

PERCEIVED WORKING CONDITIONS AND PERSONAL RESOURCES PREDICTING  
MENTAL HEALTH COUNSELOR WELL-BEING

By

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To my families and teachers – you illuminate my life

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## LIST OF TERMS

APPRAISAL	The transactional process of evaluating perceived harm, threat or challenge in the environment (Lazarus & Folkman, 1984, p. 294).
BURNOUT	Emotional exhaustion, depersonalization, and lack of personal accomplishment (Maslach, Schaufeli, & Leiter, 2001), "the process of physical and emotional depletion resulting from conditions at work or, more concisely, prolonged job stress" (Osborn, 2004. P.319).
COMPASSION FATIGUE	Compassion fatigue is conceptualized as emotional fatigue brought on by caring for traumatized clients; it emerges as the result of hearing about clients' traumatic experiences (Figley, 1995).
COMPASSION SATISFACTION	Compassion satisfaction is a term that describes the sense of satisfaction that mental health professionals experience as a result of their clinical work with clients (Stamm, 2002).
COPING	"The person's constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the person's resources" (Folkman, et al., 1986, p. 993).
COWORKER SUPPORT	perception of emotional and instrumental support from coworkers.
EMOTION-FOCUSED COPING	healthy coping strategies focused on managing the emotional response to the perceived stressor, through processes such as social support and exercise programs
GENDER	a person's biological/social status as a man or a woman
LENGTH OF TIME IN FIELD	a counselor's overall number of years of experience providing clinical services in the counseling field, excluding internship hours earned during a master's level graduate degree
MALADAPTIVE COPING	unhealthy coping strategies that may address the perceived stressors in the short term, but lead to negative effects overall (e.g. substance use, self-blame). The term 'maladaptive' describes the negative outcomes that certain types of coping strategies may have.
MINDFULNESS	paying complete attention in the present moment, with moment-to-moment non-judgmental awareness (Kabat-Zinn, 1994).

NEGATIVE WORKING CONDITIONS	workplace factors such as difficult or distressing clientele, lack of administrative and collegial support, unsupportive overall work environment.
POSITIVE WORKING CONDITIONS	workplace factors such as the nature of clientele, the nature of administration, collegial support, overall work climate, and other working conditions.
PRIMARY APPRAISAL	the process by which an individual evaluates a situation to determine if it irrelevant, benign-positive, or stressful (Lazarus & Folkman, 1984).
PROBLEM-FOCUSED COPING	healthy coping strategies using concrete solutions to address the perceived problem directly.
PSYCHOLOGICAL STRESS	“a relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being” (Lazarus & Folkman, 1984, p.21).
SECONDARY APPRAISAL	The process in which an individual assesses how to respond to a situation (Lazarus & Folkman, 1984).
SELF-CARE PRACTICES	Self-care practices are the means by which people renew and energize themselves by continually replenishing the sources that sustain them: “Self-care means finding ways to replenish the self.” (Skovholt, 2001, p. 147).
STRESS	“physical, mental, or emotional strain or tension” “a situation, occurrence, or factor causing this” (definition retrieved from Dictionary.com)
TRANSACTION	A transaction is basically a challenge that creates an adaptive response
WELL-BEING	“a subjective state consisting of the absence of psychological distress (i.e., anxiety or depression) and the presence of positive emotional states (i.e., general positive affect and behavioral/emotional control)” (McCarthy, 2006, p.23).

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This study examined the influence of counselor perceived working conditions, length of time in field, counselor gender, mindfulness attitudes, compassion satisfaction, emotion-focused coping, problem focused coping, and maladaptive coping on levels of burnout and compassion fatigue in a sample of 213 mental health counselors. Cross-sectional survey research methods were used. Counselor perceived working conditions, length of time in the field, gender, mindfulness, compassion satisfaction, emotion-focused coping, problem-focused coping, and maladaptive coping were predictive of 66.9% of the amount of variance in reported burnout scores among mental health counselors in this sample. However, these same factors were predictive of only 33.1% of the variance in the level of compassion fatigue reported by mental health counselors in this sample. Discussion of the results and implications for counseling training and practice are presented along with recommendations for future research.

## CHAPTER 1 INTRODUCTION

There is a growing awareness of the possible hazards of working in the counseling profession. The qualities that make counselors effective with clients - such as their empathy, connection, and caring - also make them vulnerable to the hazards of burnout, compassion fatigue, secondary traumatic stress, and vicarious traumatization. Moreover, mental health counselors are likely to counsel clients who have been traumatized due to the prevalence of trauma in this country, even if they do not specialize in trauma therapy (Williams, Helms, & Clemens, 2012).

Over the past two decades researchers have used a variety of approaches to study the nature of counselor job stress and its consequences. Initially, researchers attempted to identify the potentially negative consequences of caring for others through the conceptualization of the phenomena of burnout and compassion fatigue (Figley, 1995). Not only did researchers devote time to identifying the characteristics of burnout (e.g. emotional exhaustion, depersonalization, and excessive emotional detachment) and compassion fatigue (e.g. lack of appropriate empathetic response to clients); they also examined the extent and prevalence of burnout and compassion fatigue and the possible causes and contributors. For example, researchers examined the working conditions that might contribute to counselor stress by studying the volume, nature, and severity of client problems. A second line of research focused on identifying salient work place characteristics that serve to buffer counselors from negative working conditions, such as the impact of workplace staff support (Ducharme, Knudsen, & Roman, 2008). A third line of research has focused on exploring counselor characteristics that buffer stressful working conditions and contribute to counselor well-

being, such as individual wellness choices or the use of self-care practices (Venart, Vassos, & Pritcher-Heft, 2007; Skovholt, 2001). Researchers have also begun to examine the positive effects of working as a therapist, such as compassion satisfaction (Stamm, 2010) and post-traumatic growth (Tedeschi & Calhoun, 1996).

Another area of research has focused on the usefulness of mindfulness attitudes and practices in reducing stress levels. For example, there has been an increase of mindfulness research occurring with the advent of Jon Kabat-Zin's Mindfulness-Based Stress Reduction (MBSR) program. This research has begun to enter the counseling arena, as researchers have examined the impact of mindfulness training in counselor preparation. For example, Greason and Cashwell (2009) examined connections between self-efficacy, attention, and empathy and mindfulness among counselors-in-training. The impact of mental health counselors' mindfulness attitudes on their self-care and well-being has also been explored (Richards, Campenni, & Muse-Burke, 2010). Despite research linking mindfulness to stress reduction outcomes (Carlson & Garland, 2005), research exploring mindfulness and its potential impact on counselor compassion fatigue and burnout is needed. The current study seeks to explore how mental health counselors' mindfulness attitudes predict their levels of burnout and compassion fatigue.

What has been missing from conceptualizations of counselor stress, coping and well-being is the recognition of the interactive nature of a counselor's perception of a work condition, their perception of their personal and environmental resources for coping with this condition, and their actual stress reaction. Transactional stress and coping theory (Lazarus & Folkman, 1984) provides such a lens by conceptualizing both

the contextual factors that counselors may experience as stressors and the importance of perception itself in the stress response process. The use of this theoretical lens allows for a more nuanced exploration of the interaction between perceived working conditions and particular personal resources that may impact a counselor's stress level and well-being. Hence in this study, the theoretical lens of transactional stress and coping theory was used to examine the collective impact of counselor working conditions and personal coping resources upon the levels of burnout and compassion fatigue reported by mental health counselors. Mindfulness and compassion satisfaction were examined as personal resources. Emotion-focused, problem-focused, and maladaptive coping were also assessed.

Burnout and compassion fatigue were examined in this study as two distinct counselor stress outcomes. Burnout has been conceptualized as consisting of three primary aspects: emotional exhaustion, depersonalization, and lack of personal accomplishment (Maslach, Schaufeli, & Leiter, 2001). Compassion fatigue has been conceptualized as a secondary traumatic stress process that results from caring for traumatized clients resulting in a clinician's diminished capacity to be compassionate towards clients. Symptoms may include hyper-vigilance and re-experiencing traumatic material shared by clients (Figley, 1995).

### **Scope of the Problem**

Counselors work directly with people at intimate levels of personal disclosure, building a therapeutic relationship and assisting clients with self-reflection and positive change. Counseling and psychotherapy professions are unique in the vulnerability and empathy required to build effective relationships with clients. As Ducharme and her associates (2008) note: "counseling occupations are characterized by the development

and maintenance of meaningful relationships with clients in the trust-based context of the therapeutic alliance” (p. 98). Moreover, the person of the therapist is emphasized in many counseling theories as the primary tool of therapeutic change.

Counseling is a profession in which the person of the counselor serves as the instrument for the work we do. As counselors, we are taught to see the world through our client’s eyes, to experience our client’s feelings through empathy, and to connect to our client’s pain when they are vulnerable. That level of connection, commitment, and caring are among the greatest strengths that we as counselors bring to the work that we do, and they are also among the characteristics that may make us vulnerable. Witnessing the cruelty and despair in our clients’ lives places us at risk; compassion fatigue, vicarious trauma, and burnout are a few of the potential consequences of that risk (Lawson, Venart, Hazler, & Kottler, 2007, p. 5).

The qualities that make counselors effective - their empathy, connection, and caring for the client - can make them vulnerable to negative consequences associated with the stress of the profession. Experienced, effective counselors are not immune to the stresses of the profession. “Counselors may have increased susceptibility to burnout because of their training to be empathic, which is essential to the formation of a therapeutic relationship” (Lambie, 2006, p. 32). Empathy, which is essential to professional competence, can also leave counselors vulnerable to various forms of distress.

Given the personally and professionally intense nature of counseling work, counselors face unique job stressors and the associated risks of professional impairment, burnout, compassion fatigue, secondary traumatic stress, and vicarious traumatization. These states negatively affect counselor well-being and negatively impact their job performance and the care they provide to clients. There is an emerging consensus that a counselor’s wellness or lack thereof affects counselor performance and client outcomes (Lawson, 2007). For example, when a counselor’s personal well-

being deteriorates, professional performance can be compromised, resulting in burnout or even impairment (Young & Lambie, 2007). Emotional exhaustion, depersonalization, and excessive emotional detachment accompanied by a lack of personal accomplishment are aspects of burnout with potentially profound negative consequences for the counseling relationship (Maslach et al., 2001).

The inclusion of ethical codes emphasizing the importance of counselor self-monitoring for well-being and impairment to protect clients underscores the scope of this problem for the profession. The American Counseling Association Code of Ethics (2005) mandates that professional counselors self-monitor for impairment due to the possible risks clients face if they receive services from impaired clinicians. An understanding of the risks of clinician impairment has led to movements in the field to explore the negative consequences of job stress and to conduct research on the various forms of professional impairment, including burnout and compassion fatigue.

Research bears out the widespread nature of the problem of counselor impairment and the importance of counselor well-being. In a national survey of counselors conducted in 2007, Lawson found that 5.2% of counselors surveyed met the cutoff for burnout and 10.8% met the cutoff scores for compassion fatigue. This indicates that approximately 1 out of 10 counselors surveyed was experiencing compassion fatigue while still providing counseling services. Moreover, counselors and therapists who return surveys are not likely to be representative of the entire population (Linley & Joseph, 2007), so these numbers may under represent the actual prevalence of counselor impairment in various forms. These results provide a picture of counselors who meet criteria for burnout or compassion fatigue, but fail to account for counselors

who experience job stress at less severe levels. Therefore, further study of counselor working conditions and the use of particular coping resources in response to those conditions is needed to accurately portray the scope and impact of counselor job stress.

### **Perception of Working Conditions**

Researchers have suggested that counseling work can have negative consequences for counselors due to potentially stressful working conditions including factors such as a clientele with severe presenting problems (Young & Lambie, 2007), large client caseloads (Lawson, 2007; Lee et al., 2010) and the intimate nature of the work itself (Ducharme et al., 2008; Lawson et al., 2007). Other aspects of the work environment that counselors may perceive as stressful have not been explored in much detail. For example, research that explores a broad array of both positive and negative working conditions is lacking.

Several researchers have examined the outcomes of counselor job stress and drawn conclusions as to the workplace factors or conditions associated with these outcomes. For example, Lawson (2007) gathered information about caseload size and work setting and correlated these factors with counselor burnout and compassion fatigue. Lawson & Myers (2011) also examined the impact of work setting, caseload size, and caseload composition on counselor outcomes, but did not assess other workplace factors. These examinations fail to include other factors such as coworker support, workplace climate, and sense of workplace community that may buffer the impact of such stressors. The current study filled a gap in the literature by assessing a broader range of both positive and negative counselor working conditions.

Coworker support is a positive aspect of counselor working conditions that is also examined in this study. There is evidence in the literature for examining co-worker

support and its relationship with counselor stress outcomes. In a study of over 1,800 substance abuse counselors, researchers reported that “greater coworker support was associated with lower levels of counselors’ emotional exhaustion” (Ducharme et al., 2008, p. 95). These results suggest that coworker support buffers counselors from the emotional exhaustion that can be a consequence of counseling work. The current study examines co-worker support as an aspect of counselor working conditions to contextualize mental health counselors stress experiences and outcomes.

### **Length of Time in the Field**

Length of time in the field is term that refers to the total amount of time a counselor has been working in the counseling field. It has been reported that a counselor’s overall length of time in the field is associated with stress outcomes. In a study of 156 therapists, researchers documented that “therapists who reported a greater length of time working as a therapist reported more negative psychological changes ( $r = .16, p < .05$ ) and more compassion fatigue ( $r = .20, p < .01$ )” (Linley & Joseph, 2007, p.395) as compared to therapists reporting less overall time working as therapists. While length of time in the field may put counselors at greater risk for burnout and compassion fatigue, Leonard (2008) reported that more years of clinical experience are associated with higher levels of compassion satisfaction. In a study of 98 trauma therapists, Leonard reported that more years of experience was associated with higher levels of compassion satisfaction. In this study, the influence of counselor length of time working in the field in predicting levels of reported burnout and compassion fatigue was examined.

## Gender

There is a trend toward most mental health professions becoming feminized, which has been noted in the psychology field from the 1990s as the ratio of women to men in the profession changed, with women becoming the majority (Ostertag & McNamara, 1991). More recently, this trend has been noticed among psychologists in South Africa (Skinner & Louw, 2009). Given the over representation of female mental health professionals, it has been difficult to assess the relationship between gender, and mental health professionals' compassion fatigue and burnout. As Sprang et al. (2007) noted "findings regarding the role of gender in the development of CF [compassion fatigue], CS [compassion satisfaction], and burnout have been equivocal and limited by an overrepresentation of female respondents" (p. 272). The predominance of females as participants in research on mental health professionals has made drawing conclusions about gender differences more challenging.

Purvanova & Muros (2010) conducted a meta-analysis of 183 research studies which included participants from various professions to determine whether: (a) women experience higher levels of emotional exhaustion resulting from their work than do men, (b) whether men experience higher levels of depersonalization than women, and (c) whether burnout had been conceptualized as a 'female' phenomenon." (Purvanova & Muros, 2010, p.169) They also sought to explore the impact of contextual factors on the relationship between emotional exhaustion, depersonalization and gender, specifically by examining the impact of varying labor policies on these relationships.

Purvanova and Muros (2010) reported that women scored higher on the emotional exhaustion dimension of burnout, supporting their first hypothesis, corresponding to "54% of women experience emotional exhaustion vs. only 46% of men" (p. 175). They

further reported that men scored higher on the depersonalization dimension of burnout, corresponding to “57% of men experience depersonalization vs. only 43% of women” (Purvanova & Muros, 2010, p.175). They also reported that women scored higher on overall burnout than did men in the studies included in this meta-analysis (Purvanova & Muros, 2010). However, they discuss how these results reflect the differences in how women and men experience burnout, with women reporting more emotional exhaustion than men. They further reported that a connection between conservative social policies in the USA – that women in the USA are significantly more emotionally exhausted than men in the USA in contrast to women in the European Union, where there are more liberal social policies in place (Purvanova & Muros, 2010). This finding suggests that contextual factors outside of work (such as access to childcare) impact women’s experiences of emotional exhaustion at work. A limitation of the results of this study was that it was not specific to counselors; it included individuals from a broad range of professions.

In a study examining factors associated with therapist well-being, Linley and Joseph (2007) reported that women who participated in their study “reported greater levels of personal growth” and “more positive changes” than the men in their study sample (p. 395). These reported results suggest that there may be gender differences in how therapists respond to their role as counselors, with women experiencing greater gains personally. Linley and Joseph (2007) did not provide a detailed discussion of these results. Further research in this area is needed to more fully understand these possible interactions between gender and positive outcomes for the therapist associated therapeutic work.

## **Compassion Satisfaction**

Despite the stressors and risks, many counselors experience a sense of satisfaction associated with their therapeutic work. Many counselors are drawn to the field because of their interest in helping others – a sense of caring and altruism that is not to be underestimated. A growing body of literature depicts the positive impacts of clinical work such as compassion satisfaction, the satisfaction that professionals experience in their helping roles (Stamm, 2010). Compassion satisfaction has been reported to buffer counselors from the negative impact of exposure to client's traumatic material (Collins & Long, 2003). Lawson and Myers (2011) explored compassion satisfaction as an outcome and reported that counselor wellness is associated with compassion satisfaction. In the current study, compassion satisfaction was conceptualized as a counselor personal resource impacting counselor stress outcomes.

## **Type of Coping Strategy**

Despite links between the use of adaptive and maladaptive types of coping strategies and strain outcomes, maladaptive coping strategies have not been explored sufficiently in the counselor population. Instead, the existing research literature has focused upon counselor use of adaptive coping strategies labeled “counselor self-care” or “career sustaining” behaviors and their impact on counselor professional quality of life and wellness (Lawson & Myers, 2011). In another study Kraus (2005) surveyed 90 mental health professionals working with adolescent sex offenders, exploring self-care behaviors, compassion fatigue, burnout, and compassion satisfaction using an instrument developed from two self-care lists developed by Pearlman (1995) to assess clinician self-care. In each of these studies, the behaviors assessed were not based upon existing coping theories or research.

In contrast to these efforts, the current study employed a theoretically derived typology of three types of coping behaviors: emotion-focused, problem-focused, and maladaptive coping behaviors. Each type of coping behavior included both positive and negative strategies that counselors use to manage perceived stressors and offers a more detailed picture of the current state of mental health counselor coping.

In a study examining the college student coping, adjustment and well-being, researchers examined how 171 undergraduates coped with a family member's illness (Schmidt & Welsh, 2010). These researchers used the emotion-focused scales of the COPE instrument (Carver, Scheier, & Weintraub, 1989) because of their interest in how undergraduates coped with a family member's illness is considered a stressor that cannot be changed by active coping methods (Schmidt & Welsh, 2010); these researchers did not include a maladaptive coping category, but did separate each coping strategy.

The transactional theory of stress and coping has been used by psychologists and counselors to explore numerous phenomena, including client stressors. In one study exploring stressors experienced by Haitians immigrating to the United States, Belizaire and Fiertes (2011) used the transactional theory of coping to assess participants' coping strategies in the face of acculturative stress.

Examples of emotion-focused coping include seeking emotional support from others or using particular self-care practices that help regulate emotions. Examples of problem-focused coping include addressing the source of stress, such as talking directly to someone who can help resolve a problem or tackling the problem head on. Examples of maladaptive coping include behavioral disengagement, substance use, and self-

blame. Researchers studying individuals with mental health difficulties have reported that the maladaptive coping strategies of behavioral disengagement and self-blame are linked to negative psychological outcomes (Meyer, 2001). In a longitudinal study examining the validity and reliability of the Brief COPE among caregivers of people with dementia, researchers reported that the use of dysfunctional coping strategies was associated with avoidant attachment (Cooper, Katona, & Livingston, 2008).

As a result, this approach to assessing types of coping strategies distinguished this study from previous studies. This study sought to fill the need to understand how counselors cope with specific workplace stresses of the profession, rather than reporting on their self-care practices or career sustaining behaviors on a global level. The use of a theoretically derived and validated instrument to assess type of coping strategy was intended to provide a picture of counselor coping that has been lacking in the more general research explorations of self-care.

Type of coping strategy has not been researched in the context of counselor burnout and compassion fatigue. Moreover, exploring type of coping strategy used in a specific circumstance could reveal how certain behavior patterns may contribute to negative counselor outcomes. The current study addressed this theoretical and methodological oversight by using the construct of coping and measuring it with a validated instrument.

## **Mindfulness**

Although there is a growing body of literature exploring mindfulness and its positive impact on stress levels (Carlson & Garland, 2005), research exploring mindfulness and its potential impact on counselor compassion fatigue and burnout is lacking. While Linley and Joseph (2007) examined various counselor beliefs and

attitudes, they did not examine the impact of mindfulness on therapist stress outcomes. Mindfulness has been explored in the context of counselor self-efficacy, attention, and empathy (Greason & Cashwell, 2009). It has also been explored in connection with counselor self-care and well-being (Richards, Campenni, & Muse-Burke, 2010). However, mindfulness has not been studied within a transactional framework as a personal resource in a sample of mental health counselors.

Mindfulness may allow individuals to remain open to contextual clues and have a less 'foreclosed' process of cognitive appraisal. For example, rather than assuming that something that was stressful in the past will be stressful again, mindfulness processes may allow an individual to become aware of both the external stimuli and internal stimuli such as thoughts that arise in conjunction with it, without assuming that the thoughts associated with the external stimuli are necessarily an accurate representation of reality. In this study the impact of mindfulness attitudes on a counselor's perceived working conditions and levels of burnout and compassion fatigue was examined.

### **Population of Interest**

This study focused exclusively on the work life and stress outcomes of professional mental health counselors. Various states use differing terminology to designate this profession. For the purposes of this study, the term mental health counselor is inclusive of other professionals whose standards of practice and professional identity are comparable, (e.g. licensed professional counselor).

Research on the job stress of helping professionals frequently includes professionals from multiple fields with different standards of professional preparation and practice. For example, Sprang et al. (2007) included a diverse group of helping professionals including psychiatrists and social workers as well as professional

counselors. However, the working conditions of mental health counselors may differ from the working conditions experienced by psychiatrists, social workers, and other mental health professionals. Hence in this study, it was determined that an exclusive focus on mental health counselors' perceptions of their positive and negative working conditions, the impact of their personal resources, and their levels of burnout and compassion fatigue would provide important information to the mental health counseling field.

Even studies focusing on counselors, such as the one conducted by Lawson and Myers (2011), have included both school counseling professionals and mental health counselors. An underlying premise of the current study was that mental health counselors have unique training experiences, and work in particular job positions that may be distinct from other helping professions. Mental health counselors frequently work in agency and community mental health settings and have roles that are distinct from social workers or psychologists who may also work in such settings. Moreover, mental health counselors may experience a lower level of social status than coworkers from fields such as psychology, psychiatry, or social work. Mental health counselors' status within a work organization may impact their work assignments, perceptions of these working conditions, and the power they have to change unfavorable working conditions. Thus, part of the rationale for this study was to examine the working conditions that mental health counselors experience and not assume that the working conditions other mental health professionals experience will be equivalent to those of mental health counselors. This study filled a gap in the literature on counselor burnout and compassion fatigue by focusing on a national sample of mental health counselors.

Benefits of the study include adding to our understanding of the impact of working conditions on counselor job stress outcomes, which could lead to motivation within an organization to improve counselor work environments. For example, if it is found that perceptions of positive working conditions such as coworker support are related to lower levels of compassion fatigue and burnout, this finding might motivate work organizations to enhance working conditions of mental health counselors. It could also add to the existing literature by providing information about the current job settings and positive and negative working conditions that mental health counselors experience, the personal resources that they use to cope, and their stress outcomes.

### **Theoretical Framework**

The theoretical framework that guided the development of this study is the Transactional Theory of Stress and Coping (Lazarus & Folkman, 1984). This theory emphasizes the significance of cognitive appraisal in an individual's experience of stress and coping (Lazarus & Folkman, 1984). Cognitive appraisal is the transactional process by which individuals assess a situation as manageable or exceeding their perceived resources. Primary appraisal is the determination of a situation as "irrelevant, benign-positive, or stressful" and is based on the individual's perception of the situation and their own capacity to cope with it (Lazarus & Folkman, 1984, p.53). Stressful appraisals can fall into one of three categories: harm/loss, threat, or challenge (Lazarus & Folkman, 1984, p. 53). Secondary appraisal involves judging "what might and can be done" about the situation (Lazarus & Folkman, 1984, p. 53). Appraisal is essential to this theoretical understanding of stress and these two appraisals processes are interdependent (Lazarus & Folkman, 1984). Rather than assuming that stress is inherent in the environment or in the individual, this transactional model focuses on the

relationship between the individual and environment in the stress reaction process (Lazarus & Folkman, 1984). This theoretical approach takes into account the contextual factors of the environment and the appraisal factors of the individual in the experience of stress. Further, Lazarus and Folkman (1987) describe a theoretical movement towards understanding stress in terms of emotions and coping, rather than focusing on 'stress' per se.

This approach offers a nuanced understanding of the recursive nature of the process of emotional response to the environment. By acknowledging the role that perceptions have in shaping how we experience external events as stressors, the use of this theory in the exploration of counselor stress opens up new avenues of inquiry, including those that examine how counselors' attitudes and coping practices may shape their perceptions, which in turn shape their lived experience of the work environment in a transactional process.

According to Lazarus and Folkman (1984), stress cannot be viewed independently from appraisal or coping. They define psychological stress as "a relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being" (p. 21). The underlying assumption is that appraisal of stress is moderated by the individual's perceived personal resources. Using this theoretical lens, this study examined how counselor's experience of job stress is influenced by their perception of their working conditions and specific personal resources. Type of coping strategy is one such personal resource.

Lazarus and Folkman (1987) define two types of coping – problem-focused and emotion-focused. The use of problem-focused coping strategies involves applying

concrete solutions to address the perceived problem directly. In contrast, emotion-focused coping strategies focus on managing the emotional response to the perceived stressor, through processes such as social support and exercise programs. For example, a counselor facing an extremely heavy caseload might use a problem-focused coping strategy to modify the source of their stress, such as talking directly to the supervisor about the problem and discussing what might be done to reduce the caseload or handle it in a more effective way. A counselor facing the same problem might use an emotion-focused coping strategy to reduce their level of stress by seeking emotional support from other staff members, engaging in exercise (e.g. running), or using particular self-care practices such as meditation.

These two coping approaches are not mutually exclusive; in fact, they can be complementary. However, an understanding of the person's appraisal of the problem context is essential to understanding the appropriateness of the application of each type of coping strategy. These two types of coping are connected to a person's cognitive appraisal of a situation as well as his/her emotional reaction in response to this cognitive appraisal. Emotion-focused coping strategies can be defined as dysfunctional or maladaptive if they are applied inappropriately to the context (e.g. when the perceived problem needs to be addressed directly). The same can be said of problem-focused coping. For example, if a person dealing with a chronic illness determines that nothing can 'fix' their perceived problem, turning to an emotion-focused coping strategy such as mindfulness meditation would be an appropriate coping approach.

