocker & Jess, 2016). Furthermore, this study's posttests could have been a type of intervention or "booster," serving as a reminder to use skills and/or to assess CF and CS symptoms. The possible influence of "boosters" was found by examining the four treatment group participants, all CITs, who also participated in a 7-week post workshop resiliency group. While not statistically significant, CF symptoms decreased when comparing pretest and Time 2 BO and STS median scores (Figures 6 & 8). This pattern is also supported by informal feedback provided by participants on workshop and resiliency group evaluations indicating that immersion in and practicing resiliency skills are helpful in creating sustained changes in CF symptoms (data not shown). The more we are reminded of and immersed in practice, the more likely we are able to create lasting changes; the same concept appears to be true when cultivating resiliency.

Qualitative results of a study using a similar treatment were improved overall emotional health (i.e. happier and calmer), as well as an increase in energy, empathy and confidence (Potter at el., 2015). While informal qualitative workshop evaluations (collected for feedback about the workshop and not a part of this study) are consistent with this study's findings, more qualitative

studies are warranted to compare to how participants' experiences with ARP-type treatments impact them.

In summary, there are several key findings in this study. First, the control group, generally comprised of mental health professionals, reported lower CF symptoms and higher CS than the treatment group, generally comprised of CITs. This result was opposite of the hypothesis but could suggest that CITs could benefit from specific CF prevention education, like the ARP, in their graduate studies. Second, consistent with the hypothesis, the treatment group reported a non-statistically significant reduction in CF symptoms three months after the workshop. Third, for CF symptoms reduction be maintained over time, use of resiliency skill "boosters" and/or regular use of a variety of resiliency skills may be useful. Fourth, the participants in this study reported that their exposure to trauma is largely consistent with the national average. Together, these findings suggest that there is a place for intentional CF prevention and education throughout one's career in mental health.

Limitations

A major limitation of this study was the small sample size and level of attrition in both the treatment and control groups. These limitations resulted in a restricted ability to utilize inferential statistical analyses. There are no non-parametric alternatives that were appropriate to answer the research question in this study. The use of data replacement techniques, like multiple imputation methods, are not supported by any relevant parametric analyses and thus could not be used. Two-way mixed ANOVAs were conducted despite evidence of assumption violations. Specifically, the decision to retain data (after initial trimming) was made despite the presence of outliers and data that was not distributed normally. Therefore, there is an increased dependency on the utilization of descriptive statistics to understand the data obtained.

Also, an unequal distribution of CITs and mental health professionals between the treatment and control groups created challenges in comparing the two groups. The results can only speak to the influence of workshop participation on CF symptoms, and not the differential effects of workshop participation on CITs and professionals. This study was not able to address the specific gap in the literature between CF presence in CITs and professionals as originally intended. Future studies with more equal distribution of participants, perhaps using the simple quota sampling method, might yield more generalizability than this study.

As with any longitudinal study, history effects were prevalent in the study. Markedly, following the pretest data collection time, the COVID-19 pandemic engendered countless changes at global, societal, local, and individual levels and is a threat to the validity of this study. Closures of schools and all but nonessential businesses in efforts to prevent the spread of the virus sent many workers and children home. Many people reported fear and anxiety about the changes as well as specific challenges related to how the pandemic has impacted them on more personal levels. For the CITs in this study, the UM campus shut down mid-March and learning for the rest of the semester and over summer semester occurred remotely. For both CITs and the mental health professionals in this study, the delivery of clinical care transitioned to telehealth options. The pandemic could have inflated participants' responses on the STS and BO scales of the Pro-QOL at Time 1 and Time 2, creating a false negative. For example, perhaps treatment group STS and BO scores would have decreased over time as a result of attending the workshop and practicing the resiliency skills of the workshop if the pandemic did not occur. Despite the attempt to capture the impact of pandemic on work and personal lives at Time 1 and Time 2 data collection points, the full scope of long term impacts are yet to be seen. At the conclusion of this study, the COVID-19 pandemic is still raging throughout the world. Studies to understand how

the pandemic has impacted CITs' learning, particularly of clinical skills, as well as how the switch to telehealth impacts client care, the therapeutic relationship and CF symptoms are warranted. Additional history effects, such as the timing of data collection and the academic calendar, may also have impacted how participants responded to the assessment questions.

Implications and future directions

The idea of treatment dosing appears to be relevant for treating, and perhaps even eradicating, CF symptoms as evidenced by this study and by Cocker and Jess (2016). Providing both CITs and practicing mental health professionals with multiple opportunities to explore and practice resiliency skills may continue to be fruitful in efforts to reduce the experience of CF. Examples of various opportunities could include: attending a resiliency group following workshop participation, embedding CF discussions in supervision and in academic coursework, talking about CF in consultation groups, reading related literature, having quarterly "boosters" or refreshers on the topic, etc. The more we have occasions to cultivate and sustain resiliency in the face of empathic work, the more likely we are to embody it.

