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The Relationship Between Compassion Fatigue and Self-Compassion Among Mental Health Counselors

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The Relationship Between Compassion Fatigue and Self-Compassion Among Mental Health Counselors

Abstract
The purpose of this study was to examine the relationship between compassion fatigue and self-compassion among mental health counselors from the perspective of Richardson's resiliency theory. This research explored the relationship between compassion fatigue and self-compassion among licensed mental health counselors in New York State, using a quantitative, cross-sectional survey method. The sample was composed of 36 mental health counselors who were currently licensed and working in New York State. The instruments used were the Professional Quality of Life Scale and the Self-Compassion Scale, as well as a demographic questionnaire, which were all delivered electronically to potential participants. Overall, a significant negative relationship between self-compassion and compassion fatigue was identified. The data suggest that the counselors working in community agencies experienced more burnout than those working in private practice; those who saw more than 20 clients per week scored higher on the secondary traumatic stress and burnout scales, and those counselors who had less experience scored higher on the secondary traumatic stress and burnout scales than those with more experience. Recommendations include repeating the study with a larger sample and promoting self-compassion among practitioners.

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The Relationship Between Compassion Fatigue and Self-Compassion Among
Mental Health Counselors

By

Madeleine Reynolds

Submitted in partial fulfillment
of the requirements for the degree
Ed.D. in Executive Leadership

Supervised by
Joshua Fegley, Ed.D.

Committee Member
Deborah B. Johnson, Ed.D.

Ralph C. Wilson, Jr. School of Education
St. John Fisher College

August 2019
Dedication

This dissertation is dedicated to my father, William Reynolds, M.D. and my mother, Maureen Mann who believed that I could do anything that I decided to do. To Paul Bolz for your endless patience and encouragement as I undertook the journey to earn yet another degree. To Jonathan, Sam, Sarah and Tessa who inspire me to be my best self every day. To Jane, Liam, Stephanie, Anna, Michele and Sarah who make me laugh and laugh and laugh and who never let me forget who I am.

To Joshua Fegley Ed.D. for your patience, stamina, fortitude, and excellent sense of humor in the face of the many challenges I presented. To Marie Cianca, Ed.D., Shannon Cleverly-Thompson, Ed.D., Guillermo Montes, Ph.D., Betsy Christiansen, and Deborah Johnson, Ed.D., at St. John Fisher College for your kind encouragement and faith that I could complete this journey.

To Renee van der Vennet, Ph.D., of Nazareth College for believing in me when I forgot how to believe in myself.

To my teachers of mindful self-compassion, Kristen Neff, Ph.D., Christopher Germer, Ph.D., Michelle Becker, LMFT, and Steve Hickman, Psy.D. with whom I spent peaceful, affirming and life changing weeks during the dissertation process.

“Compassion for others begins with kindness to ourselves.” ~Pema Chodron
Biographical Sketch

Madeleine Reynolds is currently a mental health counselor in private practice. Ms. Reynolds attended Hartwick College from 1975 to 1979 and graduated with a Bachelor of Arts degree in 1979. She attended St. John Fisher College from 2004 to 2006 and graduated with a Master of Sciences degree in 2006. She came to St. John Fisher College in the fall of 2014 and began doctoral studies in the Ed.D. Program in Executive Leadership. Ms. Reynolds pursued her research in the relationship between compassion fatigue and self-compassion among mental health counselors under the direction of Dr. Joshua Fegley and Dr. Deborah B. Johnson and received the Ed.D. degree in 2019.
Abstract

The purpose of this study was to examine the relationship between compassion fatigue and self-compassion among mental health counselors from the perspective of Richardson’s resiliency theory. This research explored the relationship between compassion fatigue and self-compassion among licensed mental health counselors in New York State, using a quantitative, cross-sectional survey method. The sample was composed of 36 mental health counselors who were currently licensed and working in New York State. The instruments used were the Professional Quality of Life Scale and the Self-Compassion Scale, as well as a demographic questionnaire, which were all delivered electronically to potential participants. Overall, a significant negative relationship between self-compassion and compassion fatigue was identified. The data suggest that the counselors working in community agencies experienced more burnout than those working in private practice; those who saw more than 20 clients per week scored higher on the secondary traumatic stress and burnout scales, and those counselors who had less experience scored higher on the secondary traumatic stress and burnout scales than those with more experience. Recommendations include repeating the study with a larger sample and promoting self-compassion among practitioners.
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Chapter 1: Introduction

The reasons one chooses a profession are varied. Making a positive difference in the lives of others and helping or caring are often given as reasons by mental health professionals for their choice of occupation. The benefits of serving in this role include connecting to others, teaching, guiding, advising, and facilitating healing (Skovholt & Trotter-Mathison, 2016). Mental health professionals report that their profession has made them better, wiser people, and their profession has increased their self-awareness and appreciation for human relationships (Radeke & Mahoney, 2000). Overall, extending empathy and compassion to those who struggle appears to benefit mental health professionals (Skovholt & Trotter-Mathison, 2016).

The work of mental health professionals is positive, yet taxing, because clients who are experiencing distress, seek therapy. Mental health professionals regularly extend empathy and compassion to clients who are experiencing challenging emotions such as fear, confusion, rage, and helplessness. The work is sometimes described as “living in an ocean of stress emotions” (Skovholt & Trotter-Mathison, 2016, p. 78). The mental health profession is an experience of one-way caring, and it is a continual extension of empathy and sensitivity.

Mental health professionals provide psychotherapy, which is the treatment of mental or emotional illness, by talking about the patient’s problems rather than by using medicine or drugs to alleviate the symptoms of their illnesses. Psychotherapy is not designed to be reciprocal (Herkov, 2018). Successful psychotherapy is difficult to
measure; therefore, the rewards for such work can be elusive. Given these demands, it seems that care must be taken to maintain mental health professionals’ positive functioning within their profession (Skovholt & Trotter-Mathison, 2016).

This chapter explores the problem of compassion fatigue among mental health professionals from the perspective of Richardson’s (2002) resiliency theory. The chapter begins by describing the trends in mental health, in the United States, including suicide and substance abuse. Then the issue of counselor impairment is examined including symptoms and causes of impairment. There are many different, but similar, roles for mental health professionals, and this chapter distinguishes some of the differences, and it clarifies the expectations. Next, the description of a professional counselor is given, and the concept of self-compassion is introduced, and they are followed by an introduction to the framework of Richardson’s (2002) resiliency theory.

**Mental Health Terminology**

To understand the demand for mental health treatment in the United States, and to provide clarity and consistency in reporting about mental illness, a commonly used definition is helpful. The U.S. Department of Health and Human Services (HHS) discontinued the use of terms such as *chronic mental illness* in 1992 and began using the term *severe and persistent mental illness* (Substance Abuse and Mental Health Services Administration [SAMHSA], 2016). Because many forms of mental illness respond to treatment and can no longer be considered *persistent*, the term used by the federal government was changed again to *serious mental illness* (SAMHSA, 2016). The legal definition of serious mental illness is “a condition affecting persons aged 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or
emotional disorder (excluding developmental and substance use disorders) of sufficient duration . . . that has resulted in serious functional impairment” (SAMHSA, 2016, p. 2).

**Mental health trends in the United States.** Estimates indicate that in 2016, 18% of adults in the United States had a mental illness, with diagnoses ranging from mood disorders, such as depression and anxiety, to serious mental illness, such as bipolar disorder and schizophrenia (National Institute of Mental Health [NIMH], 2018). Figure 1.1 reflects the distribution of mental illness by gender, age, and race.

![Figure 1.1](image-url)

*Figure 1.1. Percentage of United States adults who experienced any mental illness in 2016. Reported by sex, age, and race/ethnicity (SAMHSA, 2016).*

Recent estimates suggest that over three million Americans have a diagnosis of schizophrenia, and approximately eight million have a diagnosis of bipolar disorder (NIMH, 2018). According to current estimates, 16 million adults in the United States, have a diagnosis of major depressive disorder (NIMH, 2018). At the same time, 4.3 million adults have a diagnosis of an anxiety disorder, including post-traumatic stress disorder (PTSD), obsessive-compulsive disorder (OCD), and specific phobia (NIMH,
Estimates suggest that 70% of Americans will experience a traumatic event during their lifetime, and 20% of these individuals will develop post-traumatic stress disorder. Because women are twice as likely to develop PTSD as men, approximately one in 10 women may meet the criteria for a diagnosis of PTSD at some point in their lifetimes (CBHSQ, 2017). Among youth, ages 13-18, 21% will experience a severe mental disorder at some point in their lives. For children in the 8-15 age group, the estimate is closer to 13% (NIMH, 2018). Unfortunately, these numbers are high relative to the number of mental health professionals in the United States, and the stakes are very high for those with serious mental illness (Mental Health America [MHA], 2018).

Estimates suggest that, each year, 9.8 million Americans experience mental health symptoms so severe that they interfere with one or more life activities, such as employment, social interaction, or education (NIMH, 2018). The symptoms may result in unemployment and isolation, which may contribute to an increase in symptoms (NIMH, 2018). Those with serious mental illness have an increased risk of chronic medical conditions resulting in death, on average, 25 years earlier than those without a serious mental illness, even when their medical conditions are treatable (NIMH, 2018).

**Mental health and suicide.** Estimates indicate that, each year, 9.6 million American adults experience suicidal ideation, having thoughts of dying through self-injury or having thoughts of no longer being alive. Figure 1.2. shows the prevalence of suicidal thoughts among American adults according to gender, age, and race (SAMHSA, 2016).
According to the Centers for Disease Control and Prevention (CDC, 2015), suicide is the 10th leading cause of death in the United States. The same report indicates that suicide is the third leading cause of death for people ages 10-14, and it is the second leading cause of death for ages 15-24 (CDC, 2015). Among veterans, the suicide rate is approximately 22% higher than for adults in the same age brackets (Office of Public and Intergovernmental Affairs, 2017).

**Mental health and substance abuse.** Substance abuse affects the lives of many Americans. The impact of substance abuse is estimated to cost Americans more than $600 billion each year. Of the estimated 8.5 million American adults with a diagnosis of a substance use disorder, 50% are thought to have a co-occurring mental illness, meaning they are experiencing multiple disorders at the same time (Center for Behavioral Health Statistics and Quality [CBHSQ], 2017). Illicit drug use, according to the National Survey on Drug Use and Health [NSDUH] includes the use of marijuana (including hashish),
cocaine (including crack), heroin, hallucinogens, and inhalants, as well as the nonmedical use of prescription-type pain relievers, tranquilizers, stimulants, and sedatives (CBHSQ, 2015).

In 2014, an estimated 27 million Americans aged 12 or older reported using an illicit drug during the month before being surveyed. The most commonly used drug was marijuana, which was used by 22.2 million people aged 12 or older. An estimated 6.5 million people reported nonmedical use of psychotherapeutic drugs in the past month, including 4.3 million who reported the illicit use of prescription pain relievers (CBHSQ, 2015). The illicit use of prescription pain relievers has led to problems with the use of opiates and opioids such as heroin. In fact, the incidence of the initial use of heroin was 19 times higher among those who reported prior nonmedical pain reliever use than among those who did not report prior nonmedical pain reliever use (Muhuri, Gfroerer, & Davies, 2013).

According to the CDC (2015), in most age groups, and at all income levels, heroin use has increased across the United States among men and women. The largest increase in heroin use has occurred in demographic groups with historically low rates of illicit drug use, such as women who are privately insured and in higher socioeconomic groups (CDC, 2017). Between 2002 and 2017, the rate of heroin-related overdose deaths nearly quadrupled across the United States (CDC, 2017). More than 64,000 Americans died from a drug overdose in 2016 (CDC, 2017).

People who have mood disorders or anxiety disorders are twice as likely to also have a substance-abuse-related diagnosis (NIDA, 2018). Although substance abuse disorders and other mental health disorders are often comorbid, it is not believed that one
causes the other (NIDA, 2018). Research has not fully explained the reason for this, but some theories are that those with mental health disorders may attempt to self-medicate with alcohol or other drugs (NIDA, 2018). It is also possible that drug use exacerbates symptoms of mental illness (NIDA, 2018). It may be that having a predisposition to one drug makes a person vulnerable to another drug or that the same area of the brain is affected by both (NIDA, 2018). Another possibility is that environmental stressors, such as living and working in crowded cities or having a poor diet, when experienced by a vulnerable person, are related to the development of both mental illness and substance abuse (NIDA, 2018).

*Mental health and the economy.* Mental illness has a significant impact on our economy. In the United States, mental illness costs $193.2 billion in lost earnings each year (CBHSQ, 2015). Healthy communities are dependent upon physical and mental health, yet mental illness and substance use problems continue to negatively impact the well-being of Americans (CBHSQ, 2015). Each year, approximately 56 million American adults experience mental illness and/or a substance use disorder (CBHSQ, 2015). The average age of onset for symptoms of 75% of chronic mental health conditions is approximately 24 years, yet the delay between the first appearance of symptoms and intervention is an average of almost a decade (National Alliance on Mental Illness [NAMI], n.d.). Approximately 46% of homeless adults have severe mental illness and/or substance use disorders. Mood disorders, including major depression, dysthymic disorder, and bipolar disorder, are the third-most common cause of all hospitalizations for those ages 18-44 years (NAMI, n.d.). In fact, depression is thought to be the leading cause of disability worldwide (NAMI, n.d.).
Mental health and national policy. While mental health needs have increased in the United States, unfunded mandates to provide services to address those needs have also increased. In 2008, the Wellstone Domenici Mental Health Parity Act made it necessary for insurance providers to ensure that financial requirements and treatment limitations for behavioral health be no more restrictive than the requirements or limitations applied to all medical/surgical benefits (American Psychological Association [APA], 2018). In the past, insurance plans could restrict coverage for behavioral health interventions.

In 2010, the Affordable Care Act increased the number of people with health insurance (HHS, 2017). The Affordable Care Act mandated a provision of preventive care for both behavioral and medical care to all insured, therefore increasing the need for providers. From 2014 to 2015, the rate of the uninsured decreased by more than 3% (from 16.3 to 13.0 million Americans), particularly in states where Medicaid was expanded (HHS, 2017).

Mental health professionals and the treatment gap. Although the Affordable Care Act gave millions of individuals with mental health conditions the opportunity to receive treatment, there is now a shortage of mental health providers. The definition of mental health treatment is “having received inpatient treatment/counseling or outpatient treatment/counseling, or having used prescription medication for problems with emotions, nerves, or mental health” (SAMHSA, 2016, p. 1). The demand, along with high turnover rates among mental health professionals, caused by a lack of social support and compensation, has created a workforce crisis (MHA, 2015). Figure 1.3 reflects the
numbers of American adults who received mental health treatment in 1 year according to gender, age, and race (NAMI, n.d.).

![Mental Health Treatment Received in Past Year Among U.S. Adults with Any Mental Illness (2016)](chart)

Data Courtesy of SAMHSA

<table>
<thead>
<tr>
<th>Percent</th>
<th>Overall</th>
<th>Female</th>
<th>Male</th>
<th>18-25</th>
<th>26-49</th>
<th>50+</th>
<th>Hispanic</th>
<th>White</th>
<th>Black</th>
<th>Asian</th>
<th>2 or More</th>
</tr>
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<tr>
<td>43.1</td>
<td>48.8</td>
<td>33.9</td>
<td>35.1</td>
<td>43.1</td>
<td>46.8</td>
<td>31.0</td>
<td>48.7</td>
<td>29.3</td>
<td>21.6</td>
<td>37.1</td>
<td></td>
</tr>
</tbody>
</table>

Figure 1.3. Data on mental health treatment received in 2016 by United States adults aged 18 or older with any mental illness (NAMI, n.d.).

The need for treatment of serious mental illness appears to be rising in the United States, and as a result, the demand for providers may be increasing (NIMH, 2016). Nationally, there is only one mental health provider for every 790 residents. In some states, such as Alabama, there is only one mental health provider for every 1,827 residents according to data from 2015 (MHA, 2015). Those seeking mental health intervention must travel several hours, or even cross state lines, to access care (Health Resources and Services Administration [HRSA], 2017). The situation is particularly dire in rural areas or cities with larger low-income populations (HRSA, 2017), and the ratio in New York State is one mental health provider for every 510 residents (MHA, 2015).

Although more Americans have insurance to pay for mental health treatment, they are often unable to find psychotherapists to provide that treatment. Unfortunately, 56%
of Americans with mental health conditions do not receive treatment, in part due to the mental health provider shortage. In addition, physicians may not adequately screen for depression. One-quarter of primary care patients experience depression, but primary care doctors identify less than 31% of these patients (APA, 2013). Among the 8.9 million adults with any mental illness and a substance use disorder, 44% received substance use or mental health treatment in the past year. Only 13.5% received both mental health and substance use treatment, and 37.6% did not receive any treatment (APA, 2018). Of young adults who reported that they had mental health needs, 4% they did not receive any treatment in the past year (APA, 2018).

**Titles in the mental health professions.** There is confusion both within and outside the mental health professions as to the titles associated with mental health professions. In 2012, to clarify the use of multiple titles in the field of mental health, the APA defined *psychotherapist* as an umbrella term covering professional counselors, social workers, creative arts therapists, marriage and family therapists, psychiatric nurses, psychologists, psychiatrists, and other closely related fields (Campbell, Norcross, Vasquez, & Kaslow, 2013). All psychotherapists engage with those individuals who need emotional support and those with mental health disorders. Each profession is qualified to provide support to individuals, families, groups, and those in crisis. All the professions under the umbrella of psychotherapist have training in the assessment and diagnosis of mental illness and an array of interventions and therapeutic techniques. These professionals work in private practice, hospitals, agencies, community clinics, and schools. To further confuse the issue, *mental health professional* is also an umbrella term covering, professional counselors, social workers, creative arts therapists, marriage and
family therapists, psychiatric nurses, psychologists, psychiatrists, school psychologists and other closely related fields (American Counseling Association [ACA], 2018).

**Differences in mental health professions.** Most of the differences in the mental health professions lie in the length and type of professional education. One can obtain licensure as a mental health counselor, marriage and family therapist, social worker, school psychologist, or a psychiatric nurse with a master’s degree. To obtain licensure as a psychologist, one must have a Ph.D. or a Psy.D. A psychiatrist is a medical doctor who has had specialized training in psychiatry. Psychiatrists and psychiatric nurse practitioners can prescribe medication, and they often focus their work on pharmacotherapy instead of psychotherapy (Bureau of Labor Statistics, 2016).

All mental health professionals support those in need of emotional support and those with mental health disorders. The reasons why one might seek the help of a mental health professional are variable and may include anger, depression, anxiety, substance abuse, marriage and relationship challenges, parenting problems, school difficulties, or career changes (ACA, 2014). Each profession is qualified to provide support to individuals, families, groups, and those in crisis. Table 1.1 lists the degree requirements, the credentialing, and the associated titles for several mental health professions.
Table 1.1

*Mental Health Profession Titles*

<table>
<thead>
<tr>
<th>Title</th>
<th>Degree Requirements</th>
<th>Licensure and Credentials</th>
<th>Associated Titles</th>
</tr>
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<tbody>
<tr>
<td>Psychologist</td>
<td>Doctor of Philosophy (Ph.D.) or Doctor of Psychology (Psy.D.)</td>
<td>Licensed by state boards in all states.</td>
<td></td>
</tr>
<tr>
<td>Counselor, Clinician</td>
<td>Master’s degree (MS or MA) in Counseling Psychology, Psychology, Marriage and Family</td>
<td>Varies by specialty and state. Licensed by state boards in all</td>
<td>LMHC, LPC, LMFT, LCADAC, CAT</td>
</tr>
<tr>
<td>Therapist</td>
<td>Therapist</td>
<td>states.</td>
<td></td>
</tr>
<tr>
<td>School Psychologist</td>
<td>Master’s degree or Ph.D. or Psy.D.</td>
<td>Varies according to state.</td>
<td></td>
</tr>
<tr>
<td>Psychiatric Nurse</td>
<td>Master’s degree</td>
<td>Licensed in all states</td>
<td>PMHNP-BC</td>
</tr>
<tr>
<td>Clinical Social Worker</td>
<td>Master’s degree in Social Work (MSW)</td>
<td>Licensed in all states</td>
<td>LICSW, LCSW, ACSW</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>Medical Doctor (MD)</td>
<td>Licensed in all states</td>
<td></td>
</tr>
<tr>
<td>Certified Peer Specialists</td>
<td>Certification</td>
<td>No license</td>
<td></td>
</tr>
<tr>
<td>Pastoral Counselors</td>
<td>Varies</td>
<td>Varies according to training and state.</td>
<td></td>
</tr>
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</table>

*Professional counselors.* Licensed professional counselor (LPC) is a protected title for those trained in mental health counseling. A professional counselor is an individual who has studied traditional psychotherapy and who utilizes a problem-solving approach to assist clients in establishing change and resolving problems (ACA, 2018). Depending on their education and experience, professional counselors offer services to clients, ranging from assessment and diagnosis to crisis management. Professional counselors work with diverse populations in a variety of settings, from schools to agencies to private practice settings. Professional counselors assist individuals, groups, families, and communities with personal, educational, family, mental health, career
decisions, and problems (Bureau of Labor Statistics, 2016). According to state licensing bodies, professional counselors may be known as LPCs, licensed mental health counselors (LMHCs), or licensed professional clinical counselors (LPCCs), or they can be known simply as counselor, as well as therapist, clinician, or psychotherapist (New York Mental Health Counselor’s Association [NYMHCA], 2016). Counselors in New York State, the setting for this study, are known as licensed mental health counselors or LMHCs.

