CARING FOR BEGINNING COUNSELORS: THE RELATIONSHIP BETWEEN EMPATHY, SUPERVISORY WORKING ALLIANCE, RESILIENCE, WELLNESS, AND COMPASSION FATIGUE AMONG COUNSELORS-IN-TRAINING

A Dissertation

by

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This dissertation meets the standards for scope and quality of
Texas A&M University-Corpus Christi and is hereby approved.

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ABSTRACT

The concept of compassion fatigue has been around since the late 1990s, with researchers examining the relationship between different concepts and compassion fatigue across various professional fields. Compassion fatigue has been described as the natural consequence of behaviors, emotions, and stress resulting from helping or wanting to help a suffering individual or trauma survivor (Figley, 1995). Counselors may experience compassion fatigue because of continual exposure to hearing clients' suffering and traumatic stories. However, beginning counselors and counselors-in-training (CITs), may experience struggles working with their clients due to lack of knowledge, experience, skillset, or support (Skovholt & Trotter-Mathison, 2016).

I designed a correlational study to investigate the associations between compassion fatigue and empathy, supervisory working alliance, resilience, and wellness among CITs in the United States. I used a demographic form, the *Brief Resilience Scale*, the *Flourishing Scale*, the *Interpersonal Reactivity Index*, the *Supervisory Working Alliance Inventory: Trainee Form,* and the *Professional Quality of Life Scale* to collect data from 84 CITs who agreed to participate in the study. I then performed a correlation analysis and a three-step hierarchical multiple regression analysis to examine the collected data and address my identified research questions.

Results of the present study revealed CITs reporting themselves as having a low risk of compassion fatigue. Results also revealed significant negative correlations between wellness and resilience with compassion fatigue, while significant positive correlations were found between empathy and resilience with wellness. Finally, hierarchical regression analysis results indicated

that wellness and resilience were significant predictors of self-reported risk of compassion fatigue among CITs.

The findings of the current study support theoretical and practical implications for counselor educators, supervisors, and future researchers. Counselor educators may consider enhancing their current training programs by including discussion topics about empirically predictive factors of compassion fatigue, such as wellness and resilience, in various courses. Supervisors may practice wellness and resilience strategies in supervision and develop interventions designed to prevent compassion fatigue from its early-onset. Future researchers may explore the effectiveness of these wellness and resilience interventions, expanding on the results of the present study.

DEDICATION

I wholeheartedly dedicate this dissertation to the memory of my father and my uncle, who always believed in my ability to be successful in the academic arena.

Dad, without your encouragement, I would never have left home, Turkey, to start a journey in the United States. My loving uncle, you always found a way to ease my life with your help and guidance. I know that your never-ending support and belief in me has made this journey possible. I wish that we could have celebrated this accomplishment together. I miss you both terribly already and will ever be grateful for everything I learned from both of you.

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CHAPTER I: INTRODUCTION

By trade, helping professionals are individuals trained to support the personal growth of their clients by addressing their behavioral, mental, emotional, physical, intellectual, and spiritual well-being. To assist their clients in reaching their full potential, helping professionals are expected to place their personal feelings aside and provide the best treatment possible in response to the presenting issues and needs for which these clients seek help (Figley, 2002a; Ray, Wong, White & Heaslip, 2013; Turgoose, Glover, Barker & Maddox, 2017). For some counselors, showing empathy may sometimes be challenging; however, empathy is an important virtue to maintain in working effectively with clients (Hill, 2009; Skovholt-Trotter-Mathison, 2016).

Counselors are expected to be dedicated and committed to helping their clients. An attitude of commitment may have personal costs. Whether working in mental health agencies, schools, or hospitals, they may experience unique stressors, including exposure to traumatic stories, limited resources, large caseloads, and minimal support (Star, 2013). Because of these challenges, some counselors may be at risk for experience physical, mental, and emotional exhaustion, as well as feelings of helplessness, isolation, and confusion (Eastwood & Ecklund, 2008; Thompson, Amatea, & Thompson, 2014). Figley (1995) coined the term *compassion fatigue* to describe this experience. Writing primarily from a social work perspective, Figley used the term compassion fatigue to define a state in which professionals become emotionally affected by vicarious, perceived or personal witness of the trauma of a client or family member. From this auspicious beginning, the concept of compassion fatigue has gained acceptance in the vernacular of helping professions and now describes the negative consequences associated with working with traumatized individuals in high-stress settings (Harr, 2013). Regardless of the definition

used, scholars agree that compassion fatigue is an occupational hazard that needs to be addressed for most mental health care professionals (Figley, 2002b; Merriman, 2015a).

Merriman (2015b) states that ongoing compassion fatigue negatively impacts counselors' health as well as their relationships with others. Compassion fatigue may lead to a decrease in motivation, empathy towards clients, and overall performance. Small tasks can become overwhelming, and counselors may project their anger towards others. Counselors may have trust issues and experience feelings of loneliness because of compassion fatigue (Harr, 2013). The demands of the counseling profession can affect many counselors' personal wellness and potentially could have a negative influence on the quality of client care (Lawson, Venart, Hazler, & Kottler, 2007; Merriman, 2015a). Eastwood and Ecklund (2008) stated that counselors experiencing compassion fatigue might have difficulties making effective clinical decisions and potentially be at-risk for harming clients.

Listening to individuals' traumatic stories is a part of the counseling profession (Decker, Brown, Ong & Stiney-Ziskind, 2015). These complex client issues, along with other stressors associated with the practice of counseling, may lead to the development of compassion fatigue among both inexperienced and experienced counselors (Stebnicki, 2007). Beginning counselors or counselors-in-training (CITs) working with trauma survivors prior to completion of their counseling training are more vulnerable to experience compassion fatigue and exhaustion due to a variety of stressors such as acute performance anxiety and fear, gaps in understanding between theory and practice, lack of experience and supervision, unrealistic expectations about client progress, and ethical and legal confusion (Merriman, 2015a; Skovholt & Trotter-Mathison, 2016; Roach & Young, 2007; Smith, Robinson, & Young, 2008).

Many researchers have studied the relationships between compassion fatigue and concepts such as empathy, gender, mindfulness, support, wellness, and other concepts. Empathy is one of the most widely studied concepts across various cultures, as it was determined to be one of the fundamental causes of compassion fatigue (Figley, 1995). However, there are controversial findings in the literature regarding the association between compassion fatigue and empathy (e.g., O'Brien & Haaga, 2015; MacRitchie &Leibowitz, 2010). Therefore, it is important for counseling scholars to continue conducting research on this concept to strengthen the knowledge base in counseling.

