EFFECTS OF A SELF-CARE INTERVENTION FOR COUNSELORS ON

COMPASSION FATIGUE AND COMPASSION SATISFACTION

Christine Marie Guthrie Koehler, B.A., M.S.

Dissertation Prepared for the Degree of

DOCTOR OF PHILOSOPHY

UNIVERSITY OF NORTH TEXAS

December 2012

APPROVED:

Dee Ray, Major Professor
Casey Barrio-Minton, Committee Member
Carolyn Kern, Committee Member
Janice Holden, Chair of the Department of
        Counseling and Higher Education
Jerry R. Thomas, Dean of the College of
        the College of Education
Mark Wardell, Dean of the Toulouse
        Graduate School

Koehler, Christine Marie Guthrie. <u>Effects of a self-care intervention for counselors on compassion fatigue and compassion satisfaction</u>. Doctor of Philosophy (Counseling), December 2012, 94 pp., 9 tables, 1 figure, references, 126 titles.

This study investigated the impact of a psychoeducational and experiential structured counselor self-care curriculum, developed by Drs. Charles and Kathleen Figley, on compassion fatigue and the prevention of professional impairment as measured by the Professional Quality of Life (ProQOL), Version 5. Volunteer licensed professional counselors, supervisors, and interns from four children's advocacy centers in Texas were assigned to treatment group $(n = 21$; 20 females, 1 male; mean age 34.4 years) or waitlist control group ($n = 21$; 19 females, 2 males; mean age 34.6 years). Participating counselors identified themselves ethnically as 64% Caucasian, 26% Hispanic, 7% African-American, and 2% Native-American.

Employing a quasi-experimental design, three reliability-corrected analysis of covariance (ANCOVA) were utilized to analyze the data with an alpha level of .05 to assess statistical significance and partial eta squared to assess effect size. With pre-test scores as the covariate, results revealed in the experimental group a statistically significant reduction with large treatment effect for burnout ($p = .01$; partial $\eta^2 = .15$), a statistically nonsignificant reduction with a medium effect for secondary traumatic stress ($p = .18$; partial $\eta^2 = .05$), and a statistically nonsignificant increase with a medium effect for compassion satisfaction ($p = .06$; partial $\eta^2 = .09$). Findings supported the use of this curriculum to train counselors on self-care as required of professional counselors by the American Counseling Association code of ethics and listed as a necessary skill in the

standards of the Council for Accreditation of Counseling and Related Educational

Programs.

ACKNOWLEDGEMENTS

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1

INTRODUCTION

Counselors by nature and inclination are emotionally attuned to the needs of others. The nature of counseling requires the giving of oneself as part of a counselor's effectiveness (Skovholt & Trotter-Mathison, 2011). Having good psychological health is important for professional counselors to assess, experience, and respond to human need while maintaining the ability to navigate and regulate the boundary between others and self (Rogers, 2007; Skovholt & Trotter-Mathison, 2011). To do so successfully is an ongoing challenge, as the very act of being a professional helper carries a number of burdens and responsibilities that can compromise psychological wellness and lead to difficulties such as distress, personal depletion, and fatigue (Figley, 2002). Kottler (2000) warned that without balanced attention to one's own needs, a counselor "will not be able to do much good for very long" (p. 73).

Occupational "hazards" are characteristically found throughout the mental health professions and those working with traumatized clients can be greatly affected by their experience (McCann & Pearlman, 1990; Yassen, 1995). Many factors may lead to considerable job related stress, such as exposure to negative and high-risk client behaviors including suicidality, violence, aggressiveness, clients with chronic difficulties who do not improve and who relapse, professional and emotional isolation, lack of therapeutic success, requirements of insurance and managed care, difficulties receiving payment for services rendered, and demanding paperwork and administrative duties (Barnett, 2007; Norcross, Guy, & Laidig, 2007). In addition to depression and suicide, substance abuse or dependence, financial strain, and familial and relationship

difficulties are further examples of professional distress (American Psychological Association, 2006). Distress, inherent to the mental health profession, can result in an individual's disequilibrium in which one's personal well-being becomes compromised (APA, 2006). Distress, if unaddressed, may lead to conditions such as burnout, compassion fatigue, substandard care or harm to clients, impaired practice, ethical violations, or provider loss due to qualified practitioners that choose to leave the profession (Barnett, 2007; Figley, 2002).

Significant evidence of distress was highlighted when researchers, Pope and Tabachnick (1994), surveyed 800 psychologists undergoing personal therapy and found that a wide range of personal problems were acknowledged including relationship difficulties, depression, anxiety, and lowered self-esteem and confidence. Of the respondents, 60% acknowledged being significantly depressed at some time during their career; 29% reported having felt suicidal, and nearly 4% had attempted suicide (Pope & Tabachnick, 1994). Among mental health professionals, suicide is rare and difficult to quantify, but it is believed to be linked to unaddressed impairment and psychological distress (Kleespies et al., 2011). In a recent inquiry into the apparent suicide deaths of 14 mental health professionals, it was found through interviews of colleagues that "more than half were thought to have had problems with depression or substance abuse, and except for one, were more likely troubled (i.e., distressed or impaired) than in trouble (i.e., legal or ethical)" (Kleespies et al., 2011, p. 247). Thus, the topic of the identification, consequences, treatment, and prevention of professional impairment has received attention in the mental health literature across professions including psychology, social work, and counseling.

As an ethical responsibility and obligation, self-care has been identified as a preventative measure and requires that professionals monitor their own level of functioning, alert to signs of impairment (Good, Khairallah, & Mintz, 2009). Barnett, Johnston, and Hillard (2006) asserted that self-care is essential as a part of one's professional identity and "not to be considered as something 'extra' or 'nice to do' if you have the time" (p. 263). A comprehensive self-care practice serves to protect clients, enhance therapy, and protect counselors (Porter, 1995).

Among professional associations and ethical codes, the American Counseling Association (ACA) code of ethics (2005) established the following principles that define ethical behavior and best practices of association members specifically regarding effectiveness, impairment, self-care, and non-maleficence:

Section A.4.a., Avoiding Harm: *Counselors act to avoid harming their clients, trainees, and research participants and to minimize or to remedy unavoidable or unanticipated harm (p. 4).*

Section C., Professional Responsibility: *Counselors engage in self-care activities to maintain and promote their emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities (p. 9).*

Section C.2.d., Monitor Effectiveness: *Counselors continuously monitor their effectiveness as professionals and take steps to improve when necessary (p. 9).*

Section C.2.g., Impairment: *Counselors are alert to the signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when such impairment is likely to harm a client or others (p. 9).*

Self-care is defined as the process of maintaining and promoting emotional, physical, mental, and spiritual well-being in pursuit of overall wellness (ACA, 2005). Counselors report that they are aware of the importance of self-care practices; however, in a recent study on counselors attitudes regarding self-care and the self-care strategies most often used, researchers found no association between the belief that rest and self-care were useful and time allocated to engage in renewal activities (Bober & Regehr, 2005). Counselors reportedly avoid engaging in practices that they acknowledge as beneficial to their own well-being.

Statement of the Problem

Counselors, educators, researchers and professional associations have long agreed that well counselors are better equipped to help clients in the work of therapy (Smith & Moss, 2009). Counselor wellness literature has established that well counselors are more likely to help clients progress and that "resiliency in counselors is not an accident" (Lawson & Myers, 2011; Meyer & Ponton, 2006). Meyer and Ponton (2006) stated that wellness is the accumulation of positive outcomes of healthy decision making. Similarly, it is agreed that to protect against conditions leading to impairment, counselors must practice self-care as a part of wellness (ACA, 2005; Figley, 2002; Smith & Moss, 2009). Preventative personal and professional self-care practices are essential to mitigate the effects of counselor distress and to also improve or sustain career longevity, ethical practice, and professional fulfillment (Figley, 2002; O'Halloran & Linton, 2000; Stebnicki, 2007; Trippany, White Kress, & Wilcoxon, 2004).

Unfortunately, much of the literature related to self-care as a preventative measure concedes that many counselors do not have a self-care practice in place nor have they received training (Culver, 2011). Although, the training of self-care is specifically addressed within the Council for Accreditation of Counseling and Related Educational Programs (CACREP) (2009) Standards and included in the ACA Code of Ethics (2005), there is a lack of training provided to counselors on self-care (Culver, 2011; Smith & Moss, 2009; Thomas & Levitt, 2010).

There is a dearth of literature related to models for teaching about self-care (Culver, 2011) and impairment (Schoener, 2007). Though important, the training of self-care, both rationale and strategies, is limited or unavailable to many, and no model for the training of self-care has been applied and studied empirically (Culver, 2011). Therefore, study regarding the effectiveness of structured self-care training to protect against impairment is needed.

Purpose of the Study

The purpose of this study was to examine the impact of a structured, self-care training utilizing the Self-Care Planning Tool (Figley & Figley, 2010) on counselors who worked extensively with trauma survivors in a two part psycho-educational and experiential workshop on self-care. Specifically, I examined the effects of participation in self-care training on lowering scores of burnout and secondary traumatic stress for counselors in agencies serving victims of trauma and abuse. Secondly, I examined the effects of self-care training on counselors' compassion satisfaction, the positive aspect derived from helping others (Stamm, 2010).

Significance of the Study

Although it has been shown that self-care should be a vital component of a practitioner's daily practice, there is a lack of training, both during and after graduate education regarding the costs of caring, the consequences of unaddressed distress, and the implementation of self-care planning to lead to basic self-care practices (Smith & Moss, 2009; Newell & Gordon, 2010). Self-care as a basic skill should be employed indefinitely as a preventative and protective measure to combat counselor distress (Figley, 2002). Due to the paucity of research on self-care training, literature reviewed includes studies conducted during counselor training and preparation as well as those conducted with practicing professionals. Literature indicates that self-care training and planning programs to encourage implementation of essential knowledge and skills could be used at any stage to enhance the well-being and effectiveness of counselors already in practice as well as to train and prepare counselors entering the field.

Organization of the Proposed Study

In this chapter, I have discussed the necessity of the psychological well-being of counselors, the nature and prevalence of counselor distress, professional impairment and self-care as an ethical obligation and mitigating factor against professional distress. I also stated that counselor training programs and professional organizations are lacking methods for self-care instruction although they advocate strongly for such training and it is clearly required by professional ethical codes. The statement of the problem, purpose of the study, research questions, significance of the study, and organization of the proposed study were also provided.

Chapter 2 contains a comprehensive literature review on the definitions and numerous considerations specific to counselor distress and impairment including trauma work, compassion fatigue, secondary traumatic stress, professional burnout, self-care practices and self-care training and education. Additionally, literature specific to self-care and professional well-being is included.

Chapter 3 explains the proposed methodology of the research including research questions, definition of terms, instruments, participants, procedures, training curriculum, and data analysis.

Chapter 4 presents the results of data analyses, and in chapter 5 I discuss findings related to the literature, implications, and recommendations for future research.

CHAPTER 2

REVIEW OF RELATED LITERATURE

In this chapter, I review literature related to counselor distress and impairment as a consequence of unaddressed professional distress as it relates to trauma work. I also review the current literature on the constructs of counselor distress such as compassion fatigue, secondary traumatic stress, and burnout and define these terms for the purpose of this study. Research into the different constructs as well as the overlapping theoretical conceptualizations is ongoing and the differentiation of the constructs themselves is beyond the scope of this study. I discuss self-care as an ethical responsibility and preventative measure against conditions that may lead to professional impairment or impaired practice. Finally, I review the empirical literature on self-care practices and the training of self-care.

Counselor Distress and Impairment

The very nature of counseling work is demanding, stressful, and potentially distressing (Barnett & Cooper, 2009, p. 17). Regardless of the preparation of counselors, unavoidable occupational "hazards" intrinsic to the mental health profession (e.g., suicidality or aggressiveness, professional and emotional isolation, lack of therapeutic success, and demanding paperwork and administrative duties) increase the likelihood of job related distress (Norcross, Guy, & Laidig, 2007). In addition to the aforementioned, factors such as depression, substance abuse or dependence, secondary trauma, financial strain, and familial and relationship difficulties are further examples of professional distress (Smith & Moss, 2009).

Distress has been characterized as a subjective experience of mental or physical anguish, while impairment has been conceptualized as an objective change in professional functioning (Schwebel, Skorina, & Shoener, 1988). Baker (2003) stated that distress in different forms often precedes impairment and may be considered a "warning signal" (p. 21). For example, addictive or compulsive behaviors including substance abuse or workaholism are often indicators of psychological distress (Dutton & Rubinstein, 1995) that may result in impairment of counselors' day to day functioning (e.g,, missed or cancelled appointments, decreased use of supervision, chronic lateness, and feelings of isolation). If unaddressed, distress may lead to conditions such as burnout or compassion fatigue, substandard care or harm to clients, ethical violations, or impaired practice (Barnett, 2007; Figley, 2002).

When distress or other physical or mental deterioration adversely alters the occupational functioning or results in the provision of substandard care, impairment has occurred (Lawson & Venart, 2005). American Counselor Association (2003) suggested the following working definition of counselor impairment:

Therapeutic impairment occurs when there is a significant negative impact on counselors' professional functioning which compromises client care or that poses the potential for harm to the client. Impairment may be due to substance abuse or chemical dependency; mental illness; personal crisis (traumatic events or vicarious trauma, burnout, life crisis); and physical illness or debilitation. Impairment in and of itself does not imply unethical behavior. Unethical behavior may occur as a symptom of impairment, or may occur in counselors who are not impaired. (p. 243)

The taskforce stated, "Counselors who are impaired are distinguished from stressed or distressed counselors who are experiencing significant stressors, but whose work is not significantly affected" (Lawson & Venart, 2005, p. 243). Research on practitioner impairment has identified risk factors such as depression, substance use, burnout, and life stressors, and has specified ethical breaches such as role and boundary violations, including sexual misconduct (College of Alberta Psychologists, 2006). Evidence of the prevalence of impairment can be found in the research of professional mental health providers including psychologists, counselors, psychotherapists, and social workers.

According to the ACA Taskforce on Wellness and Impairment, all counselors are on the spectrum from "well" to "impaired" at any given moment (ACA, 2004). In conceptualizing the wellness-impairment continuum, one can predict that when self-care is either insufficient or absent, that the counselor may passively, due to the impact of work and passage of time, move closer toward impairment on the spectrum. As such, self-care can be an ongoing practice in terms of treating or preventing impairment, while it can also be an ongoing practice in terms of enhancing wellness in all domains (Barnett & Cooper, 2009; Skovholt & Trotter-Mathison, 2011). Whichever viewpoint one ascribes to, counselors may engage in self-care activities to find a balance of self and other-care along this continuum and deter impairment. Evidence in the literature however, has suggested that impaired practice is not uncommon among mental health professionals (Gilroy, Carroll, & Murra, 2002; Guy, Poelstra, & Stark 1989).

In the 2004 survey of a random sample of ACA members, the task force found that 63.5% of counselors stated that they have known a counselor they would consider

impaired. In a sample of 318 psychologists, Guy, Polestra, and Stark (1989) found that

74.3% reported experiencing marked personal distress over the previous three years

and 36.7% indicated that their distress had significantly reduced the quality of care they

were able to provide to clients. Pope, Tabachnick, and Keith-Spiegel (1987) reported

that 62.2% of surveyed psychologists admitted to "working when too distressed to be

effective" even though 85.1% of these same individuals believed that it was unethical

to do so. Gilroy, Carroll, and Murra (2002) surveyed 1000 counselors and of the

respondents, 62% identified themselves as depressed. These findings support the

argument that some clinical services are provided by counselors who are themselves

experiencing distress severe enough to warrant concerns about their competency and

effectiveness (Guy, Poelstra, & Stark, 1989). Research on the consequences of

working with traumatized populations has been one avenue for researchers to explore

counselor distress.

