

COMPASSION FATIGUE AND MENTAL HEALTH
DISASTER RESPONSE EDUCATION

By

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A THESIS PRESENTED TO THE GRADUATE SCHOOL
OF THE UNIVERSITY OF FLORIDA IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF ARTS IN EDUCATION

UNIVERSITY OF FLORIDA

2011

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To my mom, for the encouragement when I needed it the most

ACKNOWLEDGMENTS

I thank Megan, for being the extra push I always needed to get anything done. I thank my parents, for all they've given for me to be able to have an education. I thank my committee chair, Dr. Cirecie West-Olatunji, for her mentorship, her scholarship, and her support. I thank Jeff Drayton Wolfgang and Cheryl Ricciardi, for their assistance in the thesis process. Finally, I thank the other members of my committee: Dr. Sondra Smith and Dr. Wayne Griffin, for their understanding, support, and assistance through the thesis process and through the course of my graduate education.

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August 2011

Chair: Cirecie West-Olatunji
Major: Mental Health Counseling

In responding to natural or human made disasters, mental health counselors and responders put themselves at great risk for developing Compassion Fatigue. Compassion Fatigue is a major issue affecting the effectiveness and sustainability of mental health disaster responders, but it is far less researched than related terms such as burnout, secondary traumatic stress, or posttraumatic stress disorder. Some research has been done exploring the causes, warning signs, and associated protective factors of Compassion Fatigue. Little research has been done on Compassion Fatigue prevention or education. The purpose of this study was to examine the relationship between Compassion Fatigue education prior to mental health disaster responder deployment and levels of Compassion Fatigue and Compassion Satisfaction after deployment. The study used the Professional Quality of Life Scale, Version 5, the Stressful Life Experiences – Short Form, and a series of demographic questions. These instruments provided information on the levels of Compassion Fatigue and Compassion Satisfaction of participants, their trauma history, and basic demographic information. The results of the study suggest that individuals without Compassion

Fatigue education prior to deployment had higher levels of Compassion Fatigue, and that individuals who did have Compassion Fatigue education prior to deployment had higher levels of Compassion Satisfaction. These findings are important for responders, relief organizations, and academic institutions because it highlights the importance of Compassion Fatigue education as a needed component in responder training. Ensuring that Compassion Fatigue education is vital component of any formal or informal training model may help to protect responders from Compassion Fatigue and sustain them with higher levels of Compassion Satisfaction. For graduate institutions, this highlights the need for more thorough training on Compassion Fatigue as part of disaster response training, thus promoting the graduation of better equipped and prepared counselors, ready to respond to disasters anywhere in the world.

CHAPTER 1 INTRODUCTION

Compassion Fatigue (CF) is often referred to as the cost of caring experienced by counselors working with trauma victims (Figley & Kleber, 1995). In modern times the world has experienced natural and human made disasters that have necessitated unprecedented numbers of qualified mental health providers to give support to survivors (Kennedy, 2006). Whether responding to the aftermath of the World Trade Center attacks of 2001 or the Haiti earthquake of 2010, counselors and other mental health workers are tasked with providing aid not only to the victims of the disaster but also to the first responders (Creamer & Liddle, 2005). Individuals who work with trauma survivors are susceptible to compassion fatigue, burnout, secondary traumatic victimization/stress, and, in some instances, post-traumatic stress disorder.

Compassion Fatigue needs to be clearly defined and understood in order for counselors to better prepare themselves for the stress that they often experience when working with trauma survivors. Disaster relief counselors need training that includes not only self-care strategies, but also compassion fatigue education. Clukey (2010) suggested that preventative education for disaster response workers could help them to be better prepared for the emotional reactions that they may experience as a result of caring for trauma survivors. The purpose of this study was to see if there was a relationship between the level of Compassion Fatigue education an individual has prior to their crisis response deployment and the subsequent levels of Compassion Fatigue that the individual reports following the end of their deployment. The study utilized a survey comprised of demographic questions, the Professional Quality of Life Scale 5, and the Stressful Life Experiences Screening – Short Form. The population sample consisted

of members of the Florida Crisis Response Team (FCRT); all of these individuals were voluntary participants.

Rationale for the Study

Mental health counselors in disaster response settings often have trouble continuing to do their work effectively due to Compassion Fatigue. Mental health counselors who work in disaster relief scenarios with trauma survivors and first responders are often subject to the Secondary Traumatic Stressors that accompany this work. Among these stressors, Compassion Fatigue is one of the most debilitating because it directly impairs a counselor's ability to empathize with their client (Boscarino, 2004). The importance of understanding and preventing Compassion Fatigue is not only for the benefit of the counselor but also their ability to continue serving populations in crisis. Preventing Compassion Fatigue is important because if these counselors are not sustained there will not only be fewer counselors to serve, there will be fewer counselors, able or willing, to train the future ranks of trauma counselors (Clukey, 2010). When compared to other forms of traumatic stress such as Secondary Traumatic Stress, Vicarious Trauma, or Burnout, Compassion Fatigue has a much smaller presence in the literature. Scholars agree that specialized training in crisis work can reduce the likelihood of developing Compassion Fatigue, but there is no mention in the literature of CF components in this specialized training (Craig & Sprang, 2010). There is little in the literature that examines the relationship between Compassion Fatigue specific preventative education prior to deployment with levels of Compassion Fatigue following deployment. The author seeks to determine what if any relationship exists between Compassion Fatigue education and post deployment Compassion Fatigue levels in disaster response mental health workers.

Compassion Fatigue is a serious problem given its potential to inhibit the ability of disaster response counselors to empathize with survivors. Literature relating to CF delineates the issues pertaining to the different ways it can impede the counselor's ability to assist their clients, but there is less literature relating to prevention techniques. Some literature cites specialized crisis training as a protective factor against CF, but it does not necessarily include education about CF and its effects (Craig & Sprang, 2010). Finding ways to protect and sustain disaster response counselors is vital to ensuring that the entire crisis response effort is able to fully meet the needs of survivors. The purpose of this study was to look at the role of Compassion Fatigue education as a protective factor against the likelihood of developing CF.

Significance

It is hoped that the findings of this study will contribute to the literature on Compassion Fatigue. By utilizing the Professional Quality of Life Scale, Version 5, the researcher advances knowledge about a specific population of individuals that work in disaster response. Though this study may not be generalizable to the population as a whole, it is a first step in looking at how education about Compassion Fatigue may act as a protective factor. The ultimate purpose of this study is to impact the sustainability and well being of all individuals that work as disaster relief mental health counselors.

Assumptions of the Study

The researchers of this project made three assumptions regarding the study participants. The first assumption was that the Florida Crisis Response Team members who completed the survey understood the questions presented to them. The second assumption was that the FCRT members who completed the survey answered honestly. The third and final assumption was that the FCRT members who completed the survey

had either completed a deployment or had not been deployed at all to a disaster response situation.

Definition of Terms

- **COMPASSION FATIGUE.** A function of bearing witness to the suffering of others (Figley, 2002), an occupational hazard of psychological work with trauma survivors (Bride, 2007) that results in a reduced capacity or interest in being empathetic (Boscarino, 2004), and is related to the emotional and behavioral aspects of the symptomology of the afflicted therapist (Sabin-Farrell, 2003).
- **COMPASSION SATISFACTION.** The sustaining aspect of trauma work, Compassion Satisfaction is the sense of professional satisfaction that a counselor gains from helping others (Stamm, 2002).
- **BURNOUT.** A syndrome of emotional exhaustion, depersonalization, and a lack of personal accomplishment (Maslach & Jackson, 1981). Other definitions focus on the therapist's ineffectiveness (Lambie, 2006) and the process of physical and emotional depletion caused by work conditions and stress (Osborn, 2004).
- **SECONDARY TRAUMATIC STRESS.** A syndrome of symptoms almost identical to Post Traumatic Stress Disorder (Figley, 1995). Some theorists also consider Secondary Traumatic Stress and Compassion Fatigue to be synonymous, with CF being the more pleasant term to use (Figley, 1995).
- **VICARIOUS TRAUMATIZATION.** An all encompassing term that includes Secondary Traumatic Stress according to Sabin-Farrell (2003). Vicarious Trauma is the cumulative transformative effect experienced by the counselor as a result of working with the survivors of traumatic life events (Pearlman & Saakvitne, 1995).