Skovholt and Trotter-Mathison (2016) highlighted the importance of resilience and self-care activities as protective factors for compassion fatigue. For example, Wood et al. (2017) evaluated the effectiveness of the Provider Resilience mobile application, used to reduce participants' compassion fatigue scores. The results indicated that the Provider Resilience mobile application was effective in reducing compassion fatigue. Additionally, Kapoulitsas and Corcoran (2015) asserted a positive supervision relationship is important in developing resilience among counselors. Regarding supervision, Knight (2010) found that students uncomfortable talking with their supervisor were at greater risk of compassion fatigue. Thus, an emphasis in researching concepts preventing compassion fatigue is necessary.

Although counselors are encouraged to engage in self-care activities designed to maintain and promote their own well-being (ACA, 2014; Smith et al., 2008), not all CITs are able to balance caring for self and others. When CITs are not trained in the protective factors for compassion fatigue, they tend to become more at-risk for violating the American Counseling Association (ACA) Code of Ethics (2014) (Merriman, 2015a; Merriman, 2015b). Therefore, CITs need to be educated about the risks of compassion fatigue (Craig & Sprang, 2010; Harr,

2013; Merriman, 2015a; Negash & Sahin, 2011). Additionally, examining the protective factors against compassion fatigue is necessary to prevent its onset.

Statement of the Problem

Balancing self-care and client-care is a challenge for many counselors. When mental health professionals neglect self-care, they may become vulnerable to several issues, including increased anxiety, distress, compassion fatigue, burnout, and, ultimately, impairment (Craig & Sprang, 2010; Figley, 1995; Ray et al., 2013; Stebnicki, 2007). Impairment can occur at any time during professional development, including graduate education and early counselor training (Huprich & Rudd, 2004). Thus, counselor educators are responsible to help beginning counselors develop self-care strategies so they can ameliorate the effects of compassion fatigue and effectively counsel those who seek their services.

Counseling students may face various stressors regarding their education, professional development, and training (Thompson, Frick, & Trice-Black, 2011). The transition from student to counselor-in-training creates new stressors, and beginning counselors may struggle to manage multiple roles and demands while working with complex client issues (Stalnaker-Shofer & Manyam, 2014). Skovholt and Trotter-Mathison (2016) stated that there is a gap between theory and practice in all relational-intense professions, and CITs may become more vulnerable to disappointment when they experience this gap. Additionally, inexperienced CITs may frequently feel overwhelmed and highly challenged in client sessions because they are in the early stages of their professional development (Skovholt and Trotter-Mathison, 2016). The increased anxiety, distress, and disappointment experienced may lead to a decline in therapeutic effectiveness, exhaustion, disengagement, and compassion fatigue (Huprich & Rudd, 2004; Ronnestad & Skovholt, 2013).

Most CITs are often unable to master all counselor competencies (Ronnestad & Skovholt, 2003) because they are likely to be unprepared for the emotional strain of their work and unaware of potential stressors common to the field (Star, 2013). While they are learning counseling skills to provide the best quality of care to clients, CITs may need to work with seriously troubled or traumatized clients without obtaining quality supervision and support. Lack of skills and resources would increase the likelihood of students' vulnerability in developing compassion fatigue. However, there is a lack of focus in compassion fatigue education on preparing CITs to manage compassion fatigue symptoms (Merriman, 2015a). There is also a dearth in studies examining the level of compassion fatigue among CITs and addressing its protective factors (Beamont, Durkin, Martin, & Carson, 2016; Thompsan, Amatea, & Thompsan, 2014). Subsequently, further research is needed to better understand potential protective factors that can be enhanced to offset the negative impact on CITs and the counseling process.

Purpose of the Study

The purpose of this study is to evaluate compassion fatigue levels and potential protective factors against compassion fatigue among CITs. More specifically, this study aims to (a) extend the literature by providing data regarding the level of compassion fatigue scores of CITs, (b) examine the relationship between compassion fatigue and potential protective factors (empathy, supervisory working alliance, resilience, and wellness), and (c) assess how selected predictor variables (empathy, supervisory working alliance, resilience, and wellness) explain the variance in compassion fatigue scores for CITs in the United States. These variables were selected based on their status as widely studied concepts within the compassion fatigue literature prevalent across cultures and to address any noted gaps.

Both the ACA Code of Ethics (2014) and the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2016) standards emphasize the importance of self-care and wellness in counselors. The ACA Code of Ethics (2014), under Section C: Professional Responsibility, requires counselors to be responsible for engaging in self-care activities to maintain and promote their overall well-being. Additionally, the CACREP standards (2016), under Section 3: Professional Counseling Identity, suggest that counseling curricula should include a wellness aspect and aspire to promote personal and professional development of CITs. Furthermore, counselor educators become responsible for systematically assessing each student's professional disposition throughout the program (Section 4). Therefore, an additional purpose of this study is to provide empirical data to enhance current training program curricula and help CITs become better stewards of their own self-care and well-being.

Research Questions

The present study investigates the protective factors of compassion fatigue and seeks to answer the following research questions:

1. What is the level of compassion fatigue among CITs?
2. What are the relationships among empathy, supervisory working alliance, resilience, wellness, and compassion fatigue in CITs?
3. Do empathy, supervisory-working alliance, resilience, and wellness significantly predict levels of compassion fatigue?

Significance of the Study

The research findings may provide data-driven results informing counselor educators' creation of wellness and resilience-related interventions designed to prevent CITs from possible compassion fatigue. As a result, these students may be able to develop their own coping skills

and enhance their wellness, thereby becoming wholesome novice counselors. Because CITs, as inexperienced beginning counselors, may work with trauma survivors in their internship sites, they may cause harm to clients by unintentionally breaching ethical and emotional boundaries due to compassion fatigue (Skovholt & Trotter-Mathison, 2016). Using the results of this study, counselor educators and supervisors may train CITs to prevent possible ethical violations. Additionally, with the findings of the study, counselor educators may consider adding a required discussion topic of compassion fatigue in their practicum and internship courses. Thus, CITs may complete their training with an awareness of this issue and become better aware of the ways to cope with compassion fatigue. Furthermore, with the results of this study, CITs may become fully aware of the effective protective factors of compassion fatigue. Integrating these factors into practice may help CITs make effective clinical decisions. Thus, clients will receive the best care. Finally, the researcher aims to fill a gap in the knowledge base because there is a lack of research related to compassion fatigue among CITs.

Definition of Terms

In this section, the researcher defines the terms used in this study. These definitions represent the way the researcher conceptualizes the concepts in designing the study and interpreting the results.

Counselors-in-training: Individuals enrolled in a master's level graduate counselor training program currently registered for internship coursework.