Negative Impact of Trauma Work

Following wide scale events such as terrorist attacks on 9/11 and Hurricane

Katrina, growing interest in traumatology has led researchers to study the

consequences of trauma work in relation to the functioning of professional helpers.

Researchers have reported elevated rates of distress expressed by those working

specifically with traumatized individuals (Arvay & Uhlemann, 1996; Brady, Guy,

Poelstra, & Brokaw, 1999; Chrestman, 1999; Kassam-Adams, 1995; Schauben &

Frazier, 1995). For example, in a study of 173 child welfare workers exposed to

traumatic imagery through client accounts and exposure to trauma such as violence

and threats directed at them, 12.8% scored in the high range and 46.7% reported traumatic stress symptoms in the severe range on the Impact of Events Scale (Regehr, Chau, Leslie, & Howe, 2002). Killian (2008) suggested that distress is certain as counselors are regularly interacting and working with individuals who have either recently experienced or have a history of trauma. To illustrate, in a study of 54 clients newly referred for outpatient treatment it was revealed that 84% to 94% reported a history of traumatic events such as child sexual abuse, domestic violence, or displacement (Davidson & Smith, 1990).

Subsequently, over the last two decades, interest in consequences, including impairment, of indirect exposure to trauma has resulted in the development of conceptual literature regarding the constructs of compassion fatigue (CF), secondary traumatic stress (STS), and burnout (BO). Researchers associated with the introduction and development of these terms have attempted to isolate and identify components of mental health professionals stress reactions for two main purposes: (1) to study the components independently for the purposes of intervention and prevention, and (2) to remove stigma from the professional reaction so that distress could be regarded as a natural and expected consequence (Jenkins & Baird, 2002).

Stamm (2010) argued that though there are some nuanced differences in the concepts and definitions of STS and CF, researchers who have tried to distinguish the constructs have not found evidence of substantial differences. Nonetheless, researchers continue to disagree regarding conceptual differences and similarities between the terminologies used due to conflicting and inconsistent findings in empirical validity testing of the constructs, disagreement in assessment measures, the elusive

nature of phenomena (individuals' differential vulnerabilities, rapid onset and rapidly resolved in some cases), overlap of theory, and shared symptomatology (Devilly, Wright, & Varker, 2009; Figley, 2002; Jenkins & Baird, 2002; Stamm, 2010).

Regardless of the difficulties encountered in quantifying the impact of indirect exposure of trauma on counselors, qualitative descriptions and self-report support the assumption that counselors undergo a transformation over time when exposed to the suffering of clients (Devilly, Wright, & Varker, 2009). Presumably, all mental health professionals would benefit from familiarity with concepts associated with compassion fatigue and impaired practice as well as mitigating effects of self-care. One way of educating counselors is to discuss the different concepts in the context of one's professional quality of life.

Professional Quality of Life Influences

Professional quality of life is described as helpers' experience in relation to working empathically with others (Stamm, 2010). There are both positive and negative aspects of work as a professional helper that influence one's professional quality of life (Stamm, 2010). The negative costs of caring include well-researched constructs such as burnout and more recently coined phenomena such as compassion fatigue.

Compassion Fatigue (CF)

Figley (1995) defined compassion as a feeling of deep sympathy for the pain, anguish, and hardship of another person. Compassion stress, a form of distress, is strain or pressure related to feelings of caring (Figley, 1995). The impact of responding

compassionately to clients with trauma can be substantial to the helper. Compassion fatigue (theorized as resulting from unaddressed empathic distress) as well as its etiology is not fully understood, however, as stated by Figley (1995) it is clear that "stress is a normal and natural byproduct of working with traumatized people," (p. 573). In recent studies, rates of compassion fatigue and secondary traumatic stress among mental health professionals ranged from 13-50% (Bride, 2007; Sprang, Clark & Whitt-Woosley, 2007).

Adams, Boscarino, and Figley (2006) stated that the small amount of research on CF has had several problems. First, there has been a lack of conceptual clarity regarding how CF specifically differs from other adverse work outcomes such as burnout (Jenkins & Baird, 2002). Second, there are a number of scales that attempt to measure CF, with many dissimilar items (e.g., Figley, 1995; Stamm, 2010). Third, no study fully incorporates all aspects of descriptions of CF or key variables in the stress process model (Adams et al., 2006).

While distinctions have not been clearly delineated, CF is often used interchangeably with STS, though for the purposes of this study, and consistent with the research instrument, compassion fatigue is defined as any combination of burnout (Maslach et al., 2001) and secondary traumatic stress symptoms (intrusion, avoidance, and hyperarousal) stemming from work-related, secondary exposure to extremely stressful events (Stamm, 2010). The symptoms of compassion fatigue typically have an acute onset and are usually associated with a particular event (Stamm, 2010). Symptoms may include hyper-arousal and burnout, being afraid, intrusive images,

trouble sleeping, or avoiding situations that remind the individual of the event (Stamm, 2010).

Secondary traumatic stress (STS). The concept of secondary traumatic stress (STS) has evolved over the past two decades. Secondary traumatic stress is defined as "the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a traumatized or suffering person" (Figley, 1995; p. 7). Considered a syndrome of symptoms nearly identical to post traumatic stress disorder (PTSD), STS can result from either cumulative or acute exposure to traumatic material, and has been described as an inevitable occupational hazard of those working with victims of trauma (Figley, 1995). Symptoms of STS include hyper-vigilance, avoidance, intrusive thoughts and images, and emotional numbing. Figley (1995) explained that secondary traumatic stress can manifest following just one exposure to traumatic material brought by a client.

Counselors report a variety of secondary reactions as a result of work with traumatized clients. A meta-analysis conducted by Figley (1995) categorized these reactions into three areas: psychological distress or dysfunction, relational disturbances, and cognitive shifts. Indicators of psychological distress include distressing emotions like sadness or grief, horror or dread (Figley, 1995). In addition, nightmares and intrusive images of the client's traumatic material can occur.

Relational disturbances refer to the effects of secondary exposure to trauma on personal and professional relationships and may also result in either detachment or over identification with the client (Dutton & Rubinstein, 1995). Detachment results in emotional distancing from friends and family or the client when overwhelmed by or

vulnerable to traumatic material. This may in turn result in the client feeling isolated

(Dutton & Rubinstein, 1995). Over identification with the client's traumatic material can

also result in the counselor's feelings of responsibility for the client's well-being and as

such, the counselor may become ineffective or may place the client in the position of

dependency (Dutton & Rubinstein, 1995).

Cognitive shifts due to STS refer to changes in the counselor's beliefs,

expectations and assumptions (McCann & Pearlman, 1990). Shifts of this type can

affect the counselor's sense of trust resulting in chronic suspicion of others including

colleagues, clients, and human kind in general. The individual may internally move

away from feeling safe to having a heightened sense of vulnerability. One may also

move from a sense of independence to an experience of loss of personal control and

freedom, restricting the counselor's ability to make or maintain contact with the client

(Dutton & Rubinstein, 1995).

Professional burnout (BO). The phenomenon of burnout was initially explicated

by Maslach in 1976, who described the construct as gradually accumulated,

institutional or work-related distress characterized by emotional exhaustion,

depersonalization, and a sense of reduced personal accomplishment (Maslach,

Schaufeli, & Leiter, 2001; Stamm, 2010). It is currently conceptualized as a

psychological syndrome in response to chronic interpersonal stressors on the job

(Maslach et al., 2001). Work overload, limited support, role conflict and role ambiguity

have been consistently associated with burnout and are considered primary precursors

(Devilly, Wright, & Varker, 2009).

Figley (1995) described specific symptoms as physical complaints (headaches, difficulty sleeping, fatigue, gastro-intestinal problems), emotional symptoms (irritability, anxiety, depression, or guilt), behavioral symptoms (absenteeism, substance abuse), poor work performance, interpersonal withdrawal, and intellectualization of clients' distress. The strongest factor associated with burnout is a sense that the capacity and resources of the helper are insufficient to help effectively (Figley, 1995). Researchers have found that burnout tends to be more prevalent in younger practitioners, those with a perceived lack of social and collegial support, and caseload dissatisfaction (Kruger, Botman, & Goodenow, 1991; Kruger, Bernstein, & Botman, 1994; Raquepaw & Miller, 1989).

Compassion Satisfaction (CS)

Just as there are negative effects related to counseling work, professionals report great personal fulfillment and efficacy as a result of their work. Compassion satisfaction describes positive feelings derived from doing helping work effectively (Stamm, 2010). Many mental health professionals experience feelings of fulfillment and positive affect from the experience of helping. It is important that these positive effects be regarded as meaningful and recognized as potentially career sustaining (Radey & Figley, 2007). Compassion satisfaction is important to consider in terms of the constructs related to counselor distress because it too, is believed to be a mitigating factor against secondary traumatic stress and impairment (Stamm, 2010). Stamm (2010) regarded compassion satisfaction as the positive payment that comes from caring.

In Schauben and Frazier's (1995) study, over 45% of clinicians working with survivors of sexual assault reported enjoyable aspects of work that likely counterbalanced adverse reactions to trauma work to some degree. The clinicians noted aspects such as witnessing client resilience and growth, collegial support, and sense of purpose in their work. Participants also reported that they learned about themselves through their work with clients, which helped them in their personal development (Schauben & Frazier, 1995).

Self-Care within the Context of Wellness and Impairment

The counselor is the tool with which therapeutic work is done and a counselor's wellness provides the foundation for this work (Venart, Vassos, & Pitcher-Heft, 2007). Wellness is defined as the "condition of good physical, mental, and emotional health, especially when maintained by an appropriate diet, exercise, and other lifestyle modifications" (American Heritage Medical Dictionary, 2007). Myers, Sweeney and Witmer (2000) defined wellness from a counseling perspective as "a way of life oriented toward optimal health and well-being, in which body, mind, and spirit are integrated by the individual to live life more fully within the human and natural community. Ideally, it is the optimum state of health and well-being that each individual is capable of achieving (p. 252)." Self-care is any activity of an individual or group with the intention of improving or restoring health, or treating or preventing disease (American Heritage Medical Dictionary, 2007). Counselor wellness is a necessity in order to successfully fulfill the role in the helping relationship in that it gives the counselor access to empathic understanding and allows the counselor to be a healthy

model of behavior and emotional expression (Cavanagh & Levitov, 2002). Consistent with the concepts of self-care and wellness used with clients, counselors should maintain positive mental and physical health (O'Donnell, 1988).

The importance of understanding practitioner wellness has gained greater attention in professional mental health associations as seen by movement from merely identifying and responding to counselor impairment to promoting wellness as a preventative measure (Barnett & Cooper, 2009). Wellness involves "making choices to create and maintain balance and to prioritize health of mind, body, and spirit" (Venart et al., 2007, p. 50). Different from the modern medical model, the holistic wellness model emphasizes a positive view of human nature and encourages awareness and prevention rather than simply focusing on the treatment of symptoms and disorders once they occur (Lawson & Myers, 2011; Myers & Sweeney, 2008). This is also true regarding the role of self-care in enhancing holistic wellness and preventing impairment.

It has been suggested that the self-care methods that counselors present to clients to enhance wellness should also be practiced by counselors in order to become personally familiar with the values they advocate (Skovholt et al., 2001; Myers, Sweeney, & Witmer, 2000). Just as counselors' self-care behaviors offer a healthy model for clients, counselors who work though obviously tired or physically ill "send a message to clients that one's personal wellness is less important than attending to the needs of others" (Venart, Vassos, & Pitcher-Heft, 2007, p. 50). Furthermore, mental health professionals benefit from practicing self-care to act as a preventative measure

against the negative costs of caring (Barnett & Cooper, 2009; Killian, 2008; Figley, 2002, 2007; Mahoney, 1997).

To enhance wellness in all domains is to protect against impairment, thus it is vital that a preventative rather than reactive approach be adopted by practitioners (Barnett & Cooper, 2009; Skovholt & Trotter-Mathison, 2011). While coping is a reaction to stress, self-care is an ongoing proactive practice in terms of preventing impairment. Overall, it is purely self-care that is most important in diffusing distress and preventing impairment (Smith & Moss, 2009).

Self-Care in the Context of Professional Ethics

It has been established that impaired counselors are more likely to harm clients (Lawson, Venart, Hazler, & Kottler, 2007). Evidence suggests that the causes of impairment can be prevented when individual clinicians monitor their own vulnerability and utilize self-care methods (Figley, 1995; Killian, 2008). More vulnerable than the general population to mental and emotional disorders, practitioners are susceptible to the effects of distress, which if left unaddressed may lead to unethical practices characteristic of impaired professional competence (Barnett & Cooper, 2009; Lawson & Venart, 2005). Unethical behaviors that may occur include, but are not limited to, breaches of client confidentiality, inappropriate dual relationships, and practicing outside one's area of competence (Thomas & Levitt, 2010). Thus, counselor self-care is a serious ethical issue in that the absence of the counselor's well-being may adversely impact the quality of care given to clients (Barnett, Johnston & Hilliard, 2006; Norcross, 2000; Norcross & Guy, 2007). The American Counseling Association (ACA)

code of ethics (2005) established the following principles that define ethical behavior

and best practices of association members specifically regarding effectiveness,

impairment, self-care, well-being, and non-maleficence:

Section A.4.a., Avoiding Harm: Counselors act to avoid harming their clients,

trainees, and research participants and to minimize or to remedy unavoidable or

unanticipated harm (p. 4).

Section C., Professional Responsibility: Counselors engage in self-care

activities to maintain and promote their emotional, physical, mental, and spiritual

well-being to best meet their professional responsibilities (p. 9).

Section C.2.d., Monitor Effectiveness: Counselors continuously monitor their

effectiveness as professionals and take steps to improve when necessary (p. 9).

Section C.2.g., Impairment: Counselors are alert to the signs of impairment from

their own physical, mental, or emotional problems and refrain from offering of

providing professional services when such impairment is likely to harm a client

or others (p. 9).

In addition to self-awareness, counselors are pushed to seek assistance for the

resolution of problems and if necessary to "limit, suspend, or terminate their

professional responsibilities until such time it is determined that they may safely

resume their work (A.11.b., F.8.b.)." Counselors are also called to safeguard the

profession by identifying colleagues who suffer from professional impairment and

intervene appropriately.

Munroe (1999) stated there is an ethical duty to recognize the need for regular

self-care for counselors and that well-being should be a priority of all practicing

counselors. As the ethical codes suggest, well-being and self-care are to be under

constant self-appraisal by the counselor to determine if services are delivered

according to the standards of the profession. The ability to assess one's own well-

being is a key component of one's self-care practice as they go hand in hand

(Edmonson, 2009). Unfortunately there is a lack of training on self-care as it relates to

counselor ethics and little instruction on self-care awareness or self-assessment

regarding these topics (Culver, 2011).

Self-Care in Training and Education

The training of self-care, especially for new counselors, is important preparation

for the hazards of counseling, including distress leading to burnout or impairment

(Sommer, 2008). The 2009 CACREP standards include information about counselor

well-being. For example, Professional Orientation and Ethical Practice Standard II

G.1.d. states that "counselors should receive training in…self-care strategies

appropriate to the counselor role" (p. 10). Although self-care is emphasized within the

curriculum of CACREP accredited programs and included in the ACA Code of Ethics

(2005), there is little empirical evidence regarding training provided to counselors about

self-care, or regarding which strategies are being used by counselors, or which

strategies are perceived to be the most effective when implemented (Culver, 2011).