CHAPTER 2 REVIEW OF THE LITERATURE

Compassion Fatigue is often referred to as the cost of caring experienced by counselors working with trauma victims (Figley & Kleber, 1995). In modern times the world has experienced and is experiencing natural and human made disasters that have necessitated unprecedented numbers of qualified mental health providers to give support to the survivors (Kennedy, 2006). Whether responding to the aftermath of the World Trade Center attacks of 2001 or the Haiti earthquake of 2010, counselors and other mental health workers are tasked with providing aid not only to the victims of the disaster but also to the first responders (Creamer & Liddle, 2005). Individuals who work with trauma survivors are susceptible to compassion fatigue (CF), burnout, secondary traumatic victimization/stress, and, in some instances, post-traumatic stress disorder (PTSD). Compassion fatigue needs to be clearly defined and understood in order for counselors to better prepare themselves for the stress that they often experience when working with trauma survivors. Disaster relief counselors need training that includes self-care and compassion fatigue education.

Definition

Charles Figley (2002) was one of the first researchers to study compassion fatigue as a chronic lack of self care and specifically defines it as:

A state of tension and preoccupation with the traumatized patients by re-experiencing the traumatic events, avoidance/numbing of reminders persistent arousal (e.g. anxiety) associated with the patient. It is a function of bearing witness to the suffering of others. (p. 1435)

The term, compassion fatigue, was initially used instead of Secondary Traumatic Stress Disorder because surveys among nurses and emergency responders suggested that compassion fatigue was a friendlier and favorable term. However, it has been argued that Compassion Fatigue and Secondary Traumatic Stress Disorder are identical and that they are the equivalent of Post Traumatic Stress Disorder with the exception of the direct exposure to the trauma (Figley, 1995). The terms, Secondary Traumatic Stress, Vicarious Traumatization, and Compassion Fatigue, are generally viewed as synonymous and equally hazardous for those working with trauma survivors (Bride, Radey, & Figley, 2007).), Defining CF as a reduced capacity or interest in being empathic, Boscarino, Figley, and Adams (2004) focus more on therapist empathy than on any cognitive schema change or behavioral symptoms.

Other researchers propose that the term Vicarious Traumatization encompasses the term Secondary Traumatic Stress (Sabin-Farrell & Turpin, 2003). The issues differentiating these terms are illustrated well by Sabin-Farrell and Turpin (2003) who purport that Vicarious Trauma refers to cognitive changes while Secondary Trauma reflects symptomology. Yet, other trauma researchers have identified these terms inversely. The muddled terminology, the overlap of terms, and the interchangeability of these related words have made it extremely difficult to distinguish the differences between the terms. In defining Compassion Fatigue, Sabin-Farrell and Turpin (2003) suggest that CF and Secondary Traumatic Stress (identified as interchangeable terms) focus on the symptoms and emotional responses resulting from work with trauma survivors but do not take into account the specific cognitive changes that vicarious trauma encompasses. Compassion Fatigue from this perspective is being defined as a

caregiver response to working with trauma survivors. However, the focus is on the emotional and behavioral aspects of the symptomology rather than actual changes in the way the therapist thinks or views the world. Thus, compassion Fatigue is not viewed as specific to trauma work, as Secondary Traumatic Stress and Vicarious Traumatization are. Rather, CF and burnout can be experienced in a variety of therapeutic areas. Research in the area of Compassion Fatigue (Sprang & Clark, 2007) has suggested that all of the related terms found throughout the literature are referring to secondary trauma. Overall, scholars appear to agree that counselors and other mental health workers experience secondary trauma when treating trauma survivors. Yet, there is little agreement as to which terminology is correct or if it even matters if the terms are used interchangeably.

For the purposes of this study the definition of CF used will be a combination of the Figley, Bride, Boscarino, and Sabin-Farrel definitions. CF is: (a) a function of bearing witness to the suffering of others (Figley, 2002), (b) an occupational hazard of psychological work with trauma survivors (Bride, 2007) that results in a reduced capacity or interest in being empathetic (Boscarino, 2004), and (c) related to the emotional and behavioral aspects of the symptomology of the afflicted therapist (Sabin-Farrell, 2003). This definition serves to highlight the spirit of the term as a reflection of the suffering of the therapist while maintaining a distance from the aspects of VT, Secondary Traumatic Stress, and burnout that are specific to those terms. Above all other definitions, it appears that the focus on caregiver empathic incapacitation is at the heart of differentiating CF from similar terms.

Causes of Compassion Fatigue

To fully describe CF, it is also necessary to investigate the factors contributing to the development of CF in a therapist. According to Figley (2002), there are eleven factors that contribute to the development or prevention of CF. These factors include (1) empathic ability, (2) empathic concern, (3) exposure to client, (4) empathic response, (5) compassion stress, (6) sense of achievement, (7) disengagement, (8) prolonged exposure, (9) traumatic recollections, (10) life disruptions, and (11) compassion fatigue. Compassion Fatigue is made up of at least two components that include Burnout and Secondary Trauma that can contribute then to CF (Adams, Figley, & Boscarino, 2008). Another explanation for how counselors and other mental health workers develop CF involves the actual transmission of the trauma from client to counselor. Boscarino, Figley, and Adams (2004) assert, “the psychopathology associated with psychological trauma can be vicariously transmitted through the therapeutic process” (p. 58). The field of literature regarding CF is not only vague on how to define CF, but also on what its contributing factors and causes are. While there is not a thorough and encompassing definition of CF available from the research literature, there are numerous measurements of CF that may help contribute to the understanding of the concept. The manner in which the tools conceptualize CF may give further evidence to how CF may be differentiated from similar terms.

Measurements of Compassion Fatigue

Though the research does not reflect one clear and universal definition of Compassion Fatigue, there are several assessments and instruments that can be utilized in identifying levels of CF or levels of risk for developing CF (Bride, 2007). These instruments may help in understanding what components contribute to

developing CF. Five instruments have been selected for discussion based upon a review of instruments conducted by Bride, Radey, and Figley (2007). The first is Figley's Compassion Fatigue Self Test (CFST) that focused on levels of CF and burnout in respondents (Figley, 1995). Stamm and Figley further developed this scale producing the Compassion Satisfaction and Fatigue Test (CSFT) that added the positive component of Compassion Satisfaction (CS) (Stamm, 2002). Gentry, Baranowsky, and Dunning (2002) designed a modified version of the CFST called the Compassion Fatigue Scale – Revised (CFS-R). This instrument still measured CF and burnout but used a different number of questions and scoring procedures. A further refined version of the CFS-R focused on measuring burnout with a secondary trauma subscale (Adams, Boscarino, & Figley, 2006). Stamm and Figley collaborated to modify the CFST thus producing the Professional Quality of Life Scale (ProQOL) that adds the component of Compassion Satisfaction. The ProQOL has three discrete subscales that measure CF/Secondary Traumatic Stress, Burnout, and CS (Stamm, 2005).

Compassion Satisfaction

For counselors and other mental health workers who respond to the victims of catastrophic events, there are psychological difficulties that they must face for themselves. Yet, there are also positive and professionally sustaining aspects of trauma work that allow them to cope. This sense of professional satisfaction that is derived from helping others has been labeled as Compassion Satisfaction (CS) (Stamm, 2002). Figley (1995) places Compassion Satisfaction, Compassion Stress, and Compassion Fatigue on a spectrum that starts with compassion satisfaction, then moves to Compassion Stress, and ends with CF. However, Stamm (2002) described compassion satisfaction as being in balance with CF. This suggests that counselors can suffer from

CF while simultaneously enjoying their work and gaining satisfaction. Though CF has compassion satisfaction as a counterpart, there are various terms related to CF that overlap with it that need to be explored to gather a more accurate picture of how the terms interrelate.

Related Terms

Burnout

Burnout is one of the many terms that is often portrayed in the literature as being comparable to CF. Burnout, like CF, has numerous definitions, but scholars agree on several key components of what comprises burnout. One of the most cited definitions of burnout comes from Maslach and Jackson (1981) who described burnout as a syndrome symptomized by emotional exhaustion, depersonalization, and a lack of personal accomplishment. Alternatively Meir's (1983) definition of burnout focused on it being a state of persistent expectation of low reward and high punishment at work due to a lack of valued reinforcement, controllable outcomes, or personal competence. Osborn (2004) portrayed burnout as the process of physical and emotional depletion caused by work conditions and, more specifically, prolonged job stress. Lambie's (2006) depiction of the consequences of burnout centered on the therapeutic ineffectiveness, premature occupational attrition, depression, and substance abuse that can be major detriments. Lambie described burnout as starting with the counselors' loss of caring and commitment to their clients. According to Figley (2002), burnout is characteristically slow and gradual whereas CF can set in suddenly. The core components of burnout appear to be emotional, physical, and psychological exhaustion caused by job stress.