Professional counselors often differ from those in other behavioral health disciplines because of their training to address the holistic needs of their clientele and to focus on wellness and prevention models (NYMHCA, 2016). Trained in holistic behavioral health positions, LMHCs work in integrated care settings, agencies, hospitals, and clinics as well as in private practice (NYMHCA, 2016). There are several types of specialties in the counseling professions, such as addictions counseling; child and adolescent counseling; geriatric counseling; lesbian, gay, bisexual, transgender, queer, intersex and asexual (LGBTQIA) counseling; and military counseling (ACA, 2018). LMHCs have a master's degree or higher degree in counseling or another closely related field, and they have completed a minimum of 3,000 hours of supervised post-master’s work. LMHCs are required to pass a state or national exam to obtain licensure (NYMHCA, 2016).

Mental health provider and client relationships. As mentioned earlier, many therapists enter their profession, so they can help others, which translates into “caring for the Other” (Skovholt & Trotter-Mathison, 2016, p. 19). Therapy is a one-way relational process that occurs over and over for the therapist (Skovholt, 2005). The “quality of the
counseling relationship has consistently been found to have the most significant impact on successful client outcome” (Sexton & Whiston as cited in Skovholt, 2005, p. 83). Skovholt suggested that how the therapist engages in the relationship with the client is more important than the intervention or theory being used.

The cycle of caring. Skovholt’s (2005) cycle of caring describes a continuous pattern in which the psychotherapist creates a relationship by attaching with the client, “is involved with the client, separates well, and then steps away from the professional intensity of the client relationship and begins again with another person” (Skovholt & Trotter-Mathison, 2016, p. 22).

The cycle of caring model, based on attachment theory, originally consisted of three stages in which a psychotherapist attaches, involves, and separates, both over time with each client, and each day, as clients attend therapy sessions (Skovholt, 2005). Attachment theory stresses the importance of a secure and lasting bond between an infant and a caregiver that will then inform the quality of one’s relationship throughout his or her lifespan (Bowlby, 1988). In the same way, the client and the psychotherapist form an attachment, and it is from this securely attached base that the client seeks to grow and change (Bowlby, 1988). The phases in the cycle of caring model are the empathetic attachment phase, the active involvement phase, and the felt separation phase. Over time, a fourth stage was added, which is the re-creation phase (Skovholt & Trotter-Mathison, 2016). The model suggests that the psychotherapist develops a genuine relationship with each client, and it is in this connection that therapeutic change occurs (Castonguay, Constantino, & Holtforth, 2006).
**Empathic attachment phase.** Attachment theory suggests that it is in our earliest relationships that we form patterns for future relationships (Skovholt, 2005). In the empathic attachment phase, the goal is to establish a positive alliance with the client (Skovholt, 2005). In this phase, therapists situate themselves to observe both their client and themselves, differentiating between the two. At the same time, psychotherapists allow themselves to be vulnerable by allowing themselves to care about the client sitting before them, his or her story, and the outcome—all the while maintaining boundaries that will allow separation when the time comes either at the end of the session or upon termination of the client/psychotherapist relationship (Skovholt, 2005). This diving into the relationship is sometimes described by Skovholt (2005) as the *ocean method.* In this phase, it is vital to establish the goals of therapy with the client (Skovholt, 2005).

In the empathic attachment phase, successful therapists attach with their *soft side,* to use Skovholt’s (2005) analogy of a turtle. He indicated that with the hard side of a turtle shell, therapists could protect themselves, but then they have a hard time establishing a caring relationship with the client. It is difficult to maintain balance, and an occupational hazard is “caring too much” (Skovholt, 2005, p. 88). This phase is successfully negotiated by a therapist who is skilled at establishing and maintaining boundaries regarding who is responsible for what in the therapeutic relationship (Skovholt, 2005). Given the importance of the relationship regarding successful outcomes for the client, therapists’ attachment style has a considerable impact on the process of therapy (Skovholt, 2005).

**Active involvement phase.** The active involvement phase is the phase in which the work of therapy is done based on the symptoms presented and the psychotherapist’s
knowledge of interventions. During this phase, the psychotherapist must remain attached and care for the client. The goal of this phase is to maintain optimal attachment and focus on a shared vision (Skovholt, 2005). Focusing on the vision can be difficult because of ambiguity regarding the problem the client brings to therapy. Because the list of possible presenting problems is enormous, and because the actual problem can take time to discover, the task can seem overly challenging (Skovholt, 2005). This phase also varies in length based on the presenting problem, the client or the insurance companies’ ability to pay for sessions, and the client’s readiness for change (Skovholt & Trotter-Mathison, 2016). The skills needed in this phase include the ability to focus in a sustained manner on the client and to listen reflectively. Being other-focused is not what humans are designed to do; instead, we naturally focus on data as it relates to ourselves (Skovholt, 2005).

Successful therapeutic interaction in the active involvement phase includes a balance of supporting and challenging the client. Providing encouragement and positive feedback is balanced with some pushing and sometimes making the client slightly uncomfortable (Skovholt, 2005). In this phase, the therapist also must respond to negativity without becoming negative, identify impasses, handle transference issues, and repair damage to the relationship (Skovholt, 2005). The active involvement phase can be challenging as a result of work-related fatigue and, possibly, a secondary trauma resulting from continually listening to distressing stories (Skovholt, 2005). It is in this phase that the therapist must focus on self-care and an awareness of his or her physical, mental, emotional, and spiritual domains to remain useful in a relationship with clients (Skovholt, 2005).
**Felt separation phase.** The felt separation phase is the goal of every successful therapeutic relationship, and in some ways, it may mirror the attachment and separation of each relationship experienced by every client and every psychotherapist (Skovholt & Trotter-Mathison, 2016). Depending upon their history, a therapist may experience feelings of grief and loss, felt concurrently with feelings of gain and success (Skovholt, 2005). The degree of grieving experienced depends to some degree upon the relationship established in the first two phases. Skovholt (2005) described grief, in this situation, to resemble a type of closing, such as that experienced in the healing of a wound. Ideally, the separation is planned and prepared for, but this is often far from the case, according to Skovholt (2005).

In the felt separation phase, the therapist may experience a feeling of satisfaction for having moved through the cycle well and for appropriately using expertise (Skovholt, 2005). If the therapist has not appropriately felt the loss or closure from the last therapeutic relationship, it may be difficult to attach to the next client (Skovholt, 2005). The work of this phase is critical if a therapist is to continue to function at a high level for an extended period (Skovholt, 2005).

**Re-creation phase.** The process ends with the re-creation phase in which the psychotherapist restores him- or herself, reflects on the recently concluded relationship, and prepares to begin anew. The separation may be more comfortable for the therapist if the client and the therapist engage in both internal and external rituals, such as briefly thinking over the relationship or walking around the office after each session or at the termination of the therapeutic relationship (Skovholt & Trotter-Mathison, 2016). Skovholt and Trotter-Mathison (2016) likened the work of this phase as pushing the off
button, and the authors noted that as the work of all phases in the cycle, some therapists are better at this than others.

According to Skovholt (2005), therapists may measure success through a change in their clients’ behavior or mindset or through feedback from their peers or supervisors. The problem with this is that the therapist has little control over whether the client’s change is evident at the termination of services or whether peers or supervisors give feedback. The lack of feedback is a problem because having a lack of control is a source of occupational stress (Skovholt, 2005). In the cycle of caring model, success is defined by how well the therapist negotiates the cycle as well as the therapist’s expert knowledge, both of which are in the therapist’s control, and it might lead to a feeling of success. If a therapist has successfully negotiated the cycle, he or she will be able to begin again by attaching to a new client (Skovholt & Trotter-Mathison, 2016). Expert knowledge is gained through focused continuing education, which is a requirement for most professions.

Any place in this cycle can be a source of tension that can lead to counselor impairment such as compassion fatigue or burnout. How the individual psychotherapist manages each phase is both variable and changeable (Skovholt & Trotter-Mathison, 2016). The cycle of caring suggests that the process of helping puts all mental health providers at some degree of risk for impairment. However, not all mental health providers become impaired.

Counselor impairment. The risk of impairment and distress by mental health professionals has been documented for decades by the APA (2012) and the ACA (2006). Because of the confusion regarding terms relating to impairment, the American
Counseling Association Task Force on Impaired Counselors (ACA, 2006) created the following working definition of counselor impairment:

Therapeutic impairment occurs when there is a significant negative impact on a counselor’s professional functioning, which compromises client care or poses the potential for harm to the client. Impairment may be due to: substance abuse or chemical dependency, mental illness, personal crisis (traumatic events or vicarious trauma, burnout, or life crisis), or physical illness or debilitation. Counselors who are impaired are distinguished from stressed or distressed counselors; whose work is not significantly impacted. (para. 1)

In the profession of counseling, the first journal article on the topic of impairment was published in 1988 by Stadler, Willing, Eberhage, and Ward, drawing from the literature of medicine and psychology. One of the key findings was that professionals were unlikely to intervene when they perceived one of their colleagues was impaired (Stadler et al., 1988). The authors suggested that 40% of the psychologists surveyed reported that they knew of an impaired practitioner for whom nothing was done to help (Stadler et al., 1988). There were multiple reasons the professionals chose not to intervene in these situations. One was that it might be a conflict of interest for colleagues to have to police one another (Stadler et al., 1988). Another reason was that colleagues may fear liability, or that they believe that the reporting may not be confidential (Stadler et al., 1988). Because the reporting process requires the professional to address the impairment with his or her colleague before reporting to the regulating body, a resolution may occur before reporting is required or, as Stadler et al. (1988) suggested, colleagues resolve the problem unofficially by failing to refer people to other colleagues. One may
assume that this occurs in subtle situations, where the impairment is unclear and that in extreme situations, colleagues do report to the regulating body (Stadler et al., 1988).

The initial ACA Task Force on Impaired Counselors (ACA, 2006) convened in 1991. The ACA Task Force on Impaired Counselors estimated that 10% of helping professionals experienced a diminished ability to care for their clients (ACA, 2006). The second ACA Task Force on Counselor Impairment convened in 2003, established that most states do not have adequate impairment programs for professionals, and identified a need for a precise definition of impairment, and a definition on the difference between being impaired and engaging in unethical behavior (ACA, 2006). A professional can be unethical without being impaired or impaired without being unethical. The scope of counselor impairment and intervention was clarified by a 2004 survey, which indicated that 63.5% of counselors report having known a counselor for whom they considered impaired. Counselors (75.7%) reported that impairment was a significant risk to the profession (ACA, 2006).

Counselors who are impaired may be reluctant to reach out for help when experiencing professional distress or impairment for a variety of reasons. They may fear a loss of professional reputation, employment, and related income (ACA, 2006). Many mental health professionals endorse being unaware of programs designed to help them. Given their training and experience, some counselors may feel that they should be able to manage the stressors that come with their profession. Counselors may stigmatize themselves by believing that if they can help others, then they should be able to help themselves. This mistaken belief may open the door to professional doubt (ACA, 2006).
For many reasons, counselors may be more vulnerable than the public to experiencing mental illness (Figley, 1995). Impairment is identified as a significant issue in the lives of mental health professionals (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012). The number of mental health professionals who will experience impairment at one point in their career is estimated to be between 21% and 48% (Oddie & Ousley, 2007). Therefore, it is essential for counselors to understand the risk and protective factors that may help to avoid impairment (ACA, 2006).

The standards of the accrediting body for counselor education programs, the Council for Accreditation of Counseling and Related Educational Programs (CACREP) requires that counselor education programs address self-awareness and self-care strategies (CACREP, 2016). The ACA’s Code of Ethics requires that counselors "monitor themselves for signs of impairment from their physical, mental, or emotional problems and refrain from offering or providing professional services when impaired" (ACA, 2014). According to the ACA Code of Ethics, preventing burnout and addressing the symptoms of burnout is an ethical imperative for counselors for protecting their clients (ACA, 2014).

**Types of impairment.** It appears that the actual work done by counselors is a potential threat to their well-being (Skovholt & Trotter-Mathison, 2016). A challenge for mental health professionals is to be constantly exposed to the suffering of others as they spend hours listening to the experiences of their clientele. They may fail to be cognizant of the impact the work has on their mental health (Skovholt & Trotter-Mathison, 2016).

Compassion fatigue, secondary traumatic stress, and vicarious traumatization are three terms that were all introduced in 1995 to describe potential challenges of engaging
in the work of helping professional (Stamm, 2010). A similar concept, burnout, was used and measured by Maslach (2003) in the 1970s. According to Stamm (2002), “Compassion is feeling and acting with deep empathy and sorrow for those who suffer” (p. 107). Mental health professionals who possess the skills of compassion and empathy may be more effective than those who lack in these skill areas (Bowen & Moore, 2014).

*Compassion fatigue.* Figley (1995) described compassion fatigue as stress resulting from aiding or desiring to help a traumatized person. A sense of sorrow developed by the awareness of another’s pain and a desire to alleviate the client’s suffering may result in compassion fatigue (Figley, 1995). Compassion fatigue is thought to be exhaustion due to constant exposure to the suffering of others, leading to feelings of hopelessness and despair (Stebnicki, 2007). Figley (2002) suggested that compassion fatigue results in isolation from social supports, and it encompasses a feeling of helplessness. A significant indicator of compassion fatigue is the reduced capacity to care or empathize with one’s clients (Boscarino, Adams, & Figley, 2010). Empathy is the bedrock of the counseling relationship, so experiencing compassion fatigue is of ethical importance to the client as well as to the professional (Siegel & Germer, 2012). Compassion extended by the professional appears to benefit the client, and it may be possible that extending compassion to the mental health professional could help in avoiding compassion fatigue. According to Stamm (2010), compassion fatigue is made up of two elements, secondary traumatic stress, and burnout.

*Secondary traumatic stress.* The definition of secondary traumatic stress (or vicarious traumatization) is the process of change that happens when one cares about other people who have been hurt and feels committed or responsible for helping them
It is a result of emotional impairment due to an accumulation of traumatic stories from multiple therapy sessions (McCann & Pearlman, 1990). Secondary traumatic stress develops over time as a counselor extends empathy to clients by entering the experience of their pain (Saakvitne & Pearlman, 1996). One who is experiencing secondary traumatic stress may be preoccupied with the stories of clients they have helped (Stamm, 2010). A counselor may feel “trapped, on edge, exhausted, overwhelmed, and infected by other’s trauma” (Stamm, 2010, p. 21). Symptoms of secondary traumatic stress may include insomnia, absent-mindedness, re-experiencing the trauma that occurred to another, and poor separation between work and private life (Stamm, 2010). Some counselors who experience secondary traumatic stress may even avoid situations and experiences that remind them of the trauma experienced by their clients (Stamm, 2010). Several factors are associated with a higher risk of secondary traumatic stress. Mental health professionals are more likely to experience secondary traumatic stress if they have a personal trauma history, are new to the profession, work for hospitals or agencies, as well as those who do not have adequate supervision (Abu-Bader, 2000; Craig & Sprang, 2010; Pearlman & Maclan, 1995; Raquepaw & Miller, 1989).

Burnout. The final term in describing impairment, burnout, is the part of compassion fatigue that is manifest through feelings of “unhappiness, disconnectedness, and insensitivity” toward one’s work (Stamm, 2010, p. 21). According to Stamm (2010), one who is burned out may experience “exhaustion, feelings of being overwhelmed, bogged down, out-of-touch.” A person who feels burned out may feel distant from his or her ideal self and beliefs (Stamm, 2010).
Risk factors for impairment. Despite the high numbers of mental health professionals likely to experience impairment, many do not become impaired. The risk factors for impairment are varied. On an intrapersonal level, risk factors for counselor impairment may include the following: quality of training, education, and experience (Catherall, 1995; Cerney, 1995; Saakvitne & Pearlman, 1996). Counselors who have personally experienced trauma, personal difficulties such as divorce or chronic illness, or who have limited coping abilities are at higher risk for impairment (Catherall, 1995; Cerney, 1995; Saakvitne & Pearlman, 1996). Counselors who do not readily ask for help or who feel that there is a stigma attached to impairment, and those who believe the myths about counselor invulnerability are also at high risk for distress and impairment as a result of their work (Catherall, 1995; Cerney, 1995; Saakvitne & Pearlman, 1996).

Counselors with fewer personal supports and insufficient self-care strategies are at higher risk for impairment (Newsome, Waldo, & Gruszka, 2012). Individuals often enter the profession of counseling because of their interest in helping others and to meet their own need for approval (Maslach, 2015). Counselors, in general, tend to be highly invested in their work and therefore, have high expectations of themselves (Maslach, 2015). Counseling is a profession where clients rarely give feedback, and the outcome of counseling may not be observable at discharge, therefore one’s personal characteristics, such as “motivations, needs, values, self-esteem, emotional expressiveness and control, and personal style” (Maslach, 2015, p. 95) are critical in sustaining one’s motivation and in avoiding impairment A counselor’s self-image is an essential variable in developing impairment. If one has a negative self-image, it is difficult to maintain perspective when things go wrong, leading one to focus on failures instead of successes. A cycle of
negative perception occurs when one focuses more on what went wrong than on what
went right (Maslach, 2015). Other personal characteristics that are variables in the
development of impairment, according to Maslach (2015), are understanding one’s limits
and having an awareness of one’s needs, such as the need for approval, achievement, and
personal autonomy.

Demographic risk factors. Our understanding of risk factors regarding
demographic variables of counselors is somewhat limited. Most studies have focused
primarily on Caucasian participants, partially because ethnic minorities are
underrepresented in the profession of counseling (Maslach, 2015). Numbers of
participants in various studies have been too small to conclude comparisons between the
different ethnicities (Maslach, 2015). Therefore, what we know about mental health
professional impairment is largely the Caucasian experience of impairment (Maslach,
2015). The rate of impairment appears to be very similar for Caucasians and Asian
Americans. African American mental health professionals report fewer impairment
symptoms. It remains challenging to draw conclusions about Native American and
Latino counselors because their numbers in the counseling profession have been too
small to be significant (Maslach, 2015).

One demographic feature related to impairment development is age. Younger
counselors show more symptoms of impairment than those who are older (Rupert &
Morgan, 2005). Perhaps this is because younger counselors have less experience to draw
upon than seasoned counselors or because young counselors who become impaired tend
to leave the profession. It may be that the older counselors who were surveyed had the
personal characteristics to avoid impairment when younger (Maslach, 2015). Being
childless is also related to higher rates of impairment, according to Gann (as cited in Maslach, 2015). Counselors with different levels of education appear to be very similar. Those who have completed a 4-year degree but who have not had any post-graduate education show the most significant amount of impairment, although the reasons for this are unclear (Maslach, 2015).

**Interpersonal risk factors.** The interpersonal risk factors for impairment are known as *high touch hazards*, according to Skovholt (2001). The phrase refers to any profession in which one encounters others in an intimate manner, such as counseling, in which the counselor metaphorically enters the emotional world of the client (Skovholt, 2001). Counselors regularly extend themselves empathetically and with high sensitivity. These one-way caring relationships can be taxing because there is little reciprocity, minimal feedback, and sometimes there is little awareness of the outcome of the work at the termination of the relationship (Skovholt, 2001). Because clients are human, they may present with unsolvable problems or with the inability or readiness to make the changes they desire. Counselors may fail in treatment through no fault of their own, and even when therapy is successful, the measures of success are somewhat elusive (Skovholt, 2001). Counselors may feel like they have failed, which can lead to symptoms of impairment.