One possible reason for the lack of research regarding counselor self-care is

because self-care itself is neglected by individual counselors as well as by

organizations and institutions in the training of and emphasis on self-care practices

(Figley, 2002; Norcross, 2000). Assuming that training is necessary for any counseling

skill to be practiced, it is reasonable to suggest that a lack of self-care training plays a role in the observed chronic lack of self-care (Figley, 1995).

Skovholt, Grier, and Hanson (2001) described traditional counselor training as other-focused; noting minimal instruction on how the counselor develops a focus on their own well-being, they proposed a developmental framework for self-care throughout a counselor's career. Skovholt et al. (2001) emphasized the need for balance between work and life, and self-care and other-care, for maintaining professional vitality and avoiding working while depleted and exhausted.

APA Advisory Committee on Colleague Assistance (ACCA) conducted a survey of graduate students in 2006 to inform the committee on the stressors of clinical training and training offered by programs to promote self-care and mitigate stress in students (Munsey, 2006). Almost 500 graduate students were recruited from a professional listserv with approximately 77% of the sample in doctoral programs. Results of the survey indicated that 83% of students reported that educational material on stress and self-care was not offered by their training program, 63% stated that their training program did not sponsor self-care activities, and 59% believed that their program did not encourage or promote an atmosphere of self-care (Munsey, 2006).

These results led the committee to conclude that training programs could begin with initiatives to address problems that contribute to stress such as lack of clear communication regarding school policies, minimal supervision and guidance, inconsistent faculty grading and workload expectation, and a dearth of mentoring (Munsey, 2006). They also urged students to learn to deal effectively with stress during graduate school before they enter the profession. Munsey (2006) outlined

strategies given by the committee for students to take better care of themselves. Students were urged to practice self-care, foster self-awareness, foster change, seek early intervention for impairment, and to develop concrete strategies for support (Munsey, 2006). No recommendations were given regarding how training programs can specifically address self-care in clinical training beyond reminding students of the importance of sleep, nutrition, exercise, interests and relationships outside of training programs, and setting clear boundaries (Munsey, 2006).

Educational Recommendations

In terms of depth of self-care training needed, Adams and Riggs (2008) stated that a one-time lecture or class discussion is inadequate. They stated that students need substantial training in the context of a full semester of coursework or multiple intensive workshops in order to protect themselves against the potential negative impact of counseling clients who may have experienced trauma. Pearlman and Saakvitne (1995) recommended that student training include knowledge of distress, burnout, and impairment, the importance of a fulfilling personal life, and the need to set clear boundaries. They should be advised to seek ongoing supervision and peer consultation even if licensed, strive to have balance in their life, participate in self-care, build a sense of security and safety, have someone to talk to and process, build self-trust and self-esteem, feel connected to self and others, have a sense of control, develop a sense of meaning and spirituality, develop personal coping mechanisms, and seek out crisis and trauma training (Pearlman & Saakvitne, 1995). In addition, it is

vital that a preventative approach be adopted in order to protect counselors and the public from consequences of distress and impairment (Barnett & Cooper, 2009).

Educators and supervisors have the greatest impact on student well-being when they teach and model self-care strategies with students by stressing the importance as it relates to prevention of distress, burnout, and impairment (Sommer, 2008). Clinical supervisors can play a critical role in assisting students to develop specific and effective self-care plans and providing support to disclose and process traumatic material (Neumann & Gamble, 1995). Supervisors may continually remind students that difficult material discussed by clients can stir up feelings, thoughts, or reactions. Supervisors can then recommend and discuss self-care strategies that students can use to deal with the effects they may notice (Cunningham, 2004).

O'Halloran and O'Halloran (2001) discussed the critical importance familiarizing students with self-care in the context of trauma work. The authors stated that students often experience strong emotional responses to traumatic material. They underscored the importance of setting the stage for secondary trauma reactions and its impact in a counselors training. O'Halloran and O'Halloran (2001) recommended that training of self-care practices that included behavioral strategies such as eating balanced meals, proper sleep and exercise, relaxation, recreation and play, developing and using support systems and exploring spirituality as additional prevention strategies. O'Halloran and O'Halloran (2001) also recommended that students develop self-care plans covering four categories: (a) bio behavioral (nutrition, exercise, sleep), (b) affective and cognitive (self-affirmations, humor, reframing), (c) relational (interpersonal work, building and using support systems), and (d) spiritual (religious practices, prayer,

meditation). They recommended as part of self-care plans, specific strategies such as

journaling, physical release such as crying, or talking with someone safe. Self-care

training may also encourage the counselor to recognize obstacles to help seeking such

as availability, accessibility, acceptability, and affordability (Stefl & Posperi, 1985).

Self-Care Research and Practices

The importance of self-care for counselors is becoming more visible in the

literature; however there is little empirical research regarding the self-care strategies

counselors employ and the effectiveness of those strategies (Culver, 2011; Killian,

2008; Norcross & Drewes, 2009). Although no research has shown that one method of

self-care works better than another (Killian, 2008), some form of self-care practice is

critical for a counselor to avoid fatigue, burnout, or impaired practice. A

comprehensive self-care practice serves three primary functions: (a) protecting clients

by reducing the risk factors commonly linked with ethical violations, (b) enhancing

therapy by promoting and modeling well-being, and (c) protecting counselors against

burnout and enhancing the balance between caring for self and others (Porter, 1995).

In a survey of 325 mental health professionals attending a conference on

treatment strategies, a self-report measure was given to assess basic demographics,

personal problems experienced in the past year, self-care practices during the past

year, and opinions on personal therapy (Mahoney, 1997). When asked what types of

self-care strategies that counselors employed, participants most commonly listed

pleasure reading, physical exercise, hobbies, and recreational vacations (Mahoney,

1997). Frequent responses also included peer supervision, prayer or meditation, and

volunteer work. Personal therapy, attending church services, receiving massage or chiropractic care, and keeping a personal diary were the least common among the reported forms of self-care (Mahoney, 1997). In the discussion, Mahoney (1997) concluded that emotional exhaustion was the most frequently reported personal problem, though expressed by less than 50% of respondents, and that otherwise psychotherapy practitioners presented as generally happy and healthy individuals fulfilled by their work and sustained by self-care practices and coping. In the discussion he noted that findings should be interpreted with caution due to the self-selected nature of the sample and the limitations of the self-report instrument used.

It should be distinguished though that while coping is employed as a reaction to stress, self-care is an ongoing proactive intervention to protect against distress and impairment (Skovholt & Trotter-Mathison, 2011). Kramen-Kahn and Hansen (1998) conducted a survey to identify career sustaining strategies of well-functioning of 208 mental health practitioners. Findings revealed that frequently endorsed career sustaining behaviors included maintaining a sense of humor, creating renewal through balance of work and play, use of case consultation and continuing education. According to Barnett and Cooper (2009), it is vital that this preventative rather than reactive approach be adopted by practitioners in terms of self-care and impairment.

While conducting numerous studies on the self-change of mental health professionals, Norcross (2000) commented on the paucity of systematic study on counselor self-care. He developed an outline of 10 clinician recommended and practitioner tested self-care strategies. Turner et al. (2005) later conducted a study on the self-care practices of counselor interns using the concepts presented by Norcross

(2000). Turner et al. (2005) asked 363 psychology interns to rate practices of self-care to determine the frequency of use and effectiveness of strategies categorized as recognizing the hazards of psychological practice, using self-awareness, employing stimulus control, emphasizing the human element, avoiding wishful thinking, diversifying activities, and appreciating the rewards of conducting psychotherapy.

Results of the study revealed that items with the highest mean ratings represented active problem-solving strategies, social support from family and friends, exerting control over internship choices, maintaining awareness of the impact of internship, the use of humor, and intern consultation (Turner et al., 2005). The lowest mean ratings included the use of therapy, the use of faith and spiritual practices, cultural activities, and social support from one's academic program. Findings demonstrated a strong correlation between frequency and effectiveness of self-care behaviors suggesting that interns frequently chose behaviors that most suited them and their individualized perception of effective forms of self-care. For example, the majority of self-care strategies (19 out of 35) were frequently used and frequently effective, however some of the self-care strategies demonstrated discordance for frequency and effectiveness, i.e. sometimes used and frequently effective, or rarely used and sometimes effective (Turner et al., 2005). The researchers stated that training programs should be intentional about promoting self-care and advocating for self-care as a lifelong professional priority. Limitations cited by the researchers addressed the lack of validation and reliability of the scale used to gather the data.

Some researchers argue the ability to generalize the effectiveness of individual self-care strategies. Bober and Regehr (2006) conducted a study to assess whether

counselors believed and engaged in commonly recommended forms of prevention for distress and whether engaging in those activities resulted in lower levels of distress. Using the Impact Event Scale (IES), Traumatic Stress Inventory-Belief Scale (TSI), and the Coping Strategy Inventory (CSI) in a cross-sectional study of 259 counselors, time spent counseling trauma victims most strongly predicted trauma scores on the Impact Event Scale, specifically higher levels of intrusion symptoms (nightmares, irritability, emotional numbing, avoidance of or difficulty listening to clients' accounts of events). Consequently, researchers concluded that in order to lower levels of distress, counselors must seriously consider decreasing the amount of time spent working with demanding clients in order to offset stress (Bober & Regehr, 2006).

Killian (2008) conducted a mixed methods study to identify factors related to resilience and burnout. In the qualitative analysis, Killian (2008) interviewed 20 clinicians regarding stress and coping. Data revealed themes that counselors detected stress through physical symptoms as well as changes in mood, sleeping difficulties, and difficulties with concentration (Killian, 2008). Additionally Killian asked trauma counselors to identify self-care strategies employed to ameliorate stress. Participants reported strategies including maintaining a reasonable client load, obtaining regular supervision, processing emotional challenges with peers, having a supportive work environment and social network, being optimistic, and having a sense of self-awareness. In addition, clinicians' ability to maintain family connection, a sense of spirituality, and an exercise regimen proved to be important (Killian, 2008).

In the same study, Killian (2008) surveyed 104 counselors specializing in the treatment of trauma survivors, primarily children referred for experiences of sexual

abuse. Instruments used included measures of social support, personal trauma

history, affective coping style, self-care practices, burnout, emotional self-awareness,

work environment stressors and resources, and work drain. The ProQOL was also

used to assess for CS and CF. Researchers confirmed that social support was the

most significant factor associated with higher scores on compassion satisfaction

followed by higher internal locus of control in the workplace. Higher number of hours of

clinical contact was associated with lower compassion satisfaction. Low emotional

self-awareness and a personal history of trauma were associated with higher

compassion fatigue. Results corroborated the findings of Bober and Regher (2006),

demonstrating no significant correlation between the use of various coping strategies

and reported levels of compassion satisfaction, compassion fatigue, and burnout in

clinicians working with trauma survivors. Killian (2008) concluded that coping styles,

though related to overall work stress, did not directly influence compassion satisfaction

or symptoms of compassion fatigue and burnout of those working with trauma clients.

Lower scores on work morale were significant predictors of symptoms of burnout,

highlighting the protective function of morale, cohesion, and adequate resources and

supplies. The author cited limitations including measurement issues in how coping

strategies have been operationalized (Killian, 2008).

Eastwood and Ecklund (2008) conducted a study to explore risk for compassion

fatigue among residential childcare workers and the relationship between self-care

practices and compassion fatigue using the ProQOL-R III. Data were collected from 57

residential childcare workers from facilities for distressed, traumatized, and emotionally

disturbed children. According to the findings, feelings of being supported outside of

work, engaging in a hobby, reading for pleasure, and taking pleasure trips or vacations were significant negative correlates or identified protective factors. Compassion satisfaction level appeared to have no significant ameliorative relation to compassion fatigue level, although it did with burnout risk. Perception of self-care success did not have a significant relationship to compassion fatigue risk level, though it did with burnout risk level. The authors summed that the findings were suggestive that Figley's description of compassion fatigue as a specialized form of burnout may be accurate though a better conceptualization would be seeing burnout risk level as a significant component in the etiological understanding of compassion fatigue.

Burnout can reduce one's ability to have empathic concern, inhibit empathic response, and subsequently reduce one's sense of achievement in one's work; all of which would increase the level of compassion stress one feels while attempting to help those who are suffering. Eastwood and Ecklund (2008) proposed that one of the primary ways to address compassion fatigue risk is to address concerns regarding burnout risk. Many self-care practices may not impact compassion fatigue risk directly, but may aid in the amelioration of burnout and thereby moderate workers' compassion fatigue risk levels. It was determined also that adequate training in stress management and appropriate self-care practices should be provided to all levels of staff in order to foster a greater sense of efficacy and preparedness among staff (Eastwood & Ecklund, 2008).

Meadors and Lamson (2008) conducted a quantitative study on compassion fatigue in healthcare providers of chronically ill children. The researchers provided and evaluated the effectiveness of an educational seminar on compassion fatigue to 185

health care providers working on critical care units with children. Researchers

measured awareness of compassion fatigue before and after the seminar as well as

levels of clinical and life stress on two survey measures. Results demonstrated that

the seminar was successful in raising awareness on compassion fatigue and reducing

clinical stress. Specifically, participants reported an increase in feelings that they had

the resources to prevent compassion fatigue in the future after the training. In addition

to increased knowledge about compassion fatigue, participants reported significantly

decreased tension, feeling jittery, or feeling overwhelmed, while having increased

feelings of calmness and peacefulness. Results suggested that providers who

experienced higher levels of personal stressors also experienced higher levels of

clinical stress and compassion fatigue (Meadors & Lamson, 2008). Although these

studies give a general picture of types of self-care that counselors have frequently

employed, the effectiveness and training of types of self-care methods requires further

research and analysis.

Summary of Literature Review

According to recent research, counselor distress is prevalent. Self-care is the

practice of continual self-renewing behaviors, awareness, intentions, and attitudes that

can help to mitigate distress. Survey studies have shown that counselors often do not

have a self-care plan in place and often concern themselves with the needs of others

over their own. The consequences of not engaging in self-care may include distress or

impairment, thereby putting the individual practitioner at risk for compromising client

care and potentially harming themselves or their clients through poor judgment or

infractions such as dual relationships. It falls to the counselor to continuously self-assess and seek help when distress threatens to interfere with competent work performance.

Though counselors reportedly believe that self-care is critical to enhancing wellness, this belief does not translate into action according to recent research (Bober & Regehr, 2006; Pope, Tabachnick, & Keith-Spiegel, 1987). Additionally, though counselors are aware that to practice while impaired is unethical, some counselors admitted to "working when too distressed to be effective" even though many of these same individuals believed that it was unethical to do so (Pope, Tabachnick, & Keith-Spiegel, 1987).