Measurements. The different definitions of burnout have contributed to various instruments utilized in measuring burnout levels. The factors that these instruments measure illustrate many of the core issues at the heart of burnout. The Maslach Burnout Inventory (MBI) is designed with the view that burnout is a syndrome progressively occurring over time (Arthur, 1990). The MBI measures psychological and affective dimensions and utilizes three subscales: emotional exhaustion, personal accomplishment, and depersonalization. The Staff Burnout Scale for Health Professionals (SBS) measures psychological, physiological, and behavioral dimensions and focuses on four factors: dissatisfaction with work, psychological and interpersonal tension, physical illness and distress, and unprofessional patient relationships (Arthur, 1990). These two scales suggest a focus on job dissatisfaction, psychological impairment, and a disconnection from clients. Sang (2010) cites that the MBI, while providing some insight into counselor related burnout, does not adequately address issues of burnout that directly affect counselors. Sang (2007) suggests the use of the Counselor Burnout Inventory that focuses on five factors: exhaustion, incompetence, negative work environment, devaluing of the client, and deterioration of personal life.

Risk Factors and Prevention. In his research delineating the types of burnout that counselors experience, Sang (2010) suggested that counselor burnout is primarily due to counselors' difficulty in achieving personal and workplace equilibrium. Contributing factors have included: budget cuts, managed care constraints, and high caseloads while still providing high levels of therapeutic service. Lambie (2006) found that while counselor empathy was essential in forming an effective therapeutic relationship, it also increased susceptibility for burnout. Lambie's work specifically

focused on how counselors' emotional depletion can lead to cynicism and detachment and eventually burnout. Counselor empathy, selflessness, long hours, and emotional pressures at work are all cited as contributing factors in developing burnout. Further risk factors cited by Lambie include unrealistic professional expectations, wanting to feel in control in counseling relationship, and incongruence between professional values and work behaviors. Lambie's focus on empathy as being a key risk factor for developing burnout shows overlap with the literature that suggests empathy is a key risk factor for developing CF.

Osborn's model (2004) for wellness involves seven steps that include ways to improve counselors' quality of life and overall mental health. Conversely, Lambie's (2006) work explored the need for education in the area of self care as counselors are at risk for burnout because they often focus exclusively on client care rather than self-care. Outcomes from research in this area suggests that structured supervision for counselors wherein they are able to discuss their concerns about burnout may in itself act as a protective factor against developing counselor burnout.

Vicarious Trauma and Secondary Traumatic Stress

According to Sabin-Farrell (2003) Vicarious Trauma actually encompasses Secondary Traumatic Stress in what the terms describe. It has been theorized that there is a cumulative transformative effect upon the trauma therapist from working with the survivors of traumatic life events and that this change can be called Vicarious Trauma (Pearlman & Saakvitne, 1995). It has also been suggested that "meaning of the traumatic event is in the survivor's experience of it (Pearlman & Saakvitne, p. 57)". When working with trauma survivors, counselors need to understand that the meaning making process is an ongoing and active process in which new information is constantly

being integrated, both for the client as well as themselves. This concept aligns well with Figley's work (1995) that outlined Secondary Traumatic Stress as a syndrome of symptoms nearly identical to Post Traumatic Stress Disorder. Figley and Kleber (1995) further suggested that Secondary Traumatic Stress was a natural consequence resulting from caring between two individuals when one is a victim of primary trauma and the other is indirectly affected. Research by Creamer and Liddle (2005) on disaster mental health workers from the 9/11 terrorist attacks in New York found that some of the risk factors that lead to higher levels of Secondary Traumatic Stress included heavier prior trauma case load, less professional experience, therapist discussion of their own trauma work in their own therapy, longer assignments, more time working with traumatized children, work with firefighters who suffered great losses, and work with clients discussing highly morbid material. Similarly, Pearlman and Saakvitne (1995) suggested that risk factors for VT included exposure to trauma patients, chronicity of trauma work, the individual's capacity for emotional empathy, and a history of personal trauma.

Secondary Traumatic Stress has been distinguished from Compassion Fatigue by Devilly, Wright, and Varker (2009) who suggest that, despite how often the terms are used interchangeably, the differences are that: CF often includes a burnout factor and a compassion satisfaction protective factor while the focus of Secondary Traumatic Stress is on how its symptoms parallel those of PTSD. Though these terms are forms of secondary stress that counselors experience as a result of caring, CF necessitates its own education and prevention strategies.

Compassion Fatigue Resilience: Positive Effects and Protective Factors

As stated previously, literature relating to CF and Secondary Traumatic Stress heavily focuses on the negative aspects of working with trauma survivors. Some of the causes and risk factors related to CF are: having no specialized training, being a younger professional, having a high percentage of PTSD clients in your caseload, and being an inpatient practitioner (Craig & Sprang, 2010). Additionally, proximity to the crisis situation, duration and intensity of exposure can influence levels of CF (Prati, Pietrantonio, & Cicognani, 2010). Other research focusing on the negative effects of trauma work considered how dysfunctional coping strategies, such as distraction and self criticism, could be correlated to higher levels of CF (Cicognani, Pietrantonio, Palestini, & Prati, 2009). While there are clear risks and consequences to this work, there are also positive effects, protective factors, and reasons why counselors elect to engage in this work that are not as widely published and discussed in the literature.

Leonard (2008) discussed a shift in the literature away from a focus on trauma work as being negative and hazardous to a focus on client strengths. It has been suggested that client strength and resilience (ability to maintain psychological stability in a traumatic situation) can lead to positive psychological outcomes from trauma work. Further, counselor resilience, defined as psychological growth that can be achieved through positive coping in light of adverse circumstances (Leonard). The rewards of working with trauma survivors can also include an increased sense of connection with clients, spiritual growth, an increased respect for the strength of the human spirit, and learning from witnessing the strength of their clients (Pearlman & Saakvitne, 1995). Compassion Satisfaction (Stamm, 2002) is a protective factor against CF that is comprised of the professional satisfaction that counselors experience from engaging in

their work. Resilience, Compassion Satisfaction, and the various other positive effects of counseling trauma survivors suggest that there are clearly defined advantages to working with this population despite the very real dangers and risks.

Protective Factors and Prevention

Various research suggests different preventative methods and protective factors that can help protect an individual from CF. According to Leonard (2008), lower levels of CF are associated with a greater sense of control over work, less paperwork, less disturbed clients, and a more manageable caseload (both in volume and severity). Additional research by Cicognani, Pietrantonio, Palestini, and Prati (2009) highlighted the role of work stress on the quality of life and CF of emergency workers. Their work focused on how CS has been positively correlated with efficacy beliefs, sense of community, and the use of active coping skills. This work goes further in correlating certain worker characteristics that promote higher levels of CS. The researchers suggested that length of service and level of expertise can lead to higher self efficacy and stronger use of active coping strategies. Feelings of belonging to their community where they live can also be a contributor to counselors and other mental health workers' sense of satisfaction. Thus, for a counselor working in a disaster area where they live and feel a part of the community, there is a protective factor in place in knowing that the work they are doing is as a part their own community.

Studying volunteers responding to the aftermath of Hurricane Katrina, Clukey (2010) found three themes among the responses of the relief workers that may be pertinent specifically to counselors working in these disaster situations. The three themes the research focused on were (a) emotional reactions, such as shock, fatigue, anger, grief, and sleep disturbance, (b) frustration with leadership, and (c) life changing

personal transformation. These themes confirm Leonard's (2008) belief that trauma work can positively affect counselors who are providing relief.