**Work-related risk factors.** Finally, the work-related risk factors for impairment—those typically beyond the control of the counselor—can be even more challenging (ACA, 2006). According to Maslach (2015), “burnout is not a problem of people so much as a problem of the social environment in which they work” (p. xxiii). Those working in community agencies have higher burnout, compassion fatigue, and vicarious
traumatization than those in private practice (Lawson, 2007; Rupert & Kent, 2007). In many agencies, environmental variables related to impairment are work overload, low remuneration, lack of control, unsupportive peers, and ineffective supervisors (Lloyd, King, & Chenoweth, 2002). Counselors who work for agencies may have limited control over their caseload, the population they work with, and a lack of input on policies. They may believe that they do not have the resources to engage in best-practices interventions (ACA, 2006). Non-profit agencies are typically dependent upon government funding and bottom-line outcomes, and therefore, they afford little flexibility regarding results (Rupert & Morgan, 2005). The demands of managed care, including session limits, may further increase the risk of impairment by reducing a counselor’s autonomous decision making (Acker, 2010).

For those who work in private practice, work-related variables still have an impact. Hospitals may discharge patients earlier than is optimal due to insurance limitations. Often, hospitals cannot even admit patients because of lack of availability of beds, leaving the burden of care on the private practitioner (ACA, 2006). It may be difficult to obtain high-quality supervision, and it may be a challenge for the counselor in private practice to engage in sufficient time off because of problems with backup coverage (ACA, 2006). Multiple risk factors can make a counselor vulnerable to impairment; however, the outcome of impairment can be serious for clients.

**Results of impairment.** It is essential for counselors to take the time to heal after a therapeutic relationship. Therefore, it is likely that impairment can interfere with healing (Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009; Castonguay et al., 2006). When counselors become impaired, they may develop negative feelings toward
their work, the clients, and other people in general (Maslach, 2015). Impaired counselors may often feel isolated from others, including clients, and they may not believe they are no longer competent, which can often result in extending harsh criticism of oneself (Maslach, 2015).

The symptoms of impairment may be physical and emotional exhaustion, negative self-concept, negative attitude, and loss of interest in clients (Pines & Maslach, 1978). Impairment may also appear as low energy, cynicism toward clients, hopelessness, and canceled appointments (Lambie, 2006). Several studies have identified the symptoms of impairment as reduced satisfaction with work, somatic complaints, fatigue, sleep disturbances, and impaired cognitive performance (Maslach, Schaufeli, & Leiter, 2001; Schaufeli & Enzmann, 1998; Schmidt, Neubach, & Heuer, 2007; Taris, 2006).

Impairment is a significant factor in staff retention within behavioral health treatment organizations (Morse et al., 2012). Impairment can cause financial distress for agencies due to related absenteeism and turnover (Stalker & Harvey, 2002). High absenteeism can reduce the quality of mental health care because evidence-based practices may not be correctly implemented (Morse et al., 2012; Skovholt & Trotter-Mathison, 2016). Frequent absences interfere with client-provider relationships (Morse et al., 2012). Impairment may also cause professionals to leave the field of mental health prematurely (Raquepaw & Miller, 1989). It appears that the rate of burnout among counselors is high for a variety of reasons, and yet, many counselors who experience similar demographic characteristics are successfully thriving in the profession and show no symptoms of impairment (Lakin, Leon, & Miller, 2008).
Protective factors for impairment. Although impairment in mental health professionals has been noted for decades, little is known about protective factors (Pines & Maslach, 1978). In 2012, a search was conducted that identified eight studies on the topic of prevention and intervention of impairment in mental health staff (Morse et al., 2012). Interestingly of the eight, six studies were conducted in Europe, and only two in the United States. Five of the studies reported a reduction in burnout for the participants of the interventions (Morse et al., 2012).

The interventions identified in the Morse et al. (2012) literature review identified a combination of cognitive-behavioral therapy (CBT), including mindfulness, meditation, gratitude, and personal meaning (Salyers et al., 2011); attitude and coping skills improvement (Ewers, Bradshaw, McGovern, & Ewers, 2002); assertiveness training (Scarnera, Bosco, Soleti, & Lacioni, 2008); and reduced feelings of inequity among co-workers (van Dierendonck, Schaufeli, & Buunk, 1998). Other interventions identified were third generation cognitive-behavioral interventions, such as mindfulness and meditation, based on the Eastern religions (Hayes, Follette, & Linehan, 2004). Programs for individuals focused primarily on cognitive-behavioral strategies, such as education, cognitive restructuring, progressive muscle relaxation, social skills and communication training, and skills that enhanced social support (Morse et al., 2012).

Self-care may be the most important protective factor against impairment (Craig & Sprang, 2010). Self-care can take the form of healthy eating, adequate sleep, and seeking peer support (Pearlman & MacIan, 1995). Helpful activities for counselor self-care suggested were: (a) discussing cases with colleagues, (b) attending workshops, (c) taking time with family and friends, (d) traveling, (e) taking vacations, (f) having
hobbies, (g) watching movies, (h) chatting with colleagues between sessions, (i) socializing, (j) exercise, (k) limiting caseloads, (l) spirituality, and (m) supervision (Pearlman & MacIan, 1995).

The relationship between poor self-care and compassion fatigue for mental health professionals is known (Shallcross, 2011). Compassion fatigue can be improved or prevented through self-care activities, and yet, counselors tend to neglect their self-care (Bradley, Whisenhunt, Adamson, & Kress, 2013). Counselors who are psychologically unhealthy may have poor client outcomes (Henry, Schact, & Strupp, 1990). Henry et al. (1990) defined psychological health as having personal behaviors of self-nurturance, self-acceptance, and self-help. These behaviors are like those of a self-compassionate person. However, the term, self-compassion was not in the Henry et al. (1990) research. Patsiopoulos and Buchanan (2011) to explored the possibility of a relationship between the concept of self-compassion and the improvement of compassion fatigue symptoms. The results of the study suggest that counselors are better at offering compassion to others than they are offering it to themselves (Patsiopoulos & Buchanan, 2011).

Self-compassion, a concept that originated in Buddhism, has been studied in the United States by the preeminent researcher, Kristin Neff, since 2003. According to Neff (2003), self-compassion is extending compassion to one’s self in instances of perceived inadequacy, failure, or general suffering. Self-compassion is composed of three main components: self-kindness, common humanity, and mindfulness (Neff, 2003). Since 2003, more than 200 journal articles and dissertations have examined the topic of self-compassion (Neff & Dahm, 2015). The creation of the Self-Compassion Scale (SCS) has
provided a tool to measure self-compassion, thereby making it possible to study the construct (Neff, 2003).

When Neff (2003) discussed self-kindness, she suggested that one extends kindness to oneself in the same manner that one would extend kindness to a friend or loved one. When a loved one makes a mistake, one might say *no problem; you are just learning* (Neff, 2003). Self-kindness means that we speak in the same supportive manner to ourselves (Neff, 2003). The next construct of self-compassion, common humanity, is described by Neff (2003) as the notion that difficult things happen to everyone, and we are not alone in experiencing suffering. The final construct of self-compassion, mindfulness is the awareness of what is, without judgment (Kabat-Zinn, 2005). When discussing mindfulness as it relates to self-compassion—one might notice the uncomfortable feeling of hunger without deciding that hunger is unacceptable or without trying to change it (Neff, 2003).

Self-compassion helps people to extend kindness and patience to themselves (Neff, 2011). A self-compassionate person is one who is aware that we all make mistakes and are imperfect (Neff, 2011). The evidence supporting an association between high self-compassion and overall positive life satisfaction suggests that self-compassion may mitigate the effects of work-related stress and the resulting burnout for counselors (Neff, 2011).

Neff and Dahm (2015) found that positive associations exist between self-compassion and well-being variables, such as happiness, optimism, life satisfaction, positive affect, and personality variables, such as extraversion. These findings suggest that self-compassion is important in the development, maintenance, and treatment of
various psychopathological symptoms (MacBeth & Gumley, 2012). Self-compassion may also mediate symptoms like those identified as burnout, such as mental and physical exhaustion, sleep disturbances, irritability, worry, the lack of the ability to relax, and having signs of physical distress symptoms (Schaufeli & Enzmann, 1998).

Evidence suggests that increasing self-care decreases mental health provider impairment (Newsome et al., 2012). Increasing self-compassion may increase self-care, which is significant, considering the rates of mental health provider impairment (Boellinghaus, Jones, & Hutton, 2014; Christopher & Maris, 2010). However, there is minimal research on self-compassion and counselors. In fact, a search of articles on self-compassion yielded only one study (a review of self-compassion, mindfulness, and self-care) with the word counselor in the title (Coleman, Martensen, Scott, & Indelicato, 2016). A search for the term psychotherapist and self-compassion yielded one title for a study of psychotherapy students (Beaumont, Galpin, & Jenkins, 2012). The term social work and self-compassion yielded two studies of social work students (Ying, 2009; Ying & Han, 2009), and a search for the term social worker and psychiatrist with self-compassion yielded no results.

Theoretical Rationale

Resilience theory provides a framework to explain how counselors manage the inherent stressors of their work. This study was framed in the model of resiliency created by Richardson (2002). Resiliency is a “dynamic process encompassing positive adaptation” in the face of “significant adversity” (Luthar, Cicchetti, & Becker, 2000, p. 343). Richardson’s metatheory of resiliency applies to several types of stressors. Of all the theories of resilience that abound, only Richardson’s (2002) metatheory of
resiliency incorporates ideas from many fields such as physics, psychology, and medicine (Fletcher & Sarkar, 2013).

Early studies of resilience were focused on children born on the island of Kauai, Hawaii, in 1955, to investigate why, given the same circumstances (maltreatment, traumatic life events, poverty, parental illness) some children thrived while others failed (Werner & Smith, 1982; Werner, Bierman & French, 1971). The second landmark study on resilience, the Minnesota Risk Research Project, focused on the children of schizophrenic parents (Richardson, 2002). More recent studies have focused on the presence of resilience in adults (Beaumont et al., 2012; Diedrich, Grant, Hofmann, Hiller, & Berking, 2014; Germer & Neff, 2013; Neff & Vonk, 2009; Sbarra, Smith, & Mehl, 2012; Hiraoka et al., 2015; Sirois, 2015).

Three waves of research on resilience. According to Richardson (2002), research on resilience has developed in three waves. The first wave identified characteristics that help people thrive in difficult situations. Early research by Werner (1982) and Werner and Smith (1982; 1992) identified several variables, such as high self-esteem, a strong support system, or a caring adult, which helped people develop resilience (Richardson, 2002). The second wave looked at how people could develop those qualities that could help them cope with adversity. This wave suggests that people can increase or develop resilience and that developing resilience is a process—not an event (Richardson, 2002). Flach (1997) posited that resilience is acquired through “a law of disruption and reintegration” (as cited in Richardson, 2002, p. 310). The resiliency model (Richardson, 2002) demonstrates this process of homeostasis, disruption through life events, and reintegration in a manner that is different than prior linear models of
resilience. Finally, the third wave of resilience research examined the innate motivation to be resilient. This wave asked questions such as: Why do some people weather challenging situations better than others? or How do people emerge from difficult circumstances doing better than before? (Richardson, 2002). The answer comes from merging ideas of diverse disciplines, such as physics, Eastern medicine, religion, as well as psychology (Richardson, 2002). According to Richardson (2002), “A succinct statement of resilience theory is that there is a force within everyone that drives them to seek self-actualization, altruism, wisdom, and harmony” (p. 313).

Richardson (2002) posited that all people begin the process of resilience in a state of biopsychospiritual homeostasis because they have adapted to their circumstances no matter the quality of the situation. When a disruption occurs, such as an experience of compassion-fatigue, a counselor would need to reintegrate to restore his or her biopsychospiritual homeostasis. The reintegration can happen in four ways, either by dysfunctional reintegration, reintegration with loss, a return to homeostasis, or an acquisition of a resilient state in which the counselor is better than before (Richardson, 2002). Because the work of counseling is challenging, the protective factors that an individual has may determine their ability to reintegrate with resilience (Richardson, 2002).

**Richardson’s theory of resiliency.** Richardson (2002) incorporated research from the three waves into a model of resiliency that suggests that all people naturally seek a state of biopsychospiritual homeostasis. According to Richardson’s (2002) theory of resiliency, biopsychospiritual homeostasis refers to the process, either physical, psychological, or spiritual, that occurs when a person is exposed to a disruptive event.
Richardson suggested that an individual will have one of four outcomes as a reaction to a stressor or disruption: resilient reintegration, homeostatic reintegration, maladaptive reintegration, and dysfunctional integration, as indicated in Figure 1.4 (Richardson, 2002). According to Richardson, disruption or *falling apart* is necessary for resilience to occur. Disruption is unpleasant, and, therefore, it encourages the individual to adapt and develop new resilience skills (Richardson, 2002).


A disruption occurs because of stressors that interrupt homeostasis. Protective factors may temper the stressors. After a disruption occurs, a person may achieve a
higher level of coping, referred to as resilient integration (Richardson, 2002). In this state, one has grown in self-knowledge and understanding, as well as gained increased resilience. An alternative state may be homeostatic reintegration, a state in which a person has regained his or her prior balance but has not experienced growth from the disruption (Richardson, 2002). The state of maladaptive reintegration suggests that one has lost the ability to hope and has decreased motivation or optimism (Richardson, 2002). Lastly, dysfunctional reintegration, is a state in which one attempts to return to homeostasis by using maladaptive means such as substance abuse (Richardson, 2002).

For LMHCs, resilience would be the ability to cope with the stressors inherent in their profession and continue to engage in their work with improved functioning (Skovholt & Trotter-Mathison, 2016). If the LMHC does not reintegrate in a homeostatic manner, painful emotions, such as hurt, loss, pain, or guilt may be experienced, perhaps leading to what could be described as compassion fatigue.

In summary, Richardson (2002) suggested that while the diagram of his model (Figure 1.4) reflects one event, there are multiple opportunities for disruption and reintegration occurring at any given time. The entire process can occur in seconds or over several years, depending on the situation; for example, one can reintegrate resiliently very quickly after stubbing one’s toe, whereas the death of a loved one will likely take years to integrate (Richardson, 2002). Some disruptions, such as child abuse, may cause reintegration with loss, but then years later, through counseling, the individual would be re-disrupted, and resiliency could be reintegrated (Richardson, 2002). If one does not acquire resilient qualities after disruptions, the same stressors will continue to cause disruptions to that person (Richardson, 2002). Richardson indicated that this model
applies to individuals, couples, families, organizations, and even to communities. One who is in a state of biopsychospiritual homeostasis is disinclined to improve or grow; thus, disruption is required to access innate resilience (Richardson, 2002). Moreover, the therapeutic value of the model is that one can visually experience the possibilities for growth, recovery, or loss after a disruption (Richardson, 2002).

**Protective factors for resilience.** Werner and Smith (1982) identified 15 protective factors from their studies of resilient youth who were compared to high-risk youth. The protective factors are:

- being first in birth order,
- high activity level,
- good-natured (affectionate disposition),
- responsive to people,
- free of distressing habits,
- positive social orientation,
- autonomy,
- advanced self-help skills,
- age-appropriate sensorimotor and perceptual skills,
- adequate communication skills,
- ability to focus attention and control impulses,
- special interests and hobbies,
- positive self-concept,
- internal locus of control, and
- the desire to improve themselves.
Research utilizing Richardson’s (1982) model of resiliency focused on women and found that spiritual indicators were predictive of one’s ability to be resilient, such as purpose in life, locus of control, creativity, humor, religiosity, and affect, which were considerably more significant indicators than mental or physical predictors (Dunn, 1994 as cited in Richardson, 2002).

Follow-up from the Kauai study (Werner, 2005) identified “turning points” (p. 12) that were protective factors for resilience. These were naturally occurring events in which decisions were made by the high-risk-study participants that resulted in positive change. One of the most important turning points was related to continuing education after high school (Werner, 2005). Others were marriage to a stable partner, joining and actively participating in a faith-based community, and experiencing a close encounter with death either through illness or accident (Werner, 2005). Those who used these turning points to make changes in their lives differed from those who did not. Those who changed tended to be more social and active, had better problem-solving and reading skills, and they had more positive interactions with childhood caregivers (Werner, 2005). Werner (2005) suggested that the resilient participants sought out adaptive changes instead of passively accepting adversity.

An interesting study on adapting to stress suggested that hardiness can be a protective factor (Kobasa, Maddi, & Kahn, 1982). Hardiness is described as having the three dimensions of being committed to finding meaningful purpose in life, the belief that one can influence one’s surroundings and the outcome of events, and the belief that one can learn and grow from both positive and negative life experiences (Kobasa et al.,
Hardy people tend to adapt better to stressful situations by using social supports and active coping skills (Florian, Mikulincer, & Taubman, 1995).

**Relationship between resilience and positive emotions.** There is considerable research on the relationship between resilience and positive emotions (Baker, Minchoff, & Dillon, 1985; Luther, 2015; Mahony, Burroughs, & Lippman, 2002; Ong, Bergeman, Bisconti, & Wallace, 2006). Resilience is thought to promote flexibility in thinking and problem solving as well as helping individuals recover from stressful interactions (Ong et al., 2006). Resilience increases positive emotions that counteract the physiological impact of negative emotions (Baker et al., 1985). Studies indicate that resilience improves adaptive coping as well as social relationships, and it increases well-being (Luther, 2015).

Positive emotions may result from being resilient, but they also increase one’s ability to be resilient. For example, feeling positive emotions during a stressful situation increases coping abilities (Mahony et al., 2002). Resilient people who have coping strategies are more resistant to stress (Mahony et al., 2002). Richardson’s (2002) resilience theory provides a framework for discussing how counselors respond to stress.

**Resilience and self-compassion.** A relatively recent study identified connections between the construct of self-compassion and resilience among the elderly. Smith (2015) identified a possible connection between high self-compassion and the ability to cope with stressors among senior living residents. Smith’s study validated two earlier studies with younger populations (Leary et al., 2007; Neff et al., 2007) that suggested that increasing self-compassion may play a role in developing resilience to stressful situations.
Problem Statement

The purpose of this study was to examine the relationship between compassion fatigue and self-compassion among mental health counselors from the perspective of Richardson’s (2002) resilience theory. Compassion fatigue is a significant problem for mental health counselors, and there is evidence that indicates that there may be benefits of self-compassion that could mitigate compassion fatigue. No studies were found, relating to this population, that focused on compassion fatigue and self-compassion.

Research Questions

To accomplish the objective outlined in the problem statement, the following research questions were explored:

1. What is the relationship between demographic variables of licensed mental health counselors and their reported experience of self-compassion?
2. What is the relationship between demographic variables of licensed mental health counselors and their reported experience of compassion fatigue?
3. What is the relationship between reported compassion fatigue and reported self-kindness, common humanity, and mindfulness among licensed mental health counselors?
4. What is the relationship between reported self-compassion, reported burnout, and secondary traumatic stress among licensed mental health counselors?

Significance of the Study

Compassion fatigue is a significant problem for mental health counselors. Self-compassion may mitigate some of the symptoms of compassion fatigue as well as increase compassion satisfaction and impact effectiveness as a counselor. A negative
relationship between self-compassion and compassion fatigue identified in this study may inform the work of both practicing mental health counselors and counselor education programs.

**Definition of Terms**

*Burnout* – a state of physical, emotional, and mental exhaustion caused by long-term involvement in situations that are emotionally demanding (Pines & Aronson, 1988).

*Common Humanity* – “involves recognizing that suffering and personal inadequacy is part of the shared human experience – something that we all go through rather than being something that happens to ‘me’ alone” (Neff, 2018, p. 2).

*Compassion Fatigue* – stress resulting from aiding or desiring to help a traumatized person (Figley, 1995).

*Isolation* – feeling alone and believing that unpleasant things only happen to oneself (Neff, 2003).

*Mindfulness* – “paying attention, on purpose, to the present moment” (Kabat-Zinn, 2005, p. 108). For this study, mindfulness is identified as a component of self-compassion (Neff, 2003).

*Mental Health Counselor (LMHC) or Licensed Professional Counselor (LPC)* – a protected title for those trained in mental health counseling. A professional counselor is an individual who has studied traditional psychotherapy and who utilizes a problem-solving approach to assist clients in establishing change and resolving problems. Professional counselors offer services to clients, depending on their education and experience, ranging from assessment and diagnosis to crisis management. According to
state licensing bodies, professional counselors may be known as LMHCs or LPCs or licensed professional clinical counselor (LPCC) (NYMHCA, 2016).

*Over-Identification* – becoming lost in one’s thoughts and ruminating on problems and concerns (Neff, 2003).

*Resilience* – one’s ability to overcome obstacles or adverse events (Richardson, 2002).