In the current study, transactional stress theory was used to explore whether counselors' perceptions of their working conditions and personal resources impacted their levels of burnout and compassion fatigue.

### **Need for the Study**

Professional counselors are frequently called upon to help individuals, couples, families, students, and communities in distress. Much has been written about the potential negative consequences for professionals working with people in distress and the need to buffer professionals from these stresses, yet burnout and compassion fatigue continue to impact the profession. Although counselors are ethically bound to monitor themselves for signs of impairment (C.2.g., American Counseling Association Code of Ethics, 2005), compassion fatigue and burnout are still impairment issues facing the profession (Lawson, 2007; Sprang et al., 2007). Sprang et al., (2007) found that 13% of professionals sampled were at high risk for the development of compassion fatigue or burnout and emphasized the need for further research of counselor and contextual characteristics that may impact the development of these conditions. This continued impact on the profession indicates that more research is needed to determine which specific working conditions counselors perceive as stressful and how they can more effectively cope with them. Moreover, greater understanding of the relationship between a counselor's gender and their levels of compassion fatigue and burnout is needed. Further exploration of the impact of a therapist's overall length of time in the counseling field is also needed.

Another potential benefit of the results of this study is the application of findings in the professional preparation of counselors and therapists. Counselors-in-training could benefit from a greater understanding of the impact of positive and negative counselor

working conditions, the personal resources that counselors use to cope with negative conditions, and the outcomes they experience. Data from the current study could also be used to underscore the need for specific curriculum designed to aid counselors-in-training in developing specific coping skills to meet the challenges/demands of their chosen profession.

### **Purpose of the Study**

The purpose of this study was to use the transactional stress and coping perspective to explore the influence of mental health counselor appraisal of their working conditions and personal coping resources on the levels of burnout and compassion fatigue they experience (see Figure 1). The influence of both positive and negative working conditions were examined in addition to five personal resources: use of adaptive problem-focused coping strategies, adaptive emotion-focused coping strategies, maladaptive coping strategies, compassion satisfaction, and mindfulness attitudes. The influence of counselor gender and overall length of time in the field was also examined.

### **Research Questions**

The following research questions were used to examine the variables of interest in the study:

- Is there a relationship between mental health counselors' perceptions of their working conditions and their reported level of burnout?
- Is there a relationship between mental health counselors' perceptions of their working conditions and their reported level of compassion fatigue?
- What is the influence of counselor gender on the perceived working conditions-burnout relationship in mental health counselors?
- What is the influence of counselor gender on the perceived working conditions-compassion fatigue relationship in mental health counselors?

- What is the influence of counselor length of time in field on the perceived working conditions-burnout relationship in mental health counselors?
- What is the influence of length of time in field in the perceived working conditions-compassion fatigue relationship in mental health counselors?
- What is the influence of counselor perceived working conditions, length of time in field, gender, mindfulness, compassion satisfaction, emotion-focused coping, problem-focused coping and maladaptive coping in predicting the level of burnout in mental health counselors?
- What is the influence of counselor perceived working conditions, length of time in field, gender, mindfulness, compassion satisfaction, emotion-focused coping, problem-focused coping and maladaptive coping in predicting the level of compassion fatigue in mental health counselors?

### **Overview of the Study**

Chapter 1 provides an introduction to the scope of the problem, the topic of the proposed study as well as the theoretical framework used to explore the topic. Chapter 2 provides a review of the related literature. Chapter 3 details the study methodology, including the research design, recruitment of participants, sampling procedures, data collection process, instrumentation for the study, and demographics of the resultant sample. Chapter 4 reports the results of the study. Chapter 5 provides a discussion of the findings, limitations, and implications of the study, and an overview of directions for future research based on the results of the study.

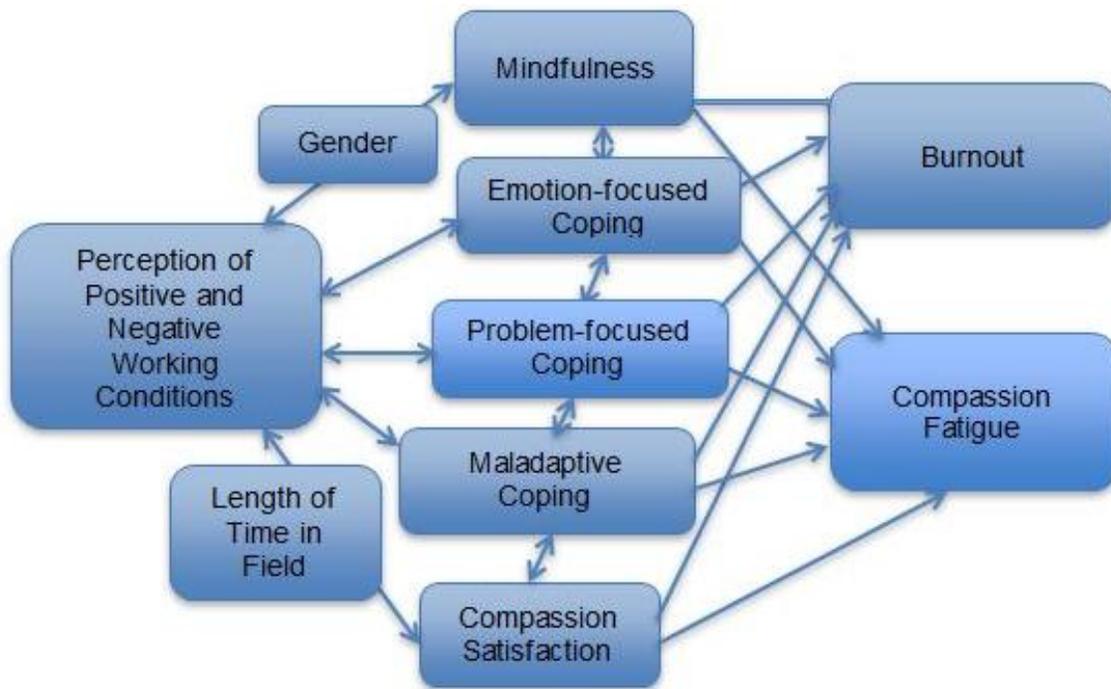


Figure 1-1. Model of burnout and compassion fatigue

## CHAPTER 2 REVIEW OF THE RELATED LITERATURE

In the following review of the related literature, research on the incidence of counselor burnout and compassion fatigue are reviewed along with research examining the working conditions and personal factors that either contribute to or seem to buffer counselors from the negative consequences of perceived workplace stress. In addition, existing research on counselors' perceptions of positive working conditions will be examined. The current research on personal coping resources and self-care practices will also be reviewed. In addition, the research on the impact of gender and length of time in the counseling field on counselor stress outcomes are examined.

### **Negative Consequences of Counselor Job Stress**

The negative consequences of counselor job stress can be severe. Unhealthy stress reactions, over time, can lead to states such as burnout and compassion fatigue: "The very act of being compassionate and empathic extracts a cost under most circumstances" (Figley, 2002, p. 1434). There is a large body of literature describing the various costs to the professional associated with providing therapeutic services.

There are a variety of terms in common usage to describe the unhealthy and unbalanced states to which counselors are susceptible, including impairment, burnout, compassion fatigue, vicarious trauma, and secondary traumatic stress. Impairment is considered a deterioration of professional functioning and competence caused by the interference of a counselor's personal distress (Lamb, Presser, Pfof, Baum, Jackson, & Jarvis, 1987). Impairment signifies that a counselor or mental health professional is offering therapeutic services that do not meet professional standards of practice (O'Conner, 2001). The American Counseling Association includes an ethical code

mandating that professional counselors monitor themselves for signs of impairment and stop providing therapeutic services when their impairment could result in harm:

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. They seek assistance for problems that reach the level of professional impairment, and, if necessary, they limit, suspend, or terminate their professional responsibilities until such time it is determined that they may safely resume their work. Counselors assist colleagues or supervisors in recognizing their own professional impairment and provide consultation and assistance when warranted with colleagues or supervisors showing signs of impairment and intervene as appropriate to prevent imminent harm to clients. (American Counseling Association, Code of Ethics, 2005)

The inclusion of this ethical code recognizes counselor impairment as a problem that merits ongoing attention from the profession. This ethical code also mandates that the counseling community remain vigilant to prevent and ameliorate counselor impairment in order to protect clients.

Burnout is a severe form of impairment that is associated with the stress of the professional role itself and impacts counselors, therapists and other helping professionals (Skovholt, 2001). There are multiple dimensions associated with burnout: emotional exhaustion, depersonalization, and lack of personal accomplishment (Maslach et al., 2001), all of which can have detrimental effects on the therapeutic relationship and on treatment outcomes. Burnout has also been defined as: "the process of physical and emotional depletion resulting from conditions at work or, more concisely, prolonged job stress" (Osborn, 2004, p.319). This definition of burnout describes it as a process of depletion resulting from prolonged job stress. Burnout among counselors can be especially detrimental: "If not closely monitored, counselor burnout, conceptualized as a combination of multiple emotional and physical ailments manifesting cognitively or within the workplace, could ensue and jeopardize both the

counselor's well-being and treatment efficacy” (Lee, Seong, Kissinger, & Ogle, 2010, p. 131). This definition includes the potential negative outcomes of burnout, both for counselor themselves and for the people that they treat.

The literature regarding potential negative consequences of working with clients who have experienced trauma is extensive. Several terms describing the potential negative impact on therapists have emerged from this body of research. Compassion fatigue, secondary traumatic stress, and vicarious traumatization are three of the main terms that are found in the literature to describe this phenomenon (Stamm, 2010). Compassion fatigue is conceptualized as emotional fatigue brought on by caring for traumatized clients; it emerges as the result of hearing about clients’ traumatic experiences (Figley, 1995). It involves the loss of interest or capacity to be compassionate towards the client (Figley, 1995). Compassion fatigue is often further characterized by symptoms that are similar to posttraumatic stress disorder such as hyper-vigilance and re-experiencing traumatic content of their client’s stories (Figley, 1995). Vicarious traumatization is generally used to describe the long-term negative consequences which counselors who work with victimized clients may experience (Schauben & Frazier, 1995). While there is some overlap between the terms secondary traumatic stress and vicarious traumatization, Baird and Kracen (2006) define various traumatization as “harmful changes that occur in professionals’ views of themselves, others, and the world, as a result of exposure to the graphic and/or traumatic material of their clients” (p. 181). These various terms exist because of the need to articulate and address the potentially negative impact of caring for traumatized clients on therapists. While not all counselors work with traumatized clientele, it has been suggested that

mental health counselors are working with more traumatized clients due to the prevalence of trauma (Williams, Helms, & Clemens, 2012), such as sexual abuse, interpersonal violence, and natural disasters (Trippany, White Kress, & Wilcoxon, 2004).

Stamm (2010) describes conceptual overlap between the terms compassion fatigue, secondary traumatic stress, and vicarious trauma: "...there are issues associated with the various terms used to describe negative effects. There are three accepted terms: compassion fatigue, secondary traumatic stress, and vicarious trauma. There do seem to be nuances between the terms but there is no delineation between them sufficient to say that they are truly different" (pg. 9). In this study, the term compassion fatigue will be used as a synonym for secondary traumatic stress, due to the lack of delineation between these terms and Stamm's use of secondary traumatic stress as the name for the subscale that was previously called the compassion fatigue scale (Stamm, 2010).

In addition to examining the impact of working with traumatized clientele on counselors, researchers have also articulated the workplace stressors that counselors from many different specialties experience.

### **Workplace Contributors to Counselor Stress**

It has been well-documented that professional counselors face a myriad of potential stressors that can lead to states of chronic stress and eventual burnout if not managed effectively. The size of their caseload (Lawson, 2007; Lee et al., 2010), their length of time in the field (Linley & Joseph, 2007), severity of client problems (Young & Lambie, 2007), type of clientele (Lawson, 2007), and theoretical orientation (Linley & Joseph, 2007) are factors that can contribute to counselor job stress.

Managing large caseloads is one of the challenges that counselors frequently encounter (Lawson, 2007). It has been reported that community counselors' mental health status is connected to the size of their caseloads and the type of clients they see (Walsh & Walsh, 2002, as cited in Lawson 2007). Large caseloads, among other factors, may contribute to the experience of burnout (Lee et al., 2010). Length of time in the field may also increase a counselor's risk of burnout. In a study of factors impacting therapist well-being, researchers reported that therapists who had been working in the field for a longer time were more likely to experience burnout than new professionals, suggesting a cumulative, negative effect associated with providing therapy over the course of many years (Linley & Joseph, 2007).

In addition to factors explored above, it has been reported that working with certain types of clientele and client problems can also impact counselors' level of stress and sense of well-being. Working with clients with severe presenting problems can be particularly stressful (Young & Lambie, 2007). In contrast, having a varied caseload has been reported to be a protective factor, shielding counselors from burnout (Lawson, 2007). The addictions field has been identified as a particularly stressful specialty in which counselors may be more likely to experience burnout because clients "are prone to high rates of relapse, yielding frustration among clinicians who invest significant emotional resources in building their therapeutic alliance" (Ducharme et al., 2008, p.83). This outcome suggests that therapist's investment in the therapeutic relationship can be taxing if they do not experience 'returns' on that investment.

Working with traumatized clients may also be especially taxing for mental health professionals. The literature on compassion fatigue, secondary traumatic stress,

vicarious traumatization, and other forms of therapist distress associated with working with traumatized clients is testament to the potentially taxing nature of this work. As mentioned previously, the terminology used to describe the potentially negative impact of working with traumatized clients can vary. Counselors who work with abused children or clients who have been traumatized by violence may also be at high risk for developing compassion fatigue and vicarious traumatization (Cunningham, 2003; Creamer & Liddle, 2005, as cited in Sprang, Clark, & Whitt-Woosley, 2007). Working with children who have been sexually abused can be particularly stressful for clinicians (Drouet Pistorius, Feinauer, Harper, Stahmann, & Miller, 2008). Moreover, counselors who have a caseload consisting of trauma survivors are reported to be at greater risk of developing of vicarious traumatization (Cunningham, 1999, as cited in Lawson, 2007).

In a qualitative study examining the impact of counseling abused children on clinicians, researchers interviewed ten female therapists (Drouet Pistorius et al., 2008). The researchers reported that two overarching themes emerged from the data analysis: impact of counseling this population on therapists' personal and professional lives and ways of coping with the stress of this work. Negative impacts described by therapists included descriptions of vicarious traumatization and compassion fatigue. The researchers reported that therapists spoke of an increased awareness of dangers and unpleasant aspects of life and an increase level of fearfulness. Researchers reported the negative impact of this work on therapist's establishment of personal boundaries. For example, therapists discussed having to be careful what they shared about the nature of their work because of people's response. Therapists also cited positive consequences, such as appreciation for life and personal growth and professional

development (Drouet Pistorius et al., 2008). The researchers reported that therapists identified several main coping resources: support systems, personal therapy and willingness to address personal issues, spirituality, humor, use of compassion and empathy in therapy, and practicing self-care. These researchers reported that therapists cited several workplace factors as contributing to their successful coping: agency environment, teamwork, supervision, and training (Drouet Pistorius et al., 2008). These qualitative results indicate that counseling sexually abused children may impact female therapists' interpersonal relationships and perceptions of the world. Moreover, these results indicated that the work environment can play an important role in helping therapists cope with stress.

Therapy work can also impact the beliefs of those who work with traumatized clients (Tehrani, 2007). In a study that aimed to examine the effect of working with traumatized clients on care workers' beliefs, Tehrani (2007) surveyed care workers (defined as caring professionals from a variety of fields including counseling and psychology) whose caseloads consisted of traumatized clients. Of the over 400 professionals contacted to participate via email or by professional contacts, 319 completed the survey. The 21-item survey consisted of items about spiritual and religious beliefs as well as support and supervision, including items regarding negative beliefs that the researchers adapted from the Trauma Belief Inventory (Scott & Stradling, 1992, as cited in Tehrani, 2007). The researchers included survey items regarding positive beliefs, which they described as "consistent with the Post Traumatic Growth Inventory's factors" (Tehrani, 2007, p.331). Participants were also asked about

the type of supervision they receive - whether managerial, personal, professional, or peer.

Tehrani (2007) sought to explore the impact of this clinical work and the secondary trauma that may be associated with it on these workers' values and beliefs. The results indicate that care workers' beliefs were impacted both positively and negatively. Tehrani reported that care workers commonly reported positive beliefs, for example, 91% of those surveyed endorsed "that they had learnt a lot from their experience" (Tehrani, 2007, p. 331). However, over 60% of care workers surveyed reported changes in their beliefs in a negative direction some of the time. Participants reported the following negative beliefs in response to their encounters with traumatized clients: "the carer should have coped better (60%), feeling overwhelmed (60%) and the belief that the world was a dangerous place (64%)" (Tehrani, 2007, p. 331). These changes in care workers' beliefs exemplify the deep impact of working with traumatized clients. Tehrani reported that this impact can have a negative effect, particularly in care workers with less confidence in their ability to handle challenging client interactions (2007).

A strong point of the Tehrani study is the preventative focus on changes in care worker beliefs that may be precursors to the development of burnout and compassion fatigue. Whereas many studies on burnout and compassion fatigue focus on symptomology, Tehrani (2007) aimed to understand the impact of working with traumatized clients before it gets to the level of symptomatic stress. Although counselors and psychologists were included as survey participants, this study had a broad definition of the term 'care worker' that included lawyers and doctors. A limitation of the study was the broad range of professions surveyed, as differences across

professions were not well accounted for in the research design nor in the results. While the results of this study reveal a broad picture of impact of trauma work on workers from many different specialties, it does not provide a detailed account of the impact on therapists. This study was designed to explore the impact of caring work with traumatized clients on caring workers' beliefs across professions. Further research exploring the impact of therapists' beliefs on their work with clients and perceptions of job stress is needed.

In a study examining compassion fatigue, burnout, and compassion satisfaction among mental health professionals, researchers conducted a survey by mail in which 1,121 professionals living in a rural state returned their completed questionnaires, (a 19.5% response rate) (Sprang et al., 2007). Participants completed a 102-item questionnaire that included the Professional Quality of Life Scale among other demographic questions. Gender was linked to higher levels of compassion fatigue, with women more likely to report it than men. Specialized training impacted reported compassion satisfaction, as counselors with specialized training in trauma work reported higher levels of compassion satisfaction than counselors without such specialized training. This result suggests the importance of specialized training for those who work with traumatized clientele. This study also explored these three phenomena across professional fields, and they found that psychiatrists reported higher levels of compassion fatigue than other mental health professionals. The researchers reported that approximately 13% of the professionals sampled are at high risk of compassion fatigue or burnout and emphasize the need for continued research to understand the impact of provider characteristics and contextual characteristics as related to

compassion fatigue and burnout (Sprang, et al., 2007). Further, these researchers recommend that future research explore the impact of gender role socialization on female counselors' experience of distress and symptomology related to compassion fatigue and burnout, as well as their reporting of burnout and compassion fatigue (Sprang, et al., 2007).

### **Workplace Resources Buffering Job Stress**

In addition to the stressful working conditions described above, researchers have begun to identify positive working conditions that seem to buffer mental health professionals from job stress. One of the most prominent of these positive working conditions is the presence of coworker support.

#### **Coworker Support**

In a study examining rates of burnout and turnover in the human services occupations, Ducharme, Knudsen and Roman (2008) explored the role of coworker support as a potential positive working condition buffering counselors from the job stress associated with this work. Co-worker support was found to be a protective factor among counselors working in the addictions field, with increased coworker support associated with decreased emotional exhaustion and turnover (Ducharme et al., 2008). The study included survey data from over 1,800 substance abuse treatment counselors. They found that "coworker support was inversely associated with exhaustion" (Ducharme et al., 2008, p.82). They also reported that lack of coworker support was associated a counselors' intention to quit. These results suggest that coworker support can be a significant protective factor, buffering individual counselors from the emotional exhaustion that can be a consequence of counseling work, and also providing the employer protection from high turnover rates. These findings suggest that co-worker

support can be an important resource positively impacting counselors' experiences of job demands.

In a study designed to examine factors associated with therapist positive and negative well-being, Linley and Joseph (2007) defined positive well-being as “personal growth, positive psychological changes and compassion satisfaction” and negative well-being as “negative psychological changes, burnout, and compassion fatigue” (p. 388). They sent out questionnaires to 400 therapists and psychologists in Great Britain whose names were gathered from professional directories and then entered into a randomizing computer program for random inclusion in the study (Linley & Joseph, 2007). They had a response rate of 40%, with 156 questionnaire packets returned (Linley & Joseph, 2007). This sample consisted of therapists engaging in an average of 30 hours per week of providing direct therapeutic services (Linley & Joseph, 2007). Linley and Joseph (2007) used the Crisis Support Scale to measure social support, the Jefferson Scale of Physician Empathy to measure empathy, and the Working Alliance Inventory Form T-Bond subscale (WAI-Bond) was used to assess personal connection between therapist and client. The Professional Quality of Life Scale was used to assess the factors comprising professional quality of life - burnout, compassion satisfaction, and compassion fatigue. The Sense of Coherence Scale – Short form was used as a measure of therapists' general approach to life and sense that life is coherent. The Posttraumatic Growth Inventory was used to assess the therapist personal growth, specifically in connection to their therapeutic work. Finally, Linley and Joseph (2007) used the Changes in Outlook Questionnaire to examine changes in outlook and belief that therapists' attributed to their clinical work. This array of instruments gave the

researchers a broad picture of therapist well-being, both positive and negative, as well as the factors associated with it.

Linley and Joseph (2007) had participants indicate whether they received clinical supervision, attended personal therapy (currently or previously), and whether they had a personal trauma history. Participants were also asked to indicate their gender. The researchers examined a broad array of factors: “Associations between therapeutic training orientations, therapeutic practice orientations, length of time working as a therapist, hours worked per week as a therapist, and outcome variables (personal growth, positive changes, compassion satisfaction, negative changes, compassion fatigue, and burnout) were assessed” (Linley & Joseph, 2007, pp. 391-392). These researchers reported several factors that were associated with therapist positive well-being: therapists who self-reported current or previous personal therapy also reported higher levels of personal growth and positive change and lower levels of burnout. Therapists who received clinical supervision and endorsed having a personal trauma history also showed greater levels of personal growth. Female therapists in this sample had greater levels of personal growth and positive changes associated with their occupational role than male therapists (Linley & Joseph, 2007).

Theoretical orientation is another factor that has been reported to play a role in therapists’ response to stress, experience of well-being, and susceptibility to burnout and other forms of impairment. Linley and Joseph (2007) reported that therapists identifying themselves as cognitive-behavioral were more likely to experience burnout than therapists who identified themselves as transpersonal or humanistic in their approach. They suggested that further research is needed to examine whether this

difference is due to theoretical orientation per se or the stresses associated with working with client populations in which a particular theoretical lens is more prevalent (Linley & Joseph, 2007).

While Linley and Joseph (2007) examined numerous factors associated with therapist well-being, both positive and negative, they did not account for the impact of the work environment on therapist attitudes and behaviors in a complex way. While the inclusion of the variable of social support expanded this research beyond individual factors impacting well-being, this study did not provide a detailed account of the therapists' perceptions of working conditions and workplace stressors. Research exploring the impact of therapists' perceptions of working conditions on therapist stress outcomes is needed.

The interaction between stressful working conditions and personal factors can lead to compromised client care when a counselor is not coping well with professional stress. For example, it has been reported that burnout can spread among staff members and "unit-level burnout among counselors and nurses has been associated with lower client satisfaction with services received" (Garman et al. 2002; Vahey et al., 2004, as cited in Ducharme et al., 2008). This suggests that negative states such as burnout can be spread between and among staff members, indicating the need for additional research exploring the interaction between perceived working conditions, personal resources, and stress outcomes.

### **Personal Contributors to Counselor Stress**

In addition to the contextual workplace factors described above, personal factors have been reported to impact mental health professionals' perception of and reaction to job stress. It has been reported that a trauma worker's personal history of stressful life

events can also contribute to the likelihood that they will develop an adverse reaction to job stress such as compassion fatigue or burnout (Collins & Long, 2003). In a literature review examining the impact of working with traumatized patients on health care workers, Collins and Long (2003) found that personal trauma history typically increased the likelihood of an adverse stress response unless the counselor had 'worked through' the personal trauma experience (p. 422). Moreover, personal stress may interfere with therapists' effective coping more than job-related stress (Bell, 2003). Therefore, attention to personal factors that may impact therapists' ability to cope with perceived stressful working conditions is warranted.

In a qualitative study on secondary trauma among social workers who work with domestic violence survivors, researchers used a strengths perspective to explore their reactions to stress: "Although examining the potential stresses of such work, use of a strengths perspective allowed an examination of the strategies and personal and environmental resources that allowed counselors to maintain their enthusiasm and energy" (Bell, 2003, p. 514). The researchers interviewed 30 counselors in-depth to explore counselor strengths. Each participant was interviewed twice, the second interview taking place approximately one year after the first. During the first interview, participants were asked to share their reactions to recent work events, including a positive event, a situation they felt was stressful, as well as a situation when they reacted atypically (Bell, 2003). The interview also covered therapists' personal history, including previous trauma that participants felt might impact their reactions to current situations. The researchers reported that participants' "personal stresses seemed to have more effect on counselors' perceived stress level than work-related stresses" (Bell,

2003, p. 517). The researchers divided participant results into three groups based on their reported stress level – a low stress group, a medium stress group, and a high stress group. Six of the counselors were included in the low stress group and reported less extreme stress in their personal and professional lives. Most of the counselors interviewed in this study (n=19) were included in a medium stress group, indicating that they identified perceived stressors and also identified resources to handle these perceived stressors. These counselors were able to draw upon personal and interpersonal resources when facing stressors. The high stress group included five counselors, who had a high level of reported stress and/or somatic symptoms of stress such as physical pain. Some in this group attributed their stress to primarily personal issues, some to work issues and some endorsed a combination of personal and work-related stress (Bell, 2003). Overall, these qualitative outcomes indicate that personal and environmental resources ameliorate the effects of stress, results which suggest the need for additional research in this area.

### **Personal Resources Buffering Job Stress**

Researchers have identified several personal resources that seem to buffer counselors from job stress. Three of these resources are compassion satisfaction, self-care practices, and specific mindfulness attitudes and practices. Research on coping strategies will also be discussed, although this construct has not yet been studied in a counselor population. These personal resources are explored below.