The impact of disaster work can lead to reflection on life meaning and, in some cases, allow workers to reassess their lives to the extent wherein they value their interpersonal relationships more and worried less about material possessions (Clukey, 2010). Craig and Sprang (2010) illustrated ways that individuals have effectively maintained higher levels of CS in response to adverse situations. According to their research, the use of evidence based practice is associated with higher levels of CS. Their assertion is that by utilizing evidence based practice, counselors are forced to continuously increase their knowledge base and subsequently have increased confidence in their ability to make decisions in crisis situations. The feeling of being capable of performing difficult tasks in a variety of disaster scenarios can serve as a protective factor against developing CF by enhancing CS (Craig & Sprang). However, there are ways to: (a) help alleviate Compassion Fatigue, (b) prevent it in some situations, and (c) increase CS. Though prior research focuses on the negative aspects of trauma work, the benefits are often under emphasized. Given the importance of trauma work, it is necessary to understand more fully the need for preparing counselors for this work so that they may be more readily able to address their own CF as well as that of their colleagues.

Need for Preparation of Disaster Mental Health Responders

Following the Oklahoma City Bombing in 1995, Disaster Mental Health Workers (DMHWs) were deployed to assist the survivors of the traumatic event. In a research study of these workers, a majority of the DMHWs scored as being high in risk for CF on the CF Self-Test for Helpers (Moore, 2004). The work that DMHWs do is very different

from that of the uniformed first responder. The uniformed first responder is trained to dissociate and ignore their feelings until the job is done, while the opposite is true for counselors and other mental health workers. Counselors have to engage the survivors and provide empathy and containment for the emotional trauma that may be overwhelming them. It is for this reason that counselors are at risk for CF (Ulman, 2008). The training involved in preparing these individuals for the difficult task of working with trauma survivors is essential for counselor efficacy. The question remains of whether or not more can be done to better prepare disaster mental health counselors for dealing with their own emotional responses to the work and subsequently the potential threat of compassion fatigue. While it has been stated that specialized training was a protective factor for those working with traumatized populations (Leonard, 2008), there was no mention of whether or not self care or CF prevention were a part of that specialized training. The idea that trauma counselors need advanced training with a component on their own emotional reactions is endorsed by (Clukey, 2010). The issues pertaining to this need for a deeper level of training at the emotional level would have to include education about compassion fatigue. Without an understanding of the potential dangers of CF, disaster mental health workers would have little context in which to understand why self care strategies are so important for them.

Clukey (2010) identified a need for research investigating the variables that support these workers and keep them supported so that the experienced workers stay healthy and effective in the field. Clukey's argument was for sustainability; if more is not done to sustain those who are willing and able to be disaster mental health counselors, then these individuals will eventually succumb to CF or burnout. Hence, there would be

fewer experienced authorities to support and develop these efforts. Clukey's work focused on sustaining individuals working with Hurricane Katrina volunteers and centered on predeployment education for workers. Other research suggests that as an adaptive strategy, professional development such as training and education would have benefits beyond simple knowledge gains (Craig & Sprang, 2010). The need for specialized training is serves as a protective factor for disaster mental health workers. Expanding that training to include Compassion Fatigue education and placing some levels of that training in the core academic training of counselors is endorsed in the literature. Though these authors have recommended these changes, little research has been focused on preventative education with Compassion Fatigue.

Research into the interventions for CF illustrates a significant gap in the literature. The research that is available focuses on primary, secondary, and tertiary prevention (Phelps, Lloyd, Creamer, & Forbes, 2010). At the primary level the focus is on identifying and minimizing stressors. The secondary level centers on early detection through self assessment. The tertiary level is meant to minimize the effects of CF and prevent further deterioration when the CF is already firmly in place. Though there is a large knowledge base to inform intervention strategies, the major focus of research into CF has been on definition and recognition rather than prevention and intervention (Phelps, Lloyd, Creamer, & Forbes, 2010). Current literature focuses on fixing present problems rather than more proactive approaches that might include CF education prior to being in the stressful situation.

Counselor Training and Preparation for Crisis Response and CF Prevention

In a study on applying critical consciousness as a training tool for counselors, Goodman and West-Olatunji (2009b) explored the need for counselors to be culturally

competent in order to provide disaster mental health services to communities in need. Utilizing culturally competence allows for the implementation of interventions that are informed by the cultural values of the population in crisis which subsequently enhances the efficacy of this approach (Goodman & West-Olatunji, 2009b). So aside from pointing out that counselors need to be culturally competent to be effective, this research shows that there are practical ways to improve pre-deployment education, whether at the master's degree level or immediately prior to deployment. This research showed one practical application that enhanced counselor efficacy, so it would seem that other training programs integrated into the education of counselors in training could at least have the potential to improve efficacy and perhaps even increase the sustainability of counselors and other DMHWs. In order to more fully understand how education for counselors working with disaster survivors can be improved, it is necessary to examine the CR education and training currently implemented to train counselors working in disaster mental health scenarios. The need for fast and effective interventions for trauma survivors is a top priority for disaster response training, but the focus of training appears to be on intervention training with survivors. Interventions such as Psychological First Aid are extremely useful in getting services to individuals in need (Ruzek, Brymer, Jacobs, Layne, Verberg, & Watson, 2007). However it is unclear what training is in place to effectively prepare counselors for the possibility of CF before it is a real danger.

Organizational Compassion Fatigue Training

The American Red Cross' website offered no evidence as to what if any mention is made of Compassion Fatigue in their training of Disaster Mental Health Workers (Red Cross, 2010). The Green Cross, a non-profit organization founded by Dr. Charles

Figley, provides crisis assistance and counseling as requested. Through this organization, an individual may obtain a certification as a Compassion Fatigue Educator or, with significantly more training, advance on to being a CF Therapist (Green Cross, 2010). This training would be a part of anyone's training who is deployed through the Green Cross, but these individuals do not necessarily have to have a specific level of education to receive this training. Uhernik (2008) highlighted the need for counselors to gain familiarity with the National Incident Management System and the Incident Command System. This recommendation comes as a response to the rising importance of the counselor in interdisciplinary disaster response teams (Uhernik, 2008). Uhernik's research furthers the idea that counselors have a growing role in the field of disaster response, and that the education for counselors to be better prepared for these situations is a vital and continuing process.

Academic Compassion Fatigue Training

There is no specific requirement for CF education in terms of the academic requirements of Counselor Education programs for crisis training. The Council for the Accreditation of Counseling and Related Educational Programs (CACREP) sets the standards for Counselor Education Programs (CACREP, 2009). The 2009 CACREP Standards highlight the eight core areas that Counselor Education students need to be familiar with and among these is Professional Orientation and Ethical Practice. This section states that:

Studies that provide an understanding of all of the following aspects of professional functioning: (c) counselors roles and responsibilities as members of an interdisciplinary emergency management response team during a local, regional, or national crisis, disaster, or other trauma causing event, and (d) self-care strategies appropriate to the counselor role. (CACREP, 2009, p. 9)

This section refers to the need for training and education for crisis intervention and for self care, but there is no apparent connection between the two issues as would be the case in the instance of CF Education.

Though there are various ways that CACREP institutions are working to implement disaster and crisis response training into their curricula, it is clear that there are some gaps in the education that they offer. However, there are still numerous programs and practices already in place in these institutions that offer ideal frameworks for potential application with CF education. Research by Goodman and West-Olatunji (2009a) explored how outreach, advocacy, service learning can be used to help counselor education students achieve praxis. As a means of implementing practical education while expanding upon issues of social justice, this research provides a method for CF education at the graduate level that could be utilized to both train counselors for future work with traumatized populations, while also improving their competence as a professional in the field of counseling (Goodman & West-Olatunji, 2009a).

CHAPTER 3 METHODOLOGY

Research into the field of post trauma counseling has yielded various issues pertaining to the stress that is experienced by counselors working with trauma survivors such as Secondary Traumatic Stress, Vicarious Trauma, Burnout, and Compassion Fatigue. Compassion Fatigue is possibly the least researched and understood of these terms, but has been shown to be an important issue impeding the efficacy, empathy, and functionality of counselors working with trauma survivors (Boscarino, 2004; Sabin-Farrel, 2003). Research based on the compassion fatigue experienced by Mental Health Counselors and other Mental Health Workers has suggested that further education and specialized training in disaster work can serve as protective factors against Compassion Fatigue (Craig & Sprang, 2010; Leonard, 2008). The framework for this study was quantitative and descriptive. The study consisted of correlational research focusing only variables that already existed within the sample population. This led the author to the following hypotheses and research questions:

Research Question 1: What is the relationship between Compassion Fatigue education prior to disaster response deployment and the levels of Compassion Fatigue?

Hypothesis 1: There is a relationship between Compassion Fatigue education, prior to disaster response deployment, and the levels of Compassion Fatigue for disaster mental health workers after the deployment period has ended.