As stated in the ACA Code of Ethics (2005) and CACREP Standards (2009), it is helpful for counselors to receive training regarding pathways to self-care and prevention of impairment (Dearing, Maddux, & Tangney, 2005). Self-care training is intended to provide conceptual and practical guidelines, information, and skills for the participant to develop a comprehensive, ongoing behavioral and attitudinal practice, to raise awareness and prevent impairment (Figley & Figley, 2010). Training can include instruction and facilitation of self-awareness, self-regulation, and strategies for the purpose of balancing self and other care (Baker, 2003; Brady, Guy, & Norcross, 1995). Although ethical standards and educational requirements are in place, it has become apparent that a serious problem exists considering a majority of counselors report a lack of self-care training (Culver, 2011). The degree to which training programs and institutions are providing specific training on self-care, impairment, or risks associated with trauma work is unclear. Assuming that training is necessary for any counseling

skill to be practiced, it is reasonable to suggest that a lack of self-care training plays a

role in the observed chronic lack of self-care (Figley, 1995). Self-care, and the training

thereof, as a possible preventative intervention for impairment should therefore be

empirically explored for effectiveness. This leads to the purpose of this study.

The proposed intervention for self-care is the Counselor Self-Care Project

curriculum (adapted from the CCFE curriculum) paired with the Self-Care Planning

Tool developed by Figley and Figley (2010) for the purpose of educating helping

professionals on risks associated with trauma work and methods to alleviate costs

associated with caring.

CHAPTER 3

METHODS AND PROCEDURES

In this chapter, I describe methods and procedures used to examine the impact of a self-care training intervention for counselors on a measure of compassion satisfaction, secondary traumatic stress, and burnout. Included in this chapter are the research questions, definition of terms, participants, instrumentation, subject recruitment and assignment, and procedures used to collect and analyze data.

Research Questions

The purpose of this study was to explore the effectiveness of a self-care training for counselors working with clients impacted by trauma. Using a between groups quasi-experimental pretest-posttest design, I compared an experimental and a control group using the dependent variables burnout, secondary traumatic stress, and compassion satisfaction as measured by the Professional Quality of Life, Version 5 (ProQOL). Research questions were as follows:

1. What is the impact of participation in a self-care intervention program on burnout (BO) for counselors practicing in high trauma environments as compared to counselors who do not participate?

2. What is the impact of participation in a self-care intervention program on secondary traumatic stress (STS) for counselors practicing in high trauma environments as compared to counselors who do not participate?

3. What is the impact of participation in a self-care intervention program on compassion satisfaction (CS) for counselors practicing in high trauma environments as compared to counselors who do not participate?

Definition of Terms

Burnout (BO): A cumulative state of physical, emotional, and mental exhaustion caused by long-term involvement in emotionally demanding situations; typically attributed to the work environment, context or job choice (Figley, 1995). For the purposes of this study, BO is operationalized by scores on the ProQOL-V (Stamm, 2009).

Compassion satisfaction (CS): The perceived joys derived from experiencing the suffering of others and succeeding in helping to relieve their suffering in some way (Figley, 2002). For the purposes of this study, CS is operationalized by scores on the ProQOL-V (Stamm, 2010).

Secondary traumatic stress (STS): A syndrome of symptoms parallel to post-traumatic stress disorder characterized by psychological distress, changes in cognitive schema, and relational disturbances. STS is conceptualized to occur through second hand exposure to the trauma histories of others (Figley, 1995). Also, for the purposes of this study, STS is operationalized by scores on the ProQOL-V (Stamm, 2010).

High trauma environment: Trauma counseling settings used in this study employ counselors who work exclusively with children and families at children's advocacy centers after a disclosure of child sexual or severe physical abuse. Children who have disclosed traumatic abuse are interviewed by a forensic interviewer and

ongoing long term mental health treatments are provided for the child and their family members.

Self-care intervention: In this study, I used a self-care intervention entitled the Counselor Self-Care Project, based on the Compassion Fatigue Certification Course and Self-Care Planning Tool developed by Figley and Figley (2010). The goals of the training are to provide each participant with the knowledge and skills necessary to reduce the secondary impact of working with traumatized populations and to develop a comprehensive self-care plan using a structured self-assessment format to facilitate awareness and guide decision making (see Appendices A - C for Counselor Self-Care Project Syllabus, Self-Care Planning Tool, and Standards of Self-Care Guidelines).

Participants

Study participants were 42 licensed professional counselors (LPC), LPC-Supervisors, and LPC-Interns recruited from similarly funded children's advocacy centers in Texas. Participants eligible were those who work with traumatized populations, specifically children referred for services after an allegation or outcry of sexual abuse. Participants worked at the agency site for a minimum of six months to be included in the study. Participants who were currently engaged in any other formal self-care training, university instruction, continuing education course, or workshops were excluded from the data collection. To determine an appropriate sample size, issues of the stability of the covariance matrix were taken into account. A power analysis using G-POWER (Version 3.1.4, 2012) indicated a sample size of 39 was sufficient to detect a medium effect size, with an alpha level of .05 and power of .80.

Forty two counselors participated in the study, evenly distributed into the intervention group (*n* = 21) or the waitlist control group (*n* = 21). A total of 3 males and 39 females participated in the study. One male and 20 females were assigned to the intervention group and 2 males and 19 females to the waitlist control group.   The mean age of participants in the treatment group was 34.38 (*SD* = 1.72) years with a maximum age of 48 and a minimum of 25. The mean age of participants in the waitlist control group was 34.62 (*SD* = 2.59) years with a maximum age of 58 and a minimum age of 26. The demographic information of the participants is presented Table 1.

Table 1

Demographic Information by Participant Group

Characteristic	Treatment (*n* = 21)	Control (*n* = 21)	Total (*n* = 42)
Sex			
Male	1	2	3
Female	20	19	39
Ethnicity			
Caucasian	10	17	27
Hispanic	9	2	11
African American	2	1	3
Native American	0	1	1
Age			
25-29	5	11	16
30-34	9	2	11
35-39	1	1	2
40-44	2	3	5
45-49	4	1	5
50-54	0	0	0
55-59	0	3	3
Mean Age	34.38	34.62	

Instrumentation

Demographic Form

Demographic information gathered included age, sex, ethnicity, highest educational degree earned, licensure, number of years in mental health field, number of hours per week of direct contact with all clients, percentage number of clients on case load with a history of trauma, previous trauma training, and previous self-care training (see Appendix A for the demographic information form).

Professional Quality of Life (ProQOL), Version V

The Professional Quality of Life Scale (ProQOL) is a revised version of the Compassion Fatigue and Satisfaction Self-Test (CFST; Figley, 1995). The original CFST was developed by Figley (1995) to assess PTSD-like symptoms of counselors in response to their work with trauma survivors, including re-experiencing of the primary survivor's traumatic event, avoidance of reminders of the event, and persistent arousal, in addition to the physical and emotional exhaustion associated with mental health work. The ProQOL was validated through assessing social workers and mental health workers providing crisis intervention services and has been effectively used in various studies of secondary exposure to trauma (Birck, 2001; Nelson-Gardell & Harris, 2003).

The construct validity of the ProQOL has been well established in the literature as the STS and BO subscale inter-correlations are relatively low, suggesting that the subscales measure distinct constructs (Stamm, 2010). Interscale correlations resulted in a 2% shared variance with secondary traumatic stress and a 5% shared variance with burnout (Stamm, 2010). The author indicated that the latest ProQOL revision,

Version V, is superior to earlier editions by distinguishing the constructs of burnout (α = .75) and secondary traumatic stress (α = .81). Compassion fatigue is identified as a combination of both burnout and secondary traumatic stress. This distinction is illustrated in Figure 1. Compassion satisfaction (α = .88) is the third construct measured by the ProQOL and measures the positive aspects of a helper's experience (Stamm, 2010).
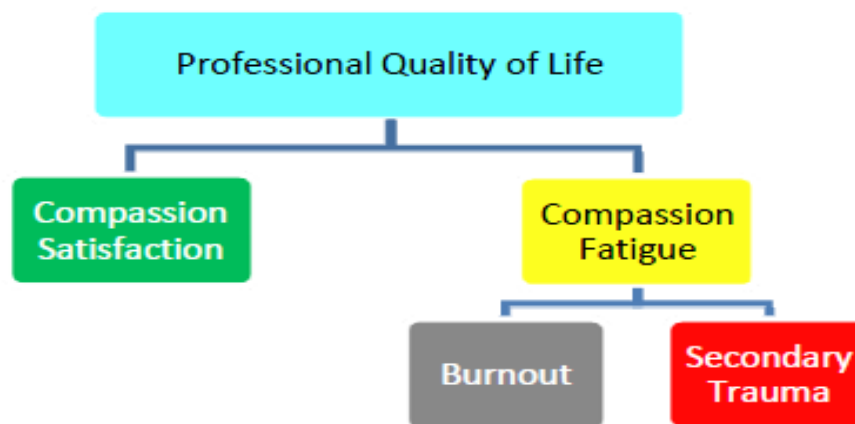
Figure 1. Stamm's model of compassion satisfaction and compassion fatigue.

The ProQOL is a 30-item self-report measure that assesses for three independent constructs: burnout (BO), secondary traumatic stress (STS), and compassion satisfaction (CS) and does not yield a composite score. Responses are rated on a 5-point Likert scale ranging from 1 = *never* to 5 = *very often* about thoughts, feelings, and behaviors related to work as a helper (Stamm, 2010). The ProQOL self-score version was used and requires the reversal of five items on the burnout scale. Scores are then summed by subscale. According to the developer, the ProQOL measure is best used in its continuous form for interpretation. Though the developer does not recommend cutoff scores associated with the total scores, she recommended that the bottom 25% be considered those in the low range (*t*-scores of 44 or less), the

middle 50% to be in the average range (*t*-scores of about 50), and the top 25% to be in the high range (*t*-scores of 57 or more).

The Burnout subscale on the ProQOL is associated with feelings of hopelessness and challenges in doing one's job effectively (Stamm, 2010). The Burnout scale consists of 10 items which address negative feelings of ineffectiveness and result from a very high workload or non-supportive work environment. An example of an item on the Burnout scale is "I feel overwhelmed by the amount of work or the size of my caseload I have to deal with." The average score on the Burnout falls between 23 and 41, estimated as a *t*-score of 50 with a standard deviation of 10. A raw score below 22 suggests that the individual has positive feelings about his or her capacity to be effective at work. A raw score above 41 may be mood contingent or may be indicative of deep dissatisfaction or feelings of professional inadequacy (Stamm, 2010).

The Secondary Traumatic Stress subscale on the ProQOL involves secondary exposure to extremely stressful or traumatic events, as opposed to the primary trauma. The Secondary Traumatic Stress scale consists of 10 separate items that assess the individual's combination of symptoms that usually have a rapid/acute onset and are associated with a particular event, including intrusive images, avoidance, fear, and sleep disruption. An example of an item on this scale is "I am losing sleep over the traumatic experiences of a person I help." The average raw score on the STS scale falls between 23 and 41, estimated as a *t*-score of 50 with a standard deviation of 10. Stamm (2010) indicated that individuals who reported raw scores above 42 are considered elevated and may benefit from some form of intervention.

Compassion satisfaction can be described as what sustains counselors to continue their work with clients in the face of potential distress (Stamm, 2010). The Compassion Satisfaction subscale on the ProQOL consists of 10 items to assess satisfaction counselors may feel from helping others, making a difference, interacting positively with colleagues, and contributing to the work setting or even the greater good of society. An example of an item on this scale is "I feel invigorated after working with those I help." The average raw score on the CS scale falls between 23 and 41, estimated as a t-score of 50 with a standard deviation of 10. Scores that fall below 40 are considered indicative of either problems with helping or satisfaction may be derived from sources other than work.

Follow-Up Questionnaire

In order to gain an understanding of experimental group participants' subjective experiences, I developed a brief follow up questionnaire that participants were asked to complete along with the posttest ProQOL (see Appendix B for follow-up questionnaire). The follow up questionnaire included three closed-ended items and four open-ended items. I included one closed-ended question to assess the following: "within which domains were your self-care goals most successfully implemented?" The following answer choices as domains described by the Self-Care Planning Tool (Figley & Figley, 2010) were used to assess participants' self-care goals: cognitive (problem solving, learning, changing self-talk), emotional (using humor, seeking out good listeners, practicing self-compassion), behavioral (limiting demands on time/energy, setting and tracking goals, asking for help, taking a break), spiritual (praying, meditating, practicing

your faith), social/interpersonal (spending time with friends, setting healthy boundaries, stating needs and wants in relationships), and physical (exercising, sleep hygiene, eating regular nutritious meals, receiving massage). Two closed-ended items asked for participants' ratings of the experience by asking: "would you recommend this training to a colleague" and "would a self-care workshop like this have been helpful to you earlier in your career, education, or training?" I included a rating scale with the following choices: *yes, highly*, *yes, likely*, *maybe* and, *no*. Four open-ended items prompted participants to share the following: "which aspects of the training did you find most helpful," "which aspects of the training did you find least helpful," "what was the most helpful information or resource you gained during your experience," and "describe two to three changes you have made as a result of this training."

Procedures

I obtained approval from the University of North Texas Institutional Review Board (IRB) before initiating recruitment (Appendix C). I acquired a list of all children's advocacy centers (CAC) in the state of Texas (www.cactx.org) and matched potential sites suitable for the study in order to help minimize potential bias. Sites were matched by the demographics of each agency on factors of annual CAC budget, service area, ages of children served, average number of children receiving first-time core CAC service per month, interagency partners listed, and presence of interagency partners on site (i. e., CPS, law enforcement). I contacted clinical directors from four children's advocacy centers in north east and south east Texas. Existing policies regarding training and continuing education for clinical staff members made it necessary to

assign participants by agency site to the treatment or waitlist control condition rather than through random assignment. Clinic policies indicated that trainings must be offered equally among clinical staff. Nonequivalent group designs involve an internal validity threat of selection where any prior differences of the groups may affect outcomes (Rubin, 2008), hence the design for this was quasi-experimental. Each clinical director agreed for his or her staff to participate in the treatment group or waitlist control group with waitlist control groups promised the training after data collection was completed. Children's advocacy staff directors then distributed advertisements during staff meetings to inform individuals of the training. The training advertisement provided an overview of content, time commitment expectations, and benefits including CEU credit (Appendix D).

At the initial session, I provided and explained information regarding the description and purpose of the study, foreseeable risks and benefits, and confidentially procedures. Contact information for the investigator was provided on the informed consent. Counselors who chose to participate in data collection agreed to the informed consent and indicated their understanding of all aspects of the research.

After informed consent was obtained, all participants completed a demographic questionnaire and the ProQOL - Version 5. Participants in the intervention group attended two 4-hour training sessions. The Counselor Self-Care Project, a psychoeducational and experiential program consisted of seven course modules split over two half-day sessions. It included didactic information about secondary traumatic stress, burnout, compassion satisfaction and self-care. Also included were assessment and corresponding reading materials, demonstrations, two video

presentations, and experiential exercises during the training that participants could draw from to develop their personal self-care plan. I provided a complete description of the Counselor Self-Care Project content and modules.

After the conclusion of the training, I contacted treatment group participants through email and provided a survey accessible via the Qualtrics website to complete the post-assessment ProQOL four weeks after the end of the training. The length of the study was chosen as a plausible time period for participants to "integrate self-care into their lives, and begin to create a new lifestyle" (J. Barnett, personal communication, May 19, 2010). I contacted participants in the waitlist control group via email and provided a hyperlink for them to use to complete the post-test ProQOL and follow-up questionnaire four weeks after the intervention.