*Secondary Traumatic Stress (or vicarious trauma)* – the process of change what happens when one cares about other people who have been hurt and one feels committed or responsible for helping others (Pearlman & McKay, 2008).

*Self-Compassion* – Being kind and understanding toward oneself in instances of pain or failure rather than being harshly self-critical; perceiving one’s experiences as part of the larger human experience rather than seeing them as isolating, and holding painful thoughts and feelings in mindful awareness rather than over-identifying with them (Neff, 2003, p. 223). Mindfulness, common humanity, and self-kindness make up the construct of self-compassion.

*Self-Judgement* – being cold and condemning toward oneself instead of encouraging and accepting (Neff, 2003).

*Self-Kindness* – being warm and understanding toward oneself when suffering, failing, or feeling inadequate, rather than ignoring our pain or flagellating ourselves with self-criticism (Neff, 2003).

*Vicarious Traumatization* – the process of change what happens when one cares about other people who have been hurt and feels committed or responsible for helping them (Pearlman & McKay, 2008).
Chapter Summary

This chapter explored the problem of compassion fatigue among mental health professionals from the perspective of Richardson’s (2002) resilience theory. The chapter began by describing the trends in mental health in the United States, including suicide and substance abuse. Skovholt’s (2005) model, the cycle of caring, was presented and described the challenges of providing mental health care. Next, the issue of counselor impairment was examined, including symptoms and causes, as well as results of impairment. Because there are many different but similar roles for mental health professionals, the chapter spells out some of the differences and clarifies the roles, ending with the role of the professional counselor. The concept of self-compassion was introduced, followed by an introduction to the theoretical framework of Richardson’s (2002) resilience theory.

In this chapter, a problem related to counselor impairment in the United States was identified. There are too few mental health providers to meet the needs of those experiencing mental health problems, especially regarding emerging issues such as the opioid epidemic (CDC, 2017; HRSA, 2017). Counseling is a challenging profession, leading to compassion fatigue among those who struggle to maintain wellness and meet the needs of their clients (ACA, 2006). Resilience theory suggests that one can recover from stressful situations either through innate abilities or by learning to become more resilient as well as through protective factors (Richardson, 2002). The body of research shows that there are self-care behaviors, such as increasing mindfulness and self-compassion, that reduce the risk of compassion fatigue caused by stressful professional interactions (Skovholt & Trotter-Mathison, 2016).
Chapter 2 examines the literature on compassion fatigue and self-compassion among helping professionals. The research design, methodology, and analysis plan are discussed in Chapter 3. Chapter 4 presents a detailed analysis of the results and findings, and Chapter 5 discusses the findings, implications, and recommendations for future research and practice.
Chapter 2: Review of the Literature

The following review of the literature is structured around Richardson’s (2002) model of resilience. According to this model, the occurrence of compassion fatigue would disrupt biopsychospiritual homeostasis, leading to feelings of hurt, loss, pain, and guilt (Richardson, 2002). Self-compassion has been shown to increase resilience, and therefore, it may enhance homeostatic reintegration (Beaumont et al., 2012; Diedrich et al., 2014; Germer & Neff, 2013; Hiraoka et al., 2015; Neff & Vonk, 2009; Sbarra et al., 2012; Sirois, 2015). This chapter begins with a review of the literature related to counselor impairment, including a discussion of the relationship between impairment and depression. Next, the literature on determinants and protective factors for impairment is reviewed, followed by the research on self-compassion as a protective factor in increasing resilience. Finally, the chapter concludes with a discussion of the research related to self-compassion and compassion fatigue.

Terminology for Impairment

A review of the body of literature on impairment for mental health professionals suggests that some terms are used interchangeably. The term burnout is applied to many of the same symptoms as the term compassion fatigue (Stamm, 2010). Other related terms include vicarious trauma, secondary traumatic stress, and impairment, which were defined in Chapter 1. Burnout is thought to be linked to long-lasting or long-term impairment, whereas compassion fatigue and vicarious traumatization are thought to be related to short-term impairment (Morse et al., 2012). Compassion fatigue and vicarious
traumatization are also considered to be contingent upon working with a client or clients, whereas burnout is used to refer to many occupational stressors (Morse et al., 2012). For this study, the research that referred to mental health professional impairment, using the terms burnout, compassion fatigue, vicarious trauma, and secondary traumatization were all included in this literature review.

**Burnout and Depression**

Multiple studies of mental health professionals and other helping professionals indicate similarities regarding the symptoms of burnout and depression (Awa, Plaumann, & Walter 2010; Bakker et al., 2000; Brenninkmeyer, Van Yperen, & Buunk, 2001; Leiter & Durup, 1994; Maslach et al., 2001; Maslach, 2015; Rai, 2010; Schaufeli & Enzmann, 1998; Sulsky & Smith, 2005). A person experiencing burnout may have difficulty relaxing, sleep disturbances, irritability, may exhibit anxiety-related behaviors, and they may have increased physical distress, as well as mental and physical exhaustion and decreased motivation (Maslach, 2015; Schaufeli & Enzmann, 1998). Other studies have identified burnout symptoms as displaying negative affect, isolating oneself, experiencing cognitive problems, and judging oneself harshly (Awa et al., 2010; Maslach et al., 2001; Maslach, 2015; Rai, 2010; Schaufeli & Enzmann, 1998; Sulsky & Smith, 2005). Still, others have reported an increase in somatic discomforts, such as flu-like symptoms, colds, sore throat, and dizziness, in helping professionals who reported high levels of burnout (Acker, 2010).

According to the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; APA, 2013), these symptoms of burnout appear to be similar to the symptoms of depression. The symptoms of depression include “depressed mood, diminished interest
or pleasure in most activities, insomnia, psychomotor agitation or retardation, fatigue, feelings of worthlessness or excessive guilt, and diminished ability to think, causing clinically significant distress in social or occupational functioning” (APA, 2013, p. 161).

The comparison of burnout symptoms to depression symptoms is a reoccurring theme in the literature. A volunteer group of human services professionals (96% female) from a Canadian teaching hospital participated in research designed to support the validity of depression and burnout as two related but different constructs (Leiter & Durup, 1994). Similarities that were identified suggest that both depression and burnout include the inability to derive pleasure from previously pleasurable activities, fatigue or loss of energy, feelings of insufficiency or guilt, and a tendency to isolate oneself (Leiter & Durup, 1994). Glass and McKnight (1996) suggested that burnout is not a form of work-related depression, but rather, it is a different concept. Bakker et al. (2000) agreed with Leiter and Durup (1994) but noted that although the symptoms are similar, they occur in different domains, suggesting that “burnout is a ‘work-related’ construct, and depression is ‘context-free’” (Bakker et al., 2000, p. 264).

An examination of the differences and similarities between burnout and depression was explored by Brenninkmeyer et al. (2001). They suggested that striving for superiority is inherent in the adaptive primate struggle for social dominance, and they sought to determine whether those who experience burnout and a low sense of superiority would meet the criteria for a diagnosis of depression (Brenninkmeyer et al., 2001). The basis for this research was a study by Buunk and Brenninkmeyer (1999) in which it was identified that depressed people feel less superior than, but not inferior to, those who are not depressed. According to their results, depressed individuals and individuals
experiencing burnout both express having a depressed mood and fatigue or loss of energy (Brenninkmeyer et al., 2001). However, their findings indicate that those with burnout but not depression, can derive pleasure, do not lose or gain weight, do not experience psychomotor agitation, and do not have marked feelings of insufficiency (Brenninkmeyer et al., 2001). The burned-out individuals are also different from those with depression in that they do not typically experience indecisiveness or inability to concentrate, and they are not likely to have suicidal thoughts (Brenninkmeyer et al., 2001). Those with burnout tend to have problems falling asleep, whereas participants in this research who were experiencing depression tended to wake up too early (Brenninkmeyer et al., 2001).

Finally, research on teachers in France found a significant overlap between burnout and depression (Bianchi, Schonfeld, & Laurent, 2014). They also found that emotional exhaustion and depersonalization, both subscales of the Maslach Burnout Inventory, were depression-like symptoms related to negative work-related environments (Bianchi et al., 2014). Bianchi et al. (2014) hypothesized that the concepts are the same with a work-related antecedent for burnout, but they acknowledged that there is a need for more rigorous research before making this assertion. More recent research focusing on physicians and nurses found that while there is some overlap between depression and burnout symptoms, there is a stronger correlation between burnout and PTSD and generalized anxiety disorder, than with depression (Colville & Smith, 2017).

In summary, research has found that burnout and depression are closely related, but they are distinct constructs (Bakker et al., 2000; Bianchi et al., 2014; Brenninkmeyer et al., 2001; Glass & McKnight, 1996; Leiter & Durup, 1994). Multiple studies have considered the similarities and differences, and all have determined that—at the very
least—the two constructs are consistently similar in symptomology (Bakker et al., 2000; Bianchi et al., 2014; Brenninkmeyer et al., 2001; Glass & McKnight, 1996; Leiter & Durup, 1994; van Dam, 2016). There also appears to be a greater correlation between burnout and PTSD than burnout and depression (Colville & Smith, 2017). The term *burnout* is also often used interchangeably with the terms *compassion fatigue* and *vicarious traumatization* (Baird & Jenkins, 2003; Beaumont, Durkin, Hollins Martin, & Carson, 2016a; Deighton, Gurris, & Traue, 2007).

**Intrapersonal Determinants of Impairment**

Much of the research on burnout has focused on demographic characteristics of helping professionals (Acker, 2010; Green, Albanese, Shapiro, & Aarons, 2014; Lawson & Myers, 2011; Lent & Schwartz, 2012; Rohland, 2000; Rupert & Kent, 2007; Tanrikulu, 2012; Thompson, Amatea, & Thompson, 2014). Multiple studies found that several characteristics, such as gender, race, marital status, and level of education, are not typically related to burnout (Ballenger-Browning et al., 2011; Green et al., 2014; Lent & Schwartz, 2012). The demographic characteristic most related to burnout among helping professionals is age (Baird & Jenkins, 2003; Rupert & Morgan, 2005). Younger counselors tend to have higher levels of burnout (Baird & Jenkins, 2003; Rupert & Morgan, 2005).

Multiple studies focused on the presentation of counselor burnout (Ballenger-Browning et al., 2011; Lent & Schwartz, 2012; Paris & Hoge, 2009; Thompson et al., 2014). Although there is prolific research related to mental health professionals, it is not yet clear which variables are optimal for avoiding impairment (Thompson et al., 2014). Several studies contradict one another regarding the demographic variables such as
gender and length of time in the profession (Merriman, 2015; Pines & Maslach, 1978; Rupert & Morgan, 2005; Thompson et al., 2014). For example, some studies found a negative correlation between age or experience and burnout, while others found no relationship (Rupert & Morgan, 2005). Lent & Schwartz (2012) identified a complicated relationship between variables of gender, race, years of experience, and burnout; although, in other studies, no one variable had a significant effect on the development of burnout. A review conducted by Paris and Hoge (2009) validated the lack of definitive causes of burnout among mental health professionals including community health nurses, psychologists, social workers, psychiatrists, and psychosocial rehabilitation workers. The review highlighted some potential causes of burnout, such as age, gender, ethnicity, and work environment, but they reported that the “studies are generally methodologically weak, and multiple studies examining the relationship of burnout to a single common variable do not exist” (Paris & Hoge, 2009, p. 523). Thompson et al. (2014) did not demonstrate an association between gender, length of time in the profession, and burnout.

Mental health professionals are at risk for vicarious traumatization, burnout, or general impairment when they do not adequately engage in self-care (Barnett, Baker, Elman, & Schoener, 2007). Killian (2008) identified that self-care strategy themes, such as spirituality, exercise, and spending time with family as well as social support and internal locus of control, were related to compassion satisfaction. A personal history of trauma was associated with lower compassion satisfaction (Killian, 2008). This research also found no significant correlations between the use of specific individual coping strategies and reported levels of compassion fatigue and burnout (Killian, 2008).
Patsiopoulos and Buchanan (2011) defined self-care as maintaining balance by engaging in holistic practices that increase self-compassion and well-being. Self-care may include eating a healthy diet, getting adequate sleep, and engaging in exercise and restorative activities, such as yoga or vacation (Shapiro, Brown, & Biegel, 2007; Wicks & Maynard, 2014). Increasing habits, such as self-reflection and increased self-care, may prevent a counselor from burnout (Lent & Schwartz, 2012). Coping resources, such as mindfulness, held the strongest negative correlation with burnout (Thompson et al., 2014).

Counselor self-care may also include ongoing self-examination through supervision, the counselor’s personal psychotherapy, as well as ongoing assessment of one’s stressors (Barnett & Cooper, 2009). Self-care can also include, increasing one’s emotion regulation abilities, self-compassion, and mindfulness or other spiritual activities (Barnett & Cooper, 2009; Boellinghaus et al., 2014; Patsiopoulos & Buchanan, 2011; Wise, Hersh, & Gibson, 2012). While the empirical research on self-care practices is vast (Barnett & Cooper, 2009; Patsiopoulos & Buchanan, 2011; Wicks & Maynard, 2014; Wise et al., 2012), research has not clearly identified the optimal strategies for counselor self-care. Rather, it has been demonstrated that self-care engagement is both personal and changeable (Barnett & Cooper, 2009; Barnett et al., 2007; Wicks & Maynard, 2014).

The literature on burnout has been inconsistent in identifying demographic characteristics such as gender, ethnicity, race, length of time in the profession and level of education in predicting burnout (Ballenger-Browning et al., 2011; Green et al., 2014; Lent & Schwartz, 2012). Age is the only intrapersonal characteristic that has a significant and evidenced relationship to burnout (Green et al., 2014). While many studies examined burnout across different types of mental health professionals, there are...
relatively few studies that address burnout among mental health counselors. Several studies indicate a need for awareness and enhancement of self-care practices (Ballenger-Browning et al., 2011; Lent & Schwartz, 2012; Rohland, 2000; Thompson et al., 2014).

**Work-Related Determinants of Impairment**

Research on job-related distress and impairment was conducted by Lent and Schwartz (2012) to investigate the relationship between burnout, work setting, demographic characteristics, and personality variables among professional counselors working in inpatient settings, community mental health settings, and private practices. Killian (2008) reported that work-related variables, such as supervision, peer debriefing, and work hours, were related to compassion satisfaction. Overall, counselors working in community mental health settings reported more burnout and emotional exhaustion than those in private practice (Lent & Schwartz, 2012). Rupert and Morgan (2005) found a relationship between caseload and burnout. While these variables may be difficult to change, counselors’ awareness of their risk for burnout gives them the opportunity to address their need for self-care (Lent & Schwartz, 2012).

Thompson et al. (2014) explored counselors’ perceptions of their work environment and other variables, including the length of time in the profession, use of coping resources, and gender, as well as personal resources of mindfulness. Their findings indicate that counselors who reported better coping abilities, greater mindfulness, as well as greater compassion satisfaction, and positive attitudes regarding their work environment, reported less burnout (Thompson et al., 2014). The findings suggest that increasing these variables will reduce the likelihood of counselor burnout.
Green et al. (2014) studied service providers (social workers, marriage and family therapists, and psychologists) across a large urban area, to identify burnout correlates related to provider demographics (age, sex, and education), work-related variables (agency tenure and caseload size), as well as leadership and work-related variables. Burnout was measured with the subscales of the Maslach Burnout Inventory, which were personal accomplishment, emotional exhaustion, and depersonalization (Green et al., 2014). Organizational and leadership variables, higher role clarity, cooperation, and higher levels of transformational leadership behaviors demonstrated the most significant differences in reported burnout (Green et al., 2014). Higher role clarity, cooperation, and transformational leadership behaviors were associated with higher scores on the personal accomplishment subscale (Green et al., 2014). These findings suggest that understanding expectations for one’s work role, as well as having a cooperative relationship with co-workers, and having an inspiring leader could be related to a sense of personal accomplishment (Green et al., 2014). Cooperation among team members and role clarity could also influence one’s sense of competence (Green et al., 2014).

Wraparound providers reported significantly less depersonalization than case managers (Green et al., 2014). Wraparound is an evidence-based case management model for youth with severe behavioral disorders (Green et al., 2014; Suter & Bruns, 2009). Wraparound providers are available to provide in-home or school services to their clients and their families as needed (Green et al., 2014; Suter & Bruns, 2009).

Work-related variables, such as those related to rurality, location in a rural county, fewer employees, smaller budgets, and more time spent in direct clinical care were compared to variables in urban work settings (Rohland, 2000). Despite high levels
of reported burnout, this research did not find a relationship between work environment variables and rates of burnout (Rohland, 2000). These findings are in contradiction to Paris and Hoge (2009), who reported much higher levels of emotional exhaustion among rural mental health professionals. Working within the constraints of managed care organizations may influence the development of burnout for social workers (Acker, 2010). A high degree of self-perceived competence with managed care appeared to mitigate the burnout symptoms (Acker, 2010).

While there does not appear to be a direct or significant relationship between gender and burnout, there may be a complex interaction between work setting and gender in the development of burnout (Ballenger-Browning et al., 2011; Lent & Schwartz, 2012). It has been found that women in agency settings have more symptoms of burnout than women in private practice (Lent & Schwartz, 2012). However, studies indicate no difference between men in agencies and men in private practice (Ballenger-Browning et al., 2011; Lent & Schwartz, 2012).

**Client-Related Determinants of Impairment**

Those who worked with individuals with severe mental illness were more likely to have high burnout scores (Acker, 2010). One risk factor for impairment among mental health professionals that has received considerable attention in the United States in the past 20 years is the impact of working with traumatized populations (Ballenger-Browning et al., 2011; Drouet Pistorius, Feinauer, Harper, Stahmann, & Miller, 2008; Killian, 2008). Many studies suggest that working with individuals who have experienced trauma is a significant risk factor for impairment. At the same time, those who work with
traumatized individuals report experiencing considerable satisfaction in their work (Ballenger-Browning et al., 2011; Drouet Pistorius et al., 2008; Killian, 2008).

Research on the impact of counseling abused children on clinicians found that the counselors experienced compassion fatigue when working with this population (Drouet Pistorius et al., 2008). The counselors indicated an increased awareness of dangers and unpleasant aspects of life and an increased level of fearfulness, which is consistent with the presentation of vicarious traumatization (Drouet Pistorius et al., 2008). Consistent with other studies, counselors also endorsed positive consequences, such as an increased appreciation for life and personal and professional growth (Drouet Pistorius et al., 2008).

A study of burnout and resilience for mental health providers in their work with trauma survivors demonstrated that the therapists experienced stress through somatic symptoms, mood changes, and sleep disturbances, and became distracted, experiencing increased difficulty in concentrating (Killian, 2008).

Finally, military mental health providers are exposed to combat stress and vicarious trauma, which may be different than the stress experienced by civilian mental health providers (Ballenger-Browning et al., 2011). However, when levels and predictors of burnout were assessed among military mental health providers and compared to their civilian counterparts, the burnout levels were remarkably similar (Ballenger-Browning et al., 2011). Surprisingly, the military providers reported less burnout than those in the Maslach Burnout Inventory, the normative sample of civilian mental health workers.

In summary, there appears to be a positive relationship between trauma-related work and burnout among mental health professionals (Ballenger-Browning et al., 2011; Drouet Pistorius et al., 2008; Killian, 2008). At the same time, counselors reported
positive benefits of trauma-related work, such as an appreciation of the good in the world, suggesting resilience (Drouet Pistorius et al., 2008). Even those who reported that they found the work challenging indicated that they also found the work to be personally satisfying (Drouet Pistorius et al., 2008).

For mental health professionals, in general, there are many paths to burnout, and the body of literature does not adequately identify which variables lead to counselor burnout (Lent & Schwartz, 2012). Several work-related variables appear to have a relationship to counselor burnout, such as work setting (Lent & Schwartz, 2012) and type of caseload, such as working with traumatized individuals or those with serious and persistent mental illness (Acker, 2010; Oddie & Ousley, 2007; Thompson et al., 2014).

Although there have been multiple studies on mental health professional impairment, there is still much that is unknown. The pathways to impairment are unclear, and although many possible variables are indicated, none are statistically significant enough to identify them as defined risk factors (Ballenger-Browning et al., 2011; Green et al., 2014; Lent & Schwartz, 2012; Rohland, 2000; Thompson et al., 2014). Instead, self-care appears to be related to personal preference and is modifiable according to convenience and interest across time (Barnett & Cooper, 2009; Barnett et al., 2007; Wicks & Maynard, 2014).