Research Question 2: What is the relationship between Compassion Fatigue education in the degree level and levels of Compassion Satisfaction after the deployment period has ended.

Hypothesis 2: There is relationship between Compassion Fatigue education and levels of Compassion Satisfaction for disaster mental health workers after the deployment period has ended.

Research Question 3: What is the relationship between Compassion Fatigue education and levels of Compassion Satisfaction after the deployment period has ended.

Hypothesis 3: Compassion Fatigue education predicts higher levels of Compassion Satisfaction among disaster response mental health workers after the deployment period has ended.

Participants

The participants in this study consisted of a sample of 101 crisis responders who have worked previously in a mental health capacity as part of a larger disaster response effort. These participants were solicited from the membership of the Florida Crisis Response Team, a group comprised of individuals who have undergone training with the National Organization for Victim Assistance in order to (1) help local decision-makers identify all the groups at risk of experiencing trauma, (2) train the local caregivers who are to reach out to those groups after the FCRT has departed, and (3) lead one or more group crisis intervention, also known as psychological first aid, sessions to show how those private sessions can help victims start to cope with their distress (National Organization for Victim Assistance, 2010). This group was chosen specifically because they are required to receive some amount of Compassion Fatigue training as part of their NOVA training. These individuals had either direct experience in responding to disaster situations and working with trauma survivors, or had not been deployed with the FCRT yet. This population provided a sample of individuals who

have both gone through various types of disaster response training and, given their trauma work experience, may have a higher likelihood of developing Compassion Fatigue than mental health workers not working in disaster response. This population will consist of individuals from various mental health professions and backgrounds as well as various education levels. The participants were asked to participate in this research through a contact with the Florida Crisis Response Team and were e-mailed a link to an online Instrument with demographic questions.

Instruments

Demographic Questionnaire

The demographic portion of the questionnaire was comprised of questions regarding gender, ethnicity, profession, education level, number and length of deployments with the FCRT, and level of training on Compassion Fatigue. For a complete list of the demographic questions (Appendix D).

Stressful Life Experiences Screening – Short Form

The Stressful Life Experiences Screening – Short Form was utilized to establish the trauma history of the study participants. This information provides a base of knowledge for how much, if any, personal trauma the participants may have been affected by in their lives. This instrument uses Likert scale type questions to establish how well a statement reflects the experiences of that participant. Please see Appendix B for the entire form.

The Professional Quality of Life Scale

The Professional Quality of Life Scale: Compassion Satisfaction and Fatigue (ProQOL) Version 5 (Stamm, 2009) is a non-diagnostic tool developed initially by Dr. Charles Figley and later updated and refined by Dr. Beth Hudnall Stamm. The intent of

the scale is to measure levels of Compassion Satisfaction, Burnout, and Secondary Traumatic Stress. The authors of the scale clearly state that their definition of Compassion Fatigue is that it is comprised of two parts, one being Secondary Traumatic Stress and the other being Burnout. The scale is a useful tool for determining the likelihood that an individual may develop Compassion Fatigue. It is again important to note the CF is not a diagnosable condition and therefore this is not a diagnostic test, merely a screening and research tool for finding individuals who may potentially be struggling with Compassion Fatigue related issues. The scale is comprised of a total of 30 questions with 10 questions on each of the CS, BO, and STS subscales as mentioned earlier.

The reliabilities for each of the ProQOL subscales are as follows: the CS scale has a Chronbach $\alpha = 0.88$ (n=1130), the BO scale has a Chronbach $\alpha = 0.75$ (n=976), and the STS scale has a Chronbach $\alpha = 0.81$ (n=1135) (Stamm, 2009). The standard errors for these measures are 0.22 for CS, 0.21 for BO, and 0.20 for STS. The ProQOL manual cites good construct validity of the instrument based on the use of the instrument in over 200 published papers and the presence of over 100,000 articles about it on the internet (Stamm, 2009). The Burnout, Secondary Traumatic Stress, and Compassion Satisfaction scales measure separate constructs. The CF scale, comprised of Burnout and Secondary Traumatic Stress, is distinct. The inter- scale correlation with Secondary Traumatic Stress is 2% shared variance ($r = -.23$; $co-\sigma = 5\%$; n=1187). The inter-scale correlation with Burnout is 5% shared variance ($r = -.14$; $co-\sigma = 2\%$; n=1187). Though there is shared variance, the Burnout and Secondary Traumatic Stress scales measure different constructs. The shared variance can be attributed to the common

areas assessed by the two scales. The ProQOL manual reports the shared variance between the Burnout and Secondary Traumatic Stress scales at 34% ($r=.58$; $\text{co-}\sigma = 34\%$; $n=1187$). Each scale is similar, but there are variations such as the subject of fear in the Secondary Traumatic Stress Scale (Stamm, 2009).

Protocols

Informed consent was approved by the Institutional Review Board (IRB) of the University of Florida (Appendix A). Solicitation to participate in the study was made to the available members of the Florida Crisis Response Team through a designated contact with the FCRT by e-mail. Participation was voluntary and there was no compensation offered. Participants had access to an online survey that included the ProQOL 5 instrument, the Stressful Life Experiences Screening – Short Form, and demographic questions. All participants were given notice at the end of the informed consent form that proceeding implied their consent. Their responses were collected in the online survey system.

Data Analysis

Based on previous studies (Leonard, 2008) the correlation could be found to be between .2 and .1. For power to be .7 to detect the effect we would need an approximate sample of 614. If the correlation is .15 for power to be .7 to detect the effect we would need a sample of 271. If the correlation is .2 for power to be .7 to detect the effect we would need a sample of 151. Since we did not know what the correlation was going to be, we took the most conservative estimate, which is a correlation of .1, and therefore attempted to gain a sample of 614. For hypothesis and question 1, a MANCOVA was conducted with the data. For hypothesis and question 2, an ANCOVA was conducted using two independent variables: Deployment status and Compassion

Fatigue Training. For hypothesis and question 3, an ANCOVA was conducted using three independent variables: Deployment status, Compassion Fatigue training, and Profession Group.

Limitations

Limitations of this study include the non-random nature of the sampling process, the bias of the study toward individuals who favor the use of e-mail over standard mail, and the multidisciplinary nature of the study. Further limitations include the lack of a specific instrument for measuring Compassion Fatigue alone rather than as a combination of Secondary Traumatic Stress and Burnout. Other limitations in the study included the indirect distribution of the survey to FCRT members. The survey, by necessity was sent through the director of the FCRT who maintains the membership lists. Thus, the researchers did not have direct access and had no control over the frequency of the distribution. This also meant that there was an unknown percentage of members of the FCRT who were not Internet accessible. Any undeliverable messages would not have been sent to the researchers, but rather to the FCRT director. There was no real way to know how many members of the team were actively receiving the invitation to participate in the survey.

CHAPTER 4 RESULTS

This chapter presents the results from this posttest-only quasi-experimental study looking at the hypothesized effects of Compassion Fatigue education on the levels of Compassion Fatigue and Compassion Satisfaction that participants self-reported in the online survey, while also looking at their history of traumatic experiences. For hypothesis and question 1, a MANCOVA was conducted with the data. For hypothesis and question 2, an ANCOVA was conducted using two independent variables: Deployment status and Compassion Fatigue Training. For hypothesis and question 3, an ANCOVA was conducted using three independent variables: Deployment status, Compassion Fatigue training, and Profession Group.

Demographics

The participants in this study were sampled from 800 potential total members of the Florida Crisis Response Team (FCRT). These members were contacted by a mass email from the director of the FCRT, inviting members to participate in the study. This invitation included a summary, purpose of the study, and a link to the online survey. At the end of a month 101 participants had attempted to complete the survey, providing a 12.6% response rate.

The sample included 73 females, 9 males, and 28 non-answers with a mean age of 51 years old ($M = 50.575$, $SD = 10.509$). The sample's ethnicities consisted of 66.33% White, 6.93% Black, 5.94% Latino, 2.97% Multicultural, and 17.8% non-answers. The professional groups to which the participants belonged were simplified into three, this included Advocates, 35.6% ($N = 36$), followed by Other professions,

29.7% (N = 30), and Mental Health professionals, 28.7% (N = 29). Demographic frequencies can be found in Tables 4-1 through 4-9.