Compassion Fatigue: Compassion fatigue has been described as an experience of distress due to extreme sympathy for a sufferer's pain and feeling a deep physical, emotional, and spiritual exhaustion (Alkema, Linton, & Davies, 2008; Figley, 2002a).

Empathy: Empathy is defined as an individual's reactions to the observed experiences of another (Davis, 1983).

Resilience: Resilience means not giving up on life and bouncing back from challenging experiences (American Psychological Association, 2015).

Supervisory Working Alliance: Working alliance is a construct referring to the collaboration for change based on mutual agreements on the goals and tasks of each partner, as well as a strong emotional bond between them (Bordin, 1983; White & Queener, 2003). Supervisory working alliance focuses on the quality of the interactions between supervisor and CITs.

Wellness: Wellness is a state of complete physical, mental and social well-being (Roscoe, 2009). High levels of well-being are referred to as *flourishing* in this study; similar to the way authors have used the term in other related studies (Hone, Jarden, Schofield, & Duncan, 2014).

CHAPTER II: REVIEW OF THE LITERATURE

In this study, my goal is to investigate the relationship between empathy, supervisory working alliance, resilience, wellness, and compassion fatigue among CITs. In this chapter, I present the theoretical orientation, history of terminology, related factors with compassion fatigue, and, specifically, the concepts of empathy, supervisory working alliance, resilience, and wellness. I also review the research study results relevant to compassion fatigue, empathy, supervisory working alliance, resilience, and wellness.

Theoretical Orientation Guiding the Study

The ability to care is fundamental for the counseling profession, as caring has been shown to be the essential quality that must be maintained in any therapeutic relationship (Rogers, 1961). Inability to care is one of the risky signals of compassion fatigue; therefore, it is important for counselors to be aware of this sign (Figley, 1995). To highlight the importance of caring in the counseling profession, the Cycle of Caring was developed in the early 2000s (Skovholt, Griger, & Hanson, 2001; Skovholt, 2005; see Figure 1); I used it as the framework for this study.

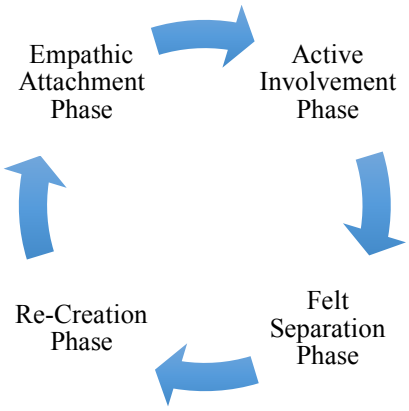

Figure 1. The Cycle of Caring. Reprinted from "The Resilient Practitioner" by T. M. Skovholt and M. Trotter-Mathison, 2016, p. 18. Copyright 2016 by Taylor & Francis Group LLC Books. Reprinted with permission.

The Cycle of Caring is a dynamic model which describes a continual series of professional attachments and separations within the one-way helping relationship (Skovholt, 2005). Professional counseling is one of the "high-touch" helping professions, meaning counselors closely work with clients by practicing the Cycle of Caring repeatedly (Skovholt et al., 2001). In this relationship, counselors are expected to constantly attach with a client, become involved in a relationship, separate from the relationship, and step away from the professional intensity. The Cycle of Caring is the summary of the professional life of a counselor, and competent counselors are expected to be skilled in all phases of the cycle. The Cycle of Caring originally had three main phases, but Skovholt and Trotter-Mathison (2016) improved the model by adding a fourth stage to the cycle. A description of the four phases follows.

Empathic Attachment Phase

Skovholt (2005) described the first stage of the cycle as *empathic attachment*; the goal of this stage is to make an optimal professional attachment with the client. Attaching, bonding, and connecting are the key elements of this phase. Attachment theory, developed by Bowlby (1988), is the foundational work for this phase. Repeatedly forming an optimal professional attachment could be difficult for some counselors. Counselors-in-training might be especially vulnerable to becoming overwhelmed by listening to difficult and painful stories of others because they are in early stages of their professional development (Skovholt, 2005). Therefore, learning emotional boundaries can be a vital skill for both CITs and novice counselors.

Active Involvement Phase

The second stage is called *active involvement.* The idea of this phase is to share a vision together with the client and work toward that goal. In other words, this is the working phase for the counselor. As beginning counselors, CITs practice continuously sustaining emotional caring

for their clients. Counselors-in-training are also involved with a continuous attachment to the client in need while practicing active listening and support-challenge balance for a change and development in this phase (Skovholt, 2005; Skovholt & Trotter-Mathison, 2016).

Felt Separation

The third stage is *felt separation,* when counselors strive to let go of the active emotional burden of the professional relationship. This professional loss process is a kind of grief process for the counselor. Beginning counselors practice termination skills in this phase. The alternative of this phase is called *caring burnout*, which means the inability to form a professional attachment with the next client (Skovholt, 2005). Skovholt and Trotter-Mathison (2016) suggested practicing an optimal level of client-care versus self-care for a proficient professional attachment in the relationship-intense fields.

Re-creation Phase

In this context, *re-creation* means having a break for self-care, rest, renovation, restoration, and return. Counselors are expected to be active and fully present in order to help their clients. After completing the first three phases as being fully present, counselors need to practice self-care in the re-creating phase because restoration is necessary to begin the cycle again (Skovholt & Trotter-Mathison, 2016). Practicing this phase, counselors, especially CITs, may benefit from learning the importance of self-care to maintain an active presence for client after client.

According to Skovholt (2005), the core of the helping profession is to provide the Cycle of Caring repeatedly to different individuals in need in a helpful and skilled way. However, repeatedly performing the cycle is a difficult professional skill to master. Therefore, it is important to monitor counselors' emotional depletion and fatigue from the amount, intensity, and

duration of their effort in listening to pain and distress in the cycle because the essential goal is to prevent compassion fatigue from its early stages and to train resilient counselors.

Review of the Literature

The researcher used the PsycINFO database, which is one of the largest resources devoted to peer-reviewed literature in behavioral science and mental health, to identify related resources examining the concept of compassion fatigue in the counseling literature. The initial research provided almost 700 results; the researcher narrowed results down by limiting publication years between 01/2000 and 01/2017. The researcher then reviewed approximately 50 dissertations and more than 500 article abstracts to choose the most relevant manuscripts to develop the literature review of this study. Eventually, the researcher examined five books, three dissertations, and more than 100 articles to provide an extensive literature review for the reader. The researcher also reviewed the reference lists of most of these selected documents to present an in-depth overview of the topic.