Experimental Group Intervention: Counselor Self-Care Project

To date, there has been no known systematic research on the Counselor Self-Care Project. The lecture material and self-care planning tool was developed by Drs. Charles and Kathleen Regan Figley in conjunction with the certification from Green Cross Academy of Traumatology for the Compassion Fatigue Educator credential. The training for CCFE (certified compassion fatigue educator) was designed for individuals to learn to educate others in the helping professions about hazards related to professional caregiving and prevention of the deleterious effects of compassion fatigue and burnout. As primary researcher, I facilitated the curriculum for all intervention groups. I am a doctoral student in a counseling program, a licensed professional counselor, and a current practitioner. I received the CCFE credential by participating in

45

an eight-hour web seminar offered by the Figley Institute which included lectures, reading material, video, experiential activities, example case studies, and quizzes. With approval from Drs. Charles and Kathleen Regan Figley, the curriculum for the CCFE was adapted for the purposes of conducting this study.

The curriculum closely followed course content established by Figley and Figley (2010). The training was held over two sessions, one week apart, with Lessons 1 through 4 covered on the first day, and Lessons 5 through 7 conducted during the second session. This structure was used because of the natural progression of the material and pre-requisite of completed assessments to inform self-care planning and goal setting. Lesson 1 provided an introduction to the course and defined the goal of the training to provide each participant with the knowledge and skills necessary to reduce the impact of working with traumatized populations. Participant objectives included learning to define compassion fatigue, secondary traumatic stress, and burnout and differentiate between concepts and presentation. Participants viewed a 20-minute educational video on compassion fatigue, *When Helping Hurts - Sustaining Trauma Workers* (Gift from Within, 2010).

Lesson 2 described ethical standards regarding compassion stress as it relates to impairment and self-care. The lesson included a lecture and quiz over the Green Cross Academy of Traumatology Standards of Self-Care that helping professionals can use to guide their ethical commitment to a self-care practice. Participants also viewed a 10-minute educational video on self-care, *Care for the Caregiver* (Martin, 2006).

Lesson 3 guided participants through the process of conducting a personal self-assessment through measures on life stress, state and trait resilience, basic needs and

coping strategies, personal vulnerabilities, and satisfaction with life. Results from the instruments were used to inform self-care planning later in the course.

Lesson 4 guided participants through the process of conducting a professional self-assessment through measures on professional quality of life, basic needs at work, early warning signs of stress, and general self-care. Results from the instruments were completed after the first session and compiled to inform self-care planning.

Lesson 5 provided experiential activities to introduce compassion stress management techniques. Activities included progressive muscle relaxation, body scan, guided imagery, expressive art mandala activity, aromatherapy, mindfulness exercise, stretching, and meditative breath work.

Lesson 6 included the self-care planning tool (Figley & Figley, 2010) through which participants applied findings from the different self-assessments. Participants then compiled a plan that reflects the individual's current level of self-care and inform the development of a minimum of three new SMART self-care goals to incorporate into their personal and professional routines (SMART: small, measurable, attainable, realistic, and time based).

Lesson 7 concluded the program with a summary lecture and course evaluation, questions, and feedback for the facilitator. Each participant received a continuing education certificate to apply to their professional licensure requirements. Participants were invited to complete an evaluation of the training and give feedback regarding their experiences.

Data Analysis

Data were analyzed to determine the effects of participating in self-care training. All statistical analyses were conducted utilizing Statistical Package for the Social Sciences, Version 17 (SPSS, 2010). I compiled descriptive statistics to quantify the characteristics of the participants. Before conducting statistical analyses, I verified all general assumptions for inferential statistics. These included use of a continuous scale measurement, independent observations, normal distribution, and homogeneity of variance. Once assumptions were met, I performed one-way ANOVAs to compare control and treatment group scores in order to determine if groups were equivalent on the pretest measures. After I concluded that the groups were statistically equivalent, I proceeded with the planned analyses.

Three analyses of covariance (ANCOVA) were run to test for statistically significant differences between groups on scores for burnout (BO), secondary traumatic stress (STS) and compassion satisfaction (CS) while using pre-test scores as the covariate. Results were interpreted according to statistical and practical significance. Statistical significance was determined according to .05 alpha level. Practical significance was interpreted according to Cohen's (1992) guidelines for interpretation of η^2 effect sizes (.01 = small; .06 = medium; .14 = large).

Research Question 1

What is the impact of participation in a self-care intervention program on burnout (BO) for counselors practicing in high trauma environments as compared to counselors who do not participate?

For Research Question 1, I conducted an analysis of covariance with group assignment as the independent variable, pretest scores on BO from the ProQOL serving as the covariate and post test scores on BO from the ProQOL as the dependent variable.

Research Question 2

What is the impact of participation in a self-care intervention program on secondary traumatic stress (STS) for counselors practicing in high trauma environments as compared to counselors who do not participate?

For Research Question 2, I conducted an analysis of covariance with group assignment as the independent variable, pretest scores on STS from the ProQOL serving as the covariate and post test scores on STS from the ProQOL as the dependent variable.

Research Question 3

What is the impact of participation in a self-care intervention program on compassion satisfaction (CS) for counselors practicing in high trauma environments as compared to counselors who do not participate?

For Research Question 3, I conducted an analysis of covariance with group assignment as the independent variable, pretest scores on CS from the ProQOL serving as the covariate and post test scores on CS from the ProQOL as the dependent variable.

CHAPTER 4

RESULTS

In this chapter, I report results of the data analyses used to describe participants and findings relevant to the research questions guiding this study. The chapter is divided in three sections. First, I describe descriptive statistics to provide a profile of the participants as measured by the demographic questionnaire. Second, I describe the inferential statistical analyses to test each of the three research questions for this study. Finally, I report the experimental group participants' responses from the follow-up questionnaire.

Forty two counselors participated in the study, evenly distributed throughout the intervention group (n = 21) and the waitlist control group (n = 21). A total of 62% of participants held a master of education degree, 7.1% held a master of psychology degree, 19% held a master of science degree, 9.5% held a master of social work degree, and 2.3% held a doctor of philosophy degree. Regarding current licensure, 19% of participants classified themselves as licensed professional counselor-interns (LPC-Intern), 61.9% of participants were licensed professional counselors (LPC), and 19% were licensed professional counselor-supervisors (LPC-S). Participants listed current position as counselors (54.8%), bilingual counselors (19.0%), clinical supervisors (16.7%), and clinical directors (9.5%). For detailed distribution, see Table 2.

Table 2

Demographic Information by Participant Group

Characteristic	Treatment (*n* = 21)	Control (*n* = 21)	Total (*n* = 42)
MEd	13	13	26
MPsy	2	1	3
MS	2	6	8
MSW	3	1	4
PhD	1	0	1
Current License			
LPC-Intern	2	6	8
LPC	15	11	26
LPC-Supervisor	4	4	8
Position			
Counselor	10	13	23
Bilingual Counselor	5	3	8
Clinical Supervisor	4	3	7
Clinical Director	2	2	4
Years in Field			
M	8.74	5.43	7.08
SD	6.73	7.24	7.11
Hours Client Contact			
M	16.43	13.14	14.79
SD	7.15	9.57	8.50
Percentage Trauma			
M	98.57	74.19	86.38
SD	3.59	26.47	22.37
Previous Training TR			
M	79.81	42.57	61.19
SD	68.85	60.14	66.57
Previous Training SC			
M	7.71	6.00	6.86
SD	7.87	8.23	7.99

Note. Hours of client contact and percentage of trauma clients on case load were weekly estimates, while previous training in trauma (TR) and self-care (SC) were overall estimates.

Other characteristics that were notable based on the reviewed literature were

also assessed on the demographic questionnaire. Among these were number of years in mental health field ($M = 7.08$, $SD = 7.11$), number of hours per week of direct contact with all clients with and without trauma history ($M = 14.79$, $SD = 8.50$), percentage of clients on case load with history of trauma ($M = 86.38$, $SD = 22.37$), number of hours of previous trauma training ($M = 61.19$, $SD = 66.57$), and number of hours of previous self-care training ($M = 6.86$, $SD = 4.00$). Participants were asked if a self-care or wellness course was offered in their educational or training program. Out of 42 participants, two (4.8%) stated that there was some sort of self-care or wellness course or training offered. Forty (95.2%) stated that no self-care or wellness course was offered in their educational or training program.

Research Question 1

Because random assignment was not possible, one-way ANOVA was conducted to compare the pretest scores on the dependent variable, Burnout (BO), for the treatment and control groups to check for pretest equivalency. There was no significant difference in pretest BO scores for treatment group ($M = 21.48$, $SD = 3.76$) and control group ($M = 19.24$, $SD = 4.22$); $t(40) = 1.81$, $p = .08$, $\eta^2 = .08$. Thus the groups were determined to be statistically equal at pretest. Pre and post-test means are provided in Table 3.

Table 3

Mean Scores on Burnout on the Professional Quality of Life Version 5 (ProQOL)

	Treatment (*n* = 21)		Control (*n* = 21)	
	Pretest	Posttest	Pretest	Posttest
M	21.48	20.05	19.24	21.29
SD	3.76	4.20	4.22	5.26

Note. A decrease in mean scores on the Burnout subscale indicates improvement.

A one-way between groups analysis of covariance was conducted to compare the effectiveness of an intervention designed to educate and prepare counselors to employ self-care in order to enhance professional quality of life. All general assumptions were met for analysis of covariance statistics. These included use of a continuous scale measurement, independent observations, and normal distribution.

The independent variable was the condition of the group as either intervention or waitlist control group and the dependent variable for this research question was scores of BO on the ProQOL after the intervention was completed. Participants' scores on the pre-intervention administration of the ProQOL were used as the covariate in this analysis. After adjusting for the pre-intervention scores, there was a statistically significant difference between the two groups on post-intervention scores of BO on the ProQOL, $F(1,39) = 7.08$, $p = .01$, partial $\eta^2 = .15$. Effect size was interpreted as large (see Table 4).

Table 4

Analysis of Covariance Summary for Burnout (BO)

Source	df	SS	MS	F	p	Partial η^2
Corrected	2	429.67	214.84	16.97	<.01	.47
Pretest	1	413.58	413.58	32.67	<.01	.46
Group	1	89.57	89.57	7.08	.01	.15
Error	39	493.66	12.66			

Research Question 2

The one-way ANOVA was conducted to compare the pretest scores on the dependent variable Secondary Traumatic Stress (STS) for the treatment and control groups. There was no statistically significant difference in pretest STS scores for treatment group (*M* = 21.90, *SD* = 5.37) and control group (*M* = 20.10, *SD* = 4.42); *t*(40) = 1.19, *p* = .24, η^2 = .03. Thus the groups were determined to be statistically equal at pretest. Pre and post test means are provided in Table 5.

Table 5

Mean Scores on Secondary Traumatic Stress on the Professional Quality of Life Version 5 (ProQOL)

	Treatment (*n* = 21)		Control (*n* = 21)	
	Pretest	Posttest	Pretest	Posttest
M	21.90	21.00	20.10	20.81
SD	5.37	4.85	4.42	4.60

Note. A decrease in mean scores on Secondary Traumatic Stress subscale indicates improvement.

All general assumptions were met for analysis of covariance statistics. These included use of a continuous scale measurement, independent observations, and normal distribution. The independent variable was the condition of the group as either

intervention or waitlist control group and the dependent variable for this research question was scores of STS on the ProQOL after the intervention was completed. Participants' scores on the pre-intervention administration of the ProQOL were used as the covariate in this analysis. ANCOVA results indicated there was no statistically significant difference between the two groups on post-intervention scores of Secondary Traumatic Stress on the ProQOL, $F(1,39) = 1.87$, $p = .18$, partial $\eta^2 = .05$. Effect size was in the approximate medium range (see Table 6). Observed power for this analysis was .27.

Table 6

Analysis of Covariance Summary for Secondary Traumatic Stress (STS)

Source	df	SS	MS	F	p	Partial η^2
Corrected	2	581.95	290.97	36.41	<.01	.65
Pretest	1	581.57	581.57	72.77	<.01	.65
Group	1	14.94	14.94	1.87	.18	.05
Error	39	311.67				

Research Question 3

In this section, I describe results of participation in a self-care intervention on compassion satisfaction (CS) for counselors practicing in high trauma environments as compared to counselors who did not participate. A one-way ANOVA was conducted to compare the pretest scores on the dependent variable Compassion Satisfaction (CS) for the treatment and control groups. There was no statistically significant difference in pretest CS scores for treatment group ($M = 41.24$, $SD = 4.32$) and control group ($M =$

55

41.43, *SD* = 5.06); *t*(40) = -.13, *p* = .90, η^2 = .76. Thus the groups were determined to

be statistically equal at pretest. Pre and post test means are provided in Table 7.

Table 7

*Mean Scores on Compassion Satisfaction on the Professional Quality of Life Version 5
(ProQOL)*

	Treatment (*n* = 21)		Control (*n* = 21)	
	Pretest	Posttest	Pretest	Posttest
M	41.24	42.48	41.43	41.00
SD	4.32	3.98	5.06	5.45

Note. An increase on the Compassion Satisfaction subscale indicates improvement.

All general assumptions were met for analysis of covariance statistics. These

included use of a continuous scale measurement, independent observations, and

normal distribution. The independent variable was the condition of the group as either

intervention or waitlist control group and the dependent variable for this research

question was scores of CS on the ProQOL after the intervention was completed.

Participants' scores on the pre-intervention administration of the ProQOL were used as

the covariate in this analysis. ANCOVA results indicated there was no statistically

significant difference between the two groups on post-intervention scores of

compassion satisfaction on the ProQOL, *F*(1,39) = 3.69, *p* = .06, partial η^2 = .09. Effect

size was in the medium range (see Table 8). Observed power for this analysis

was .47.

Table 8

Analysis of Covariance Summary for Compassion Satisfaction (CS)

Source	df	SS	MS	F	p	Partial η^2
Corrected	2	637.70	318.85	41.95	<.01	.68
Pretest	1	614.82	614.82	80.89	<.01	.68
Group	1	28.06	28.06	3.69	.06	.09
Error	39	296.42	7.60			

Follow-Up Questionnaire

The follow up questionnaire was completed by 16 participants from the treatment group. The follow up questionnaire included four open-ended items and five close-ended items. In reply to the close ended item, "within which domains were your self-care goals most successfully implemented?" participants could select one or more responses (see Table 9). Four of 16 (25%) participants stated their self-care goals included cognitive activities (problem solving, learning, changing self-talk), six of 16 (38%) stated their self-care goals included emotional goals (using humor, seeking out good listeners, practicing self-compassion), eight of 16 (50%) stated their self-care goals were behavioral (limiting demands on time/energy, setting and tracking goals, asking for help, taking a break), five of 16 (31%) participants indicated self-care goals included spiritual activities (praying, meditating, practicing your faith), seven of 16 (44%) participants reported social/interpersonal goals (spending time with friends, setting healthy boundaries, stating needs and wants in relationships), and 12 of 16

57

(75%) indicated their implemented self-care goals were physically oriented (exercising,

sleep hygiene, eating regular nutritious meals, receiving massage).