Results of the Data Analysis

Statistical analyses were performed using the Statistical Package for Social Sciences (SPSS ®) Version 19 and the R statistical software version 2.13. The data was examined for accuracy of data entry, missing values, outliers, multicollinearity, and the model assumptions were tested and were found to not violate any of the assumptions. Preliminary independent samples t-tests were conducted to determine if there were any group differences between the independent variables (demographics) and the dependent variables (CS, BO, and STS). Independent t-tests showed no significant differences.

Hypothesis 1

Hypothesis 1 stated that there would be relationship between Compassion Fatigue Training (present or not present) and Deployment status (either pre or post deployed) on the level of Compassion Fatigue.

A multivariate analysis of covariance (MANCOVA) was used to examine these effects, using Trauma History as the covariate. The dependent variables in this analysis were the two subscales on the ProQOL: Burnout(BO) and Secondary Traumatic Stress(STS), that make up Compassion Fatigue as described by Stamm (2010). Assumptions of homogeneity of variance and equality of Covariance were held as shown by Levene's test and Box's M test. The results of data with missing values indicated that the model does not significantly predict an effect for Deployment status (pre or post deployed) (Pillai's trace = 0.019, $F(2,61) = 0.607$, $p > 0.05$), Compassion Fatigue Training (Pillai's trace = 0.027, $F(2,61) = 0.833$, $p > 0.05$), or for the covariate

Trauma History (Pillai's trace = 0.067, $F(2,61) = 2.202$, $p > 0.05$) (see Table 11). This model had a sample of 66 out of 101, which is 65.3% of the total collected data. None of the interactions were significant and so were not included in the model.

Hypothesis 2

Hypothesis 2 stated that there would be a relationship between Compassion Fatigue Training (present or not present) and Deployment status (either pre or post deployed) on the level of Compassion Satisfaction.

An analysis of covariance (ANCOVA) was used to examine these effects in order to allow for greater power, sensitivity, and accuracy for the small sample size as well as accounting for and reducing the error variance (Field, 2009). With the inclusion of Trauma History as a covariate, the results of data with missing values indicated that the model does not significantly predict any effects for Deployment status (either pre or post deployed) ($F(1,62) = 3.519$, $p = 0.0654$) or Compassion Fatigue Training (present or not present) ($F(1,62) = 3.433$, $p = 0.0687$) (see Table 15). This model included 66 participants, providing 65.3% of the total collected sample.

Hypothesis 3

Hypothesis 3 stated that there would be a relationship between Compassion Fatigue Training (present or not present), Profession Group membership, and Deployment status (either pre or post deployed) on the level of Compassion Satisfaction.

With the inclusion of Trauma History as a covariate, the results of the ANCOVA indicated that Compassion Satisfaction significantly differed on the nature of Deployment status (pre or post) ($F(1,59) = 4.546$, $p < 0.05$, $\eta^2 = 0.0018$). Deployment status accounted for 0.18% of variance in Compassion Satisfaction. Compassion

Satisfaction significantly differs on Compassion Fatigue Training ($F(1,59) = 6.3697, p < 0.05, \eta^2 = 0.0025$). Compassion Fatigue Training accounted for 0.25% of variance in Compassion Satisfaction. Compassion Satisfaction significantly differs on the profession of the participants ($F(2,59) = 3.473, p < 0.05, \eta^2 = 0.0028$). Profession of participants accounted for 0.28% of variance in Compassion Satisfaction (see Table 17).

The post hoc test identified that individuals who were post deployment had higher compassion satisfaction scores than those that had never been deployed at all ($M_{\text{post}} - M_{\text{pre}} = 1.955, SE = 0.917, p < 0.05$). Participants that had Compassion Fatigue Training had higher Compassion Satisfaction scores than those without training ($M_{\text{CFtrain}} - M_{\text{NoCFtrain}} = 2.221, SE = 0.880, p < 0.05$). Children and Victim Advocates had significantly higher compassion satisfaction scores than those in the Other Professions group ($M_2 - M_3 = 2.745, SE = 1.045, p < 0.05$), but were not significantly different than Mental Health professionals ($M_2 - M_1 = 1.361, SE = 1.062, p > 0.05$). The Mental Health professionals were not significantly different from the Other Professions category either ($M_1 - M_3 = 1.384, SE = 1.138, p > 0.05$). This is possibly due to small effect size and small sample sizes within the cells. Trauma History accounted for 0.17% of variance in Compassion Satisfaction and showed a negative relationship with the dependent variable. None of the interactions were significant and so were not included in the model. The Levene's test was used and homogeneity was held. Homogeneity of regression slopes was also held as shown by interaction graphs. This model included 65 participants, providing 64.4% of the total collected data.

The MANCOVA for Question and Hypothesis 1 did not yield any significance, nor did the ANCOVA for Question and Hypothesis 2. The overall results of the study only

showed significance in Question and Hypothesis 3. The post hoc for this question yielded the finding that individuals who were post deployment had higher compassion satisfaction scores than those that had never been deployed at all. The significance of these results and further recommendations will be discussed in the section to follow.

Table 4-1. Age

	N	Non-Answers	Min	Max	Mean
Age	73	28	29	69	50.575

Table 4-2. Gender

Gender	Frequencies	Percentage	Missing
Female	73	72.28	
Male	9	8.91	
Total	82		19

Table 4-3. Race and ethnicity

Ethnicity	Frequencies	Percentage	Missing
White	67	66.34	
Black	7	6.93	
Hispanic/Latino	6	5.94	
Multicultural	3	2.97	
Total	83		18

Table 4-4. Profession

Profession	N	Frequencies	Percentage	Missing
Mental Health Professionals	19	29	28.7	
	5			
	3			
	2			
Advocates	34	36	35.6	
	2			
Other Professions	10	30	29.7	
	20			
Total	95			6

Table 4-5. Compassion Fatigue education

Compassion Fatigue Education	N	Frequencies	Percentage	Missing
No Training		31	30.69	
Any Training	8	50	49.5	
	15			
	6			
	32			
	13			
Total	81			20

Table 4-6. Education level

Education Level	Frequencies	Percentage	Missing
High School	5	4.95	
Associate's Degree	7	6.931	
College Degree	27	26.73	
Master's Degree	29	28.71	
Doctorate or Prof. Degree	13	12.87	
Other	1	0.99	
Total	82		19

Table 4-7. Descriptive frequencies for deployment length

Deployment Length	N	Non-Answers	Min	Max	Mean	SD
Shortest Deployment	65	36	0	10	1.231	1.529
Longest Deployment	64	37	0	180	8.813	24.629

Table 4-8. Descriptive frequencies for categorical individual variables

Deployment Region	Frequencies	Percentage	Missing
Local	37	36.63	
Florida	32	31.68	
National	4	3.96	
Total	73		28

Table 4-9. Deployment status

	Frequencies	Percentages	Missing
Deployment Status			
Pre (never been deployed)	23	22.77	
Post (has been deployed)	51	50.50	
Total	74		27

Table 4-10. Analysis of covariance tests with CS (Dataset with missing data)

Independent Variable	Sum Sq	Df	F value	Pr(>F)	η^2
(Intercept)	27783.3	1	2433.66	< 2e-16**	
Deployment Status(pre/post)	51.89	1	4.546	0.037**	0.0018
Compassion Fatigue Training	72.72	1	6.370	0.014**	0.0025
Reduced Professional Groups	79.29	2	3.473	0.038**	0.0028
Trauma History	49.63	1	4.347	0.041**	0.0017
Residuals	673.56	59			
Corrected Total	28710.39	64			

** $p < .05$

CHAPTER 5 DISCUSSION

Significance Of Findings

Results of this study showed that Compassion Fatigue education was a significant predictor of having higher levels of Compassion Satisfaction and that a lack of Compassion Fatigue education could predict higher levels of Compassion Fatigue. These results confirm and strengthen Stamm's assertion that Compassion Fatigue and Compassion Satisfaction are on a spectrum in which the higher the CS, the lower CF will be (Stamm, 2002). These results suggest a reduction of Compassion Fatigue risk and that, with CF education, people are finding their disaster response work to be more fulfilling, satisfying, and sustaining.

A primary purpose of this study was to seek out ways to improve the sustainability of disaster response counselors. The results of this study suggest that Compassion Fatigue education, by improving Compassion Satisfaction, reduces Compassion Fatigue. In knowing that CF education protects disaster response counselors, it is important for the further implementation of CF education in both formal and informal training to enhance the sustainability and well being of responders. By implementing this training for graduate students in CACREP programs as well as informally through workshops for responders prior to deployment, responders will be more likely to be sustained, happy, and useful.