History of Terminology

A review of the literature indicated that various terms and constructs were used to describe a natural consequence of caring of individuals who are in pain, suffering, or traumatized. These constructs include burnout (Freudenberger, 1977; Pines & Maslach, 1978), secondary victimization (Figley, 1988), vicarious traumatization (McCann & Pearlman, 1990), secondary traumatic stress (Figley, 1995), secondary survivor (Remer & Ferguson, 1995), and compassion fatigue (Figley, 1995). Several researchers have used these terms interchangeably, which may imply that scholars still disagree on these labels and constructs (Figley, 2002b; Newell & Nelson-Gardel, 2014). Various scholars have attempted to identify each of the

concepts, including Newell, Nelson-Gardel, and MacNeil (2016), who recently completed a chronological review of terminologies and provided a specific construct timeline.

"There is a cost to caring" (Figley, 1995, p.1), and it usually appears after counselors listen to clients' stories of pain, fear, and suffering again and again. Figley (1995, 2002b) particularly focused on people experiencing an emotional reaction to traumatic events because he asserted that people could be traumatized indirectly by hearing these stories. After reviewing the literature (see Table 1), the researcher identified four widely used constructs to describe the negative reactions of mental health professionals who work with trauma survivors: burnout, vicarious traumatization, secondary traumatic stress, and compassion fatigue. These terms were identified based on the common usage in the literature.

Table 1

Results of the Psycinfo Search for the Related Terminology

Related Concepts	Number of search results on Feb 28, 2017	First mention of the construct	First mention of the construct in the mental health literature
Burnout	11,056	1922	1978
Vicarious traumatization	392	1989	1995
Secondary traumatic stress	547	1986	1995
Compassion fatigue	689	1994	1995

Burnout

Per the PsycINFO database results, the concept of burnout is the oldest term, and described as a loss of will among practitioners (Freudenberger, 1977). Burnout was first mentioned in relationship to the mental health profession in the late 1970s (Pines & Maslach, 1978). Pines and Maslach (1978) investigated characteristics of staff burnout in mental health

settings and found that the longer staff had worked in the mental health field, the less they liked working with clients and the less successful they felt with themselves.

Later, the concept of burnout evolved to describe the exhaustion of individuals' capacity to maintain an intense involvement, which would have a significant impact at work (Schaufeli, Leiter, & Maslack, 2009). Rothschild and Rand (2006) reported that the meaning of burnout differs between countries. For example, the concept of burnout is used as a medical diagnosis in the Netherlands and Sweden, whereas in the U.S. and many other countries, it is a non-medical, socially accepted label used by various professionals. More recently, Mathieu (2012) described burnout as the stress and frustration caused by the workplace. Fundamental reasons for burnout include poor pay, unrealistic demands, heavy workload and shifts, and inadequate supervision (Mathiue, 2012). It is important to note that burnout can happen in any occupation, while other related concepts appear mainly in the relationship-intense fields.

Vicarious Traumatization

In the 1990s, Pearlman introduced the term vicarious traumatization into the literature and stated that counselors working with traumatized clients could indirectly experience the client's emotional traumatic reactions during the process of treatment because of continuing emphatic engagement (Pearlman & Mac Ian, 1995; Newell et al., 2016). Because of this interaction, cognitive changes appear in the counselors' sense of self and worldview (McCann & Pearlman, 1990). Mathieu (2012) described vicarious traumatization as the transformation of practitioner's view of the world because of the cumulative exposure to traumatic images and stories. Additionally, it was claimed that vicarious traumatization is the result of many secondary traumatic stress events (Pearlman & Saakvitne, 1995).

Secondary Traumatic Stress (STS)

Figley introduced the concept of STS into the literature and defined it as "the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other–the stress resulting from helping or wanting to help a traumatized or suffering person" (Figley, 1995, p. 7). In other words, STS is the result of bearing witness to a traumatic event or events, which may lead to post-traumatic stress disorder (PTSD)-like symptoms (Mathieu, 2012). Like the concept of vicarious traumatization, chronic empathic engagement with a client suffering from a traumatic experience may also lead to STS. However, while the emphasis of vicarious traumatization is on the cognitive shifts in thinking, STS focuses on counselor reactions by suggesting counselors may mirror symptoms of PTSD exhibited by their clients, albeit to a lesser degree (Figley, 1995; Newell et al., 2016). It is important to note that one of the diagnostic criteria for PTSD included in the Diagnostic and Statistical Manual of Mental Disorders, 5th. Edition (DSM-5) is "experiencing repeated or extreme exposure to adverse details of the traumatic events" (American Psychological Association, 2013, p. 271). Therefore, hearing or experiencing trauma indirectly may also result in traumatic reactions.

Compassion Fatigue (CF)

The term CF has been used for over 20 years, is user-friendly, and is the most recently used term in the literature (Newell et al., 2016; also see Table 1). Although there was a lack of clarity among concepts, Figley (1995; 2002b) used the term CF in social work literature to describe experiences of those individuals emotionally affected by the trauma of a client or a family member. In his later work, Figley (2002a) expanded the original definition and asserted that CF results in higher levels of helplessness and a feeling of being isolated from a supportive network. This evolving concept was accepted and described as the negative consequences of

working in high-stress settings with trauma survivors with heavy caseloads (Harr, 2013). Simply, CF can be defined as "the profound emotional and physical erosion that takes place when helpers are unable to refuel and regenerate" (Mathieu, 2012, p. 14). CF has also been noted as an occupational hazard in mental health professionals (Figley, 2002b; Merriman, 2015a) because it occurs when counselors continually experience challenges, including exposure to traumatic stories, limited resources, large caseloads, and often minimal support from supervisors (Star, 2013).

Table 2

Symptoms of Compassion Fatigue

Cognitive	Emotional	Behavioral	Spiritual	Relational	Somatic	Work Related
Lowered concentration	Anger	Impatient	Loss of purpose	Withdrawal	Sweating	Low Motivation
Decreased self-esteem	Depression	Irritable	Lack of self-satisfaction	Mistrust	Rapid heartbeat	Avoiding tasks
Apathy	Guilt	Sleep disturbance	Helplessness	Intolerance	Breathing difficulties	Lack of appreciation
Minimization	Numbness	Appetite change	Questioning the meaning of life	Loneliness	Aches	Poor work commitments
Rigidity	Fear	Losing things	Loss of faith in higher power	Increased interpersonal conflicts	Dizziness	Absenteeism

Note. Adapted from "Examples of Compassion Fatigue Burnout Symptoms" by C.R. Figley, 2002b, Treating Compassion Fatigue, p. 7.