More CF exploratory longitudinal studies with treatment and control groups are needed to better understand the long term efficacy of various CF treatment modalities. Additional CF research exploring the presence and patterns of CF over the course of one's career would also be helpful to the field. Similarly, comparing CF symptoms between CITs and practicing mental health professionals would be beneficial. These could help resolve discrepancies in the literature (Turgoose & Maddox, 2017) as well as produce valuable information about where CF treatment dosing might yield the best results. For example, is it more useful to have more exposure to CF in graduate school or ten years into a career in counseling or both?

This study did not differentiate CF scores based on academic progression nor between CITs in clinical mental health and school counseling tracks. Examining CF development over the course of CITs' progression through counseling programs (i.e. Do CITs enrolled in internship courses report different levels of CF than CITs enrolled in practicum or pre-practicum courses? Do clinical mental health CITs report different levels of CF than school CITs?) could warrant beneficial information for counselor educators about the placement and timing of CF training and is another idea for further study.

Qualitative approaches to understanding the lived experiences with CF symptoms as well as examining the lived experiences during and after CF treatments, like the ARP, would be helpful in understanding what the active ingredients are for meaningful CF symptom reduction in both the short term and long term. Specifically, phenomenologically exploring participants' lived experiences utilizing the skills and principals covered in the intervention could yield beneficial data for continued modification of CF treatment and prevention. Further examination of the experiences of the various CF treatment dosing efforts may help in fine tuning those prevention efforts. Additionally, CITs and mental health professionals' lived experiences of doing clinical work during the prolonged COVID-19 pandemic would also be timely research.

Conclusion

In conclusion, CF is a significant problem that requires careful attention, further research, discourse and inclusion in counselor education training programs and supervision (Alkema, et al., 2008; Craig & Sprang, 2010; Figley, 1995; Merriman, 2015; Musa & Hamid, 2008; Thompson, et al., 2014; Turgoose & Maddox, 2017; Volpe et al., 2014). An established and effective training program for the healing and prevention of CF, like the ARP and subsequent workshop trainings (Gentry et al., 2002; Gentry & Baranowsky, 1998; Gentry & Dietz, 2020;

Gentry & Monson, 2017), could result in more resilient counselors entering the mental health field upon graduation. Corroborating existing literature about CITs' baseline for CF symptomology contributes to understanding the etiology of CF, as previous studies provide mixed results (Thompson et al., 2014; Turgoose & Maddox, 2017). Further, this study provided participants with an invitation to examine their individual symptoms of STS and BO. With this awareness, participants could begin a practice of monitoring these factors throughout their career and could take deliberate action to minimize, eliminate and/or ultimately prevent CF symptoms. The ultimate ambition of this study was a call to counselor educators to include CF education, like the ARP and resiliency trainings, within program curriculum. While the results of this study were limited in scope, there is no doubt that curriculum supporting the wellness and resiliency of counselors is a worthy and meaningful effort. The outcomes of this and other studies serve as an invitation for faculty to not only equip their students with the knowledge and skills that they will need to be competent counselors, but to also equip them with skills necessary to be resilient counselors, and humans. Together, we can continue to keep the candle of hope burning brightly.

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APPENDIX A

COMPASSION SATISFACTION AND COMPASSION FATIGUE   (PROQOL) VERSION 5
(2009)

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

1=Never	2=Rarely	3=Sometimes	4=Often	5=Very Often

1.   I am happy.

2.   I am preoccupied with more than one person I *[help]*.

3.   I get satisfaction from being able to *[help]* people.

4.   I feel connected to others.

5.   I jump or am startled by unexpected sounds.

6.   I feel invigorated after working with those I *[help]*.

7.   I find it difficult to separate my personal life from my life as a *[helper]*.

8.   I am not as productive at work because I am losing sleep over traumatic experiences of a person I
        [help].

9.   I think that I might have been affected by the traumatic stress of those I *[help]*.

10.   I feel trapped by my job as a *[helper]*.

11.   Because of my *[helping]*, I have felt "on edge" about various things.

12.   I like my work as a *[helper]*.

13.   I feel depressed because of the traumatic experiences of the people I *[help]*.

14.   I feel as though I am experiencing the trauma of someone I have *[helped]*.

15.   I have beliefs that sustain me.

16.   I am pleased with how I am able to keep up with *[helping]* techniques and protocols.

17.   I am the person I always wanted to be.

18.   My work makes me feel satisfied.

19.   I feel worn out because of my work as a *[helper]*.

20.   I have happy thoughts and feelings about those I *[help]* and how I could help them.

21.   I feel overwhelmed because my case [work] load seems endless.

22.   I believe I can make a difference through my work.

23.   I avoid certain activities or situations because they remind me of frightening experiences of the   people I *[help]*.