#### **Compassion Satisfaction**

Compassion satisfaction is a term that describes the sense of satisfaction that mental health professionals experience as a result of their clinical work with clients (Stamm, 2002). This conceptualization emerged from the compassion fatigue literature,

as researchers sought to articulate how some clinicians seemed to experience a sense of fulfillment from therapeutic encounters that might fatigue others (Stamm, 1998). Compassion satisfaction has been shown to reduce the risk of burnout (Kraus, 2005). In addition to reducing the risk of burnout, compassion satisfaction has also been reported as a buffer against the negative impact of stress and exposure to counseling traumatized clients (Collins & Long, 2003). Compassion satisfaction is a concept that represents the positive side of therapeutic encounters and the fulfillment that many mental health counselors derive from their professional roles as helpers. Compassion satisfaction can be considered a personal resource from the transactional framework, as it allows counselors to effectively cope with workplace stress.

In a correlational study of 90 mental health professionals who provide clinical interventions for adolescent sex offenders, Kraus explored the relationship between self-care, compassion satisfaction, compassion fatigue, and burnout; specifically whether clinician self-care behaviors buffered compassion fatigue and burnout and increased compassion satisfaction (Kraus, 2005). Self-care behaviors were assessed with a list adapted from two self-care lists developed by Pearlman (1995). Clinicians were asked to rate on a scale of 1 to 6 how helpful they had found forty activities listed to be during the past six months. The Compassion Satisfaction and Fatigue (CSF) test is comprised of three subscales used to assess compassion fatigue, burnout and compassion satisfaction. Kraus (2005) reported that these subscales have alpha coefficients of .87 for compassion fatigue, .90 for burnout, and .87 for compassion satisfaction. Kraus (2005) reported that “there is a strong positive correlation between self-care and compassion satisfaction” (p. 85). Kraus reported that self-care was not

significantly related to either compassion fatigue or burnout. Kraus (2005) also reported that “Burnout was significantly negatively related to compassion satisfaction and significantly positively related to compassion fatigue” (p. 85). Kraus postulated that based on these correlational findings, compassion satisfaction may play a role in decreasing burnout (Kraus, 2005). These results indicate that reported self-care behaviors influence clinicians’ reported experiences of compassion satisfaction, which may in turn reduce levels of burnout (Kraus, 2005).

Kraus (2005) acknowledged the limited generalizability of correlational data and stressed the need for additional research examining the relationship between compassion satisfaction and self-care. Kraus (2005) acknowledged that the reported results run counter to previous research by Stamm (2002) indicating the importance of self-care in ameliorating negative consequences of helping. Kraus acknowledged the lack of clear validation of the self-care lists used as a limitation of the study. The lack of a clear definition of self-care is also a weakness of this study. Despite these limitations, Kraus’ findings suggest areas of research exploration in understanding the role of specific self-care practices, particularly in relation to compassion satisfaction. In the current study, type of coping strategy was explored, allowing for a theoretically grounded exploration of counselor behaviors in response to stress.

In a study surveying 509 members of American Counseling Association, Lawson and Myers (2011) explored wellness, professional quality of life, and career-sustaining behaviors. Career sustaining behaviors are defined as “specific strategies that help the counselor function effectively and maintain a positive attitude in their professional role” (Lawson & Myers, 2011, p. 166). The 5F-Wel was used to assess wellness levels. The

Professional Quality of Life Scale ProQol (Version III) was used to explore professional quality of life, consisting of three distinct subscales measuring compassion fatigue, burnout, and compassion satisfaction. The Career-Sustaining Behaviors Questionnaire, in which counselors rate the importance of strategies listed for positive professional functioning, was used to measure career-sustaining behaviors. Over two thirds of the participants in this study were licensed professional counselors (Lawson & Myers, 2011). Most participants reported working in private practice (39.3%), while 23.5% reported working in community mental health agencies, 20.6% reported working in K-12 schools, 11.7% working in college or university settings and the remaining 4.9% in hospital or residential settings (Lawson & Myers, 2011). Lawson and Myers reported that counselors who had higher wellness scores also had higher levels of compassion satisfaction and reported more engagement in career-sustaining behaviors (2011). These results suggest a connection between wellness, compassion satisfaction, and career sustaining behaviors. Further research focusing solely on mental health counselors is needed to provide a more detailed account of this unique group.

### Self-Care Practices

In the counseling field, self-care has been the primary means by which counselor coping practices have been explored. Much has been written about the necessity of caring for the self for professionals in 'high touch' fields such as counseling, teaching, and health care (Skovholt, 2001). Further, authors have reported that many counselors espouse a holistic philosophy, yet often struggle to maintain their own well-being or find time for the self-care practices they promote for their clients (Cummins et al., 2007). Professional counselors are helpers by choice. Moreover, they are trained to care about

others and show that caring through their words, non-verbal behavior, and attitude. This attitude of caring, if it not balanced by self-care, can lead to various imbalances that result in stress, distress and eventually burnout. Although self-care has been lauded as a key factor in preventing burn-out, reducing the likelihood of impairment among practitioners, and ameliorating vicarious trauma (Cummins et al., 2007), validated measures to accurately assess counselor self-care are lacking.

Defining self-care can also be challenging, as researchers have often utilized varying definitions (Richards, Campenni, & Muse-Burke, 2010). O'Hollaron and Linton (2000) linked self-care practices to six domains of holistic wellness including "social, emotional, cognitive, physical, spiritual, and vocational" (p. 356). Baker (2003) describes three components of therapist self-care "self-awareness, self-regulation, and balance" and conceptualizes self-care

as comprising the processes of self-awareness and self-regulation and the balance of connections among self (involving the psychological, physical, and spiritual, as well as the professional), others (including personal and professional relationships) and the larger community (encompassing civic and professional involvement)" (p. 13).

Skovholt (2001) considers self-care as an ongoing process essential to counselor well-being and views the outcome more important than the particular practice used. According to Skovholt (2001), the term self-care describes the means by which counselors renew and energize themselves by continually replenishing the sources that sustain them: "Self-care means finding ways to replenish the self." (p. 147). Skovholt (2001) further elaborates that "personal self-care should focus in part on producing feelings of zest, peace, euphoria, excitement, happiness, and pleasure" (p. 147). Assessment of self-care practices is crucial for counselors to evaluate their status along the continuum of well, stressed, distressed and impaired, to recognize their own

vulnerability, and to take actions to address it (Cummins et al., 2007). Kraus (2005) reported that self-care practices helped mental health professionals experience more compassion satisfaction in their work and may act as a protective factor against burnout and compassion fatigue.

Because defining self-care can be challenging, a review of the literature revealed that self-care practices, strategies and behaviors may be researched under other definitions. Self-care practices may overlap with the construct 'career-sustaining behaviors.' In a study of examining counselor wellness and impairment, 501 American Counseling Association members completed surveys to assess their levels of wellness and impairment, as well as their practice of career sustaining behaviors. The Career-Sustaining Behaviors Questionnaire (CSBQ; Stevanovic & Rupert, 2004) assesses "specific strategies for their importance in helping the counselor to function effectively and maintain a positive attitude" (Lawson, 2007, p. 23). Although not defined as self-care, many of the careers sustaining behaviors measured by this instrument are consistent with self-care behaviors as defined by other researchers (see Richards et al., 2010). For example, the behaviors assessed include "engage in physical activities" and "engage in quiet leisure activities" (Lawson, 2007). The Professional Quality of Life Scale –Third Edition-Revised (Pro-QOL-III-R; Stamm 2005) was used to assess compassion satisfaction, compassion fatigue, and burnout. A demographic questionnaire was also included to gather information about gender, ethnicity, age, and level of education, clinical setting, caseload characteristics, and personal and professional support (Lawson, 2007).

Lawson and Myers (2011) reported that 8.9% of participants in their sample scored below the cutoff point of the compassion satisfaction subscale, 6.1% scored above the burnout subscale cutoff point, and 10.3% scored above the compassion fatigue subscale cutoff point. Based on the cutoff scores described by Stamm (2005), these reported results indicate that almost 9% of participants were not getting satisfaction from their work, approximately 6% were experiencing burnout, and approximately 10% were experiencing compassion fatigue. In addition to overall prevalence, Lawson and Myers (2011) reported that counselors working in private practice settings had higher compassion satisfaction scores and lower burnout scores than counselors working in other settings such as K-12 schools, college or university settings, or community agencies.

These researchers also reported correlations between caseload variables and burnout scores. Counselors who reported a higher percentage of trauma survivors on their caseloads had higher burnout scores, as did counselors who reported a higher percentage of high-risk clients (Lawson & Myers, 2011). Additionally, these researchers reported a negative correlation between a high-risk client caseload and counselor compassion satisfaction (Lawson & Myers, 2011).

Lawson and Myers (2011) reported that participant total wellness score on the 5F-Wel was positively correlated with compassion satisfaction and negatively correlated with both burnout and compassion fatigue. They also reported that counselors who scored higher on the total wellness scores also rated the career sustaining behaviors as more important to them. While these researchers report that wellness and compassion satisfaction are related, this study does not provide a typology of career sustaining

behaviors characteristic of counselors who experience more compassion satisfaction and wellness. Further, the use of the career sustaining behavior construct does not allow for a nuanced exploration of when and how counselors engage in these strategies.

In a qualitative study exploring wellness and resiliency among mental health professionals, researchers interviewed ten peer-nominated expert practitioners in the mental health field (Skovholt, 2001). The interview questions were designed to elicit participants' views of professional stressors, emotional wellness, and professional resiliency. The inductive data analysis process resulted in five thematic categories: 1) professional stressors, 2) emergence of the expert practitioner, 3) creating a positive work structure, 4) protective factors, and 5) nurturing the self through solitude and relationships. The fifth category included the following themes: a) fostering professional stability by nurturing a personal life, b) investment in a broad array of restorative activities, c) building positive personal relationships, and d) valuing an internal focus (Mullenbach, 2000, as cited in Skovholt, 2001, pp. 164-185). The researchers concluded that participants who were peer-identified as expert practitioners demonstrated "commitment to self-care" and "high-level skill in accessing valuable resources" (Skovholt, 200, p.186). For example, Skovolt (2001) reported that these practitioners are skilled at self-observation and proactively address stressors. Moreover, they are connected with peers who provide them with "ongoing professional support." (p. 186). These results suggest that expert clinicians may utilize coping resources such as self-care and peer support more effectively than other clinicians.

## **Type of Coping Strategy**

Coping is a term that is frequently used in the stress management literature. It refers to "person's constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the person's resources" (Folkman, et al., 1986, p. 993). Type of coping strategy refers to the specific cognitive, affective, and behavioral coping practices that individuals engage in. Lazarus and Folkman (1984) identified two distinct types of coping – problem-focused coping and emotion-focused coping. In addition to these two coping approaches, researchers has also identified some coping strategies as adaptive or maladaptive (Meyer, 2001). Adaptive coping strategies are associated with positive outcomes such as reduced stress and greater well-being whereas maladaptive coping strategies are associated with negative outcomes (Meyer, 2001). Research on non-counselor populations has reported associations between coping strategies and strain outcomes. Despite these associations, type of coping strategy has not been explored in the context of counselor burnout or compassion fatigue.

## **Mindfulness**

Defining mindfulness poses a challenge, as there are multiple dimensions associated with mindfulness (Richards et al., 2010). Mindfulness has been studied as both a trait and a state in quantitative studies and confusion about how to operationalize mindfulness must be addressed (Lau et al., 2006). Contemporary literature describes mindfulness as paying complete attention in the present moment, with moment-to-moment non-judgmental awareness (Kabat-Zinn, 1994). According to a more traditional Buddhist definition, mindfulness means “attending continuously to a familiar object, without forgetfulness or distraction” (Wallace, 2006, p. 13). The traditional definition is

highly applicable in the context of meditative practice, in which practitioners focus on a specific meditative object and return their attention to that object repeatedly through the use of mindfulness.

Most literature in the fields of counseling and psychology focuses on the contemporary Western understanding of mindfulness pioneered by Jon Kabat-Zinn. Over the past decades, several prominent mindfulness-based interventions have emerged, including mindfulness-based stress reduction (MBSR; Kabat-Zinn, 1990) and mindfulness-based cognitive therapy (MBCT; Segal, Williams, & Teasdale 2002). There has also been the development of systems of therapy which seek to cultivate mindfulness skills: acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 1999) and dialectical behavior therapy (DBT; Linehan, 1993). The expanding use of mindfulness-based interventions including MBSR and MBCT exists within broader movements of holistic approaches to mental health and well-being through the use of mindfulness practices and attitudes.

These interventions conceptualize mindfulness as a set of skills that can be learned and practiced in order to reduce psychological symptoms and increase health and well-being. MBSR and MBCT rely heavily on formal meditation practices, in which participants spend up to 45 minutes each day directing their attention in specific ways. In contrast, DBT and ACT rely on a wide variety of shorter exercises in which mindfulness-related skills can be practiced without necessarily engaging in meditation. The empirical literature increasingly supports the efficacy of mindfulness-based interventions (Baer, Smith, Hopkins, Krietemeyer & Toney, 2006, p. 27).

Several quantitative measures of the construct of mindfulness have been developed which “were originally designed to assess mindfulness as a trait-like quality that is manifest as a general tendency to be mindful in daily life” (Lau et al., 2006, p.1447). However, “mindfulness can be viewed as a mode, or state-like quality, that is maintained only when attention to experience is intentionally cultivated with an open,

nonjudgmental orientation to experience” (Lau et al., 2006, p. 1447). In a research study designed to validate a measure of mindfulness, Lau et al. (2006) propose the following two-component definition of mindfulness:

(a) the intentional self-regulation of attention to facilitate greater awareness of bodily sensations, thoughts, and emotions; and (b) a specific quality of attention characterized by endeavoring to connect with each object in one’s awareness (e.g., each bodily sensation, thought, or emotion) with curiosity, acceptance, and openness to experience ( p. 1447).

As discussed above, mindfulness can be understood both as a trait and a state and is also used as a term describing the skills and/or practices that contribute to such a state. While the term mindfulness is relatively new in the fields of psychology and counseling, it has been suggested that there may be some overlap between the term self-awareness and mindfulness (Richards et al., 2010). There are also important distinctions – whereas self-awareness is typically understood as awareness directed to the subjective individual experience, mindfulness can be applied to inner experiences (in which case it overlaps with the concept of self-awareness) as well as outer experiences, including sensations and perceptions. The construct of mindfulness is also considered distinct from other self-focused states such as self-preoccupation (Bishop, Lau, Shapiro, Carlson, & Anderson, 2004).

Mindfulness practices have gained prominence in the health care field, particularly based on the extensive research on the mindfulness-based stress reduction program (MBSR) developed by Jon Kabat-Zinn. For example, participation in the MBSR program has been reported to reduce sleep and mood disturbance, while improving quality of sleep and significantly reducing stress levels among outpatient cancer patients (Carlson & Garland, 2005). In a systemic assessment of the research on the use of MBSR as supportive therapy for cancer patients, researchers concluded that MBSR is a useful

intervention that cancer patients can administer themselves (Smith, Richardson, Hoffman, & Pilkington, 2005).

Mindfulness interventions have also gained acceptance in the mental health field. A qualitative study exploring the impact of a mindfulness group on participants in an inpatient psychiatric facility was conducted (Winship, 2007). In this study, mindfulness was conceptualized as “intentionally developing an awareness of moment-to-moment experience through meditation exercises, reflecting on the findings and gaining insight into the cognitive, emotional, and physical internal processes which underlie our experience of the world” (Winship, 2007, p. 603). There were eight participants in the group who were interviewed for the study. The researchers used thematic analysis. The researchers reported that the following themes emerged from the data analysis: cognitive changes; concentration; increase sense of peace and relaxation; acceptance; exposure to problematic thoughts, beliefs and feelings; awareness; and self-management (Winship, 2007). The researchers also reported that theme of using mindfulness after being discharged from the inpatient facility. Some participants discussed negative experiences with mindfulness, such as misunderstanding the practice and having unmet expectations of a ‘quick fix’ through mindfulness practices (Winship, 2007). However, participants’ responses generally become more positive as they began to understand the concepts and practices through their engagement in the group. Overall, the results of this study indicate the usefulness of mindfulness groups within the context of inpatient psychiatric facilities.

Research has begun to explore mindfulness in the context of counselor and psychologist preparation and training, both as a means to reduce stress (Schure,

Christopher, & Christopher, 2008) and as a means to increase therapeutic attending and presence in session (McCullom & Gehart, 2010; Tannen, 2009;). For example, in a survey of 148 mental health professionals (bachelor's level and higher), researchers explored three hypothesized connections between mindfulness, self-care, self-awareness, and well-being (Richards et al., 2010). Richards et al. (2010) describe self-care in terms of four domains of experience: physical, psychological, spiritual, and support. They identify self-awareness as a possible outcome of self-care practices. They also cite various definitions of self-awareness that may overlap with the term self-consciousness. They connect mindfulness and self-awareness in several ways. These researchers also distinguish mindfulness from self-awareness, using Brown and Ryan's (2003) definition of self-awareness as "knowledge about the self" (as cited in Richards et al., 2010, p.823). They operationalized mindfulness as "knowledge and awareness of one's experience in the present moment" (Richards et al., 2010). These researchers hypothesized that self-awareness and mindfulness would be positively correlated, that mindfulness would mediate the relationship between self-care and well-being, and that "the path from self-care to self-awareness to well-being will be significantly stronger than direct path from self-care to well-being" (Richards et al., 2010, p. 252).

In this study, potential participants were recruited in two ways – either because they were listed in the phonebook as mental health professionals or via personal contacts (Richards et al., 2010). Surveys were distributed by mail, with a return rate of 35.7%. Researchers measured self-care using a scale they designed for the study. Self-awareness was assessed by the Self-Reflection and Insight Scale, mindfulness by the Mindful Attention Awareness Scale, and well-being by the Schwartz Outcomes

Scale-10. The researchers reported a positive correlation between the mental health professionals' self-care and mindfulness scores. They also reported that mindfulness appeared to function as a mediator between self-care and well-being. These results suggest that mindfulness may have a potentially powerful role to play in preventing burnout and other forms of impairment. A significant weakness of this study was that there was wide range of educational levels among participants – including Bachelor's level counselors and doctoral counseling interns as well as professional mental health counselors. Hence, some participants in the study were completing internships as part of their educational programs whereas other participants were already licensed professionals. These researchers recommend that future research gather detailed demographic information from their participants regarding educational level and work setting so that the potential impact of these factors on behaviors such as self-care can be evaluated. Therefore, future quantitative research that explores the connection between mindfulness and self-care and accounts for differences in educational levels and work setting is needed (Richards et al., 2010).

A qualitative study exploring the use of mindfulness practices by professional counselors suggests that counselors who practice mindfulness cultivate intentional living, experience a feeling of connectedness, abundant gratitude, and want others to share in these benefits. Rothuapt and Morgan (2007) recruited six participants, three men and three women, from the Rocky Mountain Association of Counselor Educators and Supervisors. All of the participants identified as White, all worked as counselors, and four of the six also worked as counselor educators (Rothuapt & Morgan, 2007). The participants in this study practiced mindfulness in different ways, yet all spoke of the

importance of breath awareness and bodily cues about their current state of mind (Rothaupt & Morgan, 2007). This qualitative study indicated that the cultivation of a counselor's personal mindfulness practice promotes the counselor's overall well-being. Further research with a more diverse participant group is needed to explore the potential impact of mindfulness practices on professional counselors' well-being and response to job stress.

In a qualitative study exploring yoga as a self-care practice, Valente and Marotta (2005) reported that yoga can help counselors learn how to reduce the negative impact of stress and increase self-awareness. The results of this study suggest that therapists who have a regular yoga practice increase their self-awareness and capacity to relax, thereby avoiding burn-out and creating a more healing environment for their clients (Valente & Marotta, 2005).

These two studies included small populations of counselors who were already engaged in these particular self-care practices. Further studies that explore the impact of mindfulness practices and other self-care practices among counselors are needed. Moreover, research exploring the efficacy of these and other mindfulness practices among counselors who do not already ascribe to these practices is needed. In addition, quantitative research linking counselor self-care practices and levels of reported stress is needed.

While the stressors faced by counselors in the field are distinct from the stressors that counselors-in-training face, several research studies on mindfulness and self-care among counselors-in-training sheds light on research directions that may be fruitful to explore with professional counselors. For example, in a quantitative study surveying 179

Master's-level and doctoral level counselors-in-training, Greason and Cashwell (2009) reported that mindfulness was predictive of counseling self-efficacy. Greason and Cashwell (2009) used Larson and Daniels' (1998) definition of counseling self-efficacy as: "one's beliefs or judgments about his or her capabilities to effectively counsel a client in the near future" (p. 2). Greason and Cashwell (2009) define mindfulness as "a state of being attentive to experience that is characterized by an attitude of openness and acceptance of experience" (p. 5). They also cited how mindfulness practices have been used to increase attention, concentration, and affect tolerance – "the ability to tolerate difficult feelings in the self or others" (p. 5). These researchers hypothesized that attention and empathy would mediate the relationship between mindfulness and self-efficacy, and that mindfulness would be predictive of counseling self-efficacy. The researchers used the Five Factor Mindfulness Questionnaire (FFMQ; Baer, Smith, Hopkins, Krietemeyer & Toney, 2006) to assess mindfulness. They used the Counselor Attention Scale (CAS; Greason, 2006) to measure attention and the Interpersonal Reactivity Index to measure empathy. Self-efficacy was measured by the Counselor Activity Self-Efficacy Scales (CASES; Lent, Hill & Hoffman, 2003). The researchers suggested that this study be replicated with a professional counselor population to see if these results are applicable to professional counselors (Greason & Cashwell, 2009).

In a four year qualitative study, Schure, Christopher, and Christopher (2008) explored the impact of teaching counseling graduate students hatha yoga, meditation, and qigong as part of a fifteen week elective 3-credit hour mindfulness-based stress reduction and self-care course. The researchers stated that the course was loosely based on the MBSR program (Schure et al., 2008). Schure et al. (2008) used journal

data from students and reported themes including positive physical, emotional, attitudinal/mental, and interpersonal changes as well as changes in spiritual awareness in their analysis of students' journal entries (Schure et al., 2008).

In exploring the effect of particular self-care practices, Schure et al. (2008) asked students to explore the following journal prompt: "Of all the practices learned in class, which one are you drawn to the most and why? How has it affected you?" (p. 49). Schure et al. (2008) described how students reported that yoga practice increased body awareness, flexibility, energy, mental clarity and concentration. Meditation generated experiences of increased awareness and acceptance of emotions, increased mental clarity and organization, greater tolerance for physical and emotional pain, as well as an enhanced feeling of relaxation (Schure et al., 2008). Students cited benefits such as increased centeredness and enhanced awareness of the mind-body-emotion connection resulting from their qigong practice (Schure et al., 2008). A weakness of this study is that the researchers based their course on the MBSR program yet did not ask participants about the impact of the course activities on their perceptions of stress and/or reactions to stress.

To address the impact of the course on therapeutic practice the researchers asked students "How, if at all, has this course affected your work with clients, both in terms of being in the room and thinking about the treatment?" (Schure et al., 2008, p.49). Students reported greater comfort with silence, increased capacity to attend to the therapy process, and changes in their view of therapy (Schure et al., 2008). These results indicate that the course activities and practices had substantial benefits for participating counseling students, both for their personal self-care and professional

practice as counselors. These results suggest that use of self-care practices such as meditation impacts how counselors-in-training approach their work with clients.

### **Summary**

Given the ethical considerations and research results outlined above, there is a need for further understanding of how counselors can successfully navigate the demands of the profession. Although much is now known about the risks of counselor impairment in its various forms, research on counselors' perceptions of positive and negative working conditions and the personal resources that serve to buffer them from potential negative working conditions is needed. There has been a trend in the literature to examine counselor factors that impact their stress levels. Examining counselor's perceptions of working conditions could help the field understand counselors' experiences of their working conditions, rather than assuming that certain working conditions are inherently stressful and lead to burnout and compassion fatigue. Therefore, the current study examined the relationship between counselors' perceptions of working conditions and their levels of burnout and compassion fatigue.

A systemic understanding of the burnout process recognizes the power of the work context to impact counselors' beliefs about their capacity to help others, as well as their perception of their own capacity to cope with perceived stressors. More nuanced examination of counselor working conditions is needed to assess the impact of the workplace on counselor stress outcomes, research results which could lay the groundwork for burnout prevention interventions at the organizational level, not just at the individual level.

Counselor perception of coworker support is another workplace factor which needs further research. Ducharme et al. (2008) explored co-worker support and found

that it buffered substance abuse counselors from emotional exhaustion; research examining coworker support as a positive working condition among mental health counselors is needed. Therefore, the current study examined the influence of a broad range of workplace factors on counselor stress outcomes.

Research on counselor coping to highlight counselors' personal resources rather than their deficits is also needed. As described in the literature review, compassion satisfaction, coping strategies, and mindfulness attitudes can be considered personal resources that may reduce the negative effects of counselor job stress. Recognition of the need for effective counselor coping acknowledges both the challenges of the profession as well as counselor strengths and resources. Therefore, the current study examined the influence of counselors' perceptions of working conditions and specific personal resources in predicting their stress outcomes.

While it can be argued that there is enough information about the negative consequences that may occur when counselors fail to effectively cope with stress, research exploring the interaction between counselor's perceptions of working conditions and specific coping strategies in response to a challenging working condition is lacking. Moreover, although there is research data to suggest that self-care is important, the construct of self-care has been defined inconsistently. Therefore, the current study used a specific coping typology grounded in transactional stress and coping theory to explore how counselors cope with specific working conditions.

Counselor mindfulness is another area for additional research exploration. Researchers who have studied counselors-in-training suggest that research exploring the impact of mindfulness on attention, empathy and counselor self-efficacy among

professional counselors is needed (Greason & Cashwell, 2009). Therefore, the current study examined the influence of counselor mindfulness attitudes on their stress outcomes.

### **Conclusion**

The current study sought to explore the transactional nature of the counselor stress experience. The current study was grounded in the transactional model of stress and coping to further understanding of the relationship between counselors' perceptions of positive and negative working conditions, personal resources, and resulting burnout and compassion fatigue levels.

Moreover, because research concerning the relationship between gender and counselor stress outcomes has been contradictory, the current study examined the effect of gender. The influence of counselor years of experience in the field and the impact of this on counselor stress outcomes was also explored.

The current study was intended to examine the role of mindfulness and coping in counselor perception of job stress. This research could inform the development of intervention programs designed to address the interaction between personal resources (e.g. coping strategies and attitudes such as mindfulness) and working conditions that impact the development of counselor burnout and compassion fatigue.

This review of the literature indicates the need for research that examines the impact of perceptions of working conditions and personal resources on counselor burnout and compassion fatigue. Moreover, the specific personal resources highlighted in this literature review – compassion satisfaction, mindfulness, and coping strategy – warrant further research. The current study was intended to meet this need by examining how counselors' perceptions of workplace stressors and the personal

resources of compassion satisfaction, mindfulness and type of coping strategy, impact their level burnout and compassion fatigue. Exploration of the role of mindfulness and other counselor attitudes on their perception of job stress was a major objective of the current study that built on the existing literature on counselor working conditions, burnout, and compassion fatigue.