Symptoms of compassion fatigue. Researchers reported that counselors experiencing CF might feel a sense of helplessness, hopelessness, isolation, confusion, difficulty concentrating, apathy, anxiety, guilt, anger, fear, sadness, appetite changes, and sleep

disturbances (Eastwood & Ecklund, 2008; Figley, 2002b; Harr, 2013). Table 2 provides an extensive list of CF symptoms based on seven main themes (cognitive, emotional, behavioral, spiritual, relational, somatic, and work related). Given the list of symptoms, addressing these risk factors to promote CITs' professional development and to prevent the negative impact of their counseling performance throughout their training seems necessary. It is also important to become familiar with these symptoms to prevent developing severe forms of CF.

The Concept of Compassion Fatigue in Research

A search of the literature revealed that the most common causes of CF were listed as bearing witness to suffering, having lack of experience, being identified with the clients, having a lack of professional supervision, experiencing unresolved personal trauma, losing clients, having multiple roles, and experiencing personal or non-work-related stressors (Florio, 2010; Portnoy, 2011). The following sections provide detailed study results of related concepts with CF.

Compassion Fatigue Research in Various Cultures and Professions

The term compassion fatigue was developed in the U.S.; however, it has been used across other countries, including Australia (Craigie et al., 2016; Drury, Craigie, Francis, Aoun, & Hegney, 2014), South Africa (Mashego, Nesengani, Ntulli, & Wyatt, 2016), Italy (Rossi et al., 2012), China (Yu, Jiang, & Shen, 2016), Korea (Jang, Kim, & Kim, 2016), Greece (Mangoulia, Koukia, Alevizopoulos, Fildissis, & Katostaras, 2015), Israel (Finzi-Dottan & Kormosh, 2016), and Turkey (Hiçdurmaz & Inci, 2015). Although the term emerged from the social work field, there has been widespread use of the concept in the medical, social sciences, therapeutic, and psychological literature (Figley, 1995). Studies have been conducted with the following main groups: nurses (e.g., Barr, 2017; Duarte & Pinto-Gouveia, 2016), social workers (e.g., Decker,

Brown, Ong, & Stiney-Ziskind, 2015; Thomas, 2013), physicians (e.g., Fernando & Consedine, 2014), police officers (e.g., Turgoose et al., 2017), hospice care givers (e.g., Whitebird, Asche, Thompson, Rossom, & Heinrich, 2013), and counselors (e.g., Beaumont, Durkin, Martin, & Carson, 2016; McKim & Smith-Adcock, 2014). Among these fields, several researchers addressed the confusion about the terminology (e.g., Baird & Kracen, 2006; Newell et al., 2016) and used the terms vicarious traumatization, secondary traumatic stress, and compassion fatigue interchangeably. In addition, some researchers used these terms to define the same variable (e.g., Mangoulia et al., 2015).

Design and Measures

The Compassion Fatigue Self-Test (CFST) and its various iterations are the main assessments used to measure the concept of compassion fatigue. The CTSF was developed by Figley, and the original version was revised many times. The Compassion Satisfaction and Fatigue Test is one of the revised versions of the CTSF and this scale was used in several research studies until the 2000s (e.g., Collins & Long, 2003; Roberts, Flannelly, Weaver, & Rigley, 2003). After this revision, Stamm reviewed and renamed the scale the Professional Quality of Life Scale (ProQOL) in the late 1990s. In various studies, different versions of the measure have been used, including the third, fourth, and fifth editions (Stamm, 2010). These scales included items related to compassion satisfaction, burnout, countertransference, compassion fatigue, secondary traumatic stress, and vicarious traumatization. With the help of research results, the concept has matured. As a result, the ProQOL-Version 5 emerged, and, as noted in Figure 2, currently it includes three main subscales: Compassion Satisfaction, Secondary Traumatic Stress, and Burnout (Stamm, 2010). Additional information regarding the scale is provided in the method section of Chapter 3 (see pp. 42-43).

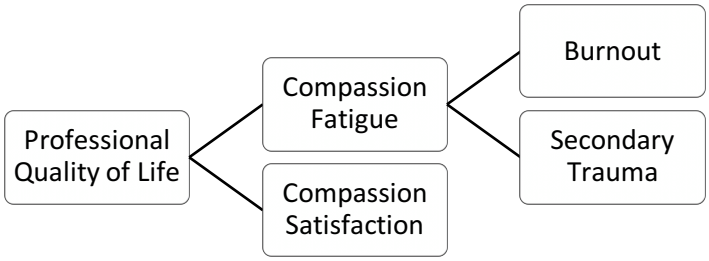

Figure 2. The Diagram of Professional Quality of Life (©Beth Hudnall Stamm, 2010)

There are a limited number of qualitative studies regarding compassion fatigue in the mental health literature. One study was designed to identify and describe the concept of compassion fatigue by conducting focus group interviews with 12 genetic counselors (Benoit, Veach, & LeRoy, 2007). In another study, researchers utilized a mixed methodology design to examine the level of STS, CF, burnout, and compassion satisfaction among social workers, while focusing on how specific organizational factors or peer support could potentially reduce the impact of these phenomena (Caringi, Hardiman, Weldon, Fletcher, Devlin, & Stanick, 2016).

Researchers predominantly conducted studies with quantitative methods regarding compassion fatigue. In these studies, they used the most recent version of ProQOL, or one of the earlier versions (e.g., CTSF; Newell et al., 2016; Turgoose et al., 2017). Per a narrative review of compassion fatigue in mental health professionals, researchers in most studies used correlation and regression analyses to test relationships between compassion fatigue and other variables (Turgoose et al., 2017). Further, group difference analyses such as *t*-tests and analyses of variance were also used, as well as chi-square analysis to investigate the risk of compassion fatigue. In short, many scholars have used qualitative methods to examine the relationship between compassion fatigue and related factors to provide a greater understanding of the concept of compassion fatigue.

Common Variables Related to Compassion Fatigue

Several researchers examined the association between compassion fatigue and other variables. Some of these variables included past traumas in professionals, empathy, high caseload, gender, mindfulness, support, and wellness. In addition, there are many studies assessing the relationship between compassion satisfaction, secondary traumatic stress, burnout, and CF. In this section, I present the most commonly studied variables to compassion fatigue in literature.

Ray, Wong, White, and Heaslip (2013) reviewed the literature and identified four main factors which place mental health professionals working with clients with trauma histories at higher risk for CF. These factors are being empathetic, having a history of traumatic experiences, having unresolved trauma, and assisting in events in which children are involved. Ray and colleagues (2013) also noted additional factors which increase the intensity of the symptoms, including the duration of an experience; a potential for recurrence; whether the worker was exposed to death, dying, or destruction; and the degree of moral conflict. Figley (1995) contributed to this list by addressing feelings of professional isolation, unreciprocated giving and attentiveness, emotional drain from empathizing, and working long hours with few resources.