**Self-Compassion**

Minimal research has been conducted on self-compassion and compassion fatigue or burnout among mental health professionals (Coleman et al., 2016). However, there are several positive relationships that have been identified between self-compassion and different, but similar, concepts for other populations. Some of these are well-being (Neff,
Self-compassion is linked to less depression, anxiety, experience of stress, and shame (Beaumont et al., 2012; Diedrich et al., 2014; Germer & Neff, 2013; Johnson & O’Brien, 2013; Patsiopoulos & Buchanan, 2011; Raes, 2010); and happiness, life satisfaction, and optimism (Neff, 2011; Neff & Dahm, 2015; Neff et al., 2007) as well as other traits linked to burnout and compassion fatigue (Germer & Neff, 2013).

**Self-compassion and depression.** Self-compassion appears to be negatively related to many forms of psychopathology such as anxiety, worry, depression, and PTSD (Breines & Chen, 2012; Finlay-Jones, Rees, & Kane, 2015; Hope, Koestner, & Milyavskaya, 2014; MacBeth & Gumley, 2012; Neff & Dahm, 2015). As mentioned earlier, the literature suggests that burnout, compassion fatigue, and depression are similar but different constructs (Awa et al., 2010; Bakker et al., 2000; Brenninkmeyer et al., 2001; Leiter & Durup, 1994; Maslach et al., 2001; Maslach, 2015; Rai, 2010; Schaufeli & Enzmann, 1998; Sulsky & Smith, 2005). Several studies found a negative relationship between self-compassion and symptoms of depression (Diedrich et al., 2014; Hall, Row, Wuensch, & Godley, 2013; Krieger, Berger, & Holtforth, 2016; MacBeth & Gumley, 2012; Shapira & Mongrain, 2010; Terry, Leary, & Mehta, 2012; Van Dam, Sheppard, Forsyth, & Earlywine, 2011). A meta-analysis of the relationship self-compassion, depression, and anxiety by MacBeth and Gumley (2012) found a decrease in
psychopathology symptoms for those who scored higher on the SCS in all reviewed studies (Hall et al., 2013; Neff, 2003; Raes, 2010; Shapira & Mongrain, 2010; Van Dam et al., 2011).

Krieger et al. (2016) sought to understand whether a lack of self-compassion is the cause of depression or if self-compassion occurs because of depression. The findings indicate that self-compassion significantly predicts depression symptoms. However, depression symptoms do not, necessarily, predict levels of self-compassion (Krieger et al., 2016).

Longitudinal research was conducted by Shapira and Mongrain (2010) to understand more about interventions that increase human strengths and positive experiences of well-being. Participants who were moderately depressed were randomly divided into three groups: a self-compassion group, an optimistic letter group, and a control group. Over the course of 1 week, the self-compassion group was asked to write themselves a daily self-compassionate letter (Shapira & Mongrain, 2010). The self-compassionate letter might have been one in which the writer focused on self-kindness, common humanity, and mindfulness. The second group wrote themselves daily optimistic letters (Shapira & Mongrain, 2010). An optimistic letter would be one in which the writer might have said things like things will get better to themselves. Finally, the third (control) group wrote daily letters to themselves about their early memories (Shapira & Mongrain, 2010).

The control letter group did not decrease in depression symptoms, but for the optimism and self-compassion groups, depression symptoms were reduced. However, at the 6-month follow-up, the optimistic group’s symptoms had returned to baseline,
whereas the self-compassionate group maintained their decrease in depression symptoms. These findings were validated in experimental research of community members with a diagnosis of major depressive disorder (Diedrich et al., 2014), therefore suggesting that those who are self-compassionate may reduce their vulnerability to depression and that self-compassion can be taught and increased (Diedrich et al., 2014). According to the literature, self-compassion appears to be negatively correlated with lower depression and anxiety symptoms (Finlay et al., 2015; Hall et al., 2013; MacBeth & Gumley, 2012; Neff, 2003; Raes, 2010; Shapira & Mongrain, 2010; Van Dam et al., 2011).

**Self-compassion and well-being.** A definition of well-being is the state of being, comfortable, healthy, or happy (Diener, 2000). Well-being occurs when one has a purpose in life, engages in self-acceptance, goal mastery, and is living up to one’s potential (Deci & Ryan, 2000). Perhaps burnout or compassion fatigue is the absence of well-being, and self-compassion indicates a state of well-being (Kyeong, 2013). A review of the literature indicates that there is a strong correlation between well-being and self-compassion (Breines & Chen, 2012; Hall et al., 2013; Hollis-Walker & Colosimo, 2011; Leary et al. 2007; Neff et al., 2007; Neely, Schallert, Mohammed, Roberts, & Chen, 2009; Shapira & Mongrain, 2010; Van Dam et al., 2011; Wei, Liao, Ku, & Shaffer, 2011).

Mindfulness, as one of the three components of self-compassion, was identified as a predictor of well-being (Van Dam et al., 2011). The definition of mindfulness regarding self-compassion is slightly different from the commonly accepted definition of mindfulness, which is *awareness of the present moment* (Kabat-Zinn, 2005).
Mindfulness, according to Neff (2018), is allowing ourselves to become aware of our feelings but not becoming overly attached to them.

The aim of a study by Van Dam et al. (2011) was to explore the relative predictive ability of mindfulness and self-compassion in relation to symptom severity and quality of life in those with anxiety and depression. The study was done using the SCS, to measure self-compassion, and the Mindful Attention Awareness Scale (MAAS), to measure mindfulness (Van Dam et al., 2011). Although mindfulness is one of the dimensions of self-compassion, Van Dam et al. (2011) studied mindfulness as a distinct concept and compared it and the composite score of the SCS (as opposed to the mindfulness subscale of the SCS) to study symptom severity of depression and anxiety. Their findings indicate that self-compassion is a better negative predictor of symptom severity for anxiety and depression, as well as quality of life, in general, than dispositional mindfulness (Van Dam et al., 2011).

Hall et al. (2013) conducted research on the relationship of self-compassion to psychological well-being. Overall, the findings indicate a positive association between self-compassion and both physical and psychological well-being (Hall et al., 2013). Various subscales of the SCS were shown to be predictive of depressive symptomatology to varying degrees (Hall et al., 2013). Self-kindness and common humanity subscales were both inversely predictive of depression (Hall et al., 2013). Self-kindness and common humanity were positively related to well-being (Hall et al., 2013).

The purpose of research by Kyeong (2013) was to explore the possibility of self-compassion as a contributor to increased well-being and decreased academic compassion fatigue among Korean college students. The findings indicate that academic compassion
fatigue was negatively associated with well-being and positively associated with depression (Kyeong, 2013). Self-compassion was positively associated with well-being and negatively associated with depression (Kyeong, 2013). As in previous studies of Çetin, Gündüz, and Akın (2008) and Barnard and Curry (2011), this research did not directly assess the relationship between compassion fatigue and self-compassion. Instead, a positive association between compassion fatigue and lower well-being was identified. Self-compassion was positively associated with increased well-being, therefore, suggesting a correlation between compassion fatigue and self-compassion (Kyeong, 2013).

According to Patsiopoulos and Buchanan (2011), it appears that counselors are better at offering compassion to their clients than they are to themselves. In narrative research, the themes they identified suggest that self-compassion plays a significant role in counselors’ recovery from their own family-of-origin wounds. These are wounds that result from stressors that occurred during childhood in one’s birth or adopted family (Patsiopoulos & Buchanan, 2011). In this research, increased self-compassion transformed counselors’ lives and cultivated balance, clarity, openness, wisdom, joy, creativity, freedom, job satisfaction, and burnout prevention (Patsiopoulos & Buchanan, 2011).

Finlay-Jones et al. (2015) found that self-compassion and emotion regulation are significant predictors of stress symptoms among mental health professionals. Further analysis found that self-compassion did not have a direct impact on stress symptoms, but rather, it reduced emotion regulation difficulties, which in turn, increased resilience or the ability to tolerate distress (Finlay-Jones et al., 2015). Overall, research indicates that self-
compassion is significantly and positively associated with well-being (Kyeong, 2013; Leary et al., 2007; Neely et al., 2009; Neff et al., 2007). These findings suggest that increasing self-compassion may increase well-being as well as decrease symptoms of depression, burnout, and compassion fatigue.

**Self-compassion and compassion fatigue.** Research conducted by Beaumont et al. (2016b) sought to explore the relationship between self-compassion, compassion fatigue, self-judgment, self-kindness, compassion for others, and the professional quality of life among midwifery students. While more than 50% of the student midwives scored in the above-average range for compassion fatigue when compared to a normative sample, self-compassion was inversely related to compassion fatigue (Beaumont et al., 2016b). These results suggest that increasing self-compassion may decrease compassion fatigue among practitioners in other helping professions (Beaumont et al., 2016b; Kyeong, 2013). Self-compassion appears to be negatively correlated to compassion fatigue (Beaumont et al., 2016b) as well as to depression symptoms (Diedrich et al., 2014; Krieger et al., 2016; Shapira & Mongrain, 2010). Self-compassion has also been positively correlated to well-being (Hall et al., 2013; Kyeong, 2013; Van Dam et al., 2011).

**Chapter Summary**

There are relatively few studies on the concept of self-compassion and counselors or related professions. As mentioned in Chapter 1, a search of articles on self-compassion yielded only one title with the word *counselor* (Coleman et al., 2016). Self-compassion appears to be positively correlated to well-being (Finlay et al., 2015; Hall et al., 2013; Kyeong, 2013; Leary et al. 2007; MacBeth & Gumley, 2012; Neely et al.,
2009; Neff, 2003; Neff, et al., 2007; Raes, 2010; Shapira & Mongrain, 2010; Van Dam et al., 2011). Therefore, perhaps a person who is self-compassionate would be likely to avoid or improve the experience with burnout and/or compassion fatigue.

Given the literature reviewed regarding burnout and compassion fatigue, there is a need to understand further how counselors successfully navigate the demands of their profession. There is considerable published research on wellness practices and burnout, as well as compassion fatigue prevention (Kissil & Nino, 2017). There is a consensus on the prevalence of counselor burnout, compassion fatigue, and related problems, such as maintaining resilience, remaining in the profession, and providing quality care (Kissil & Nino, 2017). Agreement also exists on the ethical need for self-care to protect both the counselor and their clients (ACA, 2006). There is, however, a lack of understanding on which factors are most important for engaging in self-care for avoiding impairment; thereby suggesting a need for further research into the variables that definitively aid in ameliorating burnout and compassion fatigue. Overall, there is minimal research on the possibility of a relationship between burnout and compassion fatigue, and self-compassion, therefore identifying the need for the present study.

The following chapter details the methodological foundations for this study of the relationship between self-compassion and compassion fatigue among licensed mental health counselors in New York State. This study is framed within the context of the literature review and designed to determine if the degree of reported self-compassion is correlated to the experience of compassion fatigue.
Chapter 3: Research Design Methodology

There is evidence that the stress inherent in the counseling profession may lead to adverse health outcomes including problems in emotional and cognitive functioning, such as depression, anxiety, and irritability (Figley, 1995). Additionally, counselors are susceptible to a concept known as compassion fatigue (Figley, 1995; Maslach, 2003; Maslach et al., 2001; Thompson et al., 2014). The adverse effects of compassion fatigue in professional counselors may cause problems in behavioral functioning, such as interpersonal withdrawal and somatic symptoms (Skovholt & Trotter-Matteson, 2016). These effects may not only impact counselors in their personal lives, but compassion fatigue may also reduce counselor effectiveness and interfere with client improvement (Skovholt & Trotter-Matteson, 2016). One way to mitigate the effects of compassion fatigue may be through practices of self-compassion, including self-kindness, a sense of common humanity, and mindfulness. Self-compassion is known to improve emotional and cognitive symptoms of depression, anxiety, and irritability as well as physical and somatic symptoms (MacBeth & Gumley, 2012), and it may mitigate compassion fatigue symptoms experienced by counselors (Jenaro, Flores, & Arias, 2007). Understanding the possible correlation between compassion fatigue and self-compassion may aid counselors in their self-care and assist counselor supervisors and preparation programs in developing curriculum.
In this study, the following research questions were explored:

1. What is the relationship between demographic variables of licensed mental health counselors and their reported experience of self-compassion?
2. What is the relationship between demographic variables of licensed mental health counselors and their reported experience of compassion fatigue?
3. What is the relationship between reported compassion fatigue and reported self-kindness, common humanity, and mindfulness among licensed mental health counselors?
4. What is the relationship between reported self-compassion, reported burnout, and secondary traumatic stress among licensed mental health counselors?

This study used a quantitative, cross-sectional survey method to examine the relationship between self-compassion and compassion fatigue among mental health counselors using the Self-Compassion Scale (Appendix A), the Professional Quality of Life Scale (Appendix B), and a demographic questionnaire (Appendix C). This cross-sectional, observational method was used because data collected from a section of a population may be generalizable to an entire population (Cozby & Bates, 2015).

**Research Context**

The name *licensed professional counselor* is a protected title for those trained in mental health counseling or a related field. A professional counselor is an individual who has studied traditional psychotherapy and who utilizes a problem-solving approach to assist clients in establishing change (NYMHCA, 2016). Professional counselors work with diverse populations in a variety of settings, from schools to agencies to private practice settings. Professional counselors assist individuals, groups, families, and
communities with personal, educational, family, mental health, and career decisions and problems (Bureau of Labor Statistics, 2016). In 2014, the most recent year for which statistics are available, 168,200 professional counselors were employed in the United States (Bureau of Labor Statistics, 2016). The exact scope of a professional counselor’s services is dependent on the work setting. Counselors are concerned with helping their clients obtain optimal health and wellness (American Mental Health Counselor’s Association [AMHCA], 2018). Also, the field of counseling is concerned with both prevention and wellness and not just ameliorating symptoms or deficits (AMHCA, 2016).

**Research Participants**

Mental health counselors in New York are known as licensed mental health counselors (LMHCs). The sample from which the study participants were drawn from was all New York State LMHCs. As of July 1, 2016, the most recent date of reporting by the New York State Department of Labor (2018), there were 6,459 LMHCs in New York State. An attempt was made to contact counselors through Facebook and email, but it is not possible to know how many of those LMHCs participate in those networks.

The participants for this study, LMHCs, had a master’s degree or higher in counseling or another closely related field, and they had completed a minimum of 3,000 hours of supervised, post-master’s work. LMHCs are required to pass a state or national exam to obtain licensure (NYMHCA, 2016). According to state licensing bodies, professional counselors may be known in other states as licensed professional counselors (LPCs) or licensed professional clinical counselors (LPCCs). A license is required to practice counseling in all 50 states (AMHCA, 2016). The standards of the accrediting
body for counselor education programs, CACREP, requires that counselor education programs address self-awareness and self-care strategies (CACREP, 2016).

This study collected data through the Internet. A convenience sample, based on LMHC groups who were known to the researcher, as well as postings on Facebook pages were used to recruit participants who self-selected into the study. The participants were recruited using respondent-driven sampling, meaning that the peer network structure of Facebook was used to recruit other Facebook users who were also LMHCs (Pedersen & Kurz, 2016). Those who were emailed the study information were encouraged to share the information with their known colleagues. Therefore, those who were emailed and those who saw the recruitment information on Facebook were seeds that expanded the initial sample (Pedersen & Kurz, 2016).

The recruitment letter and links to the survey (Appendix D), including the informed consent form (Appendix E), were posted on Facebook sites belonging to mental health counselor groups, which were in New York State. Individuals are more likely to participate when they are members of a group who regularly uses the Internet for communication and when the invitation comes from a familiar party (Fowler, 2014). Counselors regularly use the Internet for electronic medical records.

Multiple sources for recruiting volunteer participants help with the response bias limitation (Cozby & Bates, 2015). The sites shown in Table 3.1 were used for the recruitment of the participants because they were identified as sites typically used by the potential research participants in this study.
Table 3.1

*Recruitment Sites*

<table>
<thead>
<tr>
<th>Name of Organization</th>
<th>Online Venue</th>
<th>Approx. No. of Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Counselors of Rochester</td>
<td><a href="https://www.facebook.com/Mental">https://www.facebook.com/Mental</a> Health Counselors of Greater Rochester</td>
<td>491</td>
</tr>
<tr>
<td>New York State Mental Health Counselors Association</td>
<td><a href="https://www.facebook.com/NYMHCA-New">https://www.facebook.com/NYMHCA-New</a> York Mental Health Counselors Association</td>
<td>1,834</td>
</tr>
<tr>
<td>Rochester Counseling Private Practice Group</td>
<td><a href="mailto:LMHC_Private_Practice@yahoogroups.com">LMHC_Private_Practice@yahoogroups.com</a></td>
<td>70</td>
</tr>
</tbody>
</table>

Using multiple platforms for reaching out to LMHCs aided in the generalizability of the study and minimized selection bias to some degree. On all platforms, a link was provided to the Qualtrics survey so participants could easily access and complete the measures. The final sample for this study consisted of counselors who responded to and completed the survey. Varying results are reported regarding response rates to Internet surveys (Fowler, 2014). Due to the convenience sampling method, the actual response rate is not known (Fowler, 2014).

The eligibility requirements for participation in the study were:

1. LMHCs who were licensed by the New York State Office of the Professions to practice mental health counseling.
2. LMHCs who were currently working in the profession of mental health counseling in the State of New York.
Exclusion criteria for the study were:

1. LMHCs who were not licensed by the New York State Office of the Professions to practice mental health counseling.
2. LMHCs who were not working in the profession of mental health counseling in the State of New York.

The participants were invited to share their email addresses at the end of the survey for two purposes: (a) to receive the results of the study after the data had been analyzed, and (b) to be entered into a drawing (Appendix F) for a 1-year membership in the New York State Mental Health Counselors Association (NYMHCA). There was no penalty for those participants who declined to share their email addresses, and those that were collected were only used to contact individuals to share the results of the study or to notify the winner of the drawing. No email addresses were retained beyond the completion of the study when the raffle prize winner was notified. At the time of this study, the value of 1-year professional membership in NYMHCA was $125.00. Email addresses were not associated with the dataset, thereby maintaining the anonymity of the responses.

**Instruments Used in Data Collection**

This quantitative study used a cross-sectional survey method to collect data (Cozby & Bates, 2015). Two existing instruments, the SCS and the ProQOL scale, were used together, and a third section was added to collect demographic information and determine eligibility for the study. Permission to use these instruments was granted by the developers (Appendix G). The complete web-based survey, including the SCS, ProQOL scale, and the demographic survey, administered through Qualtrics, were
accessed through a link that was provided to the volunteer participants. The survey
instrument for this study comprised the following three sections:

**Section 1: Demographic characteristics.** The researcher designed nine
questions to collect the demographic characteristics of the participants in the study. The
demographic information gathered included age, gender, race, relationship status, highest
educational degree earned, number of years in the mental health field, number of hours
per week of direct contact with clients, work environment (private practice or agency),
and number of working days in the 12 months before the study. Age, gender, and race
were queried because of the literature that indicates a relationship between these variables
and counselor impairment (Rupert & Morgan, 2005). The body of literature reveals that
there are correlations between relationship status, length of time in the profession, and the
number of hours spent working and the type of impairment; therefore, questions were
asked about those variables. All participants were expected to have a least a master’s
degree, but it was possible that having a terminal degree would have had some impact on
symptoms of impairment. Finally, data were collected on the work environment, the
number of clients seen by the participants each week, and the participants’ work settings
because of identified relationships between those variables and the type of impairment in
the related literature (Lawson, 2007; Lloyd et al., 2002; Rupert & Kent, 2007; Rupert &
Morgan, 2005).

**Section 2: Self-Compassion Scale.** The SCS (Appendix A) was used to measure
self-compassion. The SCS is a 26-item self-report measure on which items are rated on a
Likert scale ranging from 1 (almost never) to 5 (almost always). Higher scores on the
SCS indicate greater self-compassion. Self-compassion is defined as having three
components: self-kindness, common humanity, and mindfulness. These factors and their opposites, self-judgment, isolation, and over-identification, make up the six subscales of the SCS (Neff, 2003). There is also an overall self-compassion score that was calculated, as described below.

**Self-kindness subscale versus self-judgment subscale.** Self-kindness entails being warm and understanding toward ourselves when we suffer, fail, or feel inadequate, rather than ignoring our pain or flagellating ourselves with self-criticism (Neff, 2003). Self-judgment entails being cold and judgmental toward ourselves instead of encouraging and accepting (Neff, 2003). The five items that make up the self-kindness subscale have internal consistency reliability of 0.78. The five items that make up the self-judgment subscale demonstrated internal consistency of 0.77 (Neff, 2003).