## CHAPTER 3 METHODOLOGY

This study was designed to explore the impact of counselor perception of certain working conditions and personal resources upon the reported levels of burnout and compassion fatigue of mental health counselors. The impact of the following eight predictor variables was assessed: (a) perceived working conditions, (b) length of time in field, (c) counselor gender, (d) emotion-focused coping, (e) problem-focused coping, (f) maladaptive coping, (g) mindfulness, and (h) compassion satisfaction.

### **Study Design and Relevant Variables**

This study used a cross-sectional survey design to explore how counselors' perceptions of working conditions, their length of time in the field, their gender, and their use of five personal resources predicted their levels of burnout and compassion fatigue. Cross-sectional studies examine data that is gathered at one point in time, in contrast to longitudinal studies in which data is gathered across time (Gall, Gall & Borg, 2007). Cross-sectional studies allow for examining a diverse group of participants, without the problems of attrition associated with longitudinal studies (Gall et al., 2007). In this study, a diverse sample of professional mental health counselors of different ages, with differing levels of experience who work in differing job contexts participated.

This study examined whether the following independent variables - perceived working conditions, length of time in field, gender, mindfulness, compassion satisfaction, and three types of coping strategies - predicted the dependent variables of counselor burnout and compassion fatigue.

### **Perceived Working Conditions**

Perceived working conditions are workplace factors such as the nature of clientele, the nature of administration, collegial support, overall work climate, and other working conditions that counselors experience in their work environment. The emphasis is on the individual's perception of a working condition as relevant to their experience as a counselor. A self-report instrument designed by the researcher to depict specific aspects of the work context of mental health counselors was used to assess counselors' perceptions of their work environment (Appendices C and H).

### **Length of Time in the Field**

Length of time in field has been associated with counselor stress outcomes in previous studies (Linley & Joseph, 2007) and was conceptualized in this study as a predictor variable influencing counselor work stress outcomes. Data regarding length of time in field was collected from participants through a question on the demographic questionnaire.

### **Gender**

Gender was conceptualized as predictor variable influencing counselor work stress outcomes. Participants were asked to indicate their gender on the demographic questionnaire, which was reported categorically for demographic purposes as male or female. For subsequent data analysis, gender was coded numerically; males were coded as '0' and females as '1.'

### **Type of Coping Strategy**

Coping has been defined as a "person's constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the person's resources" (Folkman, et al., 1986, p.

993). Hence, coping can be understood as the way in which individuals attempt to manage perceived stressors. 'Type of coping strategy' refers to the specific ways in which individuals enact coping cognitively, affectively and behaviorally. The type of coping strategy used by the study participants was assessed using the Brief COPE inventory, an abbreviated version of the original COPE inventory (Carver, 1997), and organized into three categories: (a) problem-focused coping, (b) emotion-focused coping, and (c) maladaptive coping. The organization of coping strategies into these three categories was guided by the transactional framework of the study as well as previous research results in which the 14 subscales of the brief COPE were grouped into three categories of emotion-focused, problem-focused and dysfunctional coping (Meyer, 2001).

### **Mindfulness**

Mindfulness, for the purposes of this study, was defined as paying complete attention in the present moment, with moment-to-moment non-judgmental awareness, and was defined as an open and receptive approach to live in the present moment. Given this conceptualization of mindfulness as a dispositional characteristic, it was assumed that an attitude of mindfulness could positively influence the stress appraisal process, thereby allowing an individual to assess a situation as more of a challenge than a threat. Mindfulness was assessed using the Mindfulness Attention Awareness Scale, trait version, which was developed based on the contemporary definition of the construct of mindfulness (MAAS; Brown & Ryan, 2003).

### **Compassion Satisfaction**

Compassion satisfaction refers to the sense of satisfaction and fulfillment that professionals experience during the helping process itself and as a result of their work

(Stamm, 2010). Compassion satisfaction represents the positive side of the act of being compassionate, the benefits and sense of success that clinicians can experience as a result of extending their compassion to others. Compassion satisfaction was measured by a subscale of the Professional Quality of Life Scale Version 5 that was designed to measure this construct and has been previously validated (ProQOL; Stamm 2009).

### **Compassion Fatigue**

Compassion fatigue is defined as emotional fatigue brought on by caring for traumatized clients; it is conceptualized as a secondary traumatic stress process resulting from hearing about clients' traumatic experiences (Figley, 1995). Compassion fatigue was measured by the secondary traumatic stress subscale (formerly called the compassion fatigue scale) of the ProQOL 5 (ProQOL; Stamm, 2009). In the 5<sup>th</sup> version of the ProQOL (Stamm, 2010), the constructs of burnout and secondary traumatic stress are conceptualized as both contributing to a broader construct labeled compassion fatigue. For the purposes of this study, compassion fatigue is considered synonymous with secondary traumatic stress and the secondary traumatic stress subscale was used to measure this construct. Compassion fatigue was examined as an outcome variable in this study.

### **Burnout**

Burnout has been defined as "the process of physical and emotional depletion resulting from conditions at work or, more concisely, prolonged job stress" (Osborn, 2004, p. 319). Burnout is characterized by emotional exhaustion, depersonalization, and lack of personal accomplishment at work (Maslach et al., 2001). Burnout was examined as an outcome variable in this study and was measured by the burnout subscale of the

ProQOL which was designed to measure this construct and has been previously validated (ProQOL; Stamm, 2010).

### **Population and Sample**

The population of interest in this study were mental health counselors in the United States of America. Mental health counseling is a unique profession with its own professional identity and professional association, the American Mental Health Counselors Association (AMHCA). According to the Bureau of Labor Statistics Occupational Employment and Wages webpage, there are approximately 114,180 mental health counselors employed in the United States (<http://www.bls.gov/oes/current/oes211014.htm> retrieved May 20th, 2012). Mental health counseling is a profession distinct from social work and marital and family therapy. The Occupational Employment and Wages webpage states that mental health counselors “work with individuals and groups to promote optimum mental and emotional health. May help individuals deal with issues associated with addictions and substance abuse; family, parenting, and marital problems; stress management; self-esteem; and aging” (<http://www.bls.gov/oes/current/oes211014.htm#nat>, retrieved July 10, 2011).

Mental health counselors provide clinical interventions including clinical services such as counseling and consultation to individuals, couples, groups, families and organizations. They are trained to diagnose and treat mental disorders. The mental health profession is also characterized by a developmental approach to helping clients re-establish mental well-being.

Mental health counselors must complete a master’s degree in mental health counseling, community counseling, or a closely related field to be eligible for licensure as a mental health or professional counselor. While each state has its own licensure

process, there has been a professional movement toward standardization and licensure portability, represented by the National Board for Certified Counselors, which has implemented a national certification process for the profession. In addition, at the counselor preparation level, the Council for Accreditation of Counseling and Related Education Programs accredits counselor education programs to ensure that all counselors-in-training receive the needed coursework and practicum experiences to be prepared for their professional roles and to meet state standards to pursue professional licensure. As of 2009, all 50 states have licensure for counselors (ACA, <http://www.counseling.org/AboutUs/OurHistory/TP/Milestones/CT2.aspx?>, retrieved July 2, 2011).

Mental health counselors practice in a variety of work settings. They may work in private practice settings, seeking clients either individually, in family units, or in groups. Mental Health Counselors may also work in community agencies providing mental health counseling services. Mental health counselors also work in crisis stabilization facilities, higher education settings, college counseling centers, and some work in alternative and public school settings providing mental health services to children. Mental health counselors are also called to provide services in disaster situations, including school shootings and natural disasters of various kinds.

Study participants were drawn from a national sample of mental health counselors and were required to meet the sampling criteria described below to be included in the study. Participants were required to have completed a master's degree (or higher degree) in mental health counseling or community counseling, or closely related field. Moreover, participants were required to be working a minimum of 20 hours a week or

more as a counselor in a clinical setting and to be paid counselors, not volunteer or unpaid counselors. Participants were also required to have worked a minimum of six months at their current job setting. Finally, study participants were required to be currently serving in a clinical capacity providing direct services to clients, rather than serving in solely administrative or other non-clinical professional roles.

### **Sampling Procedures**

A combined approach to sampling was used, consisting of a convenience sample of mental health counselors as well as a randomized sample drawn from the American Mental Health Counselors Association Membership rolls. Convenience sampling is the process of including participants who are accessible and willing to participate in the study, who also meet the criteria for a given study (Gall et al., 2007). An advantage of this sampling procedure is that it allows for recruitment of participants through multiple avenues. A disadvantage of this sampling procedure is that it is a non-probability sampling procedure (Gall et al., 2007).

Participants were recruited using a variety of different strategies. Potential participants were drawn from the American Mental Health Counseling Association (AMHCA) membership email rolls, the AMHCA Facebook page, newsletters and email announcements sent to AMHCA state and local membership, and local, state and national contacts. The first strategy was to recruit AMHCA members via individual email invitation. A second strategy was to recruit participants by posting a general invitation and request to participate in the research study on the AMHCA Facebook webpage. A third strategy was to recruit participants by contacting leaders of AMHCA divisions and requesting that they include general information about the study in newsletters and/or email announcements. A fourth strategy was to contact professionals in the mental

health counseling field, including counselors employed in private practice and community agencies, and request that they announce the study to their colleagues. The researcher provided these professionals with information about how potential participants could access the survey. Although AMCHA was one of the primary means of recruiting participants, individuals did not need to be AMHCA members to be included in the study.

The first three recruitment efforts focused on members of the American Mental Health Counselors Association (AMCHA). The American Mental Health Counseling Association is the only professional organization in the United States of America that is solely dedicated to the mental health counseling profession and has approximately 6,000 members: “The American Mental Health Counselors Association (AMHCA) is a growing community of almost 6,000 mental health counselors” (<http://www.amhca.org/about/default.aspx>, retrieved July 5, 2011). This pool of potential participants was sought because it represents a national sample of mental health counselors, the population of interest in the current study.

Following an informed consent process in which participants were given general information about the nature of the study, participants were invited to complete the survey online or via paper and pencil (see Appendices A and B).

The desired sample size was based on the statistical analyses that were conducted. Given the total number of variables to analyzed, a sample of 200-250 counselors was sought.

### **Resultant Sample**

There were 361 responses to the survey invitation. Of those, one person indicated that they did not consent to take the study and therefore did not complete the survey.

Forty-seven people read and agreed to the informed consent, but did not complete any other part of the survey, resulting in a group of 313 participants who started the survey. A further 61 were excluded due to incomplete survey responses. A further 19 participants who completed surveys were excluded because they self-reported that they did not meet the study criteria of working at least 20 hours per week. Three survey participants were excluded because they did not meet the study criteria of having been at their current job setting for at least six months. In addition, 16 more participants were excluded because they self-reported that they did not meet criteria of being a professional mental health counselor (licensed marriage and family therapist (LMFT) – 1 participant; LMFT intern – 1 participant; certified rehabilitation counselor (CRC) – 1 participant; advanced registered nurse practitioner (ARNP) – 1 participant; social work professionals – 4 participants; clinical psychologist – 1 participant; and school counseling professionals – 7 participants). One participant was excluded because they did not have a completed master's degree in counseling and were still completing an internship as part of a master's degree program.

A total of 213 participants who completed the survey met the study criteria for inclusion in the data analysis. The exact response rate is not known due the convenience sampling procedures used to recruit the participants. However, although an exact response rate is not available, information about the listservs and email addresses that the survey was sent to is detailed below. The survey invitation was posted twice to the University of Florida Counselor Education listserv: February 23, 2012 and April 26, 2012 to 450 email addresses. The survey invitation was posted twice to the Counselor Education and Supervision Network Listserv (CESNET-L): February

27, 2012 to 2181 email addresses and April 1, 2012 to 2220 email addresses. The invitation was also posted twice to the Association for Spiritual, Religious and Ethical Values in Counseling listserv which had 867 subscribers as of June 15, 2012 (R. Watts, personal communication, June 15, 2012): first on March 1, 2012 and then re-posted on March 12, 2012.

The survey invitation was sent one time directly to 1,933 random email addresses from the American Mental Health Counseling Association membership rolls. The survey invitation was sent one time via listserv to the email addresses of 496 professional members of the Ohio Counseling Association (S. Grime, personal communication, April 27, 2012). The survey invitation was sent one time to Alabama Counseling Association listserv, which includes approximately 1,900 individual email addresses (E. Wood, personal communication, April 24, 2012). While an exact response rate is not known, an approximate response rate of 20% is estimated based on the total number of individual emails reached and the 361 responses to the invitation.

### **Demographics of the Resultant Sample**

#### **Gender**

Participants were asked to self-report their gender. The resultant sample of 213 was approximately  $\frac{1}{4}$  male and  $\frac{3}{4}$  female, with 51 male participants and 162 female participants included in the final sample. Thus, approximately 24% of the sample was male and 76% of the sample was female.

#### **Age**

Participants were asked to type in their age. The participants were grouped into age categories by decade: 1) 25 and younger, 2) 26-35, 3) 36-45, 4) 46-55, 5) 56-65 and 6) 66 and older. Eight participants were 25 and younger (approximately 4 % of the

sample), 60 participants were between ages 26-35 (28% of the sample), 3) 36 participants were between the ages of 36-45 (17%), 4) 41 participants were 46-55 (19%), 5) 54 participants were 56-65 (25%), and 6) 14 participants were 66 and older (7%). The age range was from 24 years old to 78 years old. There was a wide variability of ages (see Table 3-1).

### **Race/Ethnicity**

Participants were asked to indicate their race and/or ethnicity. Participants were able to select multiple categories among the following: Native American/Alaskan Native, Asian, Black/African American, Latino/a, White/Caucasian American, Native Hawaiian or other Pacific Islander, or Multiethnic. They could also select 'other' and were then asked to specify. This was not a required question, so a participant could elect not to indicate their race/ethnicity.

Approximately 84% of the sample self-reported as White/Caucasian (n=179), 9% black/African American (n=19), 4% Latino(a) (n=9), .5% Asian (n=1), and 1 % multiethnic (n=2). Participants were able to choose more than one category. Two participants, consisting approximately 1 % of the sample, indicated multiple categories: one identified as both Hawaiian/Pacific Islander and White/Caucasian, while the other identified as White/Caucasian and Other, specifying 'Human' in the other category. One participant, approximately .5 % of the sample, chose not to identify a category (see Table 3-2).

### **Relationship Status**

Participants were asked to indicate their relationship status. Participants could not select multiple relationships statuses. Approximately 13% of the sample (n=27) self-reported as 'Single' and approximately 7% (n=14) reported that they were 'In a

relationship.’ Another approximately 8% of the sample (n= 16) self-reported that they were in a ‘Committed Partnership.’ Approximately 62% of the sample (n=131) reported that they were married, approximately 8% of the sample (n=18) reported that they were divorced, while 2% (n=5) reported they were ‘widowed.’ The remaining 1% of the sample (n=2) self-reported their relationship status as ‘other’ – one specified ‘separated’ and the other specified being in a non-monogamous committed relationship (See Table 3-3).

### **Hours Worked Per Week**

Participants were asked to report the number of hours per week that they worked as a counselor. Participants who indicated that they worked less than 20 hours per week were not included in this study because working more than 20 hours per week was a criterion for participation. Participant responses were grouped into categories consisting of increments of five hours per week. Approximately 12% (n=25) of the sample reported working between 20 and 25 hours per week. Approximately 9% (n=20) of the sample reported working between 26 and 30 hours per week, while another 9% (n=20) reported working between 31 and 35 hours per week. Approximately 41% of the sample (n=87) reported working between 36 and 40 hours per week. Approximately 14% (n=30) reported working between 41-45 hours per week, 7% (n=15) reported 46-50, 4% (n=8) reported working 51-55 hours, 2% (n=4) reported working 56-60, .5% (n=1) reported 61-65, .5% (n=1) reported 66-70 and the remaining 1% (n=2) reported working 80-85 hours per week. The largest percentage, approximately 41%, reported working between 36-40 hours per week.

Some participants indicated that they worked a range of hours per week. The researcher used the following decision rule – the mean of the range reported by the

participant was selected as representing their average number of hours. Participant responses were then grouped in the category that included that mean. If participants indicated that they worked more than a particular amount – for instance, a self-report of ‘40+,’ they were included in the next category up (41-45 hours per week). (See Table 3-4).

### **Counselor Length of Time in the Field**

Participants were asked to indicate the total number of years that they had worked in the counseling field, excluding any clinical experience they gained during their master’s degree work and only include experience gained after that. Respondents reported an average of 12.58 years of experience in the field, with the least experienced respondents reporting half a year of experience and the most experienced respondent reporting 53 years of experiences.

### **Length of Time at Current Job**

Participants were asked to indicate the number of years or months that they had worked at their current job setting. Participants who reported less than six months at their current job setting were not included in the data analysis for the current study.

### **Work Setting**

Participants were asked to indicate the nature of their work setting. Almost a third of the sample reported working in a private practice setting, 31.93%, (n=68). Another third of the sample reported working in community mental health agencies, 30.52% (n=65). The remaining percentage reported working in the following settings: 6.10% in College Counseling Centers (n=13), 2.82% in hospital settings (n=6), 1.41% in Crisis Stabilization Units (n=3), 5.16% in substance abuse treatment centers (n=11), 1.41% in

Career Counseling Centers (n=3), and the remaining 20.66% percent reported 'other' as their work setting (n=44) (see Table 3-5).

### **Salary/Income from Counseling Work**

Participants were asked to indicate how much money they make from their counseling work. Five participants elected not to respond. Two hundred and eight participants completed this question. Approximately 25 % of the sample (25.48%, n=53) reported earning between \$35,000 and \$44,999 dollars per year from their counseling work. The second largest percentages reported earning between \$25,000 and \$34,999 (17.31%, n=36). The next largest percentage was 16.83% (n=35) of participants who reported earning between \$45,000 and \$54,999 dollars per year. After that, 12.02% of participants (n=25) reported earning between \$55,000 and \$64,999. Then, 7.69% (n=16) reported earning between \$10,000 and \$24,999 dollars per year.

There remaining percentages were as follows: 5.77% (n=12) reported earning between \$65,000 and \$74,999 per year, 4.81% (n=10) participants reported earning \$75,000-\$84,999, 3.37% (n=7) reported earning between \$85,000 and \$94,999, and 4.81% (n=10) reported earning 95,000 or more. Two participants (0.96%) reported earning less than \$10,000. Two participants marked 'other' as their response (0.96%).

### **Geographic Distribution of Sample**

Participants were asked to indicate their city and state of residence. There were participants from 43 out of 50 states as well as Puerto Rico. The largest percentage was from Florida (21.13%), followed by Alabama (13.15%), Ohio (9.39%) and Texas (4.69%). The remaining percentages were less than five percent of the total sample. A full representation of the geographic distribution of the sample with participant's reported state of residence is included in Table 3-6.

## **Membership in Professional Organizations**

Participants were asked to indicate if they were members of the American Counseling Association (ACA) or the American Mental Health Counselors Association (AMHCA). Approximately 56% (n=119) of the sample reported that they were members of ACA while the remaining 44% (n=94) reported that they were not members of ACA. Approximately 38% (n=80) of the sample reported that they were members of AMHCA and 62% (n=133) reported that they were not members of AMHCA.

## **Data Collection Procedures**

Upon approval by the doctoral committee, approval from the University of Florida Institutional Review Board (IRB) was sought to conduct this study. After gaining IRB approval, recruitment of participants began on February 23<sup>rd</sup> 2012. The informed consent process for both the online and paper and pencil formats of the survey included a letter describing the nature of the study and an informed consent document (See Appendix A). In the online version, participants were asked to check a box indicating that they consented to completing the survey and participating in the study. Once they had given their informed consent, participants were invited to complete the survey online or via paper and pencil. Participants did not have access to the online survey until they had provided their consent. An invitational letter providing a brief overview of the study and informed consent information was created to precede both the online and paper and pencil versions of the survey. In the online version, participants who elected to participate in the study checked a box to provide informed consent to participate in the study before they proceeded to the survey itself. Responses to the online survey are confidential because participants were not asked to provide their names. In the paper and pencil version, participants were asked to sign the informed consent document (see

Appendix B). No participants elected to complete the survey in the paper and pencil version.

Online survey distribution represents an innovation in survey methods that has become increasingly popular (Cooper, 2000, as cited in Kaplowitz, Hadlock & Levine, 2004). Advantages of using online survey methods include elimination of the costs of printing and mailing paper and pencil surveys, elimination of the cost and time associated with manual data entry of participant responses, the potential to reach a broad range of participants in multiple sites, and reduction of the overall time needed to collect data from a chosen sample (Dillman, 2000). Despite these advantages, there are also some disadvantages to using the online survey format. One disadvantage is that access is limited to people who have access to computers with Internet connections. In a study comparing response rates to online versus paper mail distribution of surveys, researchers reported that while the substantive data procured from both methods was comparable, the mean age of respondents to the online version was younger than the mean age of respondents to the paper mail version (Kaplowitz et al., 2004). Hence, a potential disadvantage of the use of online surveys is that older participants may be less likely than younger participants to complete the survey. Therefore, the study employed both online distribution of surveys as well as paper and pencil distribution of surveys.

Participants' confidentiality was protected throughout the entire research process, from initial recruitment, through data collection, analysis and any future publications that may result from this research. Online survey responses were stored in a password protected account that only the researcher had access to. Paper versions of the survey would have been returned in stamped envelopes by mail to the researcher's home

address or handed to the researcher in person if administered in person. Data collected from the paper and pencil version of the survey would have been manually entered into the data analysis software. However, no participants elected to complete the paper and pencil survey, so the online procedures to protect confidentiality apply to all participants.

### **Instrumentation and Operationalized Variables**

The study survey was composed of five different instruments: a) the Perceived Working Conditions Scale (developed by the researcher for this study, b) the Professional Quality of Life Scale (ProQOL; Stamm, 2010), c) the Brief COPE (Carver, 1997), d) the Mindful Attention Awareness Scale (MAAS; Brown & Ryan, 2003), and e) a demographic questionnaire developed for this study by the researcher to gather descriptive information about the individual, their educational background, and work environment. These five instruments are described in detail in the following section.

#### **Counselor Perceived Working Conditions Scale**

Counselor perceptions of their working conditions were measured by an instrument designed for this study titled the Perceived Working Conditions Scale. This instrument is designed to provide a window into an individual mental health counselor's perceptions of the working conditions at their job setting. This instrument was designed to measure the occurrence and frequency with which counselors perceive and experience specific positive and negative working conditions. Unlike instruments designed to assess the strain consequences of perceived stressors, this instrument was designed to capture the counselor's experience of working conditions that are both positive and negative. Further, rather than assuming that only certain variables are stressful such as caseload size or clientele, this measure describes a variety of workplace factors that counselors might experience. Respondents are asked to rate the

frequency with which they experience the working conditions described by each item. The response format is a 5 point Likert-type scale, with 1 meaning 'never,' 2 meaning 'rarely,' 3 meaning 'occasionally,' 4 meaning 'often,' and 5 meaning 'almost always'. Sample items include: "I have the freedom to choose how I conduct my clinical interventions with clients," and "Colleagues take the time to consult with me regarding clinical issues when I need it." The instrument was comprised of 50 items, with 25 positive items and 25 negative items describing specific working conditions that mental health counselors may experience. It assesses counselor perceptions of positive and negative working conditions in the following five domain: a) Characteristics of Clientele, b) Clinical Efficacy and Preparedness, c) Nature of Coworker Relationships, d) Nature of Job Tasks (subdivided in Private Practice and Agency), and e) Nature of Administration and Overall Atmosphere. The inclusion of items in each of these domains was guided by exploration of the research literature and examination of existing instruments. Client characteristics have been discussed in the literature as a possible factor in counselor stress outcomes and therefore items related to this domain were included. There is a literature regarding counselor perceived self-efficacy and sense of preparedness, therefore items were included that tap this domain of counselor functioning. Inclusion of the domain assessing the nature of coworker relationships was inspired by the research of Ducharme, et al., 2008 who reported a relationship between higher levels of co-worker support and lower levels of emotional exhaustion in a study of over 1,800 substance abuse counselors. In the occupational stress literature, there is evidence that the type of job tasks a worker completes throughout the day and their occupational roles impact their stress level (Layne, Lohenhil, & Singh, 2004), therefore

this domain was included. The nature of administration and overall atmosphere domain was included because of a desire to gain understanding of counselor's positive or negative perception of the broader work context in which they work. An example of this is the counselor's perception of fairness in administrative decision-making. There is a precedent in the counselor burnout literature to examine the impact of the broader context on the counselor (Lee, Baker, et al., 2007). The Counselor Working Conditions Scale follows in this tradition of examining context, while including items that further assess specific working conditions such as counselor perceptions of clientele, administration, and positive aspects of the work context such as coworker support and effective supervision.

Due to the dearth of existing instruments measuring specific counselor working conditions, the teacher stress literature and occupational stress literature were examined. The Teacher Stress Inventory was of particular relevance in the development of this instrument because it examines specific teacher working conditions (Shurtz & Long, 1988). However, because this instrument was developed for the specific working conditions that teachers encounter, it was not suitable to assess the unique working contexts of mental health counselors. The Occupational Stress Inventory - Revised, which assesses general work-related stress and personal resources, was examined for possible use in this study (Layne et al., 2004). The researcher determined that the items were too general to provide a meaningful picture of the counselor working conditions.

Because the Counselor Perceived Working Conditions Scale was designed for the purpose of this study, efforts have been made to establish its reliability and validity. The development of each item was intentional. The researcher engaged in numerous

dialogues with counseling colleagues in the development of the items. To determine its internal reliability, an internal consistency estimate for the instrument was calculated. Content validity for this instrument was established through a process of vetting by an expert panel to determine whether the scale items represent relevant working conditions that counselors may experience. The researcher presented a pool of items to a panel of three experts who were asked to evaluate the representativeness of the five domains, the representativeness of the items and suggest additional domains or items that may capture an element of counselor working conditions that the researcher had not identified. The expert panel was also invited to edit existing items. The expert panel assessed an initial item pool of 57 items.

There were seven original items in the domain 'Characteristics of Clientele.' One of the original seven items was replaced with an expert reviewer's recommended item (original item: 'I work with clients who demonstrate severe pathology and have difficulty engaging in the counseling process' replaced by 'The clients I work with face such overwhelming problems, I wonder how anyone can help them.')

An eighth item suggested by an expert reviewer addressing counselors' perceptions of lack of safety with their clients was added: 'I have concerns for my safety in working with many of my clients.' In addition, the wording of three of the original seven items in this domain was revised based on expert feedback to increase clarity. Two were revised to a positive valence from negative valence based on reviewer feedback that this domain lacked positive statements. In addition, the creator of the instrument added two positive valence items to this domain based on this feedback for a total of ten items with an equal number of positive and negative items.