Gender is one of the factors that has been studied to determine its association with CF. Sprang, Clark, and Whitt-Woosley (2007) examined the relationship between CF and characteristics of mental health professionals and found that female professionals were more likely to exhibit CF. However, this result was inconsistent with gender associations with CF reported by Thompson and colleagues (2014). They found that gender did not contribute significantly to the prediction of compassion fatigue.

Flannelly, Roberts, and Weaver (2005) suggested that another key factor in the development of compassion fatigue is the number of hours spent working with trauma survivors. However, Baird and Jenkins (2003) found no correlation of hours per week of trauma counseling and number of trauma clients with the practitioner's level of compassion, regardless of the work setting.

Researchers also have studied mindfulness as an associated factor with CF. Turgoose and colleagues (2017) stated that mindfulness is associated with lower compassion fatigue. Thieleman and Cacciatore (2014) and Thomas and Otis (2010) measured dispositional mindfulness and mindfulness attitudes in their studies, then reported a relatively strong relationship, suggesting that mindfulness might play an important protective role against compassion fatigue. Additionally, Thieleman and Cacciatore (2014) found an inverse correlation between mindfulness and compassion fatigue among bereavement specialists.

According to Figley's initial theoretical model, experiencing emotional drain from empathizing is one of the leading causes of compassion fatigue (Figley, 1995). MacRitchie and Leibowitz (2010) supported this statement by analyzing 64 self-report questionnaires to explore the psychological impact on trauma workers who worked with victims of violent crimes in South Africa. Researchers specifically focused on the level of exposure to the traumatic material, the level of empathy, the level of perceived social support, and their relation to STS/CF. Results indicated that the trauma workers experience symptoms of STS/CF. It was also noted that participants' level of STS/CF increased as the level of empathy increased. Finally, the study results revealed that past traumas in professionals (in the personal lives of counselors) has a significant relationship with STS/CF (MacRitchie & Leibowitz, 2010).

Setting characteristics and caseload were used as predictive factors of CF in some studies. Sprang, Clark, and Whitt-Woosley (2007) examined the relationship between compassion fatigue, compassion satisfaction, burnout, and provider and setting characteristics among mental health providers (psychologists, psychiatrists, social workers, marriage and family therapists, professional counselors, and drug and alcohol counselors) in a rural southern state. Researchers found that provider discipline is an important factor, with psychiatrists reporting higher levels of CF than their non-medical colleagues. When providers were compared among setting characteristics using rural, urban, and rural with urban influence classifications, providers in the most rural settings reported increased levels of burnout. However, they could not be distinguished from their colleagues on the CF and CS subscales. Finally, researchers stated that the caseload percentage of PTSD clients that clinicians treated predicted their levels of CF and burnout (Sprang, Clark, & Whitt-Woosley, 2007).

There were studies conducted with mental health providers and volunteers after traumatic events such as the Oklahoma City bombing (Wee & Meyers, 2002), the September 11 attacks (Creamer & Liddle, 2005), and Hurricane Katrina (Lambert & Lawson, 2013). These studies explored the relationship between levels of CF, compassion satisfaction, and burnout among practitioners whose exposure to trauma survivors more closely compare to the general provider population outside of the catastrophic event. According to findings, resiliency and self-care strategies minimized CF symptoms (Lambert & Lawson, 2013). Although providing mental health services after a traumatic event may make mental health providers vulnerable to STS and CF, Newell and MacNeil (2010) noted that mental health professionals working with individuals other than trauma victims (such as the mentally ill) might also experience CF without experiencing STS.

Prevalence of Compassion Fatigue among Mental Health Providers

The prevalence of CF (and other related concepts) varies across studies and populations (Miller & Sprang, 2016). According to Adams and Riggs (2008) and Bride (2007), the frequency of CF ranges from 8% to 16% in graduate students and social workers working in diverse fields, whereas the prevalence of CF is over 50% in clinicians treating trauma survivors.

Thompson, Amatea, and Thompson (2014) conducted a comprehensive study with mental health counselors and developed one of the first studies focused specifically on the counseling field. In this study, researchers explored the contributions of counselor gender, years of experience, perceived working conditions, personal resources of mindfulness, use of coping strategy, and compassion satisfaction to predict compassion fatigue and burnout in a sample of 213 mental health counselors in the U.S. Multiple regression analyses revealed that among this sample, perceived working conditions, mindfulness, use of coping strategy, and compassion satisfaction accounted for 31.1% of the variance in compassion fatigue compared to 67% of the variance in burnout scores. It was also noted that the counselors in this study who reported greater compassion satisfaction reported less compassion fatigue. This finding is consistent with previous research (Collins & Long, 2003).

Another study examined CF, burnout, and compassion satisfaction in substance abuse counselors to identify the unique, challenging features of substance abuse service delivery (Perkins & Sprang, 2013). Perkins and colleague conducted interviews with 20 participants. In addition to interviews, participants completed the ProQOL-IV scale to assist in exploring these challenges. After researchers examined the interview transcripts where interviewees scored high on the CF subscale on the ProQOL-IV, two key themes emerged. These themes suggested that working with women is more challenging, and substance abuse counselors who have family

members with addiction problems or themselves are in recovery are more likely to experience CF (Perkins & Sprang, 2013).

Public and nonprofit mental health settings are the default locus of treatment for low-income, and minority patients (Sprang, Clark, & Whitt-Woosley, 2007), and CITs generally practice in these sites (clinics, agencies, hospitals, shelters, etc.) to complete their required hours of direct service for internship courses. Therefore, most of these students are likely to experience exposure to distressed and traumatized clients. Although more experienced counselors may work in the same settings with CITs, experienced counselors with longer tenure in an organization may be engaged in supervisory or administrative activities while newer hires primarily provide direct services (Thompson, Amatea, & Thompson, 2014).

Research among CITs with CF is limited. Star (2013) examined the relationship between self-care practices, burnout, compassion fatigue, and compassion satisfaction among professional counselors and CITs. A total of 253 participants were surveyed using the ProQOL and a self-care assessment worksheet. Results indicated that participants experienced higher levels of burnout and compassion fatigue with greater amounts of recent life changes. Star (2013) also found that burnout and compassion fatigue is significantly related. Additionally, in the United Kingdom, Beaumont and colleagues (2016) examined associations between self-compassion, compassion fatigue, well-being, and burnout in student counselors and student cognitive behavioral psychotherapists using validated quantitative surveys. A total of 54 participants in their final year of study completed four instruments; results revealed that student counselors and student cognitive behavioral psychotherapists who scored high on measures of self-compassion and well-being also reported less compassion fatigue and burnout (Beaumont et al., 2016). Because many mental health providers experience CF, it was concluded that the practice of self-

compassion and wellness might help student practitioners manage compassion fatigue symptoms.