The significance of this study's results is that Compassion Fatigue education can act a protective and sustaining factor for responders, while simultaneously increasing the levels of Compassion Satisfaction for responders and reducing their Compassion Fatigue levels following their deployment. The significance of this relationship suggests

the need for further education on Compassion Fatigue at various levels prior to responder deployment.

There are many professionals who work in disaster response beyond just mental health disaster responders. For these individuals, whether nurses, victim, advocates, or law enforcement members, these results are important as well. Compassion Fatigue training can act as a sustaining and protective factor for these individuals too and should be a part of their training and preparation just the same as for mental health counselors. Any profession working in disaster response could benefit from including CF training as part of the disaster response preparation and training.

Increased exposure to trauma was related to a decrease in Compassion Satisfaction, but this study was unable to ascertain whether the trauma exposure was witnessed or experienced. The Stressful Life Experiences Short Form did not delineate between whether the participant directly experienced the trauma or if they were a witness to it.

Recommendations for Counselors

The results of this study suggest that Compassion Fatigue education needs to be implemented much more systematically to provide for more prepared professionals with decreased risk of Compassion Fatigue. Current disaster response training can be broken down into formal and informal training, with formal preparation taking place at the academic or institutional level and informal preparation taking place at the organizational level prior to deployment for responders. Compassion Fatigue education needs to be more thoroughly integrated into these systems to better prepare and protect responders. CACREP institutions that already have disaster response training requirements for their curricula can improve their Compassion Fatigue education in

several ways. Rather than just briefly mentioning Compassion Fatigue during a disaster response lecture, CF education could be given an entire lesson. If this were done throughout the entire curriculum, with one lesson per course, the students prepared by CACREP programs would graduate with an incredible level of preparation for disaster response work. Additionally, training on Compassion Fatigue could be modeled after the Culture Center model (Goodman & West-Olatunji, 2009a). By giving students the opportunity to put their CF education and disaster response training into practice prior to graduation and deployment, CACREP programs could produce more graduates prepared to be disaster responders with reduced Compassion Fatigue risk. The goal of having CACREP institutions implement all of this training is to provide training for counselors that would exceed that of informal responder preparation. Programs not affiliated with CACREP could adopt a similar approach to their curricula as the CACREP programs, by implementing required Compassion Fatigue training and education that would prepare future responders to be able to respond effectively across the world.

Another recommendation would be for additional certifications on Compassion Fatigue that are more advanced and rigorous than the trainings already available. An online or in person training program for disaster mental health responders would provide more advanced training on Compassion Fatigue for any individual looking to be a better prepared responder. The goal of this training would be to provide a more thorough and advanced level of preparation than what is already offered by preparation organizations. Having multiple courses that culminate in the awarded certification could provide a greater depth and understanding of Compassion Fatigue than what one might receive from some of the training organizations.

Informal training for groups or organizations about to deploy should always include some form of Compassion Fatigue training. Even if it is limited to a one hour workshop on Compassion Fatigue education and prevention, it would still provide a measure of protection for the responders prior to deployment. The results of this study suggest that Compassion Fatigue education has a significant relationship with higher levels of Compassion Satisfaction. It then would follow that informal trainings should include CF education in order to better prepare responders. If a simple workshop on Compassion Fatigue can increase the likelihood of high Compassion Satisfaction and subsequently lowered risk of Compassion Fatigue, it absolutely should be considered an integral part of the training process.

Future Research

One of the greatest difficulties of this study was finding an instrument that could effectively evaluate Compassion Fatigue levels. The Professional Quality of Life Scale is a useful instrument, but it is also the only instrument. Future research should focus on developing new instruments to measure Compassion Fatigue and Compassion Satisfaction. Further development of the Compassion Fatigue and Satisfaction constructs could allow for assessment instruments that could give a clearly defined score for Compassion Fatigue or Satisfaction. The current framework of measuring Compassion Fatigue requires it to be broken down into Secondary Traumatic Stress and Burnout sub scores. New constructs for Compassion Fatigue and Satisfaction could eliminate this breakdown, thus allowing for greater focus on Compassion Fatigue rather than vague components that may overlap to contribute to Compassion Fatigue. A clear construct for Compassion Fatigue would give more credibility and definition to the concept of CF, rather than having to rely on related concepts for which there is no

clear delineation how or if they overlap to contribute to Compassion Fatigue. Further research into a Compassion Fatigue instrument could allow for better assessment of CF levels. This advantage is essential for two reasons. First it would allow for better evaluation of those individuals who are at risk of developing Compassion Fatigue. Second, it would allow for more specific research to be developed in advancing knowledge about Compassion Fatigue. An instrument that evaluates Compassion Fatigue in its own right would give more credibility to the existence of Compassion Fatigue and would be invaluable in advancing research about Compassion Fatigue. Further research into a new instrument for measuring Compassion Fatigue and Compassion Satisfaction is essential and could further advance what is already known about Compassion Fatigue.

Further research should also investigate the relationship between length of deployment, type of deployment, exposure to trauma (personal), and exposure to trauma (vicarious). This additional research could advance understanding about how these specific variables may impact levels of Compassion Fatigue and Compassion Satisfaction in disaster response mental health workers.

It is also recommended that there be repeated measures to determine factors that make disaster responders at risk for compassion fatigue. Knowing these primary risk factors could help responders, supervisors, and response organizations to identify, remove, or control for the risk factors.

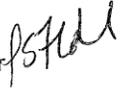
APPENDIX A
INSTITUTIONAL REVIEW BOARD DOCUMENTS

UF Institutional Review Board
UNIVERSITY of FLORIDA

PO Box 112250
Gainesville, FL 32611-2250
352-392-0433 (Phone)
352-392-9234 (Fax)
irb2@ufl.edu

DATE: February 3, 2011

TO: Steven Vutsinas

FROM: Ira S. Fischler, PhD, Chair 
University of Florida
Institutional Review Board 02

SUBJECT: Approval of Protocol #2011-U-0047

TITLE: Compassion Fatigue Education as a Protective Factor Against Compassion Fatigue

SPONSOR: None

I am pleased to advise you that the University of Florida Institutional Review Board has recommended approval of this protocol. Based on its review, the UFIRB determined that this research presents no more than minimal risk to participants, and based on 45 CFR 46.117(c), An IRB may waive the requirement for the investigator to obtain a signed consent form for some or all subjects if it finds either: (1) *That the only record linking the subject and the research would be the consent document and the principal risk would be potential harm resulting from a breach of confidentiality. Each subject will be asked whether the subject wants documentation linking the subject with the research, and the subject's wishes will govern; or (2) That the research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context.*

The IRB authorizes you to administer the informed consent process as specified in the protocol. If you wish to make any changes to this protocol, ***including the need to increase the number of participants authorized***, you must disclose your plans before you implement them so that the Board can assess their impact on your protocol. In addition, you must report to the Board any unexpected complications that affect your participants.

This approval is valid through **January 25, 2012**. If you have not completed the study by this date, please telephone our office (392-0433), and we will discuss the renewal process with you. It is important that you keep your Department Chair informed about the status of this research protocol.

ISF:dl

Informed Consent

Protocol Title: *Compassion Fatigue Education as a Protective Factor Against Compassion Fatigue*

Please read this consent document carefully before you decide to participate in this study.

Purpose of the research study: The purpose of this study is to examine the relationship between the Compassion Fatigue training of Florida Crisis Response Team (FCRT) members prior to deployment and their levels of Compassion Fatigue after the end of their deployment.

What you will be asked to do in the study: Following completion of demographic questions, you will be asked a series of questions pertaining to your experience as a member of the Florida Crisis Response Team (FCRT). These questions will focus on your experiences prior to deployment, during deployment, and after deployment.

Time required: Approximately 30 minutes

Risks and Benefits: It is possible that you may experience minimal psychological discomfort in having to recall the experiences involved with responding to crises as a member of the FCRT. If you'd like to discuss any issues raised by the surveys, you can call 1-800-273-TALK(1-800-273-8255), or visit this [link](#) for a list of Florida help lines. We do not anticipate that you will benefit directly by participating in this experiment.

Compensation: You will receive no compensation for participating in this research.