There were seven original items in the domain 'Clinical Efficacy and Preparedness.' One of the original items was replaced with an item suggested by an expert reviewer (original item: 'I don't feel prepared to help the clients on my caseload' replaced by: 'I feel that it is next to impossible to help the clients on my caseload.')

One item was removed due to redundancy, replaced by a different item suggested by a reviewer. Three of the original items were revised based on expert feedback. Three additional items were suggested by an expert reviewer. One item was then later removed due to redundancy. The review resulted in seven total items.

There were originally ten items in the domain 'Nature of Coworker Relationships.' Two items were combined based on expert feedback. Three items were removed due to redundancy. One additional item was recommended by an expert reviewer and added to the items. The wording of one item was revised based on expert feedback. The review resulted in seven total items for this domain.

There were originally seven items in the overall domain 'Nature of Job Tasks.' Expert reviewers suggested an additional eight items for potential inclusion. Two of the suggested items were used in place of two original items. Three items were deleted. Two more items were added to increase the number of positive items. Another item was revised according to expert feedback. There were five items in the final version.

There were originally seven items in the private practice subsection of the 'Nature of Job Tasks' domain. The version used in the survey included four items, with two positive and two negative items. There were originally seven items in the organizations subsection of the 'Nature of Job Tasks' domain. The wording of four original items was

revised based on expert feedback. The version used in survey included seven items in this domain.

There were originally ten items in the 'Nature of Overall Administration and Overall Atmosphere' domain. Two of the original items were replaced by two of four items suggested by expert reviewers. The wording of one item was revised based on expert feedback. Two items were changed from positive to negative items to equalize this domain. One additional item was included in the final version, so that the instrument included in the survey had eleven items in this section.

**Original subscale scoring.** The researcher originally divided the items so that 25 were included on a positive subscale and 25 were included on a negative subscale. Three positive-valence items were reverse scored for inclusion on the negative perception subscale.

The Counselor Perceived Working Conditions Scale was originally conceptualized as consisting of two subscales with two distinct scores. One subscale was intended to measure positive perceptions of working conditions, while the other was meant to measure counselor perceptions of negative working conditions. A higher score on the positive subscale was originally intended to indicate greater levels of positive perceptions, while a higher score on the negative scale was intended indicate greater levels of negative perceptions. There were 50 total items in the instrument that survey participants completed, with an equal number of items on each subscale. The subscale scores were determined by summing the scores of participant's responses to each item. The original range was 1-125 for each of the subscales.

## **Instrument Validation**

After the survey data were obtained, a confirmatory factor analysis was conducted on this instrument. The researcher downloaded the data set and the 213 participants who met criteria for inclusion in this study were included in the factor analysis.

Confirmatory factor analysis (n=213) was conducted on the summed scores for the two conceptualized subscales – positive perception subscale and negative perception subscale. A scree plot was used to determine that there was one primary factor which accounted for 27.95 % percent of the variance. A scree plot is considered an accepted means of determining factors (Costello & Osborne, 2005). After reviewing the items that comprised the primary factor indicated by the scree plot, it was determined perception of working conditions formed a continuum from positive to negative on one primary underlying factor. The negative perception items that loaded on this factor were reverse scored so higher scores indicate more positive perceptions, lower scores indicate less positive perceptions. After eliminating items with a loading of less than .4, 46 items remained. The .4 cut-off point for factor loadings is considered a robust measure for factor loading in instrument development (Costello & Osborne, 2005). The remaining 46 items were summed to form one overall score for counselor perceptions of the work environment. The sum score for this scale was then loaded it into SPSS for all subsequent data analysis. The Cronbach's Alpha was .94 for the Counselor Perceived Working Conditions Scale consisting of 46 items (See Appendix H).

The development and initial validation of this instrument was integrated with overall goal of this study. Greater understanding of counselor perceptions of specific working conditions was sought through the development of this instrument and the initial validation of the instrument on the study sample.

## **Professional Quality of Life Scale**

The Professional Quality of Life Scale 5 (ProQOL; Stamm, 2010) is an instrument designed to assess compassion satisfaction, burnout, and compassion fatigue/secondary traumatic stress among professionals in a variety of helping professions (Stamm, 2010). This instrument was used to measure the operationalized variables of compassion satisfaction, burnout, and compassion fatigue, each of which has a distinct subscale on the ProQOL. One subscale measures compassion satisfaction, which for the purposes of this study was analyzed as a predictor variable. A second subscale measures burnout, which was analyzed as an outcome variable. The third subscale measures compassion fatigue, which was also analyzed as an outcome variable. This instrument does not provide a composite score – rather, each subscale is scored distinctly (Stamm, 2010). The burnout subscale assesses feelings of exhaustion, depletion and hopelessness associated with professional work. Compassion fatigue is conceptualized as the negative consequence of the stress of secondary exposure to traumatic information, including conversations and therapeutic interactions with clients (Stamm, 2010). Burnout and compassion fatigue both represent the negative consequences of stress and will be used as outcome variables in this study. These outcome variables are consistent with the theoretical framework of the transactional theory of stress and coping.

The ProQOL consists of 30 items, which respondents rate on a 5-point Likert scale. Each subscale consists of 10 items. Sample items for the compassion satisfaction subscale include: “I feel invigorated after working with those I counsel.” And “I feel connected to others.” Sample items for the burnout subscale include “I feel overwhelmed because my case load seems endless.” And “I feel worn out because of

my work as a counselor.” The compassion fatigue subscales consists of items intended to tap the experience of secondary traumatic stress related to exposure to client trauma, including the following items “I avoid certain activities or situations because they remind me of the frightening experiences of the people I counsel.” And “I am not as productive at work because I am losing sleep over the traumatic experiences of a person I help.” While the three subscales have been demonstrated to measure independent constructs, there is a shared variance of 34% ( $r = .58$ ) between the burnout subscale and compassion fatigue/secondary traumatic stress subscale which has been attributed to the distress common to both constructs (Stamm, 2010). The reliability of the ProQOL subscales has been reported as follows: compassion satisfaction with an alpha of .87, burnout with an alpha .90 and compassion fatigue with an alpha of .87 (Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010). The ProQOL has a long track record of use with a wide variety of helping professionals and it is intended for use with this population (Stamm, 2010). There is an extensive body of literature that uses the ProQOL, which is evidence of both its validity and reliability (Stamm, 2010).

### **Brief COPE**

The Brief COPE instrument was used to assess participants’ coping strategies. The Brief COPE was developed and first administered to a sample of 168 people from a community severely impacted by a hurricane 3-6 months earlier (Carver, 1997). There were two subsequent administrations – after another six months and then one year later (Carver, 1997). The Brief COPE was created from the original 60 item COPE inventory to give researchers the opportunity to use a briefer inventory in conjunction with other relevant instruments so that coping could be measured without putting undue burden on participants (Carver, 1997).

The Brief COPE consists of 28 items, statements including “I've been getting comfort and understanding from someone” “I've been trying to come up with a strategy about what to do” and “I've been giving up trying to deal with it.” Respondents are asked to rate how frequently they use the coping strategy described each statement on a 4 point Likert scale, with a response of 1 meaning ‘I haven't been doing this at all,’ 2 meaning ‘I've been doing this a little bit,’ 3 meaning ‘I've been doing this a medium amount’, and 4 meaning ‘I've been doing this a lot.’

The Brief COPE can be used to assess dispositional or situational coping (Carver, 1997). The Brief COPE has been used as an assessment of situational coping in response to particular stressors or triggers. For example, there is a precedent for using it to assess how patients are coping with stress since they found out they needed a surgical procedure (<http://www.psy.miami.edu/faculty/ccarver/sclBrCOPE.html>). For the purposes of this study, respondents were asked to recall a specific work challenge and then to describe it in writing. Below is the statement used to introduce this section of the survey:

Research has indicated that certain working conditions may pose challenges for counselors (e.g. excessive caseload, traumatic issues of clients, lack of organizational support, and lack of needed supervision). In this section we would like to learn about a specific challenge that you experience in your work setting and how you typically cope with it. In the space below please describe a specific condition in your work environment that you have found challenging during the past 30 days.

After writing their own description of a specific working conditions, respondents were asked to respond to the Brief COPE items according to how they are coping with the specific challenge they described. The instruction for the Brief COPE instrument was intended to elicit specific workplace challenges from survey respondents and have them respond to the Brief COPE based on how they are coping with this specific

challenge. The heading for the section was titled “How you are dealing with this challenging work condition” and the instructions for the Brief COPE used in this survey is quoted below:

While different people may deal with challenges in different ways; we're interested in how you've dealt with a challenging work condition, such as the condition that you described above. Keep the challenge described above in mind as you respond to the items below. Please indicate how you are currently responding to your above example. Only keep in mind the challenge and how you are responding to it, there is no need to evaluate if your response is working or not. Using the choices below, rate how frequently you've been responding this way. Rate each item separately from every other item. Make your answers as true FOR YOU as you can.

- 1 = I haven't been doing this at all
- 2 = I've been doing this a little bit
- 3 = I've been doing this a medium amount
- 4 = I've been doing this a lot

The original 60 item COPE was reported to have strong reliability and validity (Carver et al., 1989). Carver reported that confirmatory factor analysis yielded nine factors “which accounted for 72.4% of the variance” (1997, pg.97). The Brief COPE has acceptable internal reliability for all subscales (Carver, 1997). The Brief COPE was originally conceptualized as consisting of 14 subscales, consisting of two items per subscale: active coping, planning, positive reframing, acceptance, humor, religion, using emotional support, using instrumental support, self-distraction, denial, venting, substance use, behavioral disengagement, and self-blame (Carver, 1997). There is a precedent in the research literature for grouping some of these subscales together into broader subgroups: “The scales of the Brief COPE can be grouped into adaptive versus maladaptive as well as emotion-focused versus problem-focused scales” (Meyer, 2001). The Brief COPE can be administered as a situational or dispositional inventory (Carver, 1997). In the current study, the Brief COPE was administered as a situational inventory to assess three types of coping strategies: problem-focused, emotion-focused, and

maladaptive. Research related to the grouping of the subscales into these three types of coping is detailed below.

In a longitudinal study of coping among caregivers of people with dementia, researchers grouped the original 14 subscales into three composite subscales: “dysfunctional, problem-focused or emotion-focused subscales” (Cooper, Katona, & Livingston, 2008, p. 839). There were 92 participants at time 1 and 74 participants at time 2 - two years later. They reported that the internal consistency was good for these composite subscales – alpha of 0.72 for the emotion-focused, alpha of 0.84 for the problem-focused, and 0.75 for the dysfunctional (Cooper et al., 2008). These researchers grouped the original 14 Brief COPE subscales as follows: emotion-focused strategies – acceptance, emotional support, humor, positive reframing, and religion; problem-focused strategies - active coping, instrumental support, and planning; dysfunctional strategies - behavioral disengagement, denial, self-distraction, self-blame, substance use, and venting (Cooper et al., 2008). These researchers also reported adequate test-retest reliability as well as good convergent and concurrent validity (Cooper et al., 2008). For the purposes of the current study, the term maladaptive was used instead of dysfunctional. The groupings that Cooper et al. (2008) used were examined for the problem-focused, emotion-focused and maladaptive coping subscales used in the current study.

The authors of the original COPE identified several types of coping strategies as representing problem-focused or emotion-focused coping strategies. These efforts have guided the current effort to group the 14 subscales of the Brief COPE (Carver, Scheier, & Weintraub, 1989) into three general categories. Further, these authors argue that

there can be forms of adaptive coping encompassed within the broad categories of problem-focused or emotion-focused coping. Therefore, the following Brief COPE subscales were grouped under the category of problem-focused coping: active coping, use of instrumental support, and planning. The following Brief COPE subscales will be grouped under the category of emotion-focused coping: use of emotional support, positive reframing, humor, acceptance, and religion. There is a precedent in the research literature for the term avoidance coping - which refers to coping strategies in which individuals avoid dealing directly with the problem at hand, such as minimizing or denying (Holahan, Moos, Holahan, Brennan, & Schutte, 2005). Further, there is also a research precedent for grouping some scales of the Brief COPE as maladaptive (Meyer, 2001) or dysfunctional (Cooper et al., 2008). The term 'maladaptive' describes the negative outcomes that certain types of coping strategies may have. Therefore, the following Brief COPE subscales were grouped in the category of maladaptive coping: self-distraction, denial, substance use, behavioral disengagement, venting and self-blame.

### **Mindful Attention Awareness Scale**

Mindfulness was assessed using the 15 item Mindful Attention Awareness Scale, trait version (MAAS; Brown & Ryan, 2003). This instrument assesses mindfulness as a "naturally occurring" personal characteristic or trait (Brown & Ryan, 2003). Brown and Ryan (2003) use a conceptualization of mindfulness that focuses on "*open or receptive awareness and attention*" (p. 822). This definition of mindfulness is consistent with numerous contemporary definitions of mindfulness, including Kabat-Zinn's influential definition of mindfulness as paying complete attention in the present moment, with moment-to-moment non-judgmental awareness (1994). The MAAS trait version is

designed to assess a person's dispositional tendency of mindfulness. Respondents rate the frequency with which they experience what is described by each item on a 6 point Likert scale, from 'almost always' to 'almost never.' The MAAS uses an indirect-item approach to get at various aspects of mindfulness (Brown & Ryan, 2003), including "I tend not to notice feelings of physical tension or discomfort until they really grab my attention" and "It seems I am "running on automatic," without much awareness of what I'm doing." The single-factor structure of the MAAS has been demonstrated in a college student sample of 327 people and in a national adult sample of 239 people (Brown & Ryan, 2003). Researchers reported the scale's internal consistency to be acceptable, with alphas ranging from .80 to .90 (Brown & Ryan, 2003). Further, in a study examining the construct and criterion validity of the MAAS among a sample of cancer patients with matched controls from the general community, researchers reported that "the single-factor structure of the MAAS was invariant across the groups" (Carlson & Brown, 2005, p. 29). These researchers also reported that "higher MAAS scores were associated with lower mood disturbance and stress symptoms in cancer patients, and the structure of these relations was invariant across groups" (Carlson & Ryan, 2005, p. 29). The test-retest reliability of the MAAS has also been demonstrated (Brown & Ryan, 2003). The MAAS has been used with a general population to assess mindfulness characteristics that are not dependent on particular mindfulness training (Brown & Ryan, 2003). The MAAS has also been used successfully to distinguish between individuals who have received training in meditation and those who have not, indicating that it does differentiate between mindfulness characteristics that are consistent with mindfulness

training (Brown & Ryan, 2003). For the purposes of this study, the MAAS was used to assess individual counselor's dispositional tendency to approach life with mindfulness.

### **Demographic Questionnaire**

A demographic questionnaire was developed for this study to gather information about the following participants' characteristics: gender (categorical), age in years (continuous), race/ethnicity (categorical). They were asked about their marital status (categorical), if they are parents (categorical) and if they are a caregiver for an elderly person (categorical). If they answered yes to any of these questions, they were asked to indicate on a scale of one to five how stressful that role is for them. Participants were then asked number of children (continuous), whether their children live at home (categorical) level of education (categorical), and city and state of residence (categorical). The questionnaire also included questions about participants' educational history and work context: total number of graduate credit hours completed (continuous), total number of hours worked per week (continuous), number of hours of direct client contact per week (continuous), total number of clients on caseload (continuous), number of total years in the counseling field (continuous), number of years at current position (continuous), the nature of their work setting (categorical), licensure status (categorical), additional licenses held (categorical), membership status in the American Mental Health Counselors Association (categorical), whether or not they receive supervision (categorical). If they receive supervision they were asked what type of supervision they receive from among the following options – individual clinical, group clinical, group administrative, and group clinical (categorical). Participants were also asked to indicate their income from their counseling job (categorical). Participants were also invited to write in any other information related to their work as a counselor that

they thought would be important for the researcher to know. This data was not analyzed for this research study.

### **Hypotheses**

- **H1.** There is a significant association between perceived working conditions and reported level of burnout.
- **H2.** There is a significant association between perceived working conditions and reported level of compassion fatigue.
- **H3.** There is a significant contribution of counselor gender in predicting the relationship between counselor perceived working conditions and reported level of burnout.
- **H4.** There is a significant contribution of counselor gender in predicting the relationship between counselor perceived working conditions and reported level of compassion fatigue.
- **H5.** There is a significant contribution of counselor length of time in field in predicting the relationship between counselor working conditions and reported level of burnout.
- **H6.** There is a significant contribution of counselor length of time in field in predicting the relationship between counselor working conditions and reported level of burnout.
- **H7.** There is a significant contribution of perceived working conditions, length of time in field, gender, and extent of reported mindfulness, compassion satisfaction, and type of coping strategy to the prediction of reported level of burnout.
- **H8.** There is a significant contribution of perceived working conditions, length of time in field, gender and extent of reported mindfulness, compassion satisfaction, and type of coping strategy to the prediction of reported level of compassion fatigue.

### **Summary**

The purpose of this study was to examine the effect of perceived working conditions, type of coping strategy, mindfulness, counselor gender, length of time in the field, and compassion satisfaction on counselor compassion fatigue and burnout levels. A national sample of mental health counselors was sought through recruitment efforts

involving the American Mental Health Counselors Association national email list, local and state chapters of this organization, and professional contacts locally, regionally, and nationally. Study participants completed an online survey consisting of the Perceived Working Conditions Scale, the Professional Quality of Life Scale, the Brief COPE, the Mindful Attention Awareness Scale, and a demographic questionnaire. Data was analyzed using multiple linear regression analysis. The results of the data analysis are provided in Chapter 4 and the discussion of these results and their implications are included in Chapter 5.

Table 3-1. Participant age range

Participant Age Range	Number of Participants	Percentage
25 & younger	8	3.76
26-35	60	28.17
36-45	36	16.90
46-55	41	19.25
56-65	54	25.35
66 & older	14	6.57
Grand Total	213	100.00

Table 3-2. Participant race/ethnicity

Race/Ethnicity	Number of Participants	Percentage
Asian	1	0.47
Black/African American	19	8.92
Latino(a)	9	4.23
White/Caucasian	179	84.04
Multiethnic	2	0.94
Multiple categories	2	0.94
No selection	1	0.47
Grand Total	213	100.00

Table 3-3. Relationship status of resultant sample

Relationship Status	Number of Participants	Percentage
Single	27	12.68
In a Relationship	14	6.57
Committed Partnership	16	7.51
Married	131	61.50
Divorced	18	8.45
Widowed	5	2.35
Other	2	0.94
Grand Total	213	100.00

Table 3-4. Hours worked per week as a counselor

Hours Worked Weekly	Number of Participants	Percentage
20-25	25	11.74
26-30	20	9.39
31-35	20	9.39
36-40	87	40.85
41-45	30	14.08
46-50	15	7.04
51-55	8	3.76
56-60	4	1.88
61-65	1	0.47
66-70	1	0.47
71+	2	.94
Grand Total	213	100.00

Table 3-5. Work setting

Work Setting	Number of Participants	Percentage
Private Practice	68	31.93
Community Mental Health Agency	65	30.52
College Counseling Center	13	6.10
Hospital	6	2.82
Crisis Stabilization Unit	3	1.41
Substance Abuse Treatment Center	11	5.16
Career Counseling Center	3	1.41
Other	44	20.66
Grand Total	213	100.00

Table 3-6. Geographic distribution of resultant sample

State	Number of Participants	Percentage
Alabama	28	13.15
Alaska	1	0.47
Arizona	1	0.47
Arkansas	1	0.47
California	1	0.47
Colorado	3	1.41
Connecticut	3	1.41
D. of Columbia	2	0.94
Florida	45	21.13
Georgia	7	3.29
Hawaii	1	0.47
Idaho	1	0.47
Illinois	6	2.82
Indiana	2	0.94
Louisiana	4	1.88
Maine	2	0.94
Maryland	2	0.94
Massachusetts	5	2.35
Michigan	1	0.47
Minnesota	1	0.47
Mississippi	1	0.47
Missouri	6	2.82
Montana	1	0.47
Nebraska	1	0.47
New Hampshire	1	0.47
New Jersey	2	0.94
New Mexico	2	0.94
New York	5	2.35
North Carolina	7	3.29
Ohio	20	9.39
Oklahoma	1	0.47
Oregon	3	1.41
Pennsylvania	3	1.41
Puerto Rico	1	0.47
Rhode Island	2	0.94
South Carolina	2	0.94
Tennessee	8	3.76
Texas	10	4.69
Vermont	2	0.94
Virginia	6	2.82
Washington	2	0.94
West Virginia	7	3.29
Wisconsin	2	0.94
Wyoming	1	0.47
Grand Total	213	100.00

## CHAPTER 4 DATA ANALYSIS AND RESULTS

The purpose of this study was to examine how counselor's perceptions of their working conditions and personal resources predict their level of reported well-being. Specifically, this study examined the impact of the following eight predictor variables on counselor burnout and compassion fatigue: 1) counselors' perceptions of working conditions, 2) counselor gender, 3) counselor length of time in the field, 4) mindfulness, 5) compassion satisfaction, 6) problem-focused coping, 7) emotion-focused coping, and 8) maladaptive coping. Two hundred thirteen mental health counselors participated in the study. The data analytic procedures used in this study are described. Then, the descriptive statistics for the variables of interest in this study are provided. The reliability statistics for the scales and subscales used in this study are also presented. The results of each of the eight study hypotheses are presented.

### Data Analytic Procedures

The data analytic procedures began with the calculation of descriptive statistics such as the mean, range and standard deviation to describe the demographic features of the sample and the study variables. The descriptive statistics for gender and length of time in field were calculated and then used in the subsequent analysis. Cronbach's alpha coefficients were then computed for the instruments and subscales relevant to the study: the Perceived Working Conditions Scale, the compassion fatigue, burnout, and compassion satisfaction subscales of the Professional Quality of Life Scale, the three coping subscales from the Brief COPE, and the Mindful Attention Awareness Scale. A factor analysis was then conducted on the participant responses to the Perceived Working Conditions Scale to further establish its construct validity. The results of this

analysis were presented in Chapter 3. After the internal consistencies of the scales and subscales were established, the summed or mean scores for each scale or subscale of interest in this study were then computed.

A correlation matrix was created to assess the interrelationships among each of the variables of interest. Once this was completed, two separate hierarchical multiple linear regressions were performed to predict the two outcome variables of burnout and compassion fatigue.

### **Descriptive Statistics for the Study Variables**

The survey completed by participants in this study was comprised of three existing instruments that had been previously validated, one instrument designed by the researcher to assess a variable of interest in this study, and a demographic questionnaire that was designed for this study. The descriptive statistics for the variables of interest in this study are presented in Table 4-1.

The mean score for the maladaptive coping subscale obtained from the study sample was 1.72, with participant responses ranging from a low of 1 to a high of 2.92, and standard deviation of .41. The mean score for the emotion-focused coping subscale obtained from the study sample was 2.57, with a range of 1-3.7, and a standard deviation of .54. The mean score for the problem-focused coping subscale obtained from this sample was 2.75, with a range of 1 to 4, and a standard deviation of .71. The mean score on the Mindful Attention Awareness Scale (MAAS) obtained from this sample was 4.58, with a range of 2.27-6, and standard deviation of .84.

The mean compassion satisfaction score obtained from this sample was 49.95, with a low score 18.04 and a high score of 63.9, and a standard deviation of 10.02. The mean burnout score from this sample was 49.92, with a range of a low score of 32.62 to

a high score of 81.95, with a standard deviation of 10.01. The mean compassion fatigue score obtained from this sample was 50.04, with a range with a low score of 36.97 to a high score of 85.28, and a standard deviation of 10.06.

The mean score on the Counselor Perceived Working Conditions Scale was 172.29, with participant responses ranging from of a low score of 89 to a high score of 229, with a standard deviation of 24.83.

The mean number of years of experience reported by participants in this study was 12.58, with the least amount of experience reported as half a year and the highest number of years as 53, and a standard deviation of 10.38.

### **Reliability Statistics**

The reliability statistics for the scales and subscales of interest in this study are reported below. The reliability statistics for the 12-item maladaptive coping subscale was good, with a Cronbach's Alpha of .749 for this sample. The reliability for the 10-item emotion-focused coping scale was good, with a Cronbach's alpha of .750 for this sample. The reliability statistics for the 6-item problem-focused subscale were good, with a Cronbach's Alpha of .829 for this sample.

The compassion satisfaction subscale consists of 10 items and has good reliability with a Cronbach's Alpha coefficient of .906 for this sample. The burnout subscale is comprised of 10 items and has good reliability with a Cronbach's Alpha of .787. The compassion fatigue subscale is comprised of 10 items and has a reported Cronbach's Alpha of .833. The MAAS trait version consists of 15 items and had a Cronbach's Alpha of .922 for this sample. The Counselor Perceived Working Conditions Scale consists of 46 items and had a Cronbach's Alpha of .94, indicating good internal consistency.

## Relationships among the Variables

Table 4-2 contains a correlation matrix reporting relationships that were calculated among the variables of interest in this study. Significant correlations were found between several variables of interest. Counselor perception of working conditions was inversely correlated with maladaptive coping ( $r = -.413$ ), burnout ( $r = -.643$ ), and compassion fatigue scores ( $r = -.361$ ) at a level of significance of .01. Counselor perception of working conditions was positively correlated to years as a counselor in field ( $r = .28$ ), mindfulness ( $r = .34$ ) and compassion satisfaction scores ( $r = .542$ ) at a level of significance of .01. The relationships between counselor perception of working conditions and the following variables were not significant: gender, problem-focused coping, and emotional-focused coping.

Gender and years as counselor in field were inversely correlated ( $r = -.319$ ) at a level of significance of .01. Gender was not significantly related to counselor perception of working conditions. Years working as counselor in the field was positively correlated to counselor perception of working conditions ( $r = .28$ ) and mindfulness ( $r = .243$ ) at a significance level of .01. Neither gender nor years as a counselor in the field were significantly associated with the three types of coping: emotion-focused, problem-focused or maladaptive coping. Gender was not significantly related to compassion satisfaction or burnout score. Gender was significantly related to compassion fatigue score ( $r = .223$ ) at a level of significance of .01. Gender was also inversely correlated with mindfulness ( $r = -.202$ ) at a significance level of .01.

Mindfulness was positively correlated with counselor perception of working conditions ( $r = .343$ ), years as a counselor in field ( $r = .243$ ), and compassion satisfaction t score ( $r = .42$ ), at a level of significance of .01. Mindfulness was inversely

related to gender ( $r = -.202$ ), maladaptive coping ( $r = -.418$ ), burnout score ( $r = -.546$ ), and compassion fatigue score ( $r = -.448$ ) at a level of significance of .01. Mindfulness scores were not significantly related to emotion-focused or problem-focused coping scores.