**Common humanity subscale versus isolation subscale.** Common humanity involves recognizing that suffering and personal inadequacy is part of the shared human experience—something that we all go through rather than being something that happens to me alone (Neff, 2018). Isolation entails feeling alone and believing that unpleasant things only happen to oneself (Neff, 2003). The four items that make up the common humanity subscale have internal consistency reliability of 0.80. The four items that make up the isolation subscale have internal consistency reliability of 0.79 (Neff, 2003).

**Mindfulness subscale versus over-identification subscale.** Mindfulness is “paying attention, on purpose, to the present moment” (Kabat-Zinn, 2005, p. 108). Over-identification involves becoming lost in one’s thoughts and ruminating on problems and concerns (Neff, 2003). The four items that make up the mindfulness subscale have internal consistency reliability of 0.75. The four items that make up the over-
identification subscale have internal consistency reliability of 0.81 (Neff, 2003). The internal consistency reliability for the 26-item SCS was 0.92 (Neff, 2003).

The total score of the SCS is determined by reversing the raw scores of the self-judgment, isolation, and over-identification subscales and summing the 26 scores (Neff, 2003). The SCS (Neff, 2003) has been validated in multiple studies and shown to be a useful tool for measuring self-compassion both for clinical purposes and for researchers. Because of this consistent use, researchers can compare the results of studies and draw conclusions based on the reliability of reports.

**Section 3. Professional Quality of Life Scale, V5.** The ProQOL scale (Appendix B) is a 30-item self-report, non-diagnostic measure that measures three independent constructs: burnout (BO), secondary traumatic stress (STS), and compassion satisfaction (CS), but it does not yield a composite score (Stamm, 2010). Responses are rated on a 5-point Likert scale ranging from 1 (never) to 5 (very often) to assess thought, feelings, and behaviors related to working as a helping professional (Stamm, 2010). In this study, the ProQOL scale was used as part of an online survey, and scores were not given to participants. This version requires the reversal of five items on the burnout scale, and then scores are then summed by subscale (Stamm, 2010).

The ProQOL scale is the most commonly used measure of the challenges of working with those who have experienced significant stressors (Stamm, 2010). The ProQOL scale is a revised version of the Compassion Fatigue and Satisfaction Self-Test (CFST; Figley, 1995). The CFST was developed by Figley (1995) to assess the professional distress experienced by counselors. In 1988, Stamm and Figley began collaborating. Stamm later added the positive concept of compassion satisfaction
Sometime in the late 1990s, Stamm took on full ownership of the assessment and changed the name to the ProQOL scale. Compassion satisfaction can be described as the enjoyment that helpers experience from their work (Stamm, 2010).

**Compassion satisfaction subscale.** The Compassion Satisfaction (CS) subscale on the ProQOL scale consists of 10 items to assess the positive experiences relating to counseling. An example of an item on this scale is, “I feel invigorated after working with those I help” (Stamm, 2010, p. 26). The average raw score on the CS subscale falls between 23 and 41, with an estimated $t$ score of 50 with a standard deviation of 10 (Stamm, 2010). Compassion fatigue is made up of two parts—one associated with burnout and the other associated with secondary traumatic stress (Stamm, 2010).

**Burnout subscale.** The Burnout (BO) subscale on the ProQOL scale is associated with feelings of hopelessness and struggles relating to doing one’s job well as well of disconnectedness and insensitivity toward clients (Stamm, 2010). The BO subscale consists of 10 items that address negative feelings of ineffectiveness, and they result from a large workload or an unsupportive work environment (Stamm, 2010). An example of an item on the BO subscale is, “I feel connected to others” (Stamm, 2010, p. 26). The average score on the BO subscale falls between 23 and 41, with an estimated $t$ score of 50 with a standard deviation of 10 (Stamm, 2010).

**Secondary traumatic stress subscale.** The Secondary Traumatic Stress (STS) subscale on the ProQOL scale assesses a secondary exposure to extremely stressful or traumatic events, instead of a primary trauma (Stamm, 2010). The STS subscale consists of 10 separate items that assess preoccupation with thoughts about the people one is helping (Stamm, 2010). An example of an item on this scale is, “I find it difficult to
separate my personal life from my life as a helper” (Stamm, 2010, p. 26). The average raw score on the STS subscale ranges from 23 and 41, with an estimated t score of 50 with a standard deviation of 10.

Construct validity of the ProQOL scale has been maintained with over 200 published articles (Stamm, 2010). Almost half of the research papers published on the topics of compassion fatigue, compassion satisfaction, and burnout utilized the ProQOL scale. The initial ProQOL scale was validated by assessing mental health professionals (Stamm, 2010). Of the three scales that the ProQOL scale measures, compassion fatigue is distinct (Stamm, 2010).

**Data Collection**

The study proposal was submitted to St. John Fisher College’s Institutional Review Board (IRB) for expedited review. Expedited review was requested because the measures surveyed mental health counselors about their mental health counseling work. The questions did not pose any harm or discomfort to the subjects that was greater than those ordinarily encountered in daily life for LMHCs. Therefore, the survey did not exceed minimal risk. The questions that were asked were ones that would not require written informed consent if they were done outside of the research. Because the survey asked about thoughts and feelings that routinely occur in the professional experience of LMHCs, this study did not pose any harm or discomfort greater than those ordinarily encountered in daily life, as identified in 45CFR46, Section 46.102 (Office for Human Research Protections, 2016. The estimated time for completing the survey was 20 minutes.
After receiving approval from the St. John Fisher College IRB (Appendix H), invitations were posted on the various sites described previously, requesting the participation of mental health counselors and describing the purpose of the study. Participants were asked to volunteer for the study to measure compassion fatigue and self-compassion among LMHCs. The invitation included a link to the survey. The link led participants to a secure webpage, which provided information about this study, including confidentiality, anonymity, and the right to withdraw from the study at any time, as well as the potential harm or benefits to the individual for participating in the study.

A copy of a letter of informed consent accompanied the survey, indicating that participation was voluntary. The letter of informed consent included contact information for the researcher, the dissertation committee chairperson for the researcher, and St. John Fisher College IRB. The participants were not able to proceed to the survey unless they had affirmatively checked a box indicating that they understood the nature of their consent. The participants were instructed to print a copy of the informed consent letter.

All responses were kept confidential. The participants did not have to provide any information that personally identified them. All personal information received from this survey has remained anonymous. All data were pooled and reported in aggregate form. Everything that could be done was done to protect the participants’ anonymity, but the participants were notified that anonymity could not be guaranteed for information transmitted over the Internet. It was reiterated to the participants that they did not have to participate in the survey if they did not want to and that they could change their minds at any time while completing the survey. The participants were notified that once the
survey was completed, their information could not be removed from the study because there was no way to identify their responses as being related to them. The participants were also informed that their information might be shared with appropriate governmental authorities, but only if it became known to the researcher that they or someone else was in danger, or if the researcher was required to do so by law. The raw data will be maintained in a password-protected secure, electronic file for 5 years, after the publication of this work, on a computer owned by the principal investigator.

The participants were invited to share their email addresses at the end of the survey for two purposes: (a) to receive the results of the study after the data were analyzed, and (b) to be entered in a drawing for a 1-year membership in New York State Mental Health Counselors Association. The value of 1-year professional membership in NYMHCA at the time of this research was $125.00. Email addresses were not linked to the responses, thereby maintaining the anonymity of the responses. The list of drawing participants was destroyed after the raffle winner was notified and had accepted the prize.

The method for collecting data was through the electronic survey platform Qualtrics, an online survey tool licensed for use by St. John Fisher College. The demographic questionnaire (Appendix C) consisted of nine multiple choice questions, the SCS consisted of 26 Likert scale questions, and the ProQOL scale consisted of 29 Likert scale questions. The survey was created so that an individual could not respond more than once with an identifying unique IP address. The survey did not allow those who did not agree to informed consent to proceed with the survey. To maximize the response rate, a reminder posting was made to each site 1 week after the initial posting, and it
remained public until the desired number of participants was obtained. Postings to all sites were removed before the data analysis began.

Data Analysis

The data from this survey was exported from Qualtrics to IBM SPSS Statistics, licensed for use by St. John Fisher College, for data analysis. Surveys where the participant omitted an entire section of the survey were deleted from the database. Otherwise, randomly missing data was handled using pairwise deletion, retaining as much data as possible for analysis.

Descriptive statistics were presented to describe the demographic characteristics of each of the variables. Categorical demographics were calculated to describe the degree of self-compassion and compassion fatigue of the sample. Finally, a Spearman’s rho ($r$) was calculated to determine any relationship between self-compassion and compassion fatigue.

Summary of Methodology

The purpose of this study was to survey LMHCs regarding their experiences of compassion fatigue using the Professional Quality of Life Index (Stamm, 2010) and their experience of self-compassion using the SCS (Neff, 2003). LMHCs from New York State were surveyed, and their responses were analyzed to determine if there is a relationship between the three self-compassion subscales and compassion fatigue, burnout, and compassion satisfaction. The results of the study will contribute to the literature on LMHCs’ well-being by indicating either that compassion fatigue is negatively or positively related to self-compassion.
Chapter 4: Results

Introduction

The purpose of this study was to examine the relationship between compassion fatigue and self-compassion among mental health counselors. LMHCs in New York State were surveyed using the SCS to measure reported self-compassion (Neff, 2003) and the ProQOL scale, V5, to measure compassion fatigue, burnout, and secondary traumatic stress experienced by helping professionals (Stamm, 2010). Because there is a high rate of compassion fatigue among helping professionals, it is important to explore the factors that may inform counselor self-care practices that might lead to increased resilience.

Research Questions

The research design for this study employed a quantitative cross-sectional survey method to analyze the relationship between self-compassion and compassion fatigue among LMHCs working in New York State. The following research questions guided the study:

1. What is the relationship between demographic variables of licensed mental health counselors and their reported experience of self-compassion?
2. What is the relationship between demographic variables of licensed mental health counselors and their reported experience of compassion fatigue?
3. What is the relationship between reported compassion fatigue and reported self-kindness, common humanity, and mindfulness among licensed mental health counselors?
4. What is the relationship between reported self-compassion, reported burnout, and secondary traumatic stress among licensed mental health counselors?

Data Analysis and Findings

The survey was administered using Qualtrics, and data were transferred to SPSS 24. In order to examine the data in relation to the research questions, a variety of analyses were run using SPSS 24. Given that some participants omitted entire sections of the survey, 53 survey responses were deleted from the database. Otherwise, randomly missing data was handled using pairwise deletion, by retaining as much data as possible for analysis. The data were screened prior to analysis to determine if the assumptions of normal distribution were met and for the researcher to decide whether parametric or nonparametric tests would be appropriate (Creswell, 2013).

Demographic Statistics

A total of 131 participants responded to the survey on the relationship between compassion fatigue and self-compassion among LMHCs. Of the original 131 participants, 89 participants indicated that they were licensed and working in New York State. Only 36 participants completed all sections of the survey, including the demographic survey, the SCS (Neff, 2003) and the ProQOL scale (Stamm, 2010). Demographic statistics were reported on the remaining dataset of the 36 participants to provide an understanding of the makeup of the population. The sample of 36 LMHCs comprised 83.8% females. Of the LMHCs who indicated an identified race, 83.8% were Caucasian, and 16.2% identified as being a member of a racial minority group. Most of the LMHCs in the sample identified their age as between 31 and 45 years. Table 4.1
shows the number of participants, as well as the percentages of the whole sample, who identified with each characteristic.

Table 4.1

*Categorical Demographic Characteristics of Sample*

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n</th>
<th>% of N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21-30</td>
<td>8</td>
<td>22.22</td>
</tr>
<tr>
<td>31-45</td>
<td>15</td>
<td>41.70</td>
</tr>
<tr>
<td>46-70</td>
<td>13</td>
<td>36.11</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>31</td>
<td>86.10</td>
</tr>
<tr>
<td>Relationship Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>9</td>
<td>25.00</td>
</tr>
<tr>
<td>Married</td>
<td>22</td>
<td>61.10</td>
</tr>
<tr>
<td>Partnered</td>
<td>5</td>
<td>13.90</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Hispanic White or Euro-American</td>
<td>31</td>
<td>86.10</td>
</tr>
<tr>
<td>Other Race</td>
<td>5</td>
<td>13.90</td>
</tr>
<tr>
<td>Length of time practicing as an LMHC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-10 years</td>
<td>18</td>
<td>50.00</td>
</tr>
<tr>
<td>11-15 years</td>
<td>12</td>
<td>33.30</td>
</tr>
<tr>
<td>More than 15 years</td>
<td>7</td>
<td>19.44</td>
</tr>
<tr>
<td>Number of clients seen in an average week</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-15</td>
<td>10</td>
<td>27.80</td>
</tr>
<tr>
<td>16-20</td>
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<td>27.80</td>
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<tr>
<td>More than 20</td>
<td>16</td>
<td>44.44</td>
</tr>
<tr>
<td>Primary work setting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private practice</td>
<td>23</td>
<td>63.90</td>
</tr>
<tr>
<td>Other setting</td>
<td>13</td>
<td>36.11</td>
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<td>Highest level of education</td>
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<td></td>
</tr>
<tr>
<td>Master’s degree</td>
<td>34</td>
<td>94.40</td>
</tr>
<tr>
<td>Weeks worked in the past 12 months</td>
<td></td>
<td></td>
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<tr>
<td>More than 50</td>
<td>25</td>
<td>69.44</td>
</tr>
<tr>
<td>Fewer than 50</td>
<td>11</td>
<td>30.55</td>
</tr>
</tbody>
</table>

New York State does not collect normative data on counselors (D. Hamilton, personal communication, July 29, 2018); however, some national data was collected by the U.S. Census Bureau (2014). Table 4.2 reflects the data from the national survey. The reported age range of the sample for this study was consistent with that of the national data. The national data indicates that the average age for LMHCs is 41.8 years. In the sample for this study, 43.2% of the participants identified their ages as between 31 and 45
years. Gender was reported in the study sample as 83.8% female and 10.8% male, compared to the nation sample in which 73.3% of LMHCs were identified as female, and 26.7% were identified as male (U.S. Census Bureau, 2014). Race was reported in this study sample as 83.8% Caucasian, compared to 70.2% Caucasian of the national sample (U.S. Census Bureau, 2014).

Table 4.2

National Normative Data for Counselors

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Mean</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>41.8</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
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</tr>
<tr>
<td>Female</td>
<td>73.3</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>26.7</td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>70.2</td>
<td></td>
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<tr>
<td>Black</td>
<td>19.7</td>
<td></td>
</tr>
<tr>
<td>Other Race</td>
<td>10.1</td>
<td></td>
</tr>
</tbody>
</table>

*Note.* Data retrieved from the American Community Survey, conducted by the U.S. Census Bureau (2014).

Descriptive Statistics

First, the descriptive statistics were examined for the SCS and the ProQOL scale to describe the medians of the responses for the SCS composite scale and subscales, self-kindness, common humanity, and mindfulness as well as for secondary traumatic stress, burnout, and compassion satisfaction scales. Neither the SCS nor the ProQOL scales or subscales were found to be within acceptable limits of normal distribution (Creswell, 2013). Histograms further revealed a non-normal distribution of data for the outcome variables of burnout, secondary traumatic stress, and compassion satisfaction as well as
the self-compassion composite data and the self-kindness, common humanity, and mindfulness subscales.

The ProQOL scale, V5, was used to measure the LMHCs’ reported compassion fatigue, burnout, and compassion satisfaction. Lower compassion fatigue is reflected by scores 22 or lower, whereas higher compassion fatigue is demonstrated by scores 42 or higher. In this study, the LMHCs reported compassion fatigue scores with a mean of 18.77 and burnout scores with a mean of 20.97, which suggests low compassion fatigue. Compassion satisfaction scores reflected an average of 40.19, suggesting a lower risk of compassion fatigue. Table 4.3 shows the sample in relation to both the SCS and the ProQOL scale.

The SCS was used to measure the LMHCs’ reported self-compassion. Scores ranged from 1-5, (1 = almost never, and 5 = almost always). The counselors in this sample scored slightly higher than midrange on all three subscales reported.

Last, a Spearman’s \( r \) was calculated to summarize the strength of the relationship between the self-compassion composite score and subscales, self-kindness, common humanity, and mindfulness and compassion satisfaction and compassion fatigue (Cronk, 2014).
Table 4.3

*Descriptive Statistics for the Self-Compassion and Compassion Fatigue Variables*

<table>
<thead>
<tr>
<th>ProQOL Subscales</th>
<th>Variable</th>
<th>N</th>
<th>Median</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secondary Traumatic Stress</td>
<td></td>
<td>36</td>
<td>58.00</td>
<td>High</td>
</tr>
<tr>
<td>Burnout</td>
<td></td>
<td>36</td>
<td>50.50</td>
<td>Average</td>
</tr>
<tr>
<td>Compassion Satisfaction</td>
<td></td>
<td>36</td>
<td>57.00</td>
<td>High</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SCS Subscales</th>
<th>Variable</th>
<th>N</th>
<th>Median</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Compassion Composite</td>
<td></td>
<td>36</td>
<td>3.23</td>
<td>Moderate</td>
</tr>
<tr>
<td>Self-Kindness</td>
<td></td>
<td>36</td>
<td>3.40</td>
<td>Moderate</td>
</tr>
<tr>
<td>Common Humanity</td>
<td></td>
<td>36</td>
<td>3.25</td>
<td>Moderate</td>
</tr>
<tr>
<td>Mindfulness</td>
<td></td>
<td>36</td>
<td>3.50</td>
<td>Moderate</td>
</tr>
</tbody>
</table>

The relationship between demographic variables and reported experience of self-compassion. The researcher examined the first research question using descriptive statistics for the sample, which were calculated with the self-compassion composite score and for the three subscales of self-kindness, common humanity, and mindfulness.

Categorical demographics for the SCS. An analysis of the categorical demographic data for the LMHCs revealed that while most self-compassion scores hovered around the midpoint; the LMHCs who were within the age range of 31 and 45 years scored slightly higher on the SCS, indicating more self-compassion. Males and females scored very similarly. The scores of those who had been practicing in the profession of counseling for 11-15 years indicated more self-compassion than other groups, suggesting that higher self-compassion is related to experience. The LMHCs who reported more self-compassion met with between 16 and 20 clients each week, and they worked fewer than 50 weeks per year. Table 4.4 reflects these differences.
Table 4.4

Mean of Categorical Demographic Characteristics of Sample for Self-Compassion Composite Score and Self-Kindness, Common Humanity, and Mindfulness Subscales

(N = 36)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n</th>
<th>SCS</th>
<th>SK</th>
<th>CH</th>
<th>M</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21-30</td>
<td>8</td>
<td>3.08</td>
<td>2.90</td>
<td>3.25</td>
<td>3.37</td>
</tr>
<tr>
<td>31-45</td>
<td>15</td>
<td>3.52</td>
<td>3.40</td>
<td>3.30</td>
<td>3.61</td>
</tr>
<tr>
<td>46-70</td>
<td>13</td>
<td>3.20</td>
<td>3.40</td>
<td>3.25</td>
<td>3.25</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>31</td>
<td>3.25</td>
<td>3.40</td>
<td>3.25</td>
<td>3.50</td>
</tr>
<tr>
<td><strong>Relation Status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>9</td>
<td>3.20</td>
<td>3.20</td>
<td>3.50</td>
<td>3.25</td>
</tr>
<tr>
<td>Married</td>
<td>22</td>
<td>3.21</td>
<td>3.50</td>
<td>3.25</td>
<td>3.50</td>
</tr>
<tr>
<td>Partnered</td>
<td>5</td>
<td>3.42</td>
<td>3.20</td>
<td>3.80</td>
<td>3.85</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Hispanic White or Euro-American</td>
<td>31</td>
<td>3.21</td>
<td>3.40</td>
<td>3.25</td>
<td>3.50</td>
</tr>
<tr>
<td>Other Race</td>
<td>5</td>
<td>2.70</td>
<td>2.80</td>
<td>2.50</td>
<td>3.25</td>
</tr>
<tr>
<td><strong>Length of time practicing as an LMHC</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-10 years</td>
<td>18</td>
<td>3.52</td>
<td>3.20</td>
<td>3.25</td>
<td>3.50</td>
</tr>
<tr>
<td>11-15 years</td>
<td>12</td>
<td>3.62</td>
<td>3.80</td>
<td>3.50</td>
<td>3.50</td>
</tr>
<tr>
<td>More than 15 years</td>
<td>7</td>
<td>3.28</td>
<td>3.40</td>
<td>3.00</td>
<td>3.25</td>
</tr>
<tr>
<td><strong>Number of clients seen in an average week</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-15</td>
<td>10</td>
<td>3.28</td>
<td>3.10</td>
<td>3.50</td>
<td>3.37</td>
</tr>
<tr>
<td>16-20</td>
<td>10</td>
<td>3.51</td>
<td>3.80</td>
<td>3.37</td>
<td>3.50</td>
</tr>
<tr>
<td>More than 20</td>
<td>16</td>
<td>3.13</td>
<td>3.30</td>
<td>3.25</td>
<td>3.37</td>
</tr>
<tr>
<td><strong>Primary work setting</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private practice</td>
<td>23</td>
<td>3.28</td>
<td>3.40</td>
<td>3.25</td>
<td>3.25</td>
</tr>
<tr>
<td>Other setting</td>
<td>11</td>
<td>3.21</td>
<td>3.40</td>
<td>3.50</td>
<td>3.50</td>
</tr>
<tr>
<td><strong>Highest level of education</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Master’s degree</td>
<td>34</td>
<td>3.21</td>
<td>3.40</td>
<td>3.25</td>
<td>3.37</td>
</tr>
<tr>
<td><strong>Weeks worked in the past 12 months</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>More than 50</td>
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<td>3.21</td>
<td>3.40</td>
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<td>3.50</td>
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<tr>
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<td>11</td>
<td>3.60</td>
<td>3.80</td>
<td>3.25</td>
<td>3.75</td>
</tr>
</tbody>
</table>

*Note.* SCS = Self-Compassion Composite, SK = Self-Kindness, CH = Common Humanity, and M = Mindfulness.
Demographic variables and experience of compassion fatigue. Because the ProQOL scale is not meant to be a diagnostic tool, and scores can change according to several variables, a broad range of scores suggests each level of functioning. Table 4.5 is included for interpretation of the ProQOL scale scores.