Table 9

*Responses to Closed-Ended Items on Follow-Up Questionnaire (*n = *16)*

Item/answer	*n*	Percent
On which domain(s) are you most focused to successfully implement your self-care goals?		
Cognitive	4	25%
Emotional	6	38%
Behavioral	8	50%
Spiritual	5	31%
Social/Interpersonal	7	44%
Physical	12	75%
Would you recommend this training to a colleague?		
Yes, Highly	9	56%
Yes, Likely	5	31%
Maybe	2	13%
No	0	0%
Would a self-care workshop like this have been helpful to you earlier in your training?		
Yes, Highly	7	44%
Yes, Likely	7	44%
Maybe	2	13%
No	0	0%
On which part(s) would you have liked to spend more time?		
Education and concepts	0	0%
Ethics and Impairment	0	0%
Standards of Self-Care	2	13%
Self-Assessments	4	25%
Self-Care Planning and goal setting	5	31%
Experiential activities and relaxation techniques	12	75%
Group processing and discussion	7	44%
On which part(s) would you have liked to spend less time?		
Education and concepts	5	31%
Ethics and Impairment	6	38%
Standards of Self-Care	7	44%
Self-Assessments	2	13%
Self-Care Planning and goal setting	1	6%
Experiential activities and relaxation techniques	1	6%
Group processing and discussion	1	6%

Two items asked for participants' ratings of the experience by asking: "would you recommend this training to a colleague" and, "would a self-care workshop like this have been helpful to you earlier in your career, education, or training?" I included a scale with the following choices: *yes, highly*, *yes, likely*, *maybe,* and *no*. Table 9 presents responses to close ended items.

I reviewed four open-ended items to capture participants' subjective experiences Four open ended items prompted participants to share the following: "which aspects of the training did you find most helpful," "which aspects of the training did you find least helpful," "what was the most helpful information or resource you gained during your experience," and "describe two to three changes you have made as a result of this training."

Participants indicated that group discussion and processing were of greatest benefit. Other answers indicated that experiential activities and relaxation techniques were most helpful. Self-assessments and planning were also included on what participants found most helpful. Five of 16 participants indicated that it was not helpful to spend significant time on differentiation of concepts and theoretical information involving compassion fatigue, secondary traumatic stress, and burnout.

In reply to what important information or resource was gained, participants' responses varied. Some participants indicated that the self-assessments were of greatest value, while others indicated that attitudes towards self-care and personal awarenesses were most valuable. Additional feedback indicated that participants would have liked to spend more than two sessions for the full program.

When asked what specific changes participants had made to their self-care practice, responses indicated that participants were including more healthful foods into their daily diet, taking breaks or setting aside 'downtime,' smoking less, and sleeping more.

CHAPTER 5

DISCUSSION

The purpose of this study was to examine the impact of a structured, self-care training utilizing the Self-Care Planning Tool (Figley & Figley, 2010) on the professional quality of life (Burnout, Secondary Trauma Stress, and Compassion Satisfaction) for counselors working with trauma victims in a two part psycho-educational and experiential intervention. Assuming that self-care practices do indeed protect counselors from the negative impact of trauma work, research questions were developed to measure the effects of participation in self-care training specifically on lowering scores of burnout and secondary traumatic stress, and raising scores on compassion satisfaction for counselors. In this section I summarize the results of the study and include interpretations and implications.

Summary of Results

Of the three research questions, only scores of burnout (BO) demonstrated a statistically significant improvement for the treatment versus the control group. The large effect size also indicated strong practical significance. This suggests that the intervention was beneficial in reducing symptoms of burnout for counselors who participated in the self-care training. Also notable about this particular finding was the directional change in pre and post mean scores for both groups. Scores on burnout for the treatment group improved (reduction in scores) while burnout appeared to worsen (increase in scores) for the control group. For the two remaining research questions, differences on scores of STS or CS did not reach statistical significance, though each

61

analysis revealed a medium range effect size. This suggests moderate change on the dependent variables STS and CS that could be attributed to the treatment effect. Additionally, for all three constructs, means for the experimental group improved while means for the waitlist control group worsened indicating an overall trend of improvement for the experimental group. Although statistical and practical significance are addressed, it was difficult to interpret clinical significance due to high functioning levels presented at pretest.

The patterns observed offer some support for the conceptualization of the wellness-impairment continuum (ACA, 2005). Specifically for burnout, when self-care is either insufficient or absent, the counselor may passively, due to the impact of work and passage of time, move closer toward impairment on the spectrum via burnout symptomatology. It could be reasoned that the waitlist control group lacked information, awareness, and resources regarding self-care leading to less effective or infrequent practices, though still in the low range on both BO and STS, and approximate high range for CS. The treatment group seems to have gained information, awareness, and resources to put facilitative practices in place resulting in favorable changes to their professional quality of life. This lends consideration of the curriculum as a promising intervention option for self-care training intended for the prevention of impairment.

It was unanticipated that both treatment and control mean scores at pretest would fall into the low range for BO and STS and in near high range for CS. This would suggest that the sample reported better than average professional functioning at

the outset of the study. Hypotheses regarding these findings are further discussed in the context of convergent and divergent findings as they relate to previous literature.

Findings Related to the Literature

Although range scores are provided by the developer only as a general guide, low range scores of BO and STS lie below 22, while high scores of CS lie above 42 (Stamm, 2010). Both treatment and control group mean scores fell into or very near the optimal ranges listed for each of the three constructs. There may be various explanations for the pretest scores of both groups to start in the optimal range as measured by the ProQOL.

Measurement

A primary consideration is the reliability of the measure used and the construct of STS as one that is difficult to capture. As stated in the literature, several factors make STS difficult to assess. There are conflicting and inconsistent findings in the empirical validity of the construct, validity of measurement, and the rapid onset and rapid resolution of secondary traumatic stress symptoms (Devilly, Wright, & Varker, 2009; Figley, 2002; Jenkins & Baird, 2002; Stamm, 2010). Participants in the treatment group verbally reported the presence of symptoms of STS to the facilitator though mean scores did not indicate clinically significant levels. Participants described typical STS symptoms of hyper arousal and startle response, as well as hyper vigilance, and suspicion of people, known and unknown, as potential threats to the safety of themselves or others.

Well-Functioning Sample

Assuming that the measure was accurate and sensitive to detecting BO and STS, it is possible that the participants were not experiencing notable symptoms of distress at the time of the intervention. A ceiling effect would possibly occur with this particular sample as the counselors in the present study reported lower level symptoms than Stamm's (2010) normative sample. Some of the current literature has suggested that STS prevalence is inflated and that only low rates of compassion fatigue and secondary traumatic stress truly exist among mental health professionals (Bride, 2007; Sprang, Clark & Whitt-Woosley, 2007). In earlier estimations, Mahoney (1997) found that by and large, practitioners presented as generally happy and healthy individuals fulfilled by their work and sustained by self-care practices and support. These findings could further substantiate those claims.

CS as Mitigating Factor

Compassion satisfaction as a mitigating factor could account for the low scores of BO and STS in the sample. Independently, high scores of CS could bring about lower scores on STS and BO, as has been suggested of compassion satisfaction's ameliorating effect on compassion stress (Figley & Figley, 2010). In support of Schauben and Frazier's (1995) findings, clinicians working with survivors of sexual assault reported enjoyable aspects of work that counterbalanced adverse reactions to suffering and trauma. Humor was initiated by participants throughout group discussions and was strongly identified by participants as a protective factor. There were healthy interpersonal connections among staff, and participants identified

collegial support as imperative to sustain them. In combination, these factors may increase the meaningfulness of the work and facilitate greater compassion satisfaction which in turn impacts BO and STS, though perhaps not to an equal degree.

Burnout, as the only statistically significant finding and large treatment effect suggests that CS may mitigate STS and BO inequitably. Though it is difficult to speculate given the functioning of this sample, other literature delineates the protective influence of CS. Eastwood and Ecklund (2008) found compassion satisfaction appeared to have no significant ameliorative influence on secondary traumatic stress levels of residential childcare workers, although findings suggested it did with burnout. Additionally, perceptions of self-care success did not have a significant relationship to secondary traumatic stress risk level, though it did with burnout risk level. The authors concluded that the findings supported Figley's (2002) description of compassion fatigue as a "specialized form of burnout" (p. 1435). Eastwood and Ecklund conceptualized burnout risk level, in and of itself, as a significant component in the etiological understanding of compassion fatigue. Thus, one may speculate that if the counselor can prevent burnout, then secondary traumatic stress and compassion fatigue as the combination of the two can ultimately be avoided.

Environmental Factors

If counselors were not distressed at the time of the intervention, one may posit that aside from individual efforts, the clinical environment may have also contained positive factors which acted as buffers to BO or STS symptomatology.   Participants reported that factors such as having one's own workspace were important to the career

satisfaction and stress management of staff. Two of the agencies had therapy dogs on site which reportedly became a source of immediate stress relief for clinical and administrative staff. Participants acknowledged the importance of effective supervision, boundary awareness, and ongoing training as factors necessary to their overall well-functioning (Radey & Figley, 2007). In essence, when clinical staff believes that directors, administrators, and supervisors value and support the employees' contributions, staff may be better equipped to manage experiences of STS. For this study, agency administrators voiced support of the proposed self-care training, and clinical directors and supervisors participated in the training.

Organizational Factors

In related literature, organizational culture and climate are recognized contributions to staff's ability to manage STS and BO (Killian, 2008; Maltzman, 2011). The organizational climate, culture, structure and use of resources at the participating agencies may have added to the perceived support of the clinical staff. Counselors felt supported by administrators through responsible management of STS reactions and burnout. Administrators supported counselors with cooperative problem solving, by amending caseloads, or redefining roles. Maltzman (2011) stated that when employees feel valued and cared for by administrative staff, they have greater career satisfaction and lower burnout. The internal structure of the agencies contained several community resources on hand, such as law enforcement and child protective services, which helped counselors to feel connected to and supported by the community. The presence of these factors at the participating agencies may well

support Killian's identification of work morale, cohesion, and adequate resources as a significant predictor of burnout (Killian, 2008). This study did not employ an instrument to measure perceived environmental, organizational, or collegial support which, if included, could have helped examine the relationship between environmental and relational self-care factors and the dependent variables.

Awareness

Though it was not measured specifically, awareness of compassion fatigue and self-care may have had an influence on scores on BO and STS. Prior to training, participants were asked to complete a demographic questionnaire along with the ProQOL and return the protocols to the facilitator for data to be collected and recorded before the start of the second training session. Activities intended to raise awareness were facilitated including an exercise inviting participants to reflect silently and set an intention for the day, choose a river stone and write words describing transference and countertransference feelings with a difficult client in mind. These and other activities seemed to raise awareness effectively. As participants returned the following week to begin the second half of the training, many remarked that while completing the self-assessments, participants noticed that scores on BO and STS tended to be higher than they had been on the first occasion. This was observed for participants in the treatment group at both agency sites, which may indicate that during the didactic sections, participants grew increasingly more personally aware of signs of BO and STS and ways in which they present in counselors who work with trauma.

Some stated that they had more time to consider each question carefully and felt that the second score on self-assessment administered as part of the curriculum more accurately represented their true experiences. This feedback suggests a lesser degree of awareness during the first data collection, which may have interfered with the interpretation or personalization of items presented on the ProQOL. The participants may have under endorsed items on the protocol for the initial data collection because they were unfamiliar with or unaware of the warning signs they had experienced, but previously dismissed.   Other researchers have investigated the role of awareness in understanding and preventing compassion fatigue for health care providers for chronically ill children.

Meadors and Lamson (2008) provided and evaluated the effectiveness of an educational seminar on compassion fatigue as a function of raising awareness. Researchers measured awareness of compassion fatigue before and after the seminar. Results demonstrated that the seminar was successful in raising awareness on compassion fatigue and reducing clinical stress after one 4-hour educational seminar. Participants reported a greater understanding and increased confidence in the resources available to prevent compassion fatigue.   Thus participants' lack of awareness at the initial data collection may have provided an under representation of the clinicians' functioning.

Confirmation of Lack of Self-Care Training

The lack of self-care training has been drawing greater concern among practitioners, educators, and researchers in the helping professions. Perhaps for

counselors, the concern is even greater due to the overtness of ethical guidelines and requirements listed in both the ACA Code of Ethics (2005) and CACREP (2009) standards. A study by Culver (2011) revealed that of nearly 300 participants surveyed, only 21.9% indicated that there was at least one course offered in self-care or wellness in their counselor education program, while 78.1% indicated neither course was offered. Inquiry into the rate of self-care training experience for the sample in this study revealed that of 42 participants, two (4.8%) stated that there was in fact some sort of self-care or wellness course or training offered, while forty (95.2%) stated that no self-care or wellness course was offered in their educational or training program. As with Culver's study, most participants stated that self-care training was occasionally available while they pursued continuing education opportunities. These numbers may suggest that the initiative taken by the ACA task force (2004) has had little impact on the training of counselors and potentially their ability to recognize or avoid risks leading to impaired practices.

General Limitations

Results from this research were considered in lieu of the following limitations and other limitations that may not be mentioned. A major limitation of the study is the relatively small sample size as this may affect the generalizability of the study to other training scenarios. A potential organizational piece implicates the influence of self-selection, such that, the agencies willing to participate were likely to place greater value on the health and happiness of their employees, thus scores on the measure mostly fell in the optimum range. Moreover, this study assumes that once counselors

received training in self-care and the planning thereof, they would employ the strategies that they chose to some degree of consistency. It would be helpful in the future to send a weekly booster via email or brief announcements during clinical staffing meetings to remind clinicians to attend to self-care on at least a weekly basis.

Socially desirable responding may have contributed to the ceiling effect. Some authors have suggested that counselors in particular are more likely to respond in socially desirable ways, so much so that the presence of this response bias acts as a confounding variable (Ringenbach, 2009). Specific to this study, counselors generally ascribe to a holistic model of wellness and would like to see themselves as living up to their professional and ethical values. Including a brief measure of social desirability could improve the reliability of the data in future self-care research.

Other limitations of the current research include those typically associated with convenience samples, self-report measures, and personality differences in participants who volunteer. The counselors in the present study were predominately Caucasian females treating children who presented with trauma, which may limit the generalizability of the study to diverse populations or settings. Also observed by the facilitator, staff-supervisor relationships may have impacted group dynamics during training in some way that was not measured by the present study. Some participants may have felt limited in expressing their work frustrations in the presence of their supervisors. Further, while self-care is a focus of this study, the variables measured are indirectly related to counselor self-care practices. Future studies should include measures of specific self-care behaviors and frequencies to track self-care behavior.

Participants reported that not all clinicians and supervisors attended the training. Participants voiced that the counselors on staff who appeared most exhausted or over extended opted to forego intervention or were not present due to illness. Participants' reports of specific co-workers and the researcher's observations indicated that some staff appeared to demonstrate signs of impairment. Although access to the self-care training, resources, and information was a one day investment, those appearing most in need seemed to either refuse, or have difficulty accepting help. This may be characteristic of self-sacrificing personality style or demonstrative of how habitual self-neglect may not enter into one's awareness until one is physically unwell. It is difficult to overestimate the seriousness of this theme of giving from a place of depletion or working from a place of exhaustion.

General Implications

Well measured and researched, burnout alone, can reduce capacity for empathic concern, inhibit empathic response, and subsequently can reduce one's sense of achievement through work; all of which would increase the level of compassion stress one feels while attempting to engage the client therapeutically. The results of this study demonstrate that in terms of training counselors to develop and integrate self-care practices to manage or prevent burnout, the counselor self-care curriculum and planning tool offer a promising intervention to be used with counselors at any level of education or formal training. Eastwood and Ecklund (2008) suggested that the primary way to address compassion fatigue risk is to address burnout risk. As seen with this promising intervention, self-care practices may not impact compassion

fatigue risk directly, but may aid in the amelioration of burnout and thereby moderate workers' compassion fatigue risk levels. In fulfilling ethical obligations and practicing values to which counselors ascribe, professional counselors and clients likely benefit immeasurably.