24.   I am proud of what I can do to *[help]*.

25.   As a result of my *[helping]*, I have intrusive, frightening thoughts.

26.   I feel "bogged down" by the system.

27.   I have thoughts that I am a "success" as a *[helper]*.

28.   I can't recall important parts of my work with trauma victims.

29.   I am a very caring person.

30.   I am happy that I chose to do this work.

Based on your responses, place your personal scores below. If you have any concerns, you should discuss them with a physical or mental health care professional.

Compassion Satisfaction _____

Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job.

The average score is 50 (SD 10; alpha scale reliability .88). About 25% of people score higher than 57 and about 25% of people score below 43. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 40, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job.

Burnout_____

Most people have an intuitive idea of what burnout is. From the research perspective, burnout is one of the elements of Compassion Fatigue (CF). It is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

The average score on the burnout scale is 50 (SD 10; alpha scale reliability .75). About 25% of people score above 57 and about 25% of people score below 43. If your score is below 43, this probably reflects positive feelings about your ability to be effective in your work. If you score above 57 you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a "bad day" or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

Secondary Traumatic Stress_____

The second component of Compassion Fatigue (CF) is secondary traumatic stress (STS). It is about your work related, secondary exposure to extremely or traumatically stressful events. Developing problems due to exposure to other's trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called Vicarious Traumatization. If your work puts you directly in the path of danger, for example, field work in a war or area of civil violence, this is not secondary exposure; your exposure is primary. However, if you are exposed to others' traumatic events as a result of your work, for example, as a therapist or an emergency worker, this is secondary

exposure. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

The average score on this scale is 50 (SD 10; alpha scale reliability .81). About 25% of people score below 43 and about 25% of people score above 57. If your score is above 57, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a health care professional.

In this section, you will score your test so you understand the interpretation for you. To find your score on **each section,** total the questions listed on the left and then find your score in the table on the right of the section.

Compassion Satisfaction Scale

Copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

3. ____

6. ____

12. ____

16. ____

18. ____
20. ____
22. ____
24. ____
27. ____
30. ____

Total: _____

The sum of my Compassion Satisfaction questions is	So My Score Equals	And my Compassion Satisfaction level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Burnout Scale

On the burnout scale you will need to take an extra step. Starred items are "reverse scored." If you scored the item 1, write a 5 beside it. The reason we ask you to reverse the score is because scientifically the measure works better when these questions are asked in a positive way though they can tell us more about their negative form. For example, question 1. "I am happy" tells us more about the effects of helping when you are not happy so you reverse the score.

*1. _____ = _____
*4. _____ = _____
8. _____
10. _____
*15. _____ = _____
*17. _____ = _____
19. _____
21. _____
26. _____
*29. _____ = _____

Total =_____

The sum of my Burnout Questions is	So my score equals	And my Burnout level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Secondary Traumatic Stress Scale

Just like you did on
Compassion Satisfaction,
copy your rating on each of
these questions on to this
table and add them up.
When you have added them
up you can find your score
on the table to the right.

2. _____
5. _____
7. _____
9. _____
11. _____
13. _____
14. _____
23. _____
25. _____
28. _____

Total: _____

The sum of my Secondary Trauma questions is	So My Score Equals	And my Secondary Traumatic Stress level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

APPENDIX B

Demographic Questionnaire

Please answer the following questions:

1. What is your age? _____
2. What is your gender?

    Male_____   Female_____   Non-binary_____   Other_____
3. What is your marital status?

    Single_____   Married_____   Partnered_____   Divorced_____   Widowed_____
4. What is your race/ethnicity? (check all that apply)

    African American_____   American Indian_____   Asain_____

    Caucasian_____   Hispanic/Latino____   Pacific Islander_____

    Multiracial_____   Other_____
5. What is your professional status?
    a. Graduate Student_____
        i. What year are you at in your Grad Program? _____
        ii. Approximately how many hours do you spend each week in direct counseling activities? _____
    b. Professional_____
        i. What type of degree do you have?   Masters'_____   PhD_____
        ii. What is your degree in? _____
        iii. How many years have your been practicing mental health services? _____
        iv. Approximately how many hours do you spend each week in direct counseling activities? _____
        v. What is the primary population of your case load?