Even though the literature reveals that mental health providers experience CF symptoms on different levels, minimal research has been conducted to examine CITs' level of CF and its relation to predictive variables. Because CITs enter the profession with a desire to help others, some trauma related issues, life stressors, and pressure of training process (education) may lead students to compassion fatigue. Therefore, it is necessary to conduct further CF-related research among CITs in order to address the gap and contribute to the knowledge-base.

Factors Associated with Compassion Fatigue

Empathy

Empathy is one of the important aspects of the counseling process for treatment outcomes; however, there is a lack of consistency in defining the concept. Bayne and Hays (2017) reviewed previous definitions and models of empathy, and categorized the definitions as affective, moral, cognitive, behavioral, and neurological empathy. For example, Bayne and Hays (2017) defined affective (emotive) empathy as identifying with the emotional expression or experience of another person, while cognitive empathy involves the counselor's ability to accurately understand client statements from an objective perspective. Also, researchers defined behavioral empathy as the application of verbal and nonverbal responses that convey understanding to a client (Bayne & Hays, 2017). Despite the differences in these definitions, Okun and Kantrowitz (2008) simply defined empathy as both understanding another individual's emotions and feelings from that person's frame of reference and conveying that understanding.

Although there are differences in conceptualization of empathy, previous research results universally highlighted the importance of it (Bayne & Hays, 2017; Elliot et al., 2011; Watson,

Steckley, & McMullen, 2014). Additionally, empathy helps the counselor to assess the client's problem and formulate a treatment approach. Several researchers found that the therapeutic relationship is a major predictor of the outcome of therapy (e.g., Ardito & Rabellino, 2011; Hill, 2009). Therefore, it is important for clients in therapy to be understood and supported.

When a counselor and client have a strong working alliance, they genuinely like and respect each other (Hill, 2009) because the counselor is empathic and accepts clients as they are. Empathy involves genuinely caring about the client, nonjudgmentally accepting him or her, and communicating with the client in a sensitive and accurate manner (Hill, 2009). Sometimes counselors may feel the same emotions as their clients. O'Brien & Haaga (2015) addressed the challenging position of a mental health provider who is expected "(a) to listen to traumatic self-disclosures well enough to form empathically accurate responses to clients, (b) to keep such self-disclosures and their own emotional reactions to them private, without (c) suffering excessively from compassion fatigue" (p.414). According to Figley (1995), empathy and being exposed to traumatized client experiences are two fundamental reasons for developing compassion fatigue. Although the process of empathizing with a client who experienced trauma may help the counselor to understand the client's experience better, it may also make the counselor vulnerable to compassion fatigue (Figley, 1995).

Empathy and Compassion Fatigue in Research

Empathy has been one of the widely-used concepts to study in relation with CF among various populations. Many researchers who examined the relationship between empathy and CF reported controversial findings. For example, O'Brien and Haaga (2015) compared trait empathy and empathic accuracy with CF after showing a videotaped trauma-self-disclosure among therapist trainees (a combined group of advanced and novice graduate students) and

nontherapists. The Compassion Fatigue Self-Test and the Questionnaire Measure of Emotional Empathy were used to collect data, along with a multiple choice empathic accuracy test. The results showed that the therapist trainees did not differ significantly from nontherapists in their trait empathy scores, while they reported a significantly lower state of CF compared to nontherapists. Thus, results indicated that there was no significant correlation between participants' levels of CF and empathy. It was also noted that Figley's hypothesis, which states the level of CF is largely impacted by the level of empathy, was not supported by the findings.

Some researchers reported significant results related to empathy and compassion fatigue. MacRitchie and Leibowitz (2010) explored the psychological impact on trauma workers whose clients were survivors of violent crimes, focusing on the level of empathy and its relation to CF. The Compassion Fatigue Self-Test was used to measure CF while the Interpersonal Reactivity Index was used to measure empathy. After analyzing the data, results indicated that the level of empathy has a significant relationship with CF in trauma workers.

In Thomas and Otis' (2010) study, researchers examined relationships of mindfulness, empathy, and emotional separation in all aspects of professional quality of life. Surveys included the ProQOL-IV and the Interpersonal Reactivity Index and captured the data from a random sample of licensed social workers. The results suggested that higher levels of empathy scores on several subscales were correlated with lower scores on compassion fatigue. However, these relationships were not significant in the multiple regression models. Researchers concluded that the problem is not about caring for clients or being moved by clients' painful experiences; rather, the risk appears when practitioners care for clients without keeping themselves separate.

Another study explored the relationship between empathy, burnout, STS, and compassion satisfaction using the Empathy Assessment Index and the ProQOL instruments. Among social

work practitioners, the findings indicated a significant relationship between empathy and compassion fatigue. Researchers concluded that empathy might be a factor contributing to the maintenance of well-being (Wagaman, Geiger, Shockley, Segal, 2015).

The many research results reported here suggest that empathy has been used as a concept with an association with CF. Most of the researchers hypothesized that empathy might prevent or reduce CF; however, there are some controversial findings. Therefore, more research is needed to enhance the literature to determine the true nature of empathy and CF relationship.

Supervisory Working Alliance

The concept of therapeutic alliance can be related to Freud's idea of transference, which he described as a special relationship between counselor and client. Several researchers defined it in different ways (Ardito & Rabellino, 2011). For example, Rogers defined it in the early 1950s and identified the components of a therapeutic relationship, also known as a working alliance, as empathy, congruence, and unconditional positive regard (Sharf, 2012). Later, Bordin (1983) proposed a different perspective of the concept of alliance and suggested that there are three main components of a working alliance which have been widely accepted. These components are "(1) mutual agreements and understanding regarding the goals sought in the change process, (2) the tasks of each of the partners; and (3) the bonds between the partners necessary to sustain the enterprise" (Bordin, 1983, p.35). Bordin also stated that a working alliance is not the process of therapy; it is a description of the change process.

In addition to the therapeutic working alliance in a counseling session, the supervisory working alliance has been developed. The Supervisory Working Alliance Model was originally developed by Bordin (1983) as an application of working alliance theory to the supervision process. The supervisory working alliance uses the same components, which are goals, tasks, and

bonds, and applies them to the supervisory relationship. In this model, the supervisor and supervisee must have common goals of supervision. These goals must be established through negotiation during initial supervision sessions. The tasks of supervision must be consistent with the goals, and in this relationship, there must be a common agreement on tasks. The emotional bond between the supervisor and supervisee includes the feelings of liking, caring, and trusting each other. These emotions can be strengthened by sharing the experience of supervision, and the bond provides the support necessary to sustain the work done in supervision (Wood, 2005).