Confidentiality: Responses will be anonymous - no email, names or IP address will be saved.

Voluntary participation: Your participation in this study is completely voluntary. You can skip any item or question you don't want to answer. There is no penalty for not participating.

Right to withdraw from the study: You have the right to withdraw from the study at anytime without consequence.

Whom to contact if you have questions about the study:

Steven Vutsinas, Graduate Student, Counselor Education Program, School of Human Development and Organizational Studies (HDOSE), mbasteve@ufl.edu

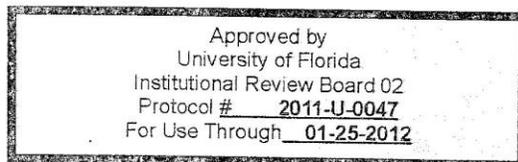
Cirecie West-Olatunji, Ph.D., Counselor Education Program, School of Human Development and Organizational Studies (HDOSE), 1204 Norman Hall, (352)273-4324, cwestolatunji@coe.ufl.edu

Whom to contact about your rights as a research participant in the study:

IRB02 Office, Box 112250, University of Florida, Gainesville, FL 32611-2250; phone 392-0433.

Agreement: I have read the procedure described above. I voluntarily agree to participate in the procedure and I have received a copy of this description.

If you agree to participate, [click here](#). (Will be linked to survey)



E-solicitation Script for UFIRB #2011-U-0047 (Compassion Fatigue Education as a Protective Factor Against Compassion Fatigue)

Dear potential Florida Crisis Response Team member,

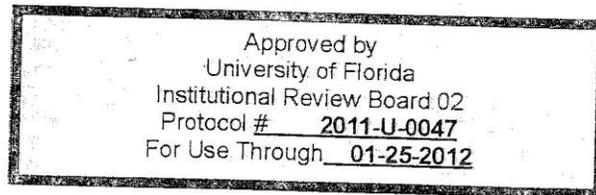
My name is Steven Vutsinas and I am a masters/specialist student in the mental health counselling program at the University of Florida. I am contacting you to invite you to participate in a research study entitled, "Compassion Fatigue Education as a Protective Factor Against Compassion Fatigue." I am conducting this investigation under the supervision of my advisor, Dr. Cirecie West-Olatunji, an associate professor in Counselor Education. This study explores the relationship between Compassion Fatigue Education and Compassion Fatigue Levels in members of the Florida Crisis Response Team.

Participation in the study involves the completion of an online survey that also includes some background information and should take approximately 20 minutes to complete.

Your participation in the study is completely voluntary. You may withdraw from participating in the study now, or at any point while participating. You are not required to include your name at any point in the survey; responses will be anonymous - no email, names or IP address will be saved. Individual data will be collected and used as part of a larger database of information for reporting. Only the researchers (Steven Vutsinas and Cirecie West-Olatunji, Ph. D.) will have access to individual data. For more information about the study, feel free to contact me via email (mbasteve@ufl.edu) or my research supervisor, Dr. West-Olatunji (cwestolatunji@coe.ufl.edu) via telephone: (352) 273-4324.

I thank you for your time and consideration. **To participate in the study, please follow the link here.**

Steven Vutsinas
Principal Investigator
UFIRB #2011-U-0047



APPENDIX B
STRESSFUL LIFE EXPERIENCES SCREENING – SHORT FORM

We are interested in learning about your experiences. Below is a list of experiences that some people have found stressful. Please fill in the number that best represents how much of the following statements describe your experiences. If you are not sure of your answer, just give us your best guess.

Describes your Experiences (use in Describes Experiences Column)

1	2	3	4	5	6	7	8	9	10
I did not exp.	A little like my exp.			somewhat like my experiences					exactly like my experiences

Describes Experience	Life Experience
	I have witnessed or experienced a natural disaster; like a hurricane or earthquake.
	I have witnessed or experienced a human made disaster like a plane crash or industrial disaster.
	I have witnessed or experienced a serious accident or injury.
	I have witnessed or experienced chemical or radiation exposure happening to me, a close friend or a family member.
	I have witnessed or experienced a life threatening illness happening to me, a close friend or a family member.
	I have witnessed or experienced the death of my spouse or child.
	I have witnessed or experienced the death of a close friend or family member (other than my spouse or child).
	I or a close friend or family member has been kidnapped or taken hostage.
	I or a close friend or family member has been the victim of a terrorist attack or torture.
	I have been involve din combat or a war or lived in a war-affected area.
	I have seen or handled dead bodies other than at a funeral.
	I have felt responsible for the serious injury or death of another person.
	I have witnessed or been attacked with a weapon other than in combat or family setting.
	As a child/teen I was hit, spanked, choked or pushed hard enough to cause injury.
	As an adult, I was hit, choked or pushed hard enough to cause injury.
	As an adult or child, I have witnessed someone else being choked, hit, spanked, or pushed hard enough to cause injury.
	As a child/teen I was forced to have unwanted sexual contact.
	As an adult I was forced to have unwanted sexual contact.
	As a child or adult I have witnessed someone else being forced to have unwanted sexual contact.
	I have witnessed or experienced an extremely stressful event not already mentioned. Please explain:

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APPENDIX C

PROFESSIONAL QUALITY OF LIFE SCALE, VERSION 5

© B. Hudnall Stamm, 2009. *Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL)*.
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(b) no changes are made, and (c) it is not sold. |

PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)

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

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

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

1. I am happy.
2. I am preoccupied with more than one person I [help].
3. I get satisfaction from being able to [help] people.
4. I feel connected to others.
5. I jump or am startled by unexpected sounds.
6. I feel invigorated after working with those I [help].
7. I find it difficult to separate my personal life from my life as a [helper].
8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].
9. I think that I might have been affected by the traumatic stress of those I [help].
10. I feel trapped by my job as a [helper].
11. Because of my [helping], I have felt "on edge" about various things.
12. I like my work as a [helper].
13. I feel depressed because of the traumatic experiences of the people I [help].
14. I feel as though I am experiencing the trauma of someone I have [helped].
15. I have beliefs that sustain me.
16. I am pleased with how I am able to keep up with [helping] techniques and protocols.
17. I am the person I always wanted to be.
18. My work makes me feel satisfied.
19. I feel worn out because of my work as a [helper].
20. I have happy thoughts and feelings about those I [help] and how I could help them.
21. I feel overwhelmed because my case [work] load seems endless.
22. I believe I can make a difference through my work.
23. I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].
24. I am proud of what I can do to [help].
25. As a result of my [helping], I have intrusive, frightening thoughts.
26. I feel "bogged down" by the system.
27. I have thoughts that I am a "success" as a [helper].
28. I can't recall important parts of my work with trauma victims.
29. I am a very caring person.
30. I am happy that I chose to do this work.

APPENDIX D
DEMOGRAPHIC QUESTIONS

1. What is your current profession?

- Counselor
- Psychologist
- Nurse
- Nurse Practitioner
- Medical doctor
- Psychiatrist
- Other (Please Specify in 30 characters or less)

2. What is the highest level of education you have obtained?

- High School Diploma
- Associate's Degree
- College Degree
- Master's Degree
- Doctorate or other Professional Degree
- Other (Please Specify)

3. What is your date of birth? (MM/DD/YYYY)

4. What is your gender?

- Female
- Male
- Other (Please Specify)

5. By what ethnicity do you identify yourself?

- Asian
- Pacific Islander
- Black
- Hispanic
- Native American
- White
- Other (Please Specify)

6. As an FCRT member, where have the majority of your deployments been?

- Local (near where you live)
- Within Florida
- National

7. Have you had additional training on Compassion Fatigue outside of FCRT training and if so at what level? (Check all that apply)

- No
- College
- Master's Program
- Doctoral or other Professional Program
- Other relief or assistance organization
- Independent Research

8. How many times have you been deployed for the FCRT? (Approximate Number of Times)

9. How long was your longest deployment? (# Months, # Weeks, # Days)

10. How long was your shortest deployment? (# Months, # Weeks, # Days)

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BIOGRAPHICAL SKETCH

Steven Vutsinas is a native of Nashville, Tennessee. He obtained his Bachelor of Science degree in Family, Youth, and Community Science with a minor in Organizational Leadership for Non-Profits, as well as a Bachelor of Arts in Classical Studies from the University of Florida. Steven received his Master of Arts in Education from the University of Florida in the summer of 2011.