Compassion Satisfaction was positively correlated with counselor perception of working conditions ( $r = .54$ ), mindfulness ( $r = .423$ ) at a level of significance of .01. It was also positively correlated with years as a counselor in field ( $r = .183$ ) at a significance level of .01. Compassion satisfaction was inversely associated with maladaptive coping ( $r = -.210$ ), burnout score ( $r = -.679$ ) and compassion fatigue score ( $r = -.205$ ) at a significance level of .01.

### **Hypothesis Testing**

The first two hypotheses were tested using results from the correlation matrix. The remaining six hypotheses were tested using results from hierarchical regression analyses. Before the regression analyses were conducted, the study data was examined to ensure that the assumptions of regression were satisfied.

- **H1.** There is a significant association between perceived positive working conditions and reported level of burnout.

A correlation matrix summarizing the relationships between the variables of interest in this study was completed to determine whether this hypothesis could be accepted. There was a significant association between perceived positive working conditions and reported level of burnout, with inverse relationship ( $r = -.643$ ) between perceived positive working conditions and reported levels of burnout at a significance level of .01. Hence, the first hypothesis was accepted.

- **H2.** There is a significant association between perceived working conditions and reported level of compassion fatigue.

The correlation matrix demonstrated a significant association between perceived positive working conditions and reported level of compassion fatigue. There is an inverse relationship ( $r = -.361$ ) between perceived positive working conditions and reported levels of compassion fatigue, at a level of significance of .01. Hence, the second hypothesis was accepted.

- **H3.** There is a significant contribution of counselor gender in predicting the relationship between counselor perceived working conditions and reported level of burnout.

The third hypothesis was examined using multiple regression analysis. The predictor variables were counselor perception of working conditions and gender. The dependent variable was burnout t score. There was no significant association by gender and reported level of burnout in the regression analysis, therefore the third hypothesis was not accepted.

- **H4.** There is a significant contribution of counselor gender in predicting the relationship between counselor perceived working conditions and reported level of compassion fatigue.

The fourth hypothesis was evaluated through multiple regression analysis. The model summary is shown in Table 4-5 and the regression coefficients in Table 4-6. Gender was not found to be a significant predictor of compassion fatigue in this model, therefore the fourth hypothesis was not accepted.

- **H5.** There is a significant contribution of counselor length of time in field in predicting the relationship between counselor working conditions and reported level of burnout.

Hypothesis five was tested using the results of multiple linear regression analysis. The regression model summary can be seen in Table 4-7 and the model coefficients in Table 4-8. Years as a counselor in the field was not found to be a significant predictor of burnout in this model, therefore the fifth hypothesis was not accepted.

- **H6.** There is a significant contribution of counselor length of time in field in predicting the relationship between counselor working conditions and reported level of compassion fatigue..

Hypothesis six was also examined through multiple linear regression analysis. The regression model summary is found in table 4-9 and the model coefficients in table 4-10. No significant association between years as a counselor in field and reported level of compassion fatigue was found in this sample. Hence, hypothesis six was not accepted.

- **H7.** There is a significant contribution of perceived working conditions, length of time in field, gender, and extent of reported mindfulness, compassion satisfaction, and type of coping strategy to the prediction of reported level of burnout.

Hypothesis seven was examined through hierarchical regression analysis. The regression model summary is found in Table 4-11 and the model coefficients are found in Table 4-12. This regression equation used eight predictor variables to predict the outcome variable of burnout. This analysis revealed an  $R = .818$ ,  $R^2 = .669$ , and adjusted  $R^2 = .656$  at a significance level of  $<.001$ .

There is a significant contribution of perceived working conditions, extent of reported mindfulness, compassion satisfaction, emotion-focused coping, and maladaptive coping to the prediction of reported level of burnout among mental health counselors. Perception of working conditions was a significant predictor of burnout, inversely related to burnout ( $B = -.109$ ,  $t = -5.084$ ,  $p = <.001$ ). Mindfulness was a significant predictor of burnout, inversely related ( $B = -2.698$ ,  $t = -4.580$ ,  $p = <.001$ ). Compassion satisfaction was also a significant predictor, inversely related to burnout with ( $B = -.386$ ,  $t = -7.550$ ,  $p = <.001$ ). Maladaptive coping was a significant predictor, positively related to burnout ( $B = 4.907$ ,  $t = 4.004$ ,  $p = <.001$ ). Emotion-focused coping was a significant predictor at the .002 level, inversely related to burnout ( $B = -2.998$ ,  $t = -$

3.176,  $p = .002$ ). Years working as a counselor in the field, gender, and problem-focused coping were not significantly predictive of burnout score in this model.

However, the overall model accounted for 66.9 % of the variance of burnout t scores reported by mental health counselors in the study sample. Hence, hypothesis seven was accepted.

- **H8.** There is a significant contribution of perceived working conditions, length of time in field, gender and extent of reported mindfulness, compassion satisfaction, and type of coping strategy to the prediction of reported level of compassion fatigue.

The final hypothesis in this study was examined through hierarchical multiple linear regression analysis. The regression model summary is found in Table 4-13 and the model coefficients are found in Table 4-14. This regression equation used eight predictor variables to predict the outcome variable of burnout. This analysis revealed an  $R = .558$ ,  $R^2 = .311$ , and adjusted  $R^2 = .284$ , at a level of significance of  $<.001$ .

The data analysis supports the final hypothesis examined in the current study. There is a significant contribution of perceived working conditions, gender, extent of reported mindfulness, and maladaptive coping to the prediction of reported level of compassion fatigue among mental health counselors. Mindfulness was a significant predictor of compassion fatigue, with an inverse relationship to compassion fatigue ( $B = -3.576$ ,  $t = -4.185$ ,  $p = <.001$ ). Maladaptive coping was a predictor of compassion fatigue at the .005 level ( $B = 5.386$ ,  $t = 3.030$ ,  $p = .003$ ). Gender, compassion satisfaction, emotion-focused coping, and problem-focused coping were not significant predictors of compassion fatigue in this prediction model. The factors in this model when examined together accounted for 31.1 % of the variance of compassion fatigue scores reported by

mental health counselors in the study sample. Therefore, hypothesis eight was accepted.

### **Summary**

Hypothesis one, which stated that there is a significant association between perceptions of working conditions and level of burnout, was accepted. Hypothesis two, which stated that there is significant association between perception of working conditions and level of compassion fatigue, was accepted. Hypothesis three, which stated that there is a significant contribution of counselor gender in predicting the relationship between counselor perceived working conditions and reported level of burnout, was not accepted. Hypothesis four, which stated there is a significant contribution of counselor gender in predicting the relationship between counselor perceived working conditions and reported level of compassion fatigue, was not accepted. Hypothesis five, which stated that there is a significant contribution of counselor length of time in field in predicting the relationship between counselor working conditions and reported level of burnout, was not accepted. Hypothesis six, which stated that there is a significant contribution of counselor length of time in field in predicting the relationship between counselor working conditions and reported level of burnout, was not accepted. Hypothesis seven, which stated that there is a significant contribution of perceived working conditions, length of time in field, gender, and extent of reported mindfulness, compassion satisfaction, and type of coping strategy to the prediction of reported level of burnout, was accepted. Hypothesis eight, which stated that there is a significant contribution of perceived working conditions, length of time in field, gender and extent of reported mindfulness, compassion satisfaction, and type of coping strategy to the prediction of reported level of compassion fatigue, was accepted.

Table 4-15 provides a summary of the results of the hypothesis testing conducted for this study.

Table 4-1. Descriptive statistics for the study's variables

Variable	Mean	Possible Range	Range Low Score	Range High Score	SD
Maladaptive	1.72	1-4	1	2.92	.41
Emotion-Focused	2.57	1-4	1	3.7	.54
Problem-Focused	2.75	1-4	1	4	.71
Mindfulness	4.58	1-6	2.27	6	.84
CS score	49.95		18.04	63.9	10.02
Burnout score	49.92		32.62	81.95	10.01
CF score	50.04		36.97	85.28	10.06
PWC	172.29	46-230	89	229	24.83
Years as a Counselor	12.58	.5-53	.5	53	10.38

Note: CS=compassion satisfaction, CF=compassion fatigue, PWC=counselor perceived working conditions

Table 4-2. Correlations among the study's variables

	1	2	3	4	5	6	7	8	9	10
1 PWC	—									
2 GDR	-.099	—								
3 YIF	.283**	-.319**	—							
4 MD	.343**	-.202**	.243**	—						
5 CS	.542**	-.044	.183**	.423**	—					
6 EF	.023	.000	-.034	-.131	.092	—				
7 PF	-.019	.047	-.068	-.050	.037	.565**	—			
8 MC	-.413**	.041	-.097	-.418**	-.210**	.300**	.212**	—		
9 BO	-.643**	.076	-.219**	-.546**	-.679**	-.037	.087	.466**	—	
10 CF	-.361**	.223**	-.186**	-.448**	-.205**	.097	.110	.411**	.499**	—

Note: PWC=counselor perceived working conditions, GDR=counselor gender, YIF=counselor years in field, MD=mindfulness, CS=compassion satisfaction, EF=emotion-focused coping, PF=problem-focused coping, MC=maladaptive coping, BO=burnout, CF=compassion fatigue

\*\*p≤ .001, N=213

Table 4-3. Gender and burnout regression model summary

Model	Sum of Squares	Mean Square	F <sub>chg</sub>	P	df1	df2
1	8793.375	4396.188	74.227	<.001	2	210

Table 4-4. Gender and burnout regression coefficients

Model 1	B	Std. Error	B	T	Significance
(Constant)	94.288	3.930		23.994	<.001
Counselor Perception of Working Conditions	-.259	.021	-.642	-12.099	<.001
Gender	.293	1.242	.013	.236	.814

Table 4-5. Gender and compassion fatigue regression model summary

Model	R	R <sup>2</sup>	R <sup>2</sup> <sub>adj</sub>	Std. Error	R <sup>2</sup> <sub>chg</sub>	F <sub>chg</sub>	P	df1	df2
1	.542	.294	.287	8.464	.294	43.702	.000	2	210

Table 4-6. Gender and compassion fatigue regression coefficients

Model 1	B	Std. Error	B	t	Significance
(Constant)	11.992	4.322		2.7759	.006
Counselor Perception of Working Conditions	.219	.024	.543	9.319	.000
Gender	.236	1.366	.010	.172	.863

Table 4-7. Burnout predicted by years in field regression model summary

Model	R	R <sup>2</sup>	R <sup>2</sup> <sub>adj</sub>	Std. Error	R <sup>2</sup> <sub>chg</sub>	F <sub>chg</sub>	p	df1	df2
1	.645	.416	.410	7.687	.416	74.645	.000	2	210

Table 4-8. Burnout predicted by years in field regression

Model 1	B	Std. Error	B	t	Significance
(Constant)	94.291	3.724		25.318	<.001
Counselor Perception of Working Conditions	-.255	.022	-.632	-11.489	<.001
Years as Counselor in Field	-.039	.053	-.041	-.739	.461

Table 4-9. Compassion fatigue predicted by years in field regression model summary

Model	R	R <sup>2</sup>	R <sup>2</sup> <sub>adj</sub>	Std. Error	R <sup>2</sup> <sub>chg</sub>	F <sub>chg</sub>	P	df1	df2
1	.371	.138	.130	9.382	.138	16.803	<.001	2	210

Table 4-10. Compassion fatigue by years in field regression model coefficients

Model 1	B	Std. Error	B	t	Significance
(Constant)	74.551	4.545		16.401	<.001
Counselor Perception of Working Conditions	-.136	.027	-.335	-5.022	<.001
Years as Counselor in Field	-.088	.065	-.091	-1.358	.176

Table 4-11. Burnout regression model summary

Model	R	R <sup>2</sup>	R <sup>2</sup> <sub>adj</sub>	Std. Error	R <sup>2</sup> <sub>chg</sub>	F <sub>chg</sub>	p	df1	df2
1	.818	.669	.656	5.867	.669	51.584	<.001	8	204

Table 4-12. Burnout regression model coefficients

Model 1	B	Std. Error	B	t	Significance
(Constant)	94.814	5.250		18.060	<.001
Counselor Perception of Working Conditions	-.109	.021	-.270	-5.084	<.001
Years as Counselor in Field	-.004	.043	-.004	-.082	.935
Gender	-.682	1.009	-.029	-.676	.500
Mindfulness	-2.698	.589	-.227	-4.580	<.001
Compassion Satisfaction	-.386	.051	-.386	-7.550	<.001
Emotion-focused coping	-2.998	.944	-.162	-3.176	.002
Problem-focused coping	1.913	.690	.136	2.775	.006
Maladaptive Coping	4.907	1.226	.199	4.004	<.001

Table 4-13. Compassion fatigue regression model summary

Model	R	R <sup>2</sup>	R <sup>2</sup> <sub>adj</sub>	Std. Error	R <sup>2</sup> <sub>chg</sub>	F <sub>chg</sub>	P	df1	df2
1	.558	.311	.284	8.511	.311	11.503	<.001	8	204

Table 4-14. Compassion fatigue regression model coefficients

Variable	B	Std. Error	B	t	Significance
Constant	64.195	7.615		8.430	<.001
Counselor Perception of Working Conditions	-.079	.031	-.196	-2.561	.011
Years as Counselor in Field	3.139	1.464	.134	2.145	.033
Gender	-.006	.062	-.006	-.095	.925
Mindfulness	-3.576	.855	-.299	-4.185	<.001
Compassion Satisfaction	.082	.074	.082	1.113	.267
Emotion-focused coping	-.857	1.369	-.046	-.626	.532
Problem-focused coping	.871	1.000	.062	.871	.385
Maladaptive Coping	5.386	1.778	.217	3.030	.003

Table 4-15. Summary of hypothesis testing results

Hypothesis	Result
H1 There is a significant association between perceived positive working conditions and reported level of burnout.	Accepted
H2 There is a significant association between perceived working conditions and reported level of compassion fatigue.	Accepted
H3 There is a significant contribution of counselor gender in predicting the relationship between counselor perceived working conditions and reported level of burnout.	Not Accepted
H4 There is a significant contribution of counselor gender in predicting the relationship between counselor perceived working conditions and reported level of compassion fatigue.	Not Accepted
H5-There is a significant contribution of counselor length of time in field in predicting the relationship between counselor working conditions and reported level of burnout.	Not Accepted
H6- There is a significant contribution of counselor length of time in field in predicting the relationship between counselor working conditions and reported level of compassion fatigue.	Not Accepted
H7 – There is a significant contribution of perceived working conditions, length of time in field, gender, and extent of reported mindfulness, compassion satisfaction, and type of coping strategy to the prediction of reported level of burnout.	Accepted
H8 – There is a significant contribution of perceived working conditions, length of time in field, gender and extent of reported mindfulness, compassion satisfaction, and type of coping strategy to the prediction of reported level of compassion fatigue.	Accepted

## CHAPTER 5 DISCUSSION

While work stress is often considered a normal occurrence in the day-to-day lives of many, the experiences of burnout and compassion fatigue go above and beyond the everyday hassles most workers experience. Burnout is characterized by emotional exhaustion, depersonalization, and lack of personal accomplishment (Maslach et al., 2001). Compassion fatigue is characterized by emotional fatigue brought on by caring for traumatized clients and develops due to exposure to clients' traumatic experiences. It results in the clinician's diminished capacity to be compassionate towards the client and may involve symptoms such as hyper-vigilance and re-experiencing client's traumatic content (Figley, 1995). As such, a secondary traumatic stress process is considered an important component of compassion fatigue (Stamm, 2010). Burnout is evaluated by a distinct scale on the ProQOL that includes items such as number 10: "I feel trapped by my job as a counselor" and number 19: "I feel worn out because of my work as a counselor." These items assess an overall sense of fatigue and exhaustion with the work context that is characteristic of burnout. The secondary traumatic stress subscale (formerly called the compassion fatigue scale) includes items such as number 2: "I am preoccupied with more than one person I counsel" and number 23: "I avoid certain activities or situations because they remind me of frightening experiences of the people I counsel." The items capture the sense of fear and preoccupation related to exposure to client's traumatic material that is characteristic of the secondary traumatic stress process associated with compassion fatigue. These examples of the items provide a window into the differences in the conceptualization of these phenomena.

Mental health counselors may experience particular types of stressful working conditions and responsibilities to clients that non-helping professionals may never encounter (e.g. assessing a client diagnosed with depression for suicidal intent). The uniquely intimate nature of the counseling relationship and the counselor's professional responsibility to foster clients' well-being create opportunities for burnout and compassion fatigue to arise. In addition, even professionals from related fields such as psychology and social work may experience different working conditions than mental health counselors. The purpose of the current study was to examine specific contextual and personal determinants that might contribute to mental health counselor burnout and compassion fatigue. This study examined the influence of counselor perceptions of their working conditions, counselor gender, length of time in the counseling field, compassion satisfaction, mindfulness, emotion-focused coping, problem focused-coping, and maladaptive coping in predicting levels of burnout and compassion fatigue reported in a sample of 213 mental health counselors.

This chapter will present a brief description of the research sample, discussion of the research results, limitations of the study, implications for theory, practice, and future research, and conclusions.

### **Research Sample**

A national sample of mental health counselors in the United States was obtained for this study. The final research sample consisted of 213 mental health or licensed professional counselors. The sample was approximately 25% male and 75% female. Approximately 62% of participants self-reported their relationship status as married; 13% as single; 7% in a relationship; 8% in a committed Partnership; 8% divorced; 2%

widowed and 1% selected other. Participants reported living in 43 out of 50 states and Puerto Rico.

Participants were at all stages of their career and represented a variety of ages, with a range of 24 years old to 78 years old. Approximately 4 % of the sample reported their age as 25 and younger, 28% were between ages 26-35, 17% were between 36-45, 19% were between ages 46-55, 25% were between ages 56-65, were 7% were 66 and older. Mental health counselors in this sample reported working in a variety of settings: 31.93% in private practice settings, 30.52% in community mental health agencies, 6.10% in College Counseling Centers, 2.82% in hospital settings, 1.41% in Crisis Stabilization Units, 5.16% in substance abuse treatment centers, 1.41% in Career Counseling Centers, and the remaining 20.66% percent reported 'other' as their work setting.

## **Discussion of Results**

### **Burnout and Compassion Fatigue**

The mean levels of burnout and compassion fatigue reported by this sample was comparable to the mean score reported in the ProQOL manual. The mean burnout score for this sample was 49.92, with a range from a low score of 32.62 to a high score of 81.95 and a standard deviation of 10.01. The mean burnout score in the ProQOL manual is 50, with a standard deviation of 10, and a reported subscale reliability of .75 (Stamm, 2010). The mean score for the compassion fatigue subscale (known as the secondary traumatic stress subscale) reported in this sample was 50.04, with a range from a low score of 36.97 to a high score of 85.28, and a standard deviation of 10.06. This was comparable to the mean score reported in the ProQOL manual for secondary

traumatic stress of 50, with a standard deviation of 10 and a reported scale reliability of .81 (Stamm, 2010).

The mean score on the compassion satisfaction subscale for this study sample was comparable to the means reported in the ProQOL manual. The sample score mean for the compassion satisfaction was 49.95, with a low score of 18.04 and a high score of 63.9, and a standard deviation of 10.02. The score mean reported in the *ProQOL* manual for the compassion satisfaction is 50, with a standard deviation of 10, and a reported scale reliability of .88 (Stamm, 2010).

### **Counselor Working Conditions, Burnout, and Compassion Fatigue**

This study sought to explore the impact of counselors' perceptions of their working conditions on their levels of burnout and compassion fatigue. Specific aspects of counselors' work environments were assessed, such as administration fairness in administrative decision-making, financial compensation, flexibility of hours worked, quality of supervision, coworker relationships, clinical preparedness to serve the types of clients on their caseload, and counselor's perceptions of the overall climate (including whether there was a competitive atmosphere at their work setting). The Counselor Perceived Working Conditions Scale was developed for this study to address the need for further understanding of how these contextual factors influenced counselor's burnout and compassion fatigue. Specific aspects of the counselor work environment have been studied in previous research. For example, Linley and Joseph (2007) reported that receiving clinical supervision was associated with greater personal growth in therapists surveyed. Linley and Joseph conducted their research in England with a population of clinical and counseling psychologists. Ducharme et al. (2008) found that perception of coworker support was associated with lower levels of emotional exhaustion among

substance abuse counselors. While the research findings above support the importance of contextual factors, the current study provided evidence that there were various workplace factors predicting mental health counselor stress outcomes in addition to coworker social support and supervision.

The first hypothesis tested in this study was whether there was significant association between perceived working conditions and reported level of burnout. This hypothesis was accepted because there was a significant inverse relationship between perceived working conditions and reported level of burnout demonstrated by the results of correlation matrix ( $r = -.643, p = .01$ ). Those counselors who reported more positive perceptions of their working conditions reported lower levels of burnout than counselors reporting more negative working conditions.

The second hypothesis was that there is a significant association between perceived working conditions and reported level of compassion fatigue. This hypothesis was also accepted because there was a significant inverse association between perceived positive working conditions and reported level of compassion fatigue. Those counselors who reported more positive perceptions of their working conditions also reported lower levels of compassion fatigue than counselors who reported more negative working conditions ( $r = -.361, p = .01$ ). This finding supports the need to recognize the contextual and perceptual factors associated with counselor compassion fatigue.

### **Gender Effect on Working Conditions, Burnout and Compassion Fatigue**

Gender has been explored in the counselor burnout and compassion fatigue literature with equivocal results. For example, Sprang et al. (2007) found gender differences in levels of burnout and compassion fatigue reported by a diverse sample of

professionals including psychiatrists, social workers, marriage and family therapists, and counselors.

The third hypothesis proposed that there would be a significant contribution of counselor gender in predicting the relationship between counselor perceived working conditions and reported level of burnout. This hypothesis was not accepted as there was no significant association between gender, perceived working conditions, and level of reported burnout found in the regression analysis. The correlation matrix also revealed no significant relationship between gender and burnout in this sample. These results differ from the results of Sprang et al. (2007), in which being female was associated with higher levels of burnout. Gender effects in the current sample may have been less relevant because all participants in the current sample were mental health counselors, meaning that potential status differences by gender were not applicable.

The fourth hypothesis proposed a significant contribution of counselor gender in addition to perception of working conditions to the prediction of compassion fatigue. This hypothesis was not accepted as gender was not found to make a significant contribution in addition to perceived working conditions in predicting compassion fatigue in the regression analysis. However, the correlation matrix revealed that gender was significantly associated with compassion fatigue ( $r = .223, p = .01$ ). Because men were coded as 0 and women as 1, the results of the correlation matrix indicate that females in this sample were more likely to experience compassion fatigue than males in this sample. Sprang et al. (2007) reported gender associations with both burnout and compassion fatigue, with being female between associated with higher risk for both.

However, in the current study, the results of the regression analyses showed no association between gender and levels of burnout and compassion fatigue.

### **Effects of Counselor Length of Time in Field**

The fifth hypothesis proposed that counselor length of time in field would be a significant contributor in addition to perceived working conditions in predicting burnout in the regression analysis. This hypothesis was not accepted. However, the correlation matrix revealed a significant association between length of time in counseling field and burnout ( $r = -.219, p = .01$ ). There was an inverse relationship between counselor length of time in field and reported burnout with more reported years working in the counseling field was associated with lower levels of reported burnout. This could be a function of tenure, as more experienced counselors may have moved up in the work organization and therefore the nature of their working conditions may have improved, resulting lower levels of reported burnout. For example, more experienced counselors with a longer tenure in a work organization may engage in more supervisory, training, and/or administrative activities as compared to newer hires who may have the bulk of their time taken up in providing direct services and documenting those services.

Hypothesis six proposed that there would be a significant contribution of counselor length of time in field in addition to counselor perceived working conditions in predicting counselor compassion fatigue. This hypothesis was not accepted because the regression analysis demonstrated no significant contribution of counselor length of time in field in addition to perceived working conditions in predicting reported level of compassion fatigue. However, the correlation matrix demonstrated that there was an inverse relationship between years a counselor in the field and compassion fatigue ( $r = -.186, p = .01$ ). Greater length of time in field was associated with less reported

compassion fatigue. These results are in contrast to the reported results of Linley and Joseph's (2007) study, in which more years of clinical experience reported more negative psychological changes and compassion fatigue than those with fewer years of experience. Linley and Joseph's sample was comprised of clinical and counseling psychologists in England, so different cultural and career factors could have accounted for the increase in psychological changes and compassion fatigue in their sample. In the current research sample, all participants were mental health counselors living and working in the United States. It is possible that the psychologists sampled in England dealt with a more severe population and became more fatigued over time as they dealt with this severe population. More information about the nature of the clientele served and the climate of the work organization is needed to determine what factors are really responsible for these types of differences. Counselor length of time in field may not account for the underlying factors that are more meaningful, such as nature of work responsibilities and specific types of client contact that professionals engage in with their clients.

### **Influence of Working Conditions and Personal Resources on Burnout**

A major objective of the current study was to examine the combined contribution of working conditions and personal resources in predicting level of burnout reported by mental health counselors. Hypothesis seven was that there would be a significant contribution of perceived working conditions, length of time in field, counselor gender, and extent of reported mindfulness, compassion satisfaction, and type of coping strategy to the prediction of reported level of burnout. The regression model had an  $R^2 = .669$  at a significance level of  $<.001$ , which indicates that these predictor variables accounted for 66.9% of the variance in the outcome variable of burnout. This result

indicates that four predictor variables in this model accounted for the majority of the variance in levels of burnout reported by this sample. Compassion satisfaction, mindfulness, maladaptive coping, and perception of working conditions were each significant predictors of burnout, at a level of significance of  $<.001$ ; a fifth variable, emotion-focused coping, was significant at a level of  $.002$

Compassion satisfaction, the strongest predictor in this model, was inversely related to reported burnout ( $B = -.386, t = -7.550, p = <.001$ ). This suggests that counselors who reported experiencing the most satisfaction in their role as counselors also reported the lowest levels of burnout. Compassion satisfaction has been linked to reduced risk of burnout (Kraus, 2005) and also has also been reported to buffer counselors from the negative effects of exposure to traumatic client material (Collins & Long, 2003). The results of the current study are in alignment with this previous research and suggest that compassion satisfaction can be a powerful resource to help counselors buffer the stress of their work settings. Compassion satisfaction may allow counselors to tolerate the aspects of their job that are less fulfilling because they gain such a sense of meaning and fulfillment from their contact with clients. Understanding how compassion satisfaction operates and what factors increase compassion satisfaction could be a fruitful area of future research. For example, exploring whether there are connections between altruistic motivations to be in the counseling profession and resulting compassion satisfaction could be a beneficial area of future research.