            Children (0-11) _____   Adolescents (12-17) _____

            Adults (18-65) _____ Geriatric (65+) _____ Other: _____
        vi. In what type of setting do you work? (check all that apply)

            Agency_____ School_____ Private Practice_____

            Non-Profit_____   Other_____
6. Did you learn about compassion fatigue in your graduate program?

    Yes_____   No_____
7. Have you participated in any other compassion fatigue or related trainings or workshops?

    Yes_____   No_____
8. *(Optional)* Have you experienced a personal trauma(s)?
    a. No_____
    b. Yes_____
        i. If yes, please classify your trauma(s): (check all that apply)

            Childhood Physical Abuse_____   Childhood Sexual Abuse_____

            Childhood Emotional Abuse_____   Adult Physical Abuse_____

            Adult Sexual Abuse_____   Adult Emotional Abuse_____

            Traumatic Event(s) _____ Other: _____

APPENDIX C

Adverse Childhood Experience (ACE) Questionnaire Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often … Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?

    Yes No; If yes enter 1 _____

2. Did a parent or other adult in the household often … Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?

    Yes No; If yes enter 1 _____

3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Try to or actually have oral, anal, or vaginal sex with you? **Yes No;** If yes enter 1 _____

4. Did you often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other? **Yes No;** If yes enter 1 _____

5. Did you often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it? **Yes No;** If yes enter 1 _____

6. Were your parents ever separated or divorced?

    Yes No; If yes enter 1 _____

7. Was your mother or stepmother: Often pushed, grabbed, slapped, or had something thrown at her? or Sometimes or often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

    Yes No; If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

    Yes No; If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?

    Yes No; If yes enter 1 _____

10. Did a household member go to prison?

    Yes No; If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

APPENDIX D

Resiliency Skills Usage Survey

How much have you used each of the following skills since participating in the Promoting Professional Resiliency: Combating Compassion Fatigue workshop on February 7th & 8th, 2020?

Self-regulation:
    "Wet Noodle" (scanning body for tense muscles and relaxing)

1	2	3	4
Never use	Use once a month	Use once a week	Use daily

    Peripheral Vision

1	2	3	4
Never use	Use once a month	Use once a week	Use daily

    Diaphragmatic Breathing

1	2	3	4
Never use	Use once a month	Use once a week	Use daily

    Pelvic Floor Muscle Relaxation

1	2	3	4
Never use	Use once a month	Use once a week	Use daily

Intentionality:
    Aligning your thoughts and behaviors with your Core Values/Code of Honor

1	2	3	4
Never use	Use once a month	Use once a week	Use daily

    Referencing your Professional Mission Statement

1	2	3	4
Never use	Use once a month	Use once a week	Use daily

Perceptual Maturation:
    Using Personal Optimization (i.e. happiness, positive psychology, mindfulness, self-validation & gratitude) to adjust ways you think about yourself and/or work

1	2	3	4
Never use	Use once a month	Use once a week	Use daily

    Using Detoxifying Workplace Attitudes (i.e. internal vs. external locus of control, Choice vs. Demand, Perceived vs. Real Threats, Personal Best Practice vs. Outcome-Driven Performance, & Acceptance of an Anxious System) to adjust ways you think about yourself and/or your work

1	2	3	4
Never use	Use once a month	Use once a week	Use daily

Social Support:

Reaching out to supportive others to hold you accountable to your Values and Mission

1	2	3	4
Never use	Use once a month	Use once a week	Use daily

Sharing your Secondary Traumatic Stress (STS) narratives with supportive other(s)

1	2	3	4
Never use	Use once a month	Use once a week	Use daily

Self-Care:

Engaging in Physical Self-Care

1	2	3	4
Never use	Use once a month	Use once a week	Use daily

Engaging in Spiritual Self-Care

1	2	3	4
Never use	Use once a month	Use once a week	Use daily

Engaging in Emotional and Psychological Self-Care

1	2	3	4
Never use	Use once a month	Use once a week	Use daily

Engaging in Professional Self-Care

1	2	3	4
Never use	Use once a month	Use once a week	Use daily

Total (sum) Use of Resiliency Skills: _____

Did you practice any of the above resiliency skills prior to the workshop?

           Yes   No

      If "yes," please briefly describe what skill(s) you practiced and how you practiced them.

What way(s) might you benefit from continued support regarding professional resiliency? (please choose any that apply)

Attending a similar workshop	Attending a different type of workshop	Attending a resiliency accountability group	Reading related material	Talking about resiliency in supervision or consultation
Talking about resiliency in personal therapy	Other (please explain):			