To conduct empirical research with the concept of therapeutic alliance, researchers needed practical ways to measure the concept. As a result, the Working Alliance Inventory (WAI) was developed. The instrument was revised several times, and some of these versions were designed to meet the needs of different clients (adults, children, couples, etc.). There are also application specific forms developed including the Session Form-Client, Session Form-Helper, and Case Manager Form (Horvath & Greenberg, 1989). The Supervisory Working Alliance Form (Efstation, Patton, & Kardash, 1990) also was developed to measure the working alliance in counselor supervision. Researchers believed that overall research on the working alliance between client and counselor may help to reinforce the positive counseling outcomes across settings, populations, and treatment interventions (Duff & Bedi, 2010; Patterson, Anderson, & Wei, 2014).

Supervisory Working Alliance and Compassion Fatigue in Research

Although findings from various studies suggest that supervision and support are related factors to CF, research in this area is still relatively recent, and a coherent picture has not yet been developed. Kapoulitsas and Corcoran (2015) conducted a study and found that a supportive work environment and positive supervision relationship play an important role in developing

resilience among mental health providers. Because supervision is an essential aspect of the counseling profession, the supervision process might be helpful or harmful. In a qualitative study, mental health practitioners reflected on both past and current experiences of supervision; their reports reinforced that supervision has a significant role in reducing CF (Kapoulitsas & Corcoran, 2015). The same study also suggested that participants had a strong need for support, a situation that allowed them to speak openly about their experiences in a safe environment. Researchers concluded that further research regarding supervision in the workplace is needed to provide a greater understanding of what constitutes supportive relationships for practitioners and how positive relationships might reduce CF (Kapoulitsas & Corcoran, 2015).

Organizational support appears to reduce CF, while a lack of support enhances practitioners' and interns' risk of developing CF symptoms (Bride, Jones, & MacMaster, 2007). Bride and colleagues (2007) conducted an exploratory study to examine the relationship between symptoms of CF/STS and the culture of supervision in an organization of child welfare workers. Using the Secondary Traumatic Stress Scale and the Professional Organizational Culture Questionnaire-Social Work, the researchers found that qualitative aspects of supervision are more important than the quantity of supervision in preventing CF. Researchers also concluded that participants with lower levels of STS were more likely to report that supervisors: "(a) are willing to help when problems arise; (b) provide visible, ongoing support for innovative ideas; and (c) provide assistance to enhance quality of services" (Bride et al., 2007, p.41). However, some aspects of the supervisory relationship were not found to be related to the level of STS experienced: supervisors (a) encourage practitioners to be the best they can be, (b) show a genuine concern for workers, and (c) are empathic with work related problems.

In Knight's (2010) exploratory study, social worker students and their field instructors were assessed for CF and protective factors. Results indicated that risk factors for students included age, experience, race, gender, and placement in a child welfare setting. Additionally, it was noted that the protective effects of advance preparation, agency support, agency supervision, and specific education about compassion fatigue was lacking. Students who felt that they could not talk with their field supervisor were at greater risk of CF (Knight, 2010).

Willams, Helm, and Clemans, (2012) conducted research with mental health therapists to examine the effects of the supervisor working alliance and organizational factors on vicarious traumatization. The Supervisory Working Alliance Inventory-Supervisee Form, the Job Satisfaction Survey, and the Trauma and Attachment Belief Scale were used to collect data regarding related variables. Results suggested that the effects of the supervisory working alliance and organizational culture on vicarious traumatization were not statistically significant.

Merriman's (2015a) article "Enhancing Counselor Supervision Through Compassion Fatigue Education" addressed the struggles experienced by CITs; it highlighted the importance of supervision to build skills that prevent compassion fatigue. Merriman (2015a) also noted that there is a need for more qualitative and quantitative research studies focusing on the supervision process along with other protective factors. Although numerous authors have underlined the importance of supervision in preventing CF in mental health professionals, there has been limited research on this concept with CITs.

Resilience

Resilience was originally understood as a personality trait associated with cognitive ability; however, more recently, the concept was redefined and understood as a psychosocial process (Kapoulitsas & Corcoran, 2015). Crowe (2016) listed a few misconceptions regarding

this concept: "resilience is not a personality characteristic, it does not refer to an absence of psychopathology nor is it associated with above average psychological adjustment" (p. 107). Resilience is bouncing back from challenging experiences and not giving up on life (American Psychological Association, 2015). It can also be defined as the ability to overcome challenges through the development of coping mechanisms (Lambert & Lawson, 2013; Walsh, 2002). Because resilience helps individuals cope with negative emotions during stressful situations, many researchers addressed the importance of relationship between resilience and CF in their studies (Fredrickson, 2011).

According to Hodges, Keeley, and Grier (2005), professional resilience progresses over time by turning adversities into growth opportunities, which eventually become part of the individual's identity and core values. Resilient individuals may still experience stress and distress during challenges; however, these symptoms are mild and temporary and will not interfere with individual's long-term functioning (Crowe, 2016). These individuals may also recover quickly after challenging situations while growing stronger. Crowe (2016) also suggested counselors utilize resiliency training regularly, not just when they experience the symptoms of CF.

Resilience and Compassion Fatigue in Research

Resilience has been identified as one of the protective factors to ensure and maintain well-being in counselors (Meyer & Ponton, 2006). Therefore, researchers conducted studies to explore the relationship between resilience and CF. The following studies are some examples from the existing literature which provide a greater understanding of the relationship.

Wood and colleagues (2017) conducted a pilot study to examine the usability, acceptability, and effectiveness of a free Provider Resilience (PR) mobile application (app) to

reduce a practitioner's compassion fatigue. A total of 30 outpatient mental health professionals utilized the app for a month. Based on the analysis on the ProQOL scale, a significant decrease was noted on the CF subscale of the ProQOL, suggesting that the PR app showed promise in reducing CF scores in mental health care providers.

The concept of resilience was used as one of the dependent variables, along with CF, in a study by Tosone, Minami, Bettmann, and Jasperson (2010). They examined the relationship between attachment, classification, resiliency, and CF in mental health providers after 9/11. Researchers used the Adult Attachment Questionnaire, the Connor-Davidson Resilience Scale, and the ProQOL-Revised. There were two main hypotheses: (1) the potential protective factors would be related to lower levels of CF and higher levels of resiliency, and (2) some risk factors would be related to higher levels of CF and lower levels of resiliency. Using hierarchical regression analysis, results revealed that secure attachment is predictive of participants' ability to cope with CF, as well as their capacity for resilience, explaining approximately 7% of the variance in both compassion fatigue and resilience. It was also found that secure attachment is highly predictive of participants' ability to cope with CF. In other words, attachment contributes to resilience as well as resistance to CF