Mindfulness was a strong and significant predictor of burnout, inversely related ( $B = -2.698, t = -4.580, p = <.001$ ). Higher reported levels of mindfulness were associated with lower reported levels of burnout in this sample of mental health counselors. In

previous studies examining mental health counselor mindfulness, associations between mindfulness and self-care and well-being have been reported (Richards et al., 2010). Mindfulness was shown to be a significant predictor of burnout among substance abuse counselors (Vilardaga et al., 2011). The results of the current study provide further evidence of the significance of mindfulness attitudes in reducing mental health counselors' risk of burnout. Mindfulness attitudes are characterized by an openness and acceptance of the present moment, so perhaps counselors who endorse higher levels of mindfulness are less likely to judge themselves or their work setting negatively.

Maladaptive coping was a strong and significant predictor, positively related to burnout ( $B = 4.907$ ,  $t = 4.004$ ,  $p = <.001$ ). The maladaptive coping subscale used in this study included items intended to capture respondents endorsement of substance use, distraction, denial, and self-blame as coping strategies. This connection between maladaptive coping and burnout suggests that some of the ways counselors cope with their stressors may have unintended negative consequences, and actually lead to the risk of more severe consequences of stress such as burnout.

Perception of working conditions was also a significant predictor of burnout ( $B = -.109$ ,  $t = -5.084$ ,  $p = <.001$ ). It was inversely related to burnout, in that positive perceptions of working conditions were associated with lower levels of reported burnout. Counseling working conditions examined in this study included various aspects of the work environment. This outcome provides evidence for why counselor working conditions matter and should be addressed in efforts to ameliorate burnout.

Emotion-focused coping was a significant predictor of burnout at the .002 level, inversely related to burnout ( $B = -2.998$ ,  $t = -3.176$ ,  $p = .002$ ). Thus, the more

counselors endorsed the use of emotion-focused techniques was associated with lower levels of reported burnout. This outcome suggests that counselors who sought ways to manage their emotional reactions to stressful situations were less likely to experience burnout. Counselors cannot control their client's problems nor how they respond to the counseling process. For this reason, perhaps emotion-focused coping strategies help counselors effectively manage the stress of the uncertainty and lack of control that is inherent in the counseling relationship.

Years as a counselor in the field, gender, and problem-focused coping were not significantly predictive of burnout t score in this model. It is possible that examining years as a counselor in the field was too general a predictor to be significant when included in this regression model. Counselor gender was not significant in this model either. Gender effects may have been minimized due to the professional homogeneity of this sample. Problem-focused coping was not significant in this model either. It is possible that the problem-focused coping subscale used in this study included too many different types of coping strategies and therefore results were not clear. For example, the problem-focused subscale included items such as: "I've been thinking hard about what steps to take" and "I've been taking action to try to make the situation better" and "I've been trying to get advice or help from other people about what to do." These items tap different aspects of problem-focused coping, such as thinking and planning, taking action, and seeking instrumental support. Further, perhaps problem-focused coping strategies are effective in handling many types of job stress, but are perhaps not as helpful in addressing stressors associated with relating to autonomous clients in a helping role.

## **Influence of Working Conditions and Personal Resources on Compassion Fatigue**

The eighth and final hypothesis tested was that there would be a significant contribution of perceived working conditions, length of time in field, counselor gender and extent of reported mindfulness, compassion satisfaction, and type of coping strategy to the prediction of reported level of compassion fatigue. This hypothesis was accepted. These factors accounted for 31.1% of the variance in compassion fatigue scores, as compared to 66.9% of the variance in burnout scores. Mindfulness was a significant predictor of compassion fatigue, with an inverse relationship to compassion fatigue ( $B = -3.576$ ,  $t = -4.185$ ,  $p = <.001$ ). Maladaptive coping was a predictor of compassion fatigue at the .003 level ( $B = 5.386$ ,  $t = 3.030$ ,  $p = .003$ ). Gender, compassion satisfaction, emotion-focused coping, and problem-focused coping were not significant predictors of compassion fatigue in this prediction model.

The variables predicting burnout explained almost double the amount of variance as the variables predicting compassion fatigue. This result indicates that these eight predictor variables when examined together accounted for a substantial amount of the variance in burnout scores, but not in compassion fatigue scores. While some of these variables were significantly predictive of compassion fatigue, they were predictive of less of the variance.

While gender was significantly correlated to compassion fatigue when examined alone, gender, compassion satisfaction, emotion-focused coping, and problem-focused coping were not significant predictors of compassion fatigue in this model. One might interpret this finding to mean that there are other factors not addressed in this study that might better explain counselor compassion fatigue. For example, therapist personal

trauma history was not examined in this study and was not included as a variable in this study. Although Leonard (2008) reported no significant associations between compassion fatigue and personal trauma history, significant associations between therapist personal trauma history and compassion satisfaction were reported. Since the relationship between compassion fatigue and compassion satisfaction is still being studied (Stamm, 2010), the inclusion of personal trauma history as a predictive variable could be useful in future models. There is also supportive evidence that a counselor's personal trauma history can impact their well-being, with Linley and Joseph (2007) reporting that therapists with a reported personal trauma history showed greater levels of personal growth.

### **Implications for Practice**

These study findings indicate that the nature of counselor working conditions matter in the occurrence of both counselor burnout and compassion fatigue. The more positively participants in this study viewed their working conditions; the less likely they were to report burnout or compassion fatigue. This finding has implications for administrators and clinicians. For example, the Counselor Perceived Working Conditions Scale included items to assess respondents' views of the general atmosphere at their work setting such as: "*I receive the administrative support that I need to care for clients.*" Exploring ways to improve counselors' working conditions could have powerful ramifications for counselor well-being. Moreover, these findings could have implications for administrators who are charged with maintaining a cohesive staff and reducing turnover rates.

The findings of this study suggest that counselor compassion satisfaction matters and that finding ways to increase compassion satisfaction among clinicians may reduce

the likelihood that clinicians will experience burnout and compassion fatigue.

Compassion satisfaction involves the satisfaction that professionals experience in their helping roles (Stamm, 2010). Perhaps counselors who report more compassion satisfaction are getting rewards from their helping role that may mitigate the negative effects of stressors that they encounter in their job settings. The findings of the current study are consistent with previous research findings. Collins and Long (2003) reported that compassion satisfaction seemed to buffer counselors from the negative impact of exposure to client's traumatic material. Lawson and Myers (2011) also reported that counselor wellness is associated with compassion satisfaction.

Moreover, these findings indicate that counselor dispositional mindfulness attitudes matter. Mindfulness was inversely related to both burnout and compassion fatigue in this study. Further exploration of applications of mindfulness in clinical practice and supervision as a way to reduce risk of counselor burnout and compassion fatigue is needed. In a qualitative study of counselor mindfulness practices, counselors who reported that they practiced mindfulness also reported experiencing connectedness and abundant gratitude. Although mindfulness was practiced in different ways, each participant emphasized awareness of breath and body in their mindfulness practice (Rothaupt & Morgan, 2007). Hence, the further exploration of how cultivation of counselor mindfulness practices may reduce counselor's likelihood of experiencing compassion fatigue and burnout is needed.

Associations between counselor mindfulness and self-care and well-being have also been reported (Richards et al., 2010). Researchers reported a positive relationship between self-care and mindfulness and also suggested that mindfulness may mediate

the relationship between counselor self-care and well-being (Richard et al., 2010). The results of the current study contribute to the literature of the impact of mindfulness for counselor well-being, as mindfulness attitudes were associated with lower levels of both burnout and compassion fatigue.

The types of coping strategies that counselors use have an impact on counselor stress outcomes such as burnout. Maladaptive coping strategies such as denial, distraction, self-blame, and substance use were associated with higher levels of reported burnout in this study. These results suggest that further examination of the associations between maladaptive coping and counselor burnout and compassion fatigue could be beneficial. In addition, exploration of how assessment of coping strategies is related to self-care assessments would be beneficial, as self-care is frequently discussed in the counseling literature (e.g. Richards et al., 2010; Skovholt, 2001). Further exploration of coping in the counselor literature could provide a richer picture of the many ways that counselors respond to the stresses they encounter, not solely the positive or beneficial ways. In the counseling literature, self-care and career sustaining behaviors have been the main constructs used. For example, Lawson and Myers (2011) included career sustaining behaviors in their study examining counselor wellness. Including a coping assessment in addition to self-care and/or career sustaining behavior assessments could provide a richer picture of the range of counselor coping behaviors.

### **Implications for Counselor Preparation**

Counselors-in-training are vulnerable to feeling overwhelmed by the volume of new knowledge that they are learning in addition to the new professional identity they are developing. Contextual aspects of a counselor education program may impact how

counselors-in-training develop professionally. Likewise, counselor work contexts may impact their professional functioning. Counselor educators could use findings from the current study to build a rationale for preparing counselors-in-training for the risks of compassion fatigue and burnout. Exploring compassion satisfaction in group and individual supervision and examining the inverse relationship between compassion satisfaction and burnout would also be a beneficial area to discuss. In addition, exploration of the possible role of gender and societal gender role socialization in the experience of compassion fatigue could be a beneficial subject for supervisory discussion.

The need for further assessment of counselors-in-trainings for risk factors associated with the development of burnout and compassion fatigue is another implication of this study. By taking a proactive approach and examining how counselors-in-training are coping with the demands of their training, perhaps prevention of burnout can begin even before graduation. For example, maladaptive coping strategies were associated with burnout in this sample of mental health counselors. While further research is needed to determine whether this correlation is found among counselors-in-trainings, the current results provide evidence that maladaptive coping and burnout are linked. Counselor educators could help counselors-in-training to self-assess their coping strategies according to this typology and develop healthy coping strategies.

### **Addressing Work Contextual Factors**

Counselors are expected to arrive at work ready to meet their client's needs. Counselor well-being has frequently been conceptualized as the individual's responsibility to maintain through self-care practices. This individualized model of stress management neglects the power of community action to cultivate new norms and create

a more supportive context. Supporting counselor well-being within a framework that recognizes that counselor stress, distress, and impairment can happen to anyone is one approach to encourage ongoing self-assessment and prevention (Lawson et al., 2007). Counselor educators can help counselors-in-training prepare for the risks and demands of the counseling profession and the types of work contexts that they may experience.

Research on counselors-in-training suggests “although counselor education students are exposed to many of the concepts of wellness, the means for effectively implementing strategies to educate and evaluate student progress in this area remains vague and largely neglected” (Roach & Young, 2007, p. 39). There is also a need for counselor educators to provide direct instruction to prevent burnout through the use of effective coping strategies.

### **Enhancing Personal Resources**

Coping strategies, mindfulness attitudes, and compassion satisfaction were all studied as personal resources in this study. The results indicated that the use of maladaptive coping strategies was correlated with higher levels of reported burnout. Maladaptive coping strategies include denial, substance use, and self-blame and were assessed on the brief COPE by items including the following: *“I’ve been refusing to believe that it has happened;”* *“I’ve been using alcohol or other drugs to help me get through it;”* and *“I’ve been blaming myself for things that happened.”* These items provide an overview of the prevailing commonality among maladaptive coping strategies – using strategies that meet an immediate need, yet fail to provide emotional or instrumental resolution to any aspect of the stressor. A benefit of assessing coping strategies versus solely assessing self-care is that this approach allows for a picture of both positive and negative strategies counselors may employ to cope with their

stressors. Thus, use of coping strategies provides a richer picture of the range of coping behaviors counselors use and how these may be predictive of their stress outcomes.

Emotion-focused coping strategies were inversely related to burnout in the current study. Emotion-focused coping strategies include seeking emotional support and thinking about a situation differently: “I've been getting emotional support from others;” and “I've been trying to see it in a different light, to make it seem more positive.” These findings suggest that counselors who employ emotion-focused coping strategies are more able to handle the demands of their jobs without experiencing burnout.

An implication of these findings is that there is a need to explore effective coping practices and avoid maladaptive coping strategies with counselors-in-training. One mode of implementation could be a training program consisting of several modules intended to explore these topics as well as educate counselors-in-training about effective means of coping. Such a program could be integrated into existing group supervision classes for practicum and internship students. Rather than being an outside observer, the professor/facilitator could be a participant observer and share stress management challenges as well as effective coping strategies they have used. This program could be an experiential form of emotion-focused coping for the counselors-in-training to both experience and learn to use similar strategies when facing future stressors.

In addition to the need for training in specific strategies to manage stress, it has been asserted that there is a need for counselors and counselors-in-training to evaluate their self-care practices and their status along the continuum of well, stressed, distressed, and impaired (Cummins et al., 2007). By gaining awareness of their own

status on this continuum, counselors can recognize their own vulnerability and take actions to address it (Cummins et al., 2007).

It might be beneficial to include approaches to enhance self-awareness when designing interventions to prevent burnout and compassion fatigue. Counselors-in-training could be encouraged to explore their own coping process through journaling and other creative practices. Journaling could assist counselors-in-training as journaling has been reported to be instrumental in easing emotional distress (Pennebaker, 1990). Reflective assignments regarding coping practices could be used to promote a proactive ongoing assessment process. Journal writing could be incorporated throughout the graduate training to increase self-awareness and assist counselors-in-training to reflect on their level of stress and well-being.

Mindfulness has also been explored in the counselor preparation literature (Schure et al., 2008). Mindfulness has also been studied in relation to counselor self-efficacy, attention, and empathy (Greason & Cashwell, 2009). Mindfulness interventions for counselors-in-training could be further studied to determine their efficacy in preventing future burnout.

### **Implications for Theory**

The findings of this study provide evidence for the relevance of examining counselor coping strategies in addition to self-care behaviors. This study explored counselor coping using a typology comprised of three types of coping – emotion-focused, problem-focused, and maladaptive coping. The exploration of coping is new in the research on counselor well-being, burnout and compassion fatigue, despite links between coping and stress outcomes in other populations such as recent immigrant populations (Belizaire & Fuyertes, 2011) and college students adjusting to a family

member's illness (Schmidt & Welsh, 2010). While counselor self-care (Richards et al., 2010) and career sustaining behaviors (Myers & Lawson, 2011) have been explored by counseling researchers, coping strategies have not been previously studied in this population. Given the unique demands of the counseling work environment, the exploration of coping in this population seems long overdue. Whereas comparisons between various research explorations of self-care have been hampered by inconsistent definitions (Richards et al., 2010), the use of a coping construct could allow for a more consistent operationalization.

The exploration of coping strategies allowed for a theoretically grounded and nuanced examination of both the positive and negative ways that counselors strive to manage the demands and stressors that they encounter. From the transactional perspective, psychological stress cannot be viewed separately from appraisal or coping (Lazarus & Folkman, 1984). Appraisal and coping are influenced by both individual and contextual factors in a recursive process. The use of this theoretical lens and the theoretically robust construct of coping allows for examination of the recursive nature of the counselor stress experience.

In addition, whereas self-care is focused on positive activities, coping includes a broad range of activities that are intended to reduce stress, but may or may not have a positive effect on the individual. For example, the use of this coping typology allowed for the exploration of maladaptive coping strategies that counselors may employ to cope with stress, such as self-blame and substance use, which are not accounted for in the self-care literature. Further, the finding in this study that maladaptive strategies were associated with burnout supports the further exploration of coping in the mental health

counselor population, as well as a theoretical shift from focusing solely of positive counselor behaviors to manage stress, to including a wide range of counselor attempts to manage stress, both negative and positive. The use of coping in the counselor well-being literature in addition to the constructs of self-care and career sustaining behavior could add to our understanding of how maladaptive attempts to cope with stress that have unintended negative consequences may hamper efforts to reduce incidence of counselor burnout.

In this study, compassion satisfaction was examined as a predictor variable, rather than an outcome variable. This approach adds to the literature on counselor compassion satisfaction, in which compassion satisfaction is conceptualized a positive outcome that may result from counseling work (Stamm, 2010). By examining compassion satisfaction as an input rather than an output, compassion satisfaction is conceptualized as something within the individual counselor that they can choose to cultivate. This conceptualization of compassion satisfaction is consistent with the transactional model of stress and coping, and represents a new conceptualization of compassion satisfaction as a personal resource rather than an outcome. This highlights the active role that counselors can play in cultivating their own level of compassion satisfaction, even as they encounter the stresses and demands of their work environment.

The results of the current study suggest that compassion satisfaction may be an important buffer in reducing counselor risk of burnout, given the significant inverse correlation found between reported levels of compassion satisfaction and burnout in this sample. While further research examination is needed, the current finding suggests that

compassion satisfaction may serve a preventative function in the etiology of burnout. In contrast, compassion satisfaction and compassion fatigue were not correlated in this study. This suggests that a counselor could be experiencing both compassion satisfaction and compassion fatigue simultaneously, which provides a window into the differences between burnout and compassion fatigue and the need for greater understanding of the predictors and buffers of counselor compassion fatigue.

### **Implications for Research**

The results of this study suggest the need for further understanding of how counselors perceive their working conditions. The instrument created for this study to assess counselors' perceptions of their working conditions could be used in future research studies to explore counselors' perceptions of their working conditions in connection with counselor well-being and turnover. Counselor turnover in substance abuse settings is related to counselor emotional exhaustion and has negative impact for clients (Ducharme et al., 2008). It has also been reported that higher occupational stress is associated with turnover intention among rehabilitation counselors (Layne et al., 2004). Research examining how work stress impacts mental health counselors' turnover rates and turnover intention is needed. Moreover, further understanding of how work context can in turn impact turnover and how interventions to improve counselors work context impact retention rates would be beneficial to the counseling profession.

One of the implications of the research on the development of the MAAS is that dispositional mindfulness levels are related to state mindfulness levels. Therefore, an area for additional research exploration is to examine if dispositional mindfulness among counselors can be increased by mindfulness training. There is a need for research which examines the relationship between mindfulness training and

dispositional mindfulness in this population, due to the correlation between increased levels of mindfulness and lower levels of reported burnout and compassion fatigue in this study. Existing research has explored the impact of mindfulness on substance abuse counselors (Villardaga et al., 2011). While workplace factors were found to be predictive of burnout, substance abuse counselor mindfulness attitudes were even better predictors. These findings suggest that mindfulness is a powerful predictor of burnout. Further, examining how counselor mindfulness attitudes and practices that may reduce burnout and compassion fatigue and how this may in turn benefit clients is also needed.

The current findings suggest a potential connection between mindfulness and compassion satisfaction, however there is in a need for further research in this area to see if these findings are replicated by other studies. Moreover, future studies could be conducted to examine whether there is a causal relationship between mindfulness and compassion satisfaction among mental health counselors. Moreover, research examining whether clinicians who practice mindfulness are less likely to use maladaptive coping strategies concurrently is needed.

In addition, exploring whether gender role socialization impacts the relationship between being a female counselor and experiencing compassion fatigue is a research area that needs further attention based on the findings of this study as well as previous research findings. Sprang et al. (2007) advocated for further research to examine the impact of gender role socialization on various aspects of compassion fatigue and burnout, including clinician disclosure of symptomology and actual differences in occurrence rates by gender. The findings of the current study suggest that there may be

differences between the phenomena of burnout and compassion fatigue such that females are more likely than men to experience compassion fatigue but no corresponding gender effect in occurrences of burnout. Further research exploration into the construct differences between burnout and compassion fatigue is needed to understand the risks and protective factors that clinicians may experience due to gender role socialization.

Another area ripe for further research is how cultural and gender identity intersect in the experience of counselor compassion fatigue and burnout. Moreover, research exploration of cross-cultural understandings of well-being, burnout and compassion fatigue is needed. Counseling researchers have advocated for research exploration of the impact of racism and other forms of discrimination on counselor wellness levels (Day-Vines & Holcomb-McCoy, 2007). The current study did not address the impact of discrimination or counselor cultural factors in the development of counselor burnout and compassion fatigue, due to the relatively homogenous sample. Future studies could recruit a more diverse sample of counselors to address this area of needed research exploration.

The current study addressed counselor burnout and compassion fatigue. Another related area of research is to study positive counselor stress outcomes such as counselor well-being. Research examining whether counselor well-being is correlated with client treatment outcomes is also needed.

While there are ethical mandates that counselors take care of themselves and self-monitor to prevent impairment (ACA Code of Ethics, 2005), there is a dearth of empirical research connecting counselor stress outcomes to client treatment outcomes.

One factor impacting the dearth of research linking counselor stress outcomes to client treatment outcomes could be the practical difficulties and confidentiality concerns involved in research that links clinician and client. However, with careful research design, such concerns could be addressed and the results of research in this domain could add to our understanding of clinician factors that are associated with client treatment outcomes. Moreover, research evidence that counselor well-being matters to client treatment outcomes could provide an empirical foundation supporting the counselor wellness movement and the impetus to further integrate issues related to counselor well-being in counselor preparation programs and continuing education and counselor accountability initiatives. If this type of research demonstrates a connection between counselor well-being and positive client treatment outcomes, the professional impetus to improve factors that impact counselor well-being or lack thereof would increase. Factors such as those addressed in this study, including counselor working conditions, compassion satisfaction, mindfulness attitudes, and coping practices, merit further research.

### **Study Limitations**

There were limitations related to the generalizability, self-report survey research design and the instrumentation used in the study. Although this study was designed to be generalizable to the population of interest, the author acknowledges certain limitations of the study design. While efforts were made to recruit mental health counselors from a variety of backgrounds who are not members of the American Mental Health Counselors Association (AMHCA), one means of recruiting participants was through the email lists of AMHCA membership. Listserv announcements were posted to professional association listservs including the Association for Spiritual, Ethical, and

Religious Values in Counseling. This may have led to a sample consisting of counselors who are active in professional associations. Therefore, the data gathered from this sample may not accurately reflect the entire population of mental health counselors in the United States, many of whom may not be active in professional associations.

In addition, participants in this study were voluntary and self-selected. Researchers have reported that research volunteers tend to have different characteristics than non-volunteers. For example, volunteers tend to seek social approval, be arousal-seeking, and be more intelligent than non-volunteers (Gall et al., 2007). Therefore the sample of research participants could have skewed the results in ways that describe research volunteers but do not necessarily generalize to the population of interest. Further, as a self-report survey method, a limitation of this study is the social desirability bias - participants may try to present themselves in the best possible light, rather than answering honestly (Gall et al., 2007).

Another limitation of the study design was that counselors who were most stressed might not have taken the time to complete the survey, due to their level of stress. Hence, the sample may not include some participants experiencing maximum amounts of stress, thereby limiting the generalizability of the results. Moreover, potential participants who were experiencing stress may not have wanted to complete the survey due to the nature of the topic itself.

The instrumentation, while carefully selected or developed to measure the variables of interest in this study, may also have posed a limitation. The researcher developed the Counselor Perceived Working Conditions Scale which does not have a previous track record of use. While the scale had strong reliability and demonstrated

effectiveness, only initial reliability and validity information is available, based on factor analysis conducted on the results of the research sample in this study.

The instrument used to measure counselor coping, the Brief COPE, was normed on a non-counselor population (Carver, 1997). The current study used this instrument on a different population than the one on which it was originally normed. In addition, the researcher utilized a method of grouping the 14 subscales of the Brief COPE into three broader subscales of emotion-focused, problem-focused, and maladaptive coping. While this grouping was based on the previous research findings (Meyer, 2001), the author acknowledges that this approach is distinct from Carver's subscale and scoring organization (1997).

In addition to these methodological limitations, there are also conceptual limitations inherent in a study of this nature; for example, it is possible that this research design was missing a key personal resource that may have also impacted the outcome variables that were explored. The results demonstrated that the specific contextual factors and personal resources hypothesized as predictors of burnout were predictive of burnout and compassion fatigue. However, the amount of variance of compassion fatigue scores accounted for by these predictors was not as great as that for burnout scores. Therefore, there may be other personal resources or contextual factors that are important predictors of compassion fatigue among mental health counselors that were not accounted for in this study. For example, Sprang et al. (2007), reported results that specialized training in working with traumatized clientele was associated with greater levels of compassion satisfaction.

Further, while an exploration of work-related contextual factors was deliberately detailed in this study, family-related contextual factors were not as well addressed in this study design and were not included as predictor variables. Future research addressing family-related contextual factors in prediction models for burnout and compassion fatigue is needed.

While coping was examined in this study, a more situation specific approach to analyzing coping responses might have yielded more meaningful results. Respondents were asked to provide a written description of a recent stressful experience at work and then were asked to respond to the Brief COPE based on how they had responded to the specified stressful experience. This is consistent with Carver's (1997) specifications that this inventory could be used a dispositional or situational inventory. Although participants were asked to think of specific stressors and write about them, it was beyond the scope of this study to analyze their qualitative responses and then connect them to their coping responses on the Brief COPE inventory.

### **Conclusion**

This study addressed the phenomena of counselor burnout and compassion fatigue using the theoretical framework of the transactional theory of stress and coping. The use of this theory represents a conceptual innovation in the counselor burnout and compassion fatigue literature, in that it acknowledges the transactional nature of mental health counselor's stress response process. A guiding aspect of this theory is the complexity of the stress response process, in which the individual's characteristics, perceptions, and ways of coping and the constellation of environmental factors that they experience are understood to concurrently and synergistically impact individual counselor's stress outcomes. In this study, mental health counselor's perceptions of

their working conditions and their length of time in the field and their gender were considered as specific contextual factors that were hypothesized to predict the outcomes of counselor burnout and compassion fatigue. The specific personal resources that are proposed to mediate these contextual factors were counselor mindfulness attitudes, compassion satisfaction, and emotion-focused, problem-focused, and maladaptive coping strategies. These variables accounted for 66.9% of the amount of variance in reported burnout among the 213 mental health counselors in this sample. However, these same factors were predictive of only 33.1% of the variance in the level of compassion fatigue reported. The difference in outcome for burnout and compassion fatigue provides further evidence for the difference between these two phenomena. Moreover, this model was strongly predictive of variance in burnout scores, which indicates that counselor working conditions, mindfulness, compassion satisfaction, and coping strategies warrant further attention in the field.

APPENDIX A  
INFORMED CONSENT DOCUMENT – ONLINE VERSION

Dear Participant,

My name is Isabel Thompson and I am doctoral candidate in Mental Health Counseling at the University of Florida. You are invited to participate in a research study which is part of my doctoral dissertation. The purpose of this study is to explore **professional counselors' working conditions, their ways of coping with these conditions, and the impact of these conditions on their well-being.**

I serve as the principal investigator of this research study. This study has been approved by my faculty adviser, doctoral dissertation committee, and by the University of Florida Institutional Review Board (IRB).

To participate in this study, it will be necessary for you to have a completed master's degree (or higher degree) in mental health counseling, community counseling, or a closely related field and work at least 20 hours per week as a paid counselor providing clinical services to clients. Further, in order to participate in this study you need to have worked in your current setting for at least 6 months.

As a participant in this study, you will be asked to complete an online survey. The survey will take approximately 20 minutes to complete.

Your identity and individual responses will remain confidential to the extent provided by law. Your name will not be collected nor used in any report. Results will be combined for data analysis and reported in the form of group data.