Research Implications

Though this study measured a small group of trauma counselors, the findings lead to continuing questions about the true prevalence of counselors' experience of secondary traumatic stress and compassion satisfaction. Along with related research, this study lends incomplete information on the perceived effectiveness of self-care methods in terms of reducing secondary traumatic stress or increasing compassion satisfaction. The most important implication of this study is the finding that self-care training appeared to reduce burnout symptoms. This reduction in burnout symptoms may be the first in line of the protective factors against secondary traumatic stress for counselors. Open-ended responses from counselors conveyed that learning to self-care is valuable to counselors as many participants confirmed that there continues to be an ongoing lack of self-care practices for the individual and self-care training within the profession. However, a randomized control group design would help to attribute improvement in burnout, secondary traumatic stress, and compassion satisfaction to the self-care curriculum.

Amid the evidence of low secondary traumatic stress detected in this study it would be helpful to measure the impact of a self-care training on counselors who measure in the high ranges for secondary traumatic stress and burnout. Future studies

could employ this training curriculum, but specifically measure self-care attitudes, habits and practices. As the literature presents counselors as people who tend to concentrate on other-care more so than self-care, the construct of self-compassion would be an interesting addition to understanding the obstacles to self-care that typically inhibit professionals from receiving care, or asking for help. Finally, considering that the population used in this study comprised of solely counselors working with trauma, another study with this same curriculum should be undertaken using populations of counselors that includes non-trauma workers. It is possible that individual vulnerabilities play a larger role in secondary traumatic stress than does the presentation of certain populations, though self-care training need not be specific to be effective. Finally, with the permission of the developers, the curriculum used in this research can be studied and modified to maximize the benefit to groups who receive the training.

Clinical Implications

Faculty members, mentors, and supervisors have unmatched influence on the developing attitudes and behaviors of students regarding help seeking in terms of self-care as a function of professional development (Dearing, Maddux, & Tangney, 2005). For this reason it is critically important for faculty, mentors, and supervisors to develop and model ethical self-care practices. The responsibility to self-care is no less of an ethical responsibility than any other. "Failure to adequately attend to self-care and the resultant impaired professional competence that may ensue place ourselves, our profession, and those we serve at risk" (Barnett & Cooper, 2009, pp. 16). As a part of

clinical practice, literature recommends that all counselors should develop a concrete self-care plan to practice and have an accountability partner with whom to check in regularly.

When counselors become advocates of self-care in their clinical settings they are practicing the idealistic values of the profession and promoting these same values for clients. On an institutional level, self-care training and ongoing self-care groups may be valuable arenas to introduce students to professional risks and concepts such as impairment. Programs may start these types of activities as offered through graduate organizations each semester. At the organizational level, agencies can protect themselves and their employees by initiating self-care planning to be conducted yearly in supervision perhaps and take initiative to offer wellness activities such as walking groups or guided imagery sessions.

APPENDIX A

DEMOGRAPHIC INFORMATION FORM

Please indicate your answers below for the purposes of data comparisons.

1) Sex: 2) Age: 3) Please indicate ethnicity:
4) Please check highest degree and program attained:

	Baccalaureate			PhD in Social Work
	Master in Social Work			PhD in Counseling
	Master in Counseling			PhD in Psychology
	Master in Psychology			PhD in Education
	Master in Education			Other:

5) Professional Licenses/Certifications. Check ALL that apply.

	LPC-Intern			Licensed Psychologist
	LPC			NCC
	LMFT			NCSC
	LCSW			None
	LCDC			Other:

6) Please indicate you present employment/staff position:

7) How many years have you worked in the mental health field *and* in what capacity?

8) According to the American Psychiatric Association (2000), trauma is associated with exposure to a situation that involves threatened or actual death, or serious injury to self or others. For the purposes of this study, trauma can include loss, physical or sexual assault, childhood sexual abuse, domestic violence, natural and man-made disasters, as well as school and work related violence.
Do you work with trauma survivors?

9) Please estimate the number of clients with trauma that you work with on average each week, including intakes and ongoing clients.

10) Please estimate the percentage of trauma clients on your case load.

11) Please estimate the total number of hours of direct contact with ALL clients, on average each week, including intakes and ongoing clients.

12) In your counselor education or in other training, was there at least one course offered specifically regarding self-care and wellness? Did you participate?

13) About how many hours of self-care or wellness training have you received?

14) In your counselor education or in other training, was there at least one course offered specifically regarding trauma work? Did you participate?

15) About how many hours of trauma work training have you received?

16) Please rate the following statement:

"Professionals working with trauma survivors should make self-care a high priority."

Strongly Agree	Moderately Agree	Mildly Agree	Neutral	Mildly Disagree	Moderately Disagree	Strongly Disagree

APPENDIX B

FOLLOW UP QUESTIONNAIRE

1. What part of this training did you find most helpful?

2. What part of this training did you find least helpful?

3. What was the most important information/resource that you gained during your participation?

4. How well did this project prepare you to begin a new self-care practice?

5. In what domain are you most confident that you will successfully implement your new self-care goals?

spiritual	intellectual	cognitive	behavioral	physical	emotional	social

6. Would a self-care training like this have been helpful to you earlier in your career?

Yes, Highly	Yes, Likely	Maybe	No

7. Would you recommend this training to a colleague?

Yes, Highly	Yes, Likely	Maybe	No

APPENDIX C

INSTITUTIONAL REVIEW BOARD APPROVAL

UNT
UNIVERSITY OF
NORTH★TEXAS
Discover the power of ideas.

February 14, 2012

Supervising Investigator: Dr. Dee Ray
Student Investigator: Christine Guthrie
Department of Counseling
University of North Texas

Re: Human Subjects Application No. 12045

Dear Dr. Ray:

As permitted by federal law and regulations governing the use of human subjects in research projects (45 CFR 46), the UNT Institutional Review Board has reviewed your proposed project titled "Impact of Counselor Self-Care Training on Burnout, Compassion Fatigue, and Compassion Satisfaction." The risks inherent in this research are minimal, and the potential benefits to the subject outweigh those risks. The submitted protocol is hereby approved for the use of human subjects in this study. **Federal Policy 45 CFR 46.109(e) stipulates that IRB approval is for one year only, February 14, 2012 to February 13, 2013.**

Enclosed is the consent document with stamped IRB approval. Please copy and **use this form only** for your study subjects.

It is your responsibility according to U.S. Department of Health and Human Services regulations to submit annual and terminal progress reports to the IRB for this project. The IRB must also review this project prior to any modifications.

Please contact Shelia Bourns, Research Compliance Analyst, or Boyd Herndon, Director of Research Compliance, at extension 3940, if you wish to make changes or need additional information.

Sincerely,

Patricia L. Kaminski, Ph.D.
Associate Professor
Department of Psychology
Chair, Institutional Review Board

PK:sb

APPENDIX D

PROJECT ADVERTISEMENT

THE COUNSELOR SELF-CARE PROJECT

"The same tendencies we have for compassionately helping others make us especially vulnerable to overlooking our own needs."

~ Charles Figley

As you have likely experienced, there is a substantial cost associated with caring for children and families who have been impacted by trauma and abuse. Whether the result is burnout, vicarious trauma, or compassion fatigue, children's advocacy work has been described in the mental health literature as "high touch" and "hazardous" (Skovholt, 2001). Here are several ways in which any of these threats impact counselors and agencies.

WORK PERFORMANCE	MORALE	INTERPERSONAL	BEHAVIORAL
Decrease in quality	Decrease in confidence	Withdrawal from colleagues	Absenteeism
Decrease in quantity	Loss of interest	Impatience	Exhaustion
Low motivation	Dissatisfaction	Decrease in quality of relationships	Faulty judgment
Avoidance of job tasks	Negative attitude	Poor communication	Irritability
Increase in mistakes	Apathy	Subsume own needs	Tardiness
Setting perfectionistic standards	Demoralization	Staff conflicts	Irresponsibility
Obsession about details	Lack of appreciation		Overwork
	Detachment		Frequent job change
	Feelings of incompleteness		

Source: Yassen, J. (1995). "Preventing Secondary Traumatic Stress Disorder" Compassion Fatigue: New York: Brunner/Mazel, p.191.

As we know, healthy, psychologically present, and committed counselors are in a better position to offer assistance than those who suffer from symptoms of compassion fatigue and burnout (Killian, 2008). It is an ethical requirement to engage in self-care, and yet few counselors actually have a self-care plan in practice! Please join me for a training on the costs of caring and learn how to compassionately and responsibly care for yourself in this project aimed at caring for you and only you!

In this training:

- We will look at burnout, compassion fatigue and how trauma work leads to an inability to tap into empathy, compassion, and other internal resources essential to your work.
- We will spend time identifying and reflecting upon your personal and professional stressors as well as life experiences that may require extra attention to sustain your resilience.
- We will go step-by-step getting to know what you need in terms of self-care, and how to make it happen given the many obstacles that practicing counselors typically encounter.

Please join me in caring for you.
Participants will be entered into a drawing
for a free massage or facial at Massage Envy!

Coming spring, 2012
Specific dates to be determined
Eight free CEU credits.

REFERENCES

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

Adams, S. A., & Riggs, S. A. (2008). An exploration study of vicarious trauma among counselor trainees. *Training and Education in Professional Psychology, 2*, 26-34.

American Counseling Association. (2004). *ACA Taskforce on Counselor Wellness and Impairment.* Retrieved October 31, 2011 from http://www.counseling.org/wellness_taskforce/index.htm.

American Counseling Association. (2005). *ACA code of ethics*. Alexandria, VA: Author.

American Counseling Association. (2011). *The 2011 statistics on mental health professionals.* Retrieved from http://www.counseling.org/publicpolicy/pdf/mental_health_professions%20_statistics_2011.pdf

American Heritage medical dictionary (2nd ed.). (2007). Boston, MA: Houghton Mifflin.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: Author.

American Psychological Association. (2006). *Advancing colleague assistance in professional psychology.* Retrieved from: http://www.apa.org/practice/resources/assistance/monograph.pdf

Arvay, M. J., & Uhlemann, M. R. (1996). Counselor stress in the field of trauma: A preliminary study. *Canadian Journal of Counseling, 30*, 193-210.

Awa, W. L., Plaumann, M., & Walter, U. (2010). Burnout prevention: A review of intervention programs. *Patient Education and Counseling, 78*, 184-190.

Baird, S., & Jenkins, S. R. (2003). Vicarious traumatization, secondary traumatic stress, and burnout in sexual assault and domestic violence agency staff. *Violence and Victims, 18,* 71-86.

Baker, E. K. (2003). *Caring for ourselves: A therapist's guide to personal and professional well-being.* Washington, DC: American Psychological Association.

Barnett, J. E. (2007). Who needs self-care anyway? *Professional Psychology: Research and Practice, 38*, 603-612.

Barnett, J. E., & Cooper, N. (2009). Creating a culture of self-care. *Clinical Psychology: Science and Practice, 16,* 16-20.

Barnett, J. E., Baker, E. K., Elman, N. S., & Schoener, G. R. (2007). In pursuit of wellness: The self-care imperative. *Professional Psychology: Research and Practice, 38*, 603-612.

Barnett, J. E., Johnston, L. C., & Hilliard, D. (2006). Psychotherapist wellness as an ethical imperative. In VandeCreek, L., & Allen, J. B. (Eds.), *Innovations in clinical practice: Focus on health and wellness,* (251-271). Sarasota, FL: Professional Resources Press.

Bergin, A., & Jasper, L. (1969). Correlates of empathy in psychotherapy: A replication. *Journal of Abnormal Psychology, 74*, 477-481.

Birck, A. (2001). Secondary traumatization and burnout in professionals working with torture survivors. *Traumatology, 7,* 87-91.

Bober, T., & Regehr, C. (2005). Strategies of reducing secondary or vicarious trauma: Do they work? *Brief Treatment and Crisis Intervention, 6,* 1-9.

Boscarino, J. A., Figley, C. R., & Adams, R. E. (2004). Evidence of compassion fatigue following the September 11 terrorist attacks: A study of secondary trauma among social workers in New York. *International Journal of Emergency Mental Health, 6,* 98-108.

Brady, J. L., Guy, J. D., & Norcross, J. C. (1995). Managing your own distress: Lessons from psychotherapists healing themselves. In L. VandeCreek & S. Knapp (Eds.), *Innovations in clinical practice: A source book,* (293-306). Sarasota, FL: Usource Press/Professional Resource Exchange, Inc.

Brady, J. L., Guy, J. D., Polestra, P. L., & Brokaw, R. F. (1999). Vicarious traumatization, spirituality, and the treatment of sexual abuse survivors: A national survey of women psychotherapists. *Professional Psychology: Research and Practice, 30*, 386-393.

Brady, J., & Post, P. (1991). Impaired students: Do we eliminate them from the counselor education programs? *Counselor Education and Supervision, 31*, 100-108.

Bride, B. E. (2007). Prevalence of secondary trauma stress in social workers. *Social Work, 52*, 63-70.

Bride, B. E., Radey, M., & Figley, C. R. (2007). Measuring compassion fatigue. *Clinical Social Work, 35*, 155-163.

Buchanan, M., Anderson, J. O., Uhlemann, M. R., & Horwitz, E. (2006). Secondary traumatic stress: An investigation of Canadian mental health workers. *Traumatology, 12*(4), 272-281.

Cavanaugh, M. E., & Levitov, J. E. (2002). *The counseling experience: A theoretical and practical approach* (2nd ed.). Waveland Press, Inc.

Chrestman, K. R. (1999). Secondary exposure to trauma and self-reported distress among counselors. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (2nd ed., pp. 29-36). Baltimore, MD: Sidran Press.

Cohen, J. (1992). A power primer. *Psychological Bulletin, 112*, 155-159.

Council for Accreditation of Counseling and Related Educational Programs. (1994). *Accreditation standards and procedures manual*. Alexandria, VA: Author.

Culver, L. M. (2011) *Counselor perceptions of the efficacy of training and implementation of self-care strategies related to trauma work* (Doctoral dissertation). University of New Orleans. Retrieved from http://scholarworks.uno.edu/td/1298

Cunningham, M. (2004). Impact of trauma work on social work clinicians: Empirical findings. *Social Work, 48*, 451-459.

Davidson, J. R., & Smith, R. D. (1990). Traumatic experiences in psychiatric outpatients. *Journal of Traumatic Stress, 3*, 459-475.

Dearing, R. L., Maddux, J. E., & Tangney, J. P. (2005). Predictors of psychological help seeking in clinical and counseling psychology students. *Professional Psychology: Research and Practice, 36,* 323-329.

Deutsch, C.1. (1985). A survey of counselor personal problems and treatment. *Professional Psychology: Research and Practice,* 16, 305-315.

Devilly, G. J., Wright, T., & Varker, T. (2009). Vicarious trauma, secondary traumatic stress or simply burnout? Effects of traumat therapy on mental heatlh professionals. *Australian and New Zealand Journal fo Psychiatry, 43*, 373-385.

Dutton, M. A., & Rubinstein, F. L. (1995). Working with people with PTSD: Research implications. In C. R. Figley (Ed.), *Compassion fatigue: Secondary traumatic stress disorders in those who treat the traumatized* (pp. 82-100). New York: Brunner-Mazel.

Eastwood, C. D., & Ecklund, K. (2008). Compassion fatigue risk and self-care practices among residential treatment center childcare workers. *Residential Treatment for Children and Youth, 25,* 103-122.

Edmonson, D. (2009). *From shattered assumptions to weakened worldviews: Evidence of anxiety buffer disruption in individuals with trauma symptoms* (Doctoral dissertation). Retrieved from Digital Commons. (AAI3361004.)