Table 4.5

**ProQOL Range of Scores**

<table>
<thead>
<tr>
<th>Sum of ProQOL Subscale Questions</th>
<th>Score Range</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>23 or less</td>
<td>43 or less</td>
<td>Low</td>
</tr>
<tr>
<td>Between 23 and 41</td>
<td>Around 50</td>
<td>Average</td>
</tr>
<tr>
<td>42 or more</td>
<td>57 or more</td>
<td>High</td>
</tr>
</tbody>
</table>

Categorical demographic statistics for the sample were calculated for the ProQOL scale and indicated that most participants in the sample scored in the average range for compassion satisfaction and in the low range for compassion fatigue, which is typical due to the known negative correlation of these two variables (Stamm, 2010). All age groups reported high levels of secondary traumatic stress. All groups reported secondary traumatic stress in the high range except for those who worked less than 50 weeks per year, who saw fewer than 20 clients per week, and/or who reported working in the profession of counseling for more than 15 years. Table 4.6 shows these characteristics for the entire sample.

The relationship between reported compassion fatigue and reported self-kindness, common humanity, and mindfulness. Given the low number of participants in the final sample, a post hoc analysis of bivariate correlations were calculated on the self-compassion and compassion fatigue variables instead of on multiple linear
Table 4.6

Mean of Categorical Demographic Characteristics of Sample for Compassion Satisfaction, Burnout, and Secondary Traumatic Stress Scales (N = 36)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n</th>
<th>STS</th>
<th>Median BO</th>
<th>CS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21-30</td>
<td>8</td>
<td>61</td>
<td>53</td>
<td>56</td>
</tr>
<tr>
<td>31-45</td>
<td>15</td>
<td>58</td>
<td>46</td>
<td>56</td>
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<tr>
<td>46-70</td>
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<td></td>
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<tr>
<td>Female</td>
<td>31</td>
<td>58</td>
<td>51</td>
<td>57</td>
</tr>
<tr>
<td>Relationship Status</td>
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<td></td>
</tr>
<tr>
<td>Single</td>
<td>9</td>
<td>56</td>
<td>51</td>
<td>55</td>
</tr>
<tr>
<td>Married</td>
<td>22</td>
<td>61</td>
<td>51</td>
<td>57</td>
</tr>
<tr>
<td>Partnered</td>
<td>5</td>
<td>56</td>
<td>46</td>
<td>57</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Hispanic White or Euro-American</td>
<td>31</td>
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<td>51</td>
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<tr>
<td>Other Race</td>
<td>5</td>
<td>56</td>
<td>49</td>
<td>59</td>
</tr>
<tr>
<td>Length of time practicing as an LMHC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-10 years</td>
<td>18</td>
<td>58</td>
<td>52</td>
<td>55</td>
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<tr>
<td>11-15 years</td>
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<tr>
<td>More than 15 years</td>
<td>7</td>
<td>56</td>
<td>46</td>
<td>55</td>
</tr>
<tr>
<td>Number of clients seen in an average week</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-15</td>
<td>10</td>
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<td>16-20</td>
<td>10</td>
<td>55</td>
<td>46</td>
<td>56</td>
</tr>
<tr>
<td>More than 20</td>
<td>16</td>
<td>64</td>
<td>53</td>
<td>57</td>
</tr>
<tr>
<td>Primary work setting</td>
<td></td>
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<tr>
<td>Private practice</td>
<td>23</td>
<td>58</td>
<td>46</td>
<td>57</td>
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<tr>
<td>Other setting</td>
<td>11</td>
<td>58</td>
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<td>56</td>
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<tr>
<td>Highest level of education</td>
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<tr>
<td>Master’s degree</td>
<td>34</td>
<td>60</td>
<td>51</td>
<td>57</td>
</tr>
<tr>
<td>Weeks worked in the past 12 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>More than 50</td>
<td>25</td>
<td>60</td>
<td>51</td>
<td>55</td>
</tr>
<tr>
<td>Fewer than 50</td>
<td>11</td>
<td>56</td>
<td>45</td>
<td>59</td>
</tr>
</tbody>
</table>

Note. STS = Secondary Traumatic Stress, BO = Burnout, and CS = Compassion Satisfaction.

regression, as stated in Chapter 3. The independent variables were the self-compassion composite scale and the three subscales of self-kindness, common, humanity, and mindfulness. The dependent variables were the compassion fatigue subscales, compassion satisfaction, burnout, and secondary traumatic stress. A Spearman’s $r$ was calculated to examine the relationship between these variables because of the nonparametric nature of the sample.
The results of the Spearman’s $r$ identified a correlation between the variables of Research Question 3, which are depicted in Table 4.7. Burnout was negatively correlated with self-kindness ($\rho = -.430, p < .01$), common humanity ($\rho = -.428, p < .01$), and mindfulness ($\rho = -.375, p < .05$), suggesting that, as burnout decreases, self-kindness, common humanity, and mindfulness increase. Secondary trauma was also negatively correlated with self-kindness ($\rho = -.390, p < .05$) suggesting that, as secondary trauma decreases, self-kindness increases. There was no statistically significant correlation between secondary trauma and common humanity or mindfulness. The strongest correlation among this sample was a positive correlation between compassion satisfaction and common humanity ($\rho = .619, p < .05$) and with mindfulness ($\rho = .513, p < .05$), indicating that, as compassion satisfaction increases, common humanity and mindfulness also increase.

**The relationship between reported self-compassion, reported burnout, and secondary traumatic stress.** A Spearman’s $r$ was calculated as a post hoc analysis, because of the small $n$ to examine the relationship between these variables. Given the low number of participants in the sample, it was not possible to predict compassion fatigue. However, as seen in Table 4.7, the analysis indicates that self-compassion was negatively correlated to secondary trauma to a statistically significant degree ($\rho = -.520, p < .01$), and burnout ($\rho = -.641, p < .01$) was the most influential predictor in the correlation.
Table 4.7

Summary of Correlation Between Variables from Spearman’s Rho

<table>
<thead>
<tr>
<th>Correlations</th>
<th>SCS-C</th>
<th>SK</th>
<th>CH</th>
<th>M</th>
<th>STS</th>
<th>B</th>
<th>CS</th>
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<td>SCS</td>
<td>1.000</td>
<td>.735**</td>
<td>.577**</td>
<td>.747**</td>
<td>-.520**</td>
<td>-.641**</td>
<td>.537**</td>
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<td>0.000</td>
<td>0.001</td>
<td>0.000</td>
<td>0.001</td>
<td>0.001</td>
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<tr>
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<td>36</td>
<td>36</td>
<td>36</td>
<td>36</td>
<td>36</td>
</tr>
<tr>
<td>Self</td>
<td>.735**</td>
<td>1.000</td>
<td>.300</td>
<td>.524**</td>
<td>-.390*</td>
<td>-.430**</td>
<td>.385*</td>
</tr>
<tr>
<td>Kindness</td>
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<td>.075</td>
<td>.000</td>
<td>.019</td>
<td>.009</td>
<td>.021</td>
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<td>36</td>
</tr>
<tr>
<td>Common</td>
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<td>.300</td>
<td>1.000</td>
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<td>-.095</td>
<td>-.428**</td>
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<td>.000</td>
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<td>Mindfulness</td>
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<td>.637**</td>
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<td>-.375*</td>
<td>.513**</td>
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<tr>
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<td>-.095</td>
<td>-.196</td>
<td>1.000</td>
<td>.490**</td>
<td>-.239</td>
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<tr>
<td>STS</td>
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<tr>
<td>Burnout</td>
<td>-.641**</td>
<td>-.430**</td>
<td>-.428**</td>
<td>-.375*</td>
<td>.490**</td>
<td>1.000</td>
<td>-.785**</td>
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<tr>
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<td>.513**</td>
<td>-.239</td>
<td>-.785**</td>
<td>1.000</td>
</tr>
<tr>
<td>Satisfaction</td>
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</tbody>
</table>

Note. *Correlation is significant at the 0.05 level (2-tailed); **Correlation is significant at the 0.01 level (2-tailed).

Summary of Results

This chapter reported the findings of this study that examined the relationship between self-compassion and compassion fatigue. The researcher calculated descriptive statistics, conducted analyses of variance, and calculated Spearman’s r to answer the research questions. A Spearman’s r suggests that, overall, the self-compassion subscales
predicted compassion fatigue. The implications of these findings and recommendations for future research are discussed in Chapter 5.
Chapter 5: Discussion

Introduction

This study contributes to the research regarding the high levels of compassion fatigue and burnout that lead LMHCs to provide lower quality care to their clients. Specifically, the purpose of this study was to research counselor wellness and self-care practices by exploring the relationship between reported level of self-compassion and reported compassion fatigue levels among LMHCs in New York State. Compassion and empathy are necessary for mental health professionals to provide effective psychotherapy (Figley, 2002), and yet, Morse et al. (2012) reported that 21-67% of mental health workers experience elevated levels of burnout. According to Richardson’s (1990) theoretical model of resilience, the occurrence of compassion fatigue disrupts one’s biopsychospiritual homeostasis, leading to feelings of hurt, loss, pain, and guilt. Self-compassion has been shown to increase resilience, and, therefore, it may enhance homeostatic reintegration (Beaumont et al., 2012; Diedrich et al., 2014; Germer & Neff, 2013; Hiraoka et al., 2015; Neff & Vonk, 2009; Sbarra et al., 2012; Sirois, 2015).

There is a large body of research on self-compassion and a robust collection of research on compassion fatigue (Acker, 2010; Finlay et al., 2015; Hall et al., 2013; Kyeong, 2013; Leary et al. 2007; Lent & Schwartz, 2012; MacBeth & Gumley, 2012; Neely et al., 2009; Neff, 2003; Neff, et al., 2007; Oddie & Ousley, 2007; Raes, 2010; Shapira & Mongrain, 2010; Thompson et al., 2014; Van Dam et al., 2011). There is limited literature addressing the relationship between the two constructs, and there is even less research on
self-compassion and compassion fatigue among professional counselors (Beaumont et al., 2016b). Only one study has examined the relationship between self-compassion and compassion fatigue among counselors in the United States (Ringenbach, 2009). Research on other mental health professional populations, however, indicates that self-compassion is negatively correlated with symptoms of burnout, compassion fatigue, and depression (Beaumont et al., 2016b; Diedrich et al., 2014; Kyeong, 2013; Krieger et al., 2016; Shapira & Mongrain, 2010; Van Dam et al., 2011).

Self-compassion and emotion regulation are significant predictors of stress symptoms among mental health professionals (Finlay-Jones et al., 2015). The high rate of compassion fatigue among helping professionals suggests that it is vital to explore the factors that can inform counselor self-care practices that might lead to increased resilience and the ability to continue working effectively in this challenging profession (Skovholt & Trotter-Mathison, 2016). In this study, the relationship between self-compassion and compassion fatigue among counselors was explored with the purpose of identifying effective self-care practices. This chapter is divided into the following sections: (a) the implications of the findings of this research study as is relates to the existing literature; (b) the limitations and (c) recommendations of this study; which is followed by (d) a summary of this chapter.

**Implications of Findings**

To accomplish the objective outlined in Chapter 1, the following research questions were explored:

1. What is the relationship between demographic variables of licensed mental health counselors and their reported experience of self-compassion?
2. What is the relationship between demographic variables of licensed mental health counselors and their reported experience of compassion fatigue?

3. What is the relationship between reported compassion fatigue and reported self-kindness, common humanity, and mindfulness among licensed mental health counselors?

4. What is the relationship between reported self-compassion, reported burnout, and secondary traumatic stress among licensed mental health counselors?

**Demographic variables, self-compassion, and compassion fatigue.** A large body of research exists on the demographic characteristics of helping professionals that are similar to the findings of this present study (Acker, 2010; Ballenger-Browning et al., 2011; Green et al., 2014; Lawson & Myers, 2011; Lent & Schwartz, 2012; Paris & Hoge, 2009; Rohland, 2000; Rupert & Kent, 2007; Tanrikulu, 2012; Thompson et al., 2014).

The data in this present study suggests that three demographic variables are related to avoiding counselor impairment. The data indicates that (a) those working in community agencies experience more burnout than those working in private practice, (b) those who saw more clients per week scored higher on the secondary traumatic stress and burnout scales and, (c) counselors who reported working 1-10 years scored higher on the secondary traumatic and burnout scales.

In the current study, private practitioners and those working in agencies scored in the average range on the burnout subscale. However, the agency-employed group scored higher on the burnout subscale, suggesting a greater probability of experiencing burnout. This finding supports the results of several studies where it was found that counselors working in community mental health settings reported more burnout and emotional
exhaustion than those in private practice (Lawson, 2007; Lent & Schwartz, 2012; Rupert & Kent, 2007). Also, in this present study, those who reported seeing more than 20 clients per week scored higher on the secondary traumatic stress and burnout scales than did the groups who saw fewer clients per week. Rupert and Morgan (2005) and Ballenger-Browning et al. (2011) reported a relationship between caseload and burnout, suggesting that having more clients per week was correlated with higher rates of burnout. Counselors in the sample for this study, who reported working 1-10 years scored higher on the secondary traumatic and burnout scales of the ProQOL than did those who had worked for more than 15 years. This suggests that less experienced counselors have a higher likelihood of experiencing compassion fatigue.

The number of participants in this study was small; therefore, the findings can only be attributed to those who completed the survey. However, there are many studies in the body of literature that contradict one another regarding demographic variables such as gender and length of time in the profession (Merriman, 2015; Rupert & Morgan, 2005; Thompson et al., 2014). Some studies found that none of the demographic variables examined had a significant effect on the development of burnout or compassion fatigue (Lent & Schwartz, 2012; Rupert & Morgan, 2005). According to a review conducted by Paris and Hoge (2009), studies have identified some potential contributors to burnout or compassion fatigue in mental health professionals, but, in general, these studies were “methodologically weak, and multiple studies examining the relationship of burnout to a common variable do not exist” (p. 253). One study examined several variables, including the length of time in the profession, but they found that their data did not suggest that any of the demographic variables influenced burnout (Thompson et al., 2014). Another study
found no significant correlation between caseload size and level of burnout, continuing the uncertainty regarding demographic variables and the development of compassion fatigue and burnout (Green et al., 2014).

Many studies do highlight the importance of awareness and enhancement of self-care practices among mental health professionals (Ballenger-Browning et al., 2011; Lent & Schwartz, 2012; Rohland, 2000; Thompson et al., 2014). However, despite the prolific amount of research related to mental health professionals, it is not yet clear which variables are optimal for avoiding impairment (Thompson et al., 2014). Due to the shortage of research on self-compassion and mental health professionals, little is known about the relationship of self-compassion to the demographic variables associated with mental health professionals, including counselors.

**Relationship of compassion fatigue to self-compassion.** The results of the present study indicate a significant and negative correlation between self-compassion and secondary traumatic stress. The self-kindness subscale of the SCS was negatively correlated with both secondary traumatic stress and burnout. The subscales measuring common humanity and mindfulness indicate a negative correlation with burnout. The self-compassion composite score and all three subscales of self-kindness, common humanity, and mindfulness, all demonstrate a positive correlation between self-compassion and compassion satisfaction. This suggests that self-compassion may decrease secondary trauma and burnout.

Compassion fatigue is a severe problem among mental health professionals, specifically LMHCs (Skovholt & Trotter-Mathison, 2016), and, yet, this present study is the first to investigate the relationship between self-compassion and compassion fatigue.
among mental health counselors in the United States in 10 years (Ringenbach, 2009). In
the past 10 years, the gap between the need for effective mental health intervention and
the number of providers has continued to widen, therefore changing the mental health
landscape for providers. Some of the reasons for this gap are related to an increased
understanding of preventative measures, especially in the field of substance abuse. As
the United States population continues to age there are unique mental health concerns
within this population. There has been increase in the use of technology, especially
social media, that appears to be linked to anxiety and depression as well as internet
addiction (Anxiety and Depression Association of America, 2018).

The Affordable Care Act mandates a provision of preventive care for both
behavioral and medical care to all insured, therefore increasing the need for providers
(HHS, 2017). Finally, veterans from Iraq and Afghanistan who have experienced
physical and emotional trauma increase the need for mental health support (National
Veterans Foundation, 2016). This study examined the phenomenon of the relationship
between self-compassion and compassion fatigue among counselors in what is clearly a
different social context than previous, dated studies.

This present study adds to the existing literature of factors that influence or
predict compassion fatigue for other mental health professional populations (Beaumont et
al., 2016b; Diedrich et al., 2014; Durkin et al., 2016; Kyeong, 2013; Krieger et al., 2016;
Shapira & Mongrain, 2010; Van Dam et al., 2011). Findings from the current study
support the evidence found in previous studies of the relationship between self-
compassion and compassion fatigue, to include a new population—LMHCs.
In this study of LMHCs, the compassion fatigue subscales, secondary traumatization, and burnout were significantly and negatively correlated with the self-compassion composite score. Burnout was also negatively associated with the self-kindness, common humanity and mindfulness subscales on the SCS. A study by Kyeong (2013) found that self-compassion was positively associated with increased well-being, therefore, suggesting a correlation between compassion fatigue and self-compassion (Kyeong, 2013). Other studies on helping professional populations other than LMHCs saw similar results and suggest that increasing self-compassion may decrease compassion fatigue among practitioners (Beaumont et al., 2016b; Durkin et al., 2016). In a study of student midwives utilizing both the SCS and ProQOL scale, Beaumont et al. (2016b) reported that self-compassion was reported by the participants to be negatively associated with burnout. This is similar to the findings in this present study that suggest that higher self-compassion scores are related to lower compassion fatigue scores.

**Limitations**

Although this study provides a useful contribution to the literature, there are several limitations. The first limitation relates to sample size, the second relates to recruitment via the Internet, and the third limitation is associated with the generalizability of the results. The sample in this study was adequate for data analysis; however, the number of participants with complete data was small. Small sample size does not allow for statistical analysis that would lead to an understanding of the ability of variables to predict or to suggest causality (Cronk, 2014). The analysis in this study does not provide information on the directionality of the variables. The data do not provide information on whether a moderate score on the SCS can predict a low score on the ProQOL scale nor
whether low compassion fatigue predicts moderate self-compassion. As a result of the small sample size, this study can be better seen as a proof-of-concept study such as Olsen and Kemper’s (2014) study of medical trainees.

The second limitation is the same for all Internet-based research techniques—there is no guarantee of the authenticity of the participants’ identities or answers (Pedersen & Kurz, 2016). Collecting data from participants via Facebook excludes those who do not have Facebook accounts. The same is true when surveys are emailed to possible participants with membership in a specific group. In this study, the survey was posted on Facebook sites belonging to mental health counselor groups, which were located in New York State. Recruitment information was also sent to a group of private practitioners who are known to the researcher. Studies typically report recruitment rates lower than 1% of the targeted population, especially when using social media such as Facebook (Pedersen & Kurz, 2016).