All aspects of the data collection and transmission process are protected by security technology. There is a minimal risk that security of any online data may be breached, but since (1) no individually identifying information will be collected, (2) the online host uses several layers of encryption, and (3) all data will be kept in a secure electronic database and removed upon completion of the study, it is highly unlikely that a security breach of the online data will result in any adverse consequence for you. For further information on the security of your data please visit <http://www.psychdata.com/content/security.asp>.

There are no known risks or benefits of participating in this study. No monetary or other form of compensation will be provided for participation in this study.

Your participation in this study is completely voluntary. You may withdraw from this study at any time without penalty. Your responses will not be included in the study data if you choose to discontinue the survey.

If you have questions about this study, please contact me at (352) 273-4334 or [ithompson@ufl.edu](mailto:ithompson@ufl.edu). Or you may contact my supervisor, Dr. Ellen S. Amatea at the University of Florida, School of Human Development and Organizational Studies in Education, 1202 Norman Hall, P.O. Box 117046, Gainesville, FL 32611-7046, phone (352) 273-4322 or via email at

eamatea@coe.ufl.edu. Questions or concerns about your rights as a research participant can be directed to the IRB02 office, PO Box 112250, University of Florida, Gainesville, FL 32611-2250; phone (352) 392-0433.

By clicking 'yes' below you are consenting to participate in this study.

APPENDIX B  
INFORMED CONSENT DOCUMENT – PAPER AND PENCIL VERSION

Dear Participant,

My name is Isabel Thompson and I am doctoral candidate in Mental Health Counseling at the University of Florida. You are invited to participate in a research study which is part of my doctoral dissertation. The purpose of this study is to explore **professional counselors' working conditions, their ways of coping with these conditions, and the impact of these conditions on their well-being.**

I serve as the principal investigator of this research study. This study has been approved by my faculty advisor, doctoral dissertation committee, and by the University of Florida Institutional Review Board (IRB).

To participate in this study, it will be necessary for you to have a completed master's degree (or higher degree) in mental health counseling, community counseling, or a closely related field and work at least 20 hours per week as a paid counselor providing clinical services to clients. Further, in order to participate in this study you need to have worked in your current setting for at least 6 months.

As a participant in this study, you will be asked to complete a survey. The survey will take approximately 20 minutes to complete. Your individual responses will remain confidential. Results will be combined for data analysis and reported in the form of group data.

There are no known risks or benefits of participating in this study. No monetary or other form of compensation will be provided for participation in this study.

Your participation in this study is completely voluntary. You may withdraw from this study at any time without penalty. Your responses will not be included in the study data if you choose to discontinue the survey.

If you have questions about this study, please contact me at (352) 273-4334 or [ithompson@ufl.edu](mailto:ithompson@ufl.edu). Or you may contact my supervisor, Dr. Ellen S. Amatea at the University of Florida, School of Human Development and Organizational Studies in Education, 1202 Norman Hall, P.O. Box 117046, Gainesville, FL 32611-7046 phone (352) 273-4322 or via email at [eamatea@coe.ufl.edu](mailto:eamatea@coe.ufl.edu). Questions or concerns about your rights as a research participant can be directed to the IRB02 office, PO Box 112250, University of Florida, Gainesville, FL 32611-2250; phone (352) 392-0433.

By signing and dating below you are consenting to participate in this study.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## APPENDIX C COUNSELOR PERCEIVED WORKING CONDITIONS

In this survey, we'll be asking you questions about the working conditions you experience as a counselor and how you've been responding to these specific conditions. We'll then ask about how you respond to your day-to-day experiences in general. We'll also ask you about how these working conditions effect how you think of yourself as a counselor. At the end of survey, we'll ask you to tell us a little bit more about yourself and your work and educational history.

### Part 1

This part of the survey asks you to share your thoughts and feelings about the specific working conditions that you are experiencing. Please rate the frequency with which you experience each of the working conditions described below in the past 30 days. (If you never experience this working condition in your current work setting, select never).

1=never	2=rarely	3=occasionally	4=often	5=almost always	
1. My interactions with my clients are very rewarding emotionally.	1	2	3	4	5
2. The atmosphere at my work setting is collegial.	1	2	3	4	5
3. I receive the administrative support that I need to care for clients.	1	2	3	4	5
4. My work colleagues don't seem to care about my knowledge or experiences.	1	2	3	4	5
5. The amount of paperwork I have to complete is overwhelming.	1	2	3	4	5
6. Billing and insurance concerns take up too much of my time.	1	2	3	4	5
7. Colleagues take the time to consult with me regarding clinical issues when I need it.	1	2	3	4	5
8. My caseload includes many clients who are actively suicidal or self-injurious.	1	2	3	4	5
9. I have the freedom to choose how I conduct clinical interventions with clients.	1	2	3	4	5
10. My boss is reasonable in her/his demands.	1	2	3	4	5
11. My coworkers seem discouraged and overwhelmed.	1	2	3	4	5
12. The clients I work with face such overwhelming problems, I wonder how anybody can help them.	1	2	3	4	5
13. I receive an adequate salary and healthcare benefits.	1	2	3	4	5
14. I have the ability to set my own work schedule at my work setting.	1	2	3	4	5
15. I feel that it is next to impossible to help the clients on my caseload.	1	2	3	4	5

16. I am able to take time off from work when I need to.	1	2	3	4	5
17. It seems too difficult to help the clients I work with make changes	1	2	3	4	5
18. I believe that the organization I work for doesn't care about my well-being.	1	2	3	4	5
19. I have the skills to help my clients make progress with their problems/issues.	1	2	3	4	5
20. I feel cut off from my colleagues at my work setting.	1	2	3	4	5
21. The size of my caseload is reasonable given the other commitments that I have at my work setting.	1	2	3	4	5
22. I have the training I need to work effectively with each of the clients on my caseload.	1	2	3	4	5
23. Counselors at my work setting cooperate to ensure that clients receive the best care possible.	1	2	3	4	5
24. My caseload includes a balance of different types of cases and levels of severity of client issues.	1	2	3	4	5
25. Profit is the top priority in this work organization.	1	2	3	4	5
26. I seem to take more responsibility for helping my clients make changes than they do.	1	2	3	4	5
27. The supervision I receive provides me what I need to be effective as a counselor.	1	2	3	4	5
28. Counselors at my work setting have to compete with one another to get ahead in their careers.	1	2	3	4	5
29. My clients have so many problems that it is hard to even know where to start.	1	2	3	4	5
30. My cultural background is respected at my work setting.	1	2	3	4	5
31. The people I counsel are motivated to make positive changes in their lives.	1	2	3	4	5
32. I spend too much time completing paperwork and not enough time providing therapeutic services.	1	2	3	4	5
33. I feel empowered to speak out about how clients are treated at my work setting.	1	2	3	4	5
34. My supervisor wants me to excel and helps me build on existing skills.	1	2	3	4	5

35. Effective client treatment is a top priority in this work organization.	1	2	3	4	5
36. I feel as though my clients are engaged in the treatment process.	1	2	3	4	5
37. It is difficult for me to predict the kind of income I am going to have from week to week.	1	2	3	4	5
38. Decisions that impact me in my work setting are made in a fair and open way.	1	2	3	4	5
39. Because we are so understaffed at my work setting, I cannot take time off when I need to.	1	2	3	4	5
40. I have concerns for my safety in working with many of my clients.	1	2	3	4	5
41. I believe that there is an unfair distribution of cases at my work setting.	1	2	3	4	5
42. The clients I work with make too many demands on me.	1	2	3	4	5
43. I see the clients I work with making positive changes in their lives.	1	2	3	4	5
44. My work setting provides me with ongoing education to further develop my skills.	1	2	3	4	5
45. Staff in my work setting are open to trying new innovative counseling approaches.	1	2	3	4	5
46. The pace of my work creates little time for me to reflect on how to work with my clients.	1	2	3	4	5
47. The clients I work with tell me they are benefiting from our counseling work.	1	2	3	4	5
48. I am comfortable approaching my colleagues about consultation or support.	1	2	3	4	5
49. In my work setting, we are expected to do more with fewer resources.	1	2	3	4	5
50. I enjoy the types of work that I complete throughout the day at my work setting.	1	2	3	4	5

## APPENDIX D SURVEY PART II

The following section deals with possible working conditions you experience as a counselor and how you cope with them. Research has indicated that certain working conditions may be stressful for counselors (e.g. excessive caseload, traumatic issues of clients, lack of organizational support, and lack of needed supervision). We are interested in finding out about a specific stressful working condition that you experience in your work setting and what helps you cope with it.

In the space below please describe a condition in your work environment that you have found stressful during the past 30 days.

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While different people may deal with stress in different ways; we're interested in how you've dealt with a stressful/challenging work condition, such as the one that you described above. Keep the situation described above in mind as you respond to the items below. Please indicate how you are currently responding to your above example. There is no need to evaluate if your response is working or not. Using the choices below, rate how frequently you've been responding this way. Rate each item separately from every other item. Make your answers as true FOR YOU as you can.

- 1 = I haven't been doing this at all
- 2 = I've been doing this a little bit
- 3 = I've been doing this a medium amount
- 4 = I've been doing this a lot

- |                                                                                      |               |
|--------------------------------------------------------------------------------------|---------------|
| 1. I've been turning to other activities to take my mind off things.                 | 1   2   3   4 |
| 2. I've been concentrating my efforts on doing something about the situation I'm in. | 1   2   3   4 |
| 3. I've been saying to myself "this isn't real."                                     | 1   2   3   4 |
| 4. I've been using alcohol or other drugs to make myself feel better.                | 1   2   3   4 |
| 5. I've been getting emotional support from others.                                  | 1   2   3   4 |
| 6. I've been giving up trying to deal with the situation.                            | 1   2   3   4 |

- |                                                                                                                                          |   |   |   |   |
|------------------------------------------------------------------------------------------------------------------------------------------|---|---|---|---|
| 7. I've been taking action to try to make the situation better.                                                                          | 1 | 2 | 3 | 4 |
| 1 = I haven't been doing this at all                                                                                                     |   |   |   |   |
| 2 = I've been doing this a little bit                                                                                                    |   |   |   |   |
| 3 = I've been doing this a medium amount                                                                                                 |   |   |   |   |
| 4 = I've been doing this a lot                                                                                                           |   |   |   |   |
| 8. I've been refusing to believe that it has happened.                                                                                   | 1 | 2 | 3 | 4 |
| 9. I've been saying things to let my unpleasant feelings escape.                                                                         | 1 | 2 | 3 | 4 |
| 10. I've been getting help and advice from other people.                                                                                 | 1 | 2 | 3 | 4 |
| 11. I've been using alcohol or other drugs to help me get through this situation.                                                        | 1 | 2 | 3 | 4 |
| 12. I've been trying to see it in a different light, to make it seem more positive                                                       | 1 | 2 | 3 | 4 |
| 13. I've been criticizing myself.                                                                                                        | 1 | 2 | 3 | 4 |
| 14. I've been trying to come up with a strategy about what to do.                                                                        | 1 | 2 | 3 | 4 |
| 15. I've been getting comfort and understanding from someone.                                                                            | 1 | 2 | 3 | 4 |
| 16. I've been giving up the attempt to cope with the situation.                                                                          | 1 | 2 | 3 | 4 |
| 17. I've been looking for something good in what is happening.                                                                           | 1 | 2 | 3 | 4 |
| 18. I've been making jokes about this situation.                                                                                         | 1 | 2 | 3 | 4 |
| 19. I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping. | 1 | 2 | 3 | 4 |
| 20. I've been accepting the reality of the fact that it has happened.                                                                    | 1 | 2 | 3 | 4 |
| 21. I've been expressing my negative feelings.                                                                                           | 1 | 2 | 3 | 4 |
| 22. I've been trying to find comfort in my religion or spiritual beliefs.                                                                | 1 | 2 | 3 | 4 |
| 23. I've been trying to get advice or help from other people about what to do.                                                           | 1 | 2 | 3 | 4 |
| 24. I've been learning to live with the situation.                                                                                       | 1 | 2 | 3 | 4 |
| 25. I've been thinking hard about what steps to take.                                                                                    | 1 | 2 | 3 | 4 |
| 26. I've been blaming myself for things that happened.                                                                                   | 1 | 2 | 3 | 4 |
| 27. I've been praying or meditating.                                                                                                     | 1 | 2 | 3 | 4 |
| 28. I've been making fun of the situation.                                                                                               | 1 | 2 | 3 | 4 |

APPENDIX E  
PROFESSIONAL QUALITY OF LIFE

**Counselor Experiences**

When you counsel 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 counselor. 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 counsel.
- \_\_\_\_\_ 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 counselor.
- \_\_\_\_\_ 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 counselor.
- \_\_\_\_\_ 11. Because of my counseling, I have felt "on edge" about various things.
- \_\_\_\_\_ 12. I like my work as a counselor.
- \_\_\_\_\_ 13. I feel depressed because of the traumatic experiences of the people I counsel.
- \_\_\_\_\_ 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 counseling 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 counselor.
- \_\_\_\_\_ 20. I have happy thoughts and feelings about those I counsel and how I could help them.
- \_\_\_\_\_ 21. I feel overwhelmed because my caseload 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 counsel.
- \_\_\_\_\_ 24. I am proud of what I can do to help.
- \_\_\_\_\_ 25. As a result of my counseling, I have intrusive, frightening thoughts.
- \_\_\_\_\_ 26. I feel "bogged down" by the system.
- \_\_\_\_\_ 27. I have thoughts that I am a "success" as a counselor.
- \_\_\_\_\_ 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 F  
MINDFUL ATTENTION AWARENESS SCALE

Instructions: Below is a collection of statements about your everyday experience. Using the 1-6 scale below, please indicate how frequently or infrequently you currently have each experience. Please answer according to what really reflects your experience rather than what you think your experience should be. Please treat each item separately from every other item.

1	2	3	4	5	6
Almost Never	Very Infrequently	Somewhat Infrequently	Somewhat Frequently	Very Frequently	Almost Always
I could be experiencing some emotion and not be conscious of it until some time later.					
1	2	3	4	5	6
I break or spill things because of carelessness, not paying attention, or thinking of something else.					
1	2	3	4	5	6
I find it difficult to stay focused on what's happening in the present.					
1	2	3	4	5	6
I tend to walk quickly to get where I'm going without paying attention to what I experience along the way.					
1	2	3	4	5	6
I tend not to notice feelings of physical tension or discomfort until they really grab my attention.					
1	2	3	4	5	6
I forget a person's name almost as soon as I've been told it for the first time.					
1	2	3	4	5	6
It seems I am "running on automatic," without much awareness of what I'm doing.					
1	2	3	4	5	6
I rush through activities without being really attentive to them.					
1	2	3	4	5	6
I get so focused on the goal I want to achieve that I lose touch with what I'm doing right now to get there.					
1	2	3	4	5	6
I do jobs or tasks automatically, without being aware of what I'm doing.					
1	2	3	4	5	6
I find myself listening to someone with one ear, doing something else at the same time.					
1	2	3	4	5	6

1	2	3	4	5	6
Almost Never	Very Infrequently	Somewhat Infrequently	Somewhat Frequently	Very Frequently	Almost Always

I drive places on 'automatic pilot' and then wonder why I went there.

1	2	3	4	5	6
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I find myself preoccupied with the future or the past.

1	2	3	4	5	6
---	---	---	---	---	---

I find myself doing things without paying attention.

1	2	3	4	5	6
---	---	---	---	---	---

I snack without being aware that I'm eating.

1	2	3	4	5	6
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APPENDIX G  
DEMOGRAPHIC QUESTIONNAIRE

Gender (please circle): Male/Female

Please write in your age in years. \_\_\_\_\_

Race/Ethnicity (please check which apply):

Native American/Alaskan Native

Asian

Black/African American

Latino/a

White/Caucasian American

Native Hawaiian or other Pacific Islander

Multiethnic

Other (please specify) \_\_\_\_\_

Relationship Status: percentages

Single

In a relationship

Committed Partnership

Married

Divorced

Widowed

Other (please specify) \_\_\_\_\_

If you are in a relationship, how stressful is it for you to manage the demands of your relationship? Please circle the number that applies to you: 1=Not stressful, 2=Somewhat Stressful, 3=Fairly Stressful, 5=Very Stressful

Not Stressful      1                  2                  3                  4                  Very Stressful

If you are a caregiving for an elderly or disabled relative, how stressful is it for you to manage the demands of caregiving? Please circle the number that applies to you: 1=Not stressful, 2=Somewhat Stressful, 3=Fairly Stressful, 5=Very Stressful

Not Stressful      1                      2                      3                      4                      Very Stressful

Do you have children?

Yes / No

If you indicated that you have children, how many do you have?

If you indicated that you have children, do they currently live with you?

If you are a parent, how stressful is it for you to manage the demands of parenting? Please circle the number that applies to you: 1=Not stressful, 2=Somewhat Stressful, 3=Fairly Stressful, 5=Very Stressful

Not Stressful      1                      2                      3                      4                      Very Stressful

**Please indicate the city and state in which you live:**

**Educational Background.**

Please check the degrees that you have completed.

B.A. \_\_\_\_\_

M.A. \_\_\_\_\_

M.Ed. \_\_\_\_\_

Ed.S. \_\_\_\_\_

Ph.D. /EdD \_\_\_\_\_

Other (please specify) \_\_\_\_\_

How many graduate credit hours have you earned in total? Please include graduate credits from all degrees, including post-master's degrees. \_\_\_\_\_

**Current Work Involvement**

Please indicate the total number of hours you work per week. \_\_\_\_\_

Please indicate the number of hours you spend providing direct services to clients. \_\_\_\_\_

Please indicate the total number of clients on your caseload. \_\_\_\_\_

Please indicate the total number of years you have worked in the counseling field. \_\_\_\_\_

Please indicate the number of months or years you have worked at your current job setting.  
Minimum of 6 months at current job for inclusion in this study. \_\_\_\_\_

What is your salary/yearly income from your counseling work?  
Please include only income from your counseling work.

- \_\_\_\_\_ Less than 10,000
- \_\_\_\_\_ 10,000-24,999
- \_\_\_\_\_ 25,000-34,999
- \_\_\_\_\_ 35,000-44,999
- \_\_\_\_\_ 45,000-54,999
- \_\_\_\_\_ 55,000-64,999
- \_\_\_\_\_ 65,000-74,999
- \_\_\_\_\_ 75,000-84,999
- \_\_\_\_\_ 85,000-94,999
- \_\_\_\_\_ 95,000 or more
- \_\_\_\_\_ Other (please specify): \_\_\_\_\_

How would you describe your work setting?

- \_\_\_\_\_ Individual Private Practice
- \_\_\_\_\_ Group Private Practice
- \_\_\_\_\_ Community Mental Health Agency
- \_\_\_\_\_ College Counseling Center
- \_\_\_\_\_ Hospital
- \_\_\_\_\_ Crisis Stabilization Unit
- \_\_\_\_\_ Substance Abuse Treatment Center
- \_\_\_\_\_ Career Counseling Center
- \_\_\_\_\_ Other (please specify): \_\_\_\_\_

If you work in a private practice setting, how many clinicians work in your practice?

Please write in number. \_\_\_\_\_

What is your current licensure status? Please check all that apply.

\_\_\_\_ Fully licensed in your state

\_\_\_\_ Registered Intern Status

\_\_\_\_ National Certified Counselor

\_\_\_\_ Other (please specific): \_\_\_\_\_

None specified \_\_\_\_\_

What licenses do you hold? Since many states have different licensure titles for professional mental health counselors, please write in your licensure here. If you are dually licensed in another profession, please indicate that here.

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Does your workplace promote a particular theoretical orientation?

Yes/No

If you answered yes to the question above, which theoretical orientation does your workplace promote/endorse? (Please briefly describe the theory that your workplace promotes). \_\_\_\_\_

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Do you currently receive supervision?

Yes/No

If you currently receive supervisor, please describe the nature of the supervision you currently receive below.

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Are you a member of the American Counseling Association (ACA)?

Yes/No

Are you a member of the American Mental Health Counselors Association (AMHCA)?

Yes/No

Are you a member of any of the following professional associations? Please check all that apply and/or write in another association.

- American Association of Marriage and Family Therapists (AAMFT)
- Association for Assessment in Counseling and Education (AACE)
- Association for Adult Development and Aging (AADA)
- Association for Child and Adolescent Counseling (ACAC)
- Association for Creativity in Counseling (ACC)
- American College Counseling Association (ACCA)
- Association for Counselors and Educators in Government (ACEG)
- Association for Counselor Education and Supervision (ACES)
- Association for Humanistic Counseling (AHC)
- Association for Lesbian, Gay, Bisexual and Transgender Issues in Counseling (ALGBTIC)
- Association for Multicultural Counseling and Development (AMCD)
- American Rehabilitation Counseling Association (ARCA)
- American School Counselor Association (ASCA)
- Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC)
- Association for Specialists in Group Work (ASGW)
- Counselors for Social Justice (CSJ)
- International Association of Addictions and Offender Counselors (IAAOC)
- International Association of Marriage and Family Counselors (IAMFC)
- National Career Development Association (NCDA)
- National Employment Counseling Association (NECA)
- Other (please specify): \_\_\_\_\_

How easy is it for you to let go of difficult emotions after an intense session with a client?

Please circle the number that applies to you: 1=very hard to let go, 2=somewhat hard to let go, 3=Neither hard nor easy to let go, 4=somewhat easy to let go, 5=Easy to let

Very hard to let go      1                      2                      3                      4                      5                      Easy to  
let go

Is there any other information related to your work as a counselor that you think that it would be important for us to know?

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Thank you!

APPENDIX H  
COUNSELOR PERCEIVED WORKING CONDITIONS SCALE

Please rate the frequency with which you experience each of the working conditions described below in the past 30 days. (If you never experience this working condition in your current work setting, select never).

1=never	2=rarely	3=occasionally	4=often	5=almost always
1. The atmosphere at my work setting is collegial.	1	2	3	4 5
2. I receive the administrative support that I need to care for clients.	1	2	3	4 5
3. The amount of paperwork I have to complete is overwhelming.	1	2	3	4 5
4. Colleagues take the time to consult with me regarding clinical issues when I need it.	1	2	3	4 5
5. I have the freedom to choose how I conduct clinical interventions with clients.	1	2	3	4 5
6. My boss is reasonable in her/his demands.	1	2	3	4 5
7. My coworkers seem discouraged and overwhelmed.	1	2	3	4 5
8. The clients I work with face such overwhelming problems, I wonder how anybody can help them.	1	2	3	4 5
9. I receive an adequate salary and healthcare benefits	1	2	3	4 5
10. I have the ability to set my own work schedule at my work setting.	1	2	3	4 5
11. I feel that it is next to impossible to help the clients on my caseload.	1	2	3	4 5
12. I am able to take time off from work when I need to.	1	2	3	4 5
13. It seems too difficult to help the clients I work with make changes.	1	2	3	4 5
14. I believe that the organization I work for doesn't care about my well-being.	1	2	3	4 5
15. I have the skills to help my clients make progress with their problems/issues.	1	2	3	4 5
16. I feel cut off from my colleagues at my work setting.	1	2	3	4 5

17. The size of my caseload is reasonable given the other commitments that I have at my work setting. 1 2 3 4 5
18. I have the training I need to work effectively with each of the clients on my caseload. 1 2 3 4 5
19. Counselors at my work setting cooperate to ensure that clients receive the best care possible. 1 2 3 4 5
20. My caseload includes a balance of different types of cases and levels of severity of client issues. 1 2 3 4 5
21. Profit is the top priority in this work organization. 1 2 3 4 5
22. I seem to take more responsibility for helping my clients make changes than they do. 1 2 3 4 5
23. The supervision I receive provides me what I need to be effective as a counselor. 1 2 3 4 5
24. Counselors at my work setting have to compete with one another to get ahead in their careers. 1 2 3 4 5
25. My clients have so many problems that it is hard to even know where to start. 1 2 3 4 5
26. My cultural background is respected at my work setting. 1 2 3 4 5
27. The people I counsel are motivated to make positive changes in their lives. 1 2 3 4 5
28. I spend too much time completing paperwork and not enough time providing therapeutic services. 1 2 3 4 5
29. I feel empowered to speak out about how clients are treated at my work setting. 1 2 3 4 5
30. My supervisor wants me to excel and helps me build

on existing skills.	1	2	3	4	5
31. Effective client treatment is a top priority in this work organization.	1	2	3	4	5
32. I feel as though my clients are engaged in the treatment process.	1	2	3	4	5
33. It is difficult for me to predict the kind of income I am going to have from week to week.	1	2	3	4	5
34. Decisions that impact me in my work setting are made in a fair and open way.	1	2	3	4	5
35. Because we are so understaffed at my work setting, I cannot take time off when I need to.	1	2	3	4	5
36. I have concerns for my safety in working with many of my clients.	1	2	3	4	5
37. I believe that there is an unfair distribution of cases at my work setting.	1	2	3	4	5
38. The clients I work with make too many demands on me.	1	2	3	4	5
39. I see the clients I work with making positive changes in their lives.	1	2	3	4	5
40. My work setting provides me with ongoing education to further develop my skills.	1	2	3	4	5
41. Staff in my work setting are open to trying new innovative counseling approaches.	1	2	3	4	5
42. The pace of my work creates little time for me to reflect on how to work with my clients.	1	2	3	4	5
43. The clients I work with tell me they are benefiting from our counseling work.	1	2	3	4	5
44. I am comfortable approaching my colleagues about consultation or support.	1	2	3	4	5
45. In my work setting, we are expected to do more with fewer resources.	1	2	3	4	5

46. I enjoy the types of work that I complete throughout the day  
at my work setting.

1 2 3 4 5

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## BIOGRAPICAL SKETCH

Isabel A. Thompson was born in Abidjan, Ivory Coast and spent her early childhood in Dhaka, Bangladesh and New Delhi, India. Her family then moved to Bethesda, Maryland where they lived for four years. In 1994, she moved to St. Petersburg, Florida. Before pursuing graduate studies, she completed her B.A. in literature/Hispanic language and culture at New College of Florida. She met her future husband Eric S. Thompson at New College of Florida in 2000.

Isabel Thompson graduated in 2006 with her M.A. in mental health counseling and certificate in marriage and family therapy from the University of Central Florida. She is currently a registered mental health counselor intern working toward licensure in the state of Florida, with counseling experience in school, private practice, and community settings.

In August 2012, Isabel will graduate with her Ph.D. in Counselor Education and Supervision from the University of Florida. Isabel actively researches, publishes, and presents on counselor well-being and family-school partnerships for students at risk. She also leads workshops on creativity and mindfulness. Isabel has studied Spanish in Spain and Ecuador. She is also a certified yoga instructor and certified in contemplative approaches to managing emotions. Her transcultural experiences inform her integrative approach to research, teaching, supervision, and counseling.

Isabel currently lives with her husband Eric in Gainesville, Florida. When not working on their doctoral studies, they enjoy bike rides on nature trails, traveling, and meditation retreats.