Farber, B. A. (1983). Psychotherapists' perceptions of stressful patient behavior. *Professional Psychology: Research and Practice, 19*, 621-629.

Farber, B. A. (1990). Burnout in psychotherapists: Incidents, types and trends. *Psychotherapy in Private Practice, 8*, 35-44.

Figley, C. & Figley, K. R. (2010). *Compassion fatigue educator certification course*. Figley Institute. Retrieved from http://www.figleyinstitute.coursehost.com/Engine/Academic/Tools/CoursePublicize.asp?pk=74104&LID=1&ky=d_BPDiQVRgHzDiPRUmf_DgHzrpTOtoHz

Figley, C. R. (1993). Compassion stress: Toward its measurement and management. *Family Therapy News, 24*, 1-10.

Figley, C. R. (1995). *Compassion fatigue: Secondary traumatic stress disorders in those who treat the traumatized*. New York: Brunner-Mazel.

Figley, C. R. (1999). Compassion fatigue: Toward a new understanding of the costs of caring. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (2nd ed., pp. 3-28). Baltimore, MD: Sidran Press.

Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self-care. *Psychotherapy in Practice, 58*, 1433-1441.

Figley, C. R. (2007). *The art and science of caring for others without forgetting self-care.* Retrieved from: http://www.ptsdsupport.net/dont_forget_selfcare.html

Follette, V. M., Polusny, M. M., & Milbeck, K. (1994). Mental health and law enforcement professional's trauma history, psychological symptoms, and impact of providing services to child sexual abuse survivors. *Professional Psychology: Research and Practice, 25,* 275-282.

Gilroy, P. J., Carrol, L., & Murra, J. (2002). A preliminary survey of counseling psychologists' personal experiences with depression and treatment. *Professional Psychology: Research and Practice, 33,* 402-407.

Good, G. E., Khairallah, T., & Mintz, L. B. (2009). Wellness and impairment: Moving beyond noble us and troubled them. *Journal of Clinical Psychology: Science and Practice, 16,* 21-23.

Guy, J. D. (2000). Holding the holding environment together: Self-psychology and psychotherapist care. *Professional Psychology: Research and Practice, 31,* 351-352.

Guy. J., Poelstra, P., & Stark, M. (1989). Personal distress and therapeutic effectiveness: *Psychology: Research and Practice*, *20,* 48-50.

Holzman, L. A., Searight, H. R., & Hughes, H. M. (1996). Clinical psychology graduate students and personal psychotherapy: Results of an exploratory survey. *Professional Psychology: Research and Practice, 27,* 98-101.

Jaccard, J., & Wan, C. K. (1996). *Approaches to interaction effects in multiple regression.* Thousand Oaks, CA: Sage Publications, Inc.

Jenkins, S. R., & Baird, S. (2002). Secondary traumatic stress and vicarious trauma: A validation study. *Journal of Traumatic Stress, 15*(5), 423-432.

Kassam-Adams, N. (1999). The risk of treating sexual trauma: Stress and secondary trauma in psychotherapists. In B. H. Stamm (Ed), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (2nd ed., pp. 37-48). Baltimore, MD: Sidran Press.

Killian, K. D. (2008). Helping till it hurts: A multi-method study of compassion fatigue, burnout, and self-care in clinicians working with trauma survivors. *Traumatology, 14,* 32-44.

Kleespies, P. M., Bongar, B., Bufka, L. F., Galper, D. I., Van Orden, K. A., Bridgeman, D., Hillbrand, M., & Yufit, R. I. (2011). Psychologist suicide: Incidence, impact, and suggestions for prevention, intervention, and postvention. *Professional Psychology: Research and Practice, 42*, 244-251.

Kluft, R. P. (2004). Treating compassion fatigue. *American Journal of Clinical Hypnosis.* Retrieved February 17, 2009, from http://findarticles.com/p/articles/mi_qa4087/is_200410/ai_n9460072

Kottler, J. A. (2000). *Doing good: Passion and commitment for helping others.* Philadelphia, PA: Brunner-Routledge.

Kramen-Kahn, B., & Hansen, N. D. (1998). Rafting the rapids: Occupational hazards, rewards and coping strategies of psychotherapists. *Professional Psychology: Research and Practice, 29*, 130-134.

Kruger, L., Botman, H., & Goodenow, C. (1991). An investigation of social support and burnout among residential counselors. *Child and Youth Care Forum, 20,* 335-352.

Kruger, L., Bernstein, G., & Botman, H. (1994). The relationship between team friendships and burnout among residential counselors. *Journal of Social Psychology, 135,* 191-201.

Lawson, G. & Myers, J. E. (2011). Wellness, professional quality of life, and career sustaining behaviors: What keeps us well? *Journal of Counseling and Development, 89,* 163-171.

Lawson, G., & Venart, B. (2005). *Preventing counselor impairment: Vulnerability, wellness, and resilience.* In G. R. Walz & R. K. Yep (Eds.), *VISTAS: Compelling perspectives on counseling, 2005* (pp. 243-246). Alexandria, VA: American Counseling Association.

Lawson, G. Venart, E., Hazler, R., & Kottler, J. (2007). Toward a culture of counselor wellness. *Journal of Humanistic Counseling, Education, and Development, 46,* 5-19.

Mahoney, M. J. (1997). Psychotherapists' personal problems and self-care patterns. *Professional Psychology: Research and Practice, 28,* 14-16.

Maltzman, S. (2011). An organizational self-care model: Practical suggestions for development and implementation. *The Counseling Psychologist, 39*, 303-319.

Martin, S. (CETV). (2006). *Care for the caregiver.* Retrieved from http://www.youtube.com/watch?v=6YtjAQNIGUU

Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. *Annual Review of Psychology, 52,* 397-422.

McCann, L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3*, 131-149.

Meadors, P., & Lamson, A. (2008). Compassion fatigue and secondary traumatization: Provider self-care on intensive care units for children. *Journal of Pediatric Health Care, 22*, 24-34.

Meadors, P., Lamson, A., Swanson, M., White, M., & Sira. N. (2009). Secondary traumatization in pediatric healthcare providers: Compassion fatigue, burnout, and secondary traumatic stress. *Omega, 60*, 103-128.

Meyer, D., & Ponton, R. (2006). The healthy tree: A metaphorical review of the counselor wellness literature. *Journal of Mental Health Counseling, 28,* 189-201.

Munroe, J. F. (1999). Ethical issues associated with secondary trauma in counselors. In B. H. Stamm (1999). *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (2nd ed., pp. 211-229). Baltimore, MD: Sidran Press.

Munsey, C. (2006). Helping colleagues to help themselves. *Monitor on Psychology, 37,* 35-40.

Myers, J. E. & Sweeney, T. J. (2008). Wellness counseling: The evidence base for practice. *Journal of Counseling and Development, 86,* 482-493.

Myers, J. E., Sweeney, T. J., & Witmer, J. M. (2000). The wheel of wellness counseling for wellness: A holistic model for treatment planning. *Journal of Counseling and Development, 78,* 251-266.

Nelson-Gardell, D., & Harris, D. (2003). Childhood abuse history: Secondary traumatic stress and child welfare workers. *Child Welfare, 82,* 5-26.

Neumann, D. A. & Gamble, S. J. (1995). Issues in the professional development of psychotherapists: Countertransference and VT in the new trauma therapist. *Psychotherapy, 32,* 341-347.

Newell, J. M. & MacNeil, G. (2010). Professional burnout, secondary traumatic stress, and compassion fatigue: A review of theoretical terms, risk factors, and preventive methods for clinicians. *Best Practices in Mental Health, 6*, 57-68.

Norcross, J. C. & Drewes, A. A. (2009). Self-care for child therapists: Leaving in at the office. In A. A. Drewes (Ed.), *Blending play therapy with cognitive behavioral therapy. Evidence-based and other effective treatments and techniques* (pp.3-16). New York: John Wiley & Sons.

Norcross, J. C., Guy, J. D., & Laidig, J. (2007). Recognizing the hazards. In J. C. Norcross & J. D. Guy (Eds.), *Leaving it at the office: A guide to psychotherapist self-care* (pp. 35-63). New York: Guilford Press.

Norcross, J. C. (2000). Psychotherapist self-care: Practitioner-tested, research-informed strategies. *Professional Psychology: Research and Practice, 31,* 710-713.

O'Donnel, J. M. (1988). Focus groups: A habit-forming evaluation technique. *Training and Development Journal, 42*, 71-73.

O'Halloran, M. S., & O'Halloran, T. (2001). Secondary traumatic stress in the classroom: Ameliorating stress in graduate students. *Teaching of Psychology, 28,* 92-96.

O'Halloran, T. M., & Linton, J. M. (2000). Stress on the job: Self-care resources for counselors. *Journal of Mental Health Counseling, 22*, 354-364.

Pearlman, L. A., & Mac Ian, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma counselors. *Professional Psychology: Research and Practice, 26*,558-565.

Pearlman, L. A., & Saakvitne, K. W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. New York, NY: Norton.

Pope, K. S., & Tabachnick, B. G. (1994). Counselors as patients: A national survey of psychologists' experiences, problems and beliefs. *Professional Psychology: Research and Practice, 25*, 247-258.

Pope, K. S., Tabachnick, B. G., & Keith-Spiegel, P. (1987). Ethics of practice: The beliefs and behaviors of psychologists as counselors. *American Psychologist, 42*, 993-1006.

Porter, N. (1995). Therapist self-care: A proactive ethical approach. In C. Larsen & E. Rave (Eds.), *Ethical decision-making in feminist therapy.* New York: Guildford Press.

Qualtrics Lab Inc. (2012*).* Survey Research Suite. Provo, UT. http://www.qualtrics.com

Racquepaw, J., & Miller, R. S. (1989). Psychotherapist burnout Componential analysis. *Professional Psychology: Research and Practice, 20*, 32-36.

Radey, M. & Figley, C. (2007). The social psychology of compassion. *Clinical Social Work Journal, 35*, 207-214.

Regehr, C., Chau, S., Leslie, B., & Howe, P. (2002). Inquiries into deaths of children in care: The impact on child welfare workers and their organization. *Children and Youth Services Review, 24,* 885-902.

Ringenbach, R. (2009). *A comparison between counselors who practice meditation and those who do not on compassion fatigue, compassion satisfaction, burnout, and self-compassion (*Doctoral dissertation). Retrieved from http://etd.ohiolink.edu/view.cgi?acc_num=akron1239650446

Roach, L. F., & Young, M. E. (2007). Do counselor education programs promote wellness in their students? *Counselor Education and Supervision, 47*, 29-45.

Rogers, C. R. (2007). The necessary and sufficient conditions of therapeutic personality change. *Psychotherapy: Theory, Research, Practice, Training, 44*(3), 240-248.

Rosenberg, T., & Pace, M. (2006). Burnout among mental health professionals: Special considerations for the marriage and family counselor. *Journal of Marital and Family Therapy, 32,* 87-99.

Rubin. A. (2008). *Practitioner's guide to using research for evidence-based practice.* Hoboken, NJ: John Wiley & Sons, Inc.

Schauben, L. J., & Frazier, P. A. (1995). Vicarious trauma: The effects on female counselors of working with sexual violence victims. *Psychology of Women Quarterly, 19,* 49-64.

Schaufeli, W. B., Maslach, C., & Marek, T. (Eds.). (1993). *Professional burnout: Recent developments in theory and research.* Washington, DC: Taylor &: Francis.

Schoener, G. R. (2007). Do as I say, not as I do. In J. Barnett (Ed.) *In pursuit of wellness: The self-care imperative* (pp.610-612). *Professional Psychology: Research and Practice, 38*, 603-612.

Schwebel, M., Skorina, J. K., & Schoener, G. (1988). *Assisting impaired psychologists: Program development for state psychological associations.* Washington, DC: American Psychological Association.

Skorupa, J., & Agresti, A. A. (1993). Ethical beliefs about burnout and continued professional practice. *Professional Psychology, 24*, 281-285.

Skovholt, T. M., & Trotter-Mathison, M. (2011). *The resilient practitioner: Burnout prevention and self-care strategies for counselors, therapists, teachers, and health care professionals.* New York: Routledge.

Skovholt, T. M., Grier, T. L., & Hanson, M. R. (2001). Career counseling for longevity: Self-care and burnout prevention strategies for counselor resilience. *Journal of Career Development, 27*, 167-176.

Smith, P. L., & Moss, S. B. (2009). Psychologist impairment: What is it, how can it be prevented, and what can be done to address it? *Clinical Psychology: Science and Practice, 16,* 1-15.

Sommer, C. A. (2008). Vicarious traumatization, trauma-sensitive supervision, and counselor preparation. *Counselor Education and Supervision, 48,* 119-134.

Sprang, G., Clark, J. J., & Whitt-Woosley, A. (2007). Compassion fatigue, compassion satisfaction, and burnout: Factors impacting a professional's quality of life. *Journal of Loss and Trauma, 12,* 259-280.

Stamm, B. H. (2002). Measuring compassion satisfaction as well as fatigue: Developmental history of the Compassion Satisfaction and Fatigue Test. In C. R. Figley (Ed.), *Treating compassion fatigue* (pp. 107-119). New York: Brunner-Routledge.

Stamm, B. H. (2010). *The ProQOL test manual.* Retrieved from http://www.proqol.org/ProQOl_Test_Manuals.html

Stamm, B. H. (2010). Professional quality of life: Compassion satisfaction and fatigue (Version 5). Retrieved from http://www.proqol.org/uploads

Statistical Package for the Social Sciences, Version 17 (SPSS, 2010).

Stebnicki, M. A. (2007). Empathy fatigue: Healing the mind, body, and spirit of professional counselors. *American Journal of Psychiatric Rehabilitation, 10*, 317-338.

Stefl, M. E., & Prosperi, D. C. (1985). Barriers to mental health service utilization. *Community Mental Health Journal, 21,* 167-177.

Stefl, M. E., & Prosperi, D. C. (1985). Barriers to mental health service utilization. *Community Mental Health Journal, 21,* 167-177.

Strada, E. A. (2011). Professional self-care Chapter 16 End of Life Issues, Grief, and Bereavement: What clinicians need to know, 294-309.

Tehrani, N. (2007). The cost of caring: The impact of secondary trauma on assumptions, values and beliefs. *Counselling Psychology Quarterly, 20,* 325-339.

Thomas, A. M., & Levitt, D. (2010). Self-care: An ethical obligation and preventive tool. *Counseling Today,* August, 44-55.

Thomas, B. J. (2007). *The relationship between affect balance, self-care behavior, and secondary traumatic stress reactions*. (Doctoral dissertation). Retrieved from ProQuest. http://udini.proquest.com/view/the-relationship-between-affect-goid:304705814/

Trippany, T. L., White Kress, V. W., & Wilcoxon, S. A. (2004). Preventing vicarious trauma: What counselors should know when working with trauma survivors. *Journal of Counseling and Development, 82,* 31-37.

Turner, J. A., Edwards, L. M., Eucken, I. M., Yokoyama, K., Castro, J. R., Tran, A. N., & Haggins, K. L. (2005). Intern self-care: An exploratory study into strategy use and effectiveness. *Professional Psychology: Research and Practice, 36,* 674-680.

Venart, E., Vassos, S., & Pitcher-Heft, H. (2007). What individual counselors can do to sustain wellness. *Journal of Humanistic Counseling, Education and Development, 46,* 50-65.

Yassen, J. (1995). Preventing secondary traumatic stress disorder. In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized,* pp. 178-208. New York: Brunner/Mazel.