The third limitation is that the demographic data for the sample in this study cannot be compared to the demographic data of the larger population of LMHCs in New York State because that data has not been collected (D. Hamilton, personal communication, July 29, 2018). This lack of information limits the generalizability of the study to LMHCs who were part of the study sample. The sample in this present study was confined to volunteers from New York State, therefore the geographic limitation may have also reduced the generalizability of the findings. A larger and more diverse respondent group might have produced different results.
Recommendations

The results of this study suggest several recommendations for future research and practice. The stakeholders interested in these recommendations might be administrators of training programs for mental health professionals, executive leaders of organizations providing mental health care, those providing supervision to mental health professionals, and mental health professionals themselves. The following sections address those groups.

Future research. Replicating this study with a larger sample of counseling professionals from multiple states would increase the diversity of the sample and, therefore, increase generalizability. A larger sample size would also allow the use of statistical analysis to determine the ability to predict the relationship between self-compassion and compassion-fatigue, thus providing useful information such as the level of self-compassion needed to avoid or mitigate compassion-fatigue or increase resilience.

Future studies on mental health professionals and the relationship between self-compassion and compassion fatigue might explore the perspective of the clients on their outcomes. If the therapeutic relationship is different based on the counselor’s level of self-compassion, client reports may reflect this difference. If higher levels of self-compassion are related to lower levels of compassion fatigue, it may be useful to understand how that relates to the care provided by the professional from the perspective of their clients.

Training programs for mental health professionals. The findings in this present study are important for preparatory programs for mental health professionals, specifically for LMHCs. The negative relationship between the self-compassion
composite scale and the secondary traumatic stress and the burnout subscales suggest that increasing self-compassion might help counseling students to avoid the experience of compassion fatigue. For example, training in self-compassion appears to be helpful for students of mental health professions such as social work (Iacono, 2017). In this present study, counselors who had been in the profession for between 1 and 10 years scored the lowest of the three groups in self-kindness and common humanity. Therefore, to effectively integrate self-compassion into the practice of LMHCs, it is imperative to stress its importance as individuals are socialized into the profession.

Research on self-compassion interventions shows that self-compassion is teachable through empirically supported interventions (Smeets, Neff, Alberts, & Peters, 2014) such as mindful self-compassion (MSC; Neff & Germer, 2013; Germer & Neff, 2019), and compassionate mind training (CMT; Gilbert, 2014) that may help increase self-compassion and therefore reduce compassion fatigue (Beaumont, Rayner, Durkin, & Bowling, 2017). Both CMT and MSC are designed to help individuals develop and increase self-compassion (Iacono, 2017). Multiple studies have found empirical evidence to support the effectiveness of both CMT and MSC (Gilbert & Procter, 2006; Neff & Germer, 2013). Both programs are designed to increase compassion for self and, therefore, for others through mindful meditation practice as well as group and self-reflection on the nature of compassion.

Several studies have recommended that self-care should play a critical role in graduate training for mental health professionals (Colman et al., 2016). Unfortunately, there is limited consensus on what type of self-care activities are effective (Colman et al., 2016). CACREP (2016), the accrediting body for counselor education programs, does
not require the programs to include education on self-care practices. The same is true of
the New York State Office of Professions (2019). Because of the high rates of
impairment among counselors and the negative relationship between self-compassion and
compassion fatigue and burnout found in this study, it appears that students would benefit
from self-compassion education as well as other self-care practices in their training
programs.

Counselor education programs routinely assess their students for readiness for the
profession through supervision, observation, and measurement of competencies. Another
way in which the relationship between self-compassion and compassion fatigue might
inform policy in counselor education programs is by utilizing an assessment of self-
compassion, such as the SCS, to assist students in identifying their strengths related to
avoiding impairment. This might be done along with other measures of protective factors
used by counselor education programs to identify their student’s readiness for the
profession.

**Executive leaders of mental health organizations.** Executive leaders of mental
health professionals, if truly serving their staff and clients, set organizational culture
through the development of policies and create environments that are supportive and
health promoting. Impairment is a significant problem in mental health staff retention
(Morse et al., 2012). Agencies may experience challenges related to financial distress
due to absenteeism and turnover (Stalker & Harvey, 2002).

It may be challenging for mental health organizations to recruit and maintain an
adequate workforce. Since the passage of the Mental Health Parity and Addiction Equity
Act of 2008 and the Affordable Care Act, many more Americans ostensibly have better
access to behavioral health care. However, the mental health workforce has not increased at nearly the same rate as the need for providers, leaving a shortfall of mental health providers (Leonard, 2014). This trend is expected to continue with a national shortfall of approximately 200,000 social workers by 2030 (Lin, Lin, & Zhang, 2016). Shortfalls exist and are expected to increase for addictions counselors, marriage and family therapists, mental health counselors, school counselors, psychologists, and psychiatrists (Pasternak, 2018).

In New York State, 65% of counties are designated as mental health shortage areas. The shortage leaves over three million people in New York State without access to adequate mental health care (Health Resources and Services Administration, 2019). The reasons for the shortage of providers are varied and include high turnover rates, an aging workforce, and low compensation (Pasternak, 2018).

The results of this study suggest that increasing self-compassion appears to be related to a decrease in compassion fatigue. The findings in this study also suggest that limiting caseloads, as suggested by Pearlman and Maclan (1995), might be beneficial to LMHCs seeking to avoid compassion fatigue as well as to their employers who seek to retain a healthy workforce. This is especially important in a state such as New York where the mental health workforce is inadequate.

Organizational policy might include voluntary assessment of the self-compassion of their mental health workforce as part of ongoing wellness programs or through employee assistance programs (EAPs) to prevent professional attrition. Wellness programs and EAPs are situated to provide support to organizations hoping to maintain a physically and mentally healthy workforce. Those who are trained to teach MSC, CMT
and other self-compassion focused programs are available to organizations to support their staff. Alternately, individuals can be referred to self-compassion focused EAP therapists if they wish to learn more about the concept. Some other possibly helpful interventions may be a combination of cognitive-behavioral therapy (CBT), including mindfulness, meditation, gratitude, and personal meaning; attitude and coping skills improvement, and assertiveness training, cognitive restructuring, progressive muscle relaxation, social skills and communication training, as well as skills that enhance social support (Ewers, Bradshaw, McGovern, & Ewers, 2002; Morse et al., 2012; Salyers et al., 2011; Scarnera, Bosco, Soleti, & Lacioni, 2008).

**Supervisory relationships.** The relationship that LMHCs have with their supervisors may provide an opportunity to promote self-compassion among individual practitioners. Receiving ongoing supervision is an ethical mandate, although not a licensing requirement for LMHCs. The present study suggests that as self-compassion increases, secondary traumatic stress and burnout decrease. Therefore, self-compassion may be a protective factor for counselor resilience in the same manner as having a positive self-concept, a positive social orientation, adequate communication skills, and the ability to focus attention and control impulses (Werner & Smith, 1982). If a supervisor were to observe low self-compassion, they could then encourage increased wellness activity or intervention, such as MSC, for their supervisees to avoid compassion fatigue.

**Mental health professional self-care.** Mental health professionals support the healthy development of the individuals they counsel; however, it appears that they may not participate in the self-care that supports their own well-being. Self-compassion may
be a protective factor for counselor resilience in the same manner as having a positive self-concept, a positive social orientation, adequate communication skills, and the ability to focus attention, and control impulses (Werner & Smith, 1982). In the present study, the findings suggest that as self-compassion increases, secondary traumatic stress and burnout decrease. In the language of Richardson’s (2002) theory of resilience, compassion fatigue disrupts one’s biopsychospiritual homeostasis, and self-compassion appears to increase resilience; therefore, self-compassion may enhance homeostatic reintegration (Beaumont et al., 2012; Diedrich et al., 2014; Germer & Neff, 2013; Hiraoka et al., 2015; Neff & Vonk, 2009; Sbarra et al., 2012; Sirois, 2015).

As mentioned above, mental health professionals, specifically LMHCs, have an ethical mandate to engage in self-care to avoid impairment (ACA, 2014). Compassion fatigue and burnout are prevalent in mental health professions (Morse et al., 2012), and the results of this study suggest that increasing self-compassion may lower secondary traumatic stress and burnout. The practice of self-compassion, as well as periodic self-assessment of self-compassion, may help practitioners manage or even avoid the symptoms of compassion fatigue and subsequently improve their professional quality of life (Beaumont et al., 2016a).

Conclusion

Recently, the literature on self-compassion and depression, well-being, and even compassion fatigue has identified many correlations between the constructs, but the populations studied have been helping professionals but not often LMHCs. The overall differences between the helping professions examined in other research on self-compassion or compassion fatigue may be relatively small, but differences do exist; so it
is beneficial to conduct research on counselors. Additionally, many studies took place outside the United States. While the diversity of that research is important, without extensive study of the culture related to the sample, the findings may not be useful, so it is essential to conduct research on counselors in the United States. This present study is the first of its kind and addresses the gap mentioned above.

The work of mental health professionals is positive, yet challenging, because clients who are experiencing distress, seek therapy. The work of mental health professionals is to extend empathy and compassion to clients who are experiencing challenging emotions such as fear, confusion, rage, and helplessness (Skovholt & Trotter-Mathison, 2016). This work includes one-directional relationships, with a continual extension of empathy and sensitivity that may result in compassion fatigue (Figley, 1995).

The findings of this current study support the findings in prior studies by suggesting that self-compassion helps to manage stressors related to counseling work. Overall, higher self-compassion appears to be related to lower compassion fatigue. Counselors who see fewer clients, work in private practice, and have been practicing counseling for a longer period than others report lower compassion fatigue, and perhaps they will continue to remain in the profession providing care to those experiencing mental health problems.

Given the challenges of the profession of counseling, as well as the increasing need for mental health providers in general, the findings in this study are important. Increasing self-compassion among counselors may help them to avoid impairment. It is essential that there are systems in place to provide care for those who care for others.
These systems, based on the findings of this study and past research, may support a competent mental health workforce that will continue to provide a positive impact on individuals and communities.
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Acker, G. M. (2010). The challenges in providing services to clients with mental illness: Managed care, burnout and somatic symptoms among social workers. *Community Mental Health Journal, 46*(6), 591-600.


Appendix A
Self-Compassion Scale

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

<table>
<thead>
<tr>
<th>Almost never</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Almost always</th>
<th>5</th>
</tr>
</thead>
</table>

1. I’m disapproving and judgmental about my own flaws and inadequacies.
2. When I’m feeling down I tend to obsess and fixate on everything that’s wrong.
3. When things are going badly for me, I see the difficulties as part of life that everyone goes through.
4. When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world.
5. I try to be loving towards myself when I’m feeling emotional pain.
6. When I fail at something important to me I become consumed by feelings of inadequacy.
7. When I’m down and out, I remind myself that there are lots of other people in the world feeling like I am.
8. When times are really difficult, I tend to be tough on myself.
9. When something upsets me I try to keep my emotions in balance.
10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.
11. I’m intolerant and impatient towards those aspects of my personality I don’t like.
12. When I’m going through a very hard time, I give myself the caring and tenderness I need.
13. When I’m feeling down, I tend to feel like most other people are probably happier than I am.
14. When something painful happens I try to take a balanced view of the situation.
15. I try to see my failings as part of the human condition.
16. When I see aspects of myself that I don’t like, I get down on myself.
17. When I fail at something important to me I try to keep things in perspective.
18. When I'm really struggling, I tend to feel like other people must be having an easier time of it.

19. I'm kind to myself when I'm experiencing suffering.

20. When something upsets me I get carried away with my feelings.

21. I can be a bit cold-hearted towards myself when I'm experiencing suffering.

22. When I'm feeling down I try to approach my feelings with curiosity and openness.

23. I'm tolerant of my own flaws and inadequacies.

24. When something painful happens I tend to blow the incident out of proportion.

25. When I fail at something that's important to me, I tend to feel alone in my failure.

26. I try to be understanding and patient towards those aspects of my personality I don't like.
Appendix B

Professional Quality of Life (ProQOL) Scale

Compassion Satisfaction and Compassion Fatigue (ProQOL) Version 5 (2009)

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

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

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

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Appendix C

Demographic Questionnaire

1. Are you licensed in New York State as a mental health counselor?  Yes/No

Those who answer “no” will be taken to a page that says “Thank you for your participation in this study. I appreciate your time. Best wishes in your counseling work.”

2. Are you currently working as a mental health counselor?  Yes/No

Those who answer “no” will be taken to a page that says “Thank you for your participation in this study. I appreciate your time. Best wishes in your counseling work.”

3. How long have you been practicing as a mental health counselor?
   Drop down:  less than 1 year
               1-5 years
               6-10 years
               11-15 years
               16-20 years
               21-25
               More than 25 years

4. How many clients do you see in an average week?
   Drop down:  1-10
               11-15
               16-20
               21-25
               26-30
               More than 30

5. How many weeks did you work in the last 12 months?
   Drop down:  51-52
               49-50
               47-48
               46
               Fewer than 46
6. What is your highest level of education?
   Drop down: Master's Degree
              Doctorate

7. What is your age range?
   Drop down:  21-25
              26-30
              31-45
              46-60
              61-70
              Over 70

8. What gender do you identify as?
   Drop down: Female
              Male
              Non-binary
              Prefer not to identify

9. Which best describes your relationship status?
   Drop down: Single
              Married
              Partnered
              Divorced
              Separated
              Widowed

10. Choose one or more groups that best identify you.
    Drop down: Non-Hispanic White or Euro-American
               Black, Afro-Caribbean or African American
               Latino or Hispanic American
               East Asian or Asian American
               South Asian or Indian American
               Middle Eastern or Arab American
               Native American or Alaskan Native
               Other

11. What is your primary work setting?
    Drop down, check all that apply:
    Private Practice
    Community Agency
    Hospital
    Higher Education
    K-12 School
    None of these
Appendix D

Recruitment Letter and Links to Survey for Facebook, Listservs, and Emails

I am a doctoral candidate at St. John Fisher College, investigating the relationship between compassion fatigue and self-compassion for LMHCs. If you have a few minutes would you consider completing my survey? The link is below, and it should only take you about 20 minutes. Your responses may help our profession by identifying protective factors for avoiding or ameliorating compassion fatigue. Your responses are completely anonymous, and at the end of the survey, you will be given a chance to send me your email address separately. Your email address will never be associated with any data, and it can be useful for two reasons: (1) If you wish, I will send you a summary of the results of the study. (2) If you wish, you may enter a drawing for a one-year membership in NYMHCA!

If you are interested, click the link now which will take you to the informed consent page. You can withdraw at any point by closing your browser (you won't be able to enter again though). St. John Fisher College’s IRB has approved this study. Please message me at 585-_______ if you have any questions or email at ____@sjfc.edu.
Appendix E

Informed Consent Form

St. John Fisher College

INFORMED CONSENT FORM

Title of study: The Relationship Between Compassion Fatigue and Self-Compassion Among Licensed Mental Health Counselors

Name(s) of researcher(s): Madeleine Reynolds

Faculty Supervisor: Joshua Fegley                Phone for further information: ____________

Purpose of study: I am conducting this research to determine whether there is a relationship between compassion fatigue and self-compassion. This study is meant to compare a counselor's self-reported compassion fatigue with their self-reported self-compassion. The results of this study will be published in my doctoral dissertation and may also be reported in academic journals or professional publications. The results may be presented at academic or professional conferences and may inform future training and education for counselors and counseling students. The results may also lead to information which will improve counselor wellness.

Place of study: internet                                    Length of participation: one time, approximately 20 minutes

Method(s) of data collection: Electronic Survey

Risks and benefits: The expected risks and benefits of participation in this study are explained below:

Benefits: Participation in this research study will not benefit you directly. The results may benefit the counseling profession. Understanding more about compassion fatigue and self-compassion may help counselors to avoid impairment and may also help counselor educators to improve education for future counseling students.

Risks: Participating in this study only exposes you to minimal risk. Because the survey asks about thoughts and feelings that routinely occur in the professional experience of LMHCs, this study does not pose any harm or discomfort greater than those ordinarily encountered in daily life. There are no physical risks associated with this survey. There are no costs to you for participating.

Method for protecting confidentiality/privacy of subjects: All responses will be kept confidential. You will not be providing any information that will personally identify you. All personal information received from this survey will be anonymous. All data will be pooled and
reported in aggregate form. Everything that can be done will be done to protect your anonymity but please note that absolute anonymity cannot be guaranteed for information transmitted over the internet. You do not have to participate in this survey if you do not want to and you can change your mind at any time while completing the survey. Once you have completed the survey, your information cannot be removed from the study because there will not be a way to identify your responses as being related to you. Your information may be shared with appropriate governmental authorities ONLY if your responses suggest that you or someone else is in danger, or if we are required to do so by law.

Method for protecting confidentiality/privacy of data collected: I will maintain the raw data in a password protected secure, electronic file.

Your rights: As a research participant, you have the right to:

1. Have the purpose of the study, and the expected risks and benefits fully explained to you before you choose to participate.
2. Withdraw from participation at any time without penalty.
3. Refuse to answer a question without penalty.
4. Be informed of the results of the study.

If you have any further questions regarding this study, please contact the researcher(s) listed above. If you experience emotional or physical discomfort due to participation in this study, please contact your personal health care provider or an appropriate crisis service provider (411). The Institutional Review Board of St. John Fisher College has reviewed this project. For any concerns regarding this study/or if you feel that your rights as a participant (or the rights of another participant) have been violated or caused you undue distress (physical or emotional distress), please contact Jill Rathbun by phone during normal business hours at (585) _______ or irb@sjfc.edu. She will contact a supervisory IRB official to assist you.

By clicking the link below, you agree to the following statement:
I have read this form, and I have been given information about how to ask questions about this study. I voluntarily agree to be in this study. I agree to allow the use and sharing of my study-related records as described above.
I have read, understood the above consent form and desire of my own free will to participate in this study.

() yes, I agree to participate in the study.
() no, I want to leave the study
Appendix F

Drawing Information

If you would like to be entered in a drawing for a one-year membership in New York State Mental Health Counselors Association (NMHCA), please click below.

Your information will not be associated with your survey responses. You will be notified by email if you are chosen.

( ) Please enter my email address in the drawing.

Email address ___________________________
Appendix G

Request Permission to Use Self-Compassion Scale

To Whom it May Concern:

Please feel free to use the Self-Compassion Scale in your research. Masters and dissertation students also have my permission to use and publish the Self-Compassion Scale in their theses. The appropriate reference is listed below.

Best,

Kristin Neff, Ph. D.
Associate Professor
Educational Psychology Dept.
University of Texas at Austin

e-mail: kneff@austin.utexas.edu

Reference:

Coding Key:
Self-Kindness Items: 5, 12, 19, 23, 26
Self-Judgment Items: 1, 8, 11, 16, 21
Common Humility Items: 3, 7, 10, 15
Isolation Items: 4, 13, 18, 25
Mindfulness Items: 9, 14, 17, 22
Over-identified Items: 2, 6, 20, 24

Subscale scores are computed by calculating the mean of subscale item responses. To compute a total self-compassion score, reverse score the negative subscale items before calculating subscale means - self-judgment, isolation, and over-identification (i.e., 1 = 5, 2 = 4, 3 = 3, 4 = 2, 5 = 1) - then compute a grand mean of all six subscale means. Researchers can choose to analyze their data either by using individual sub-scale scores or by using a total score.

(This method of calculating the total score is slightly different than that used in the article referenced above, in which each subscale was added together. However, I find it is easier to interpret the total score if a mean is used.)
Permission to Use the ProQOL Scale

Permission for Use of the ProQOL (Professional Quality of Life Scale: Compassion Satisfaction and Compassion fatigue) www.proqol.org

Accompanied by the email to you, this document grants you permission to use for your study or project

*The ProQOL (Professional Quality of Life Scale: Compassion Satisfaction and Compassion fatigue) www.ProQOL.org*

Prior to beginning your project and at the time of any publications, please verify that you are using the latest version by checking the website. All revisions are posted there. If you began project with an earlier version, please reference both to avoid confusion for readers of your work.

This permission covers non-profit, non-commercial uses and includes permission to reformat the questions into a version that is appropriate for your use. This may include computerizing the measure.

Please print the following reference or credit line in all documents that include results gathered from the use of the ProQOL.


Permission granted by
Beth Hudnall Stamm, PhD
Author, ProQOL
ProQOL.org
info@proqol.org

Help us help all of us. Please consider donating a copy of your raw data to the data bank. You can find more about the data bank and how you can donate at www.proqol.org and www.proqol.org/Donate_Data.html. Data donated to the ProQOL Data Bank allow us to advance the theory of compassion satisfaction and compassion fatigue and to improve and norm the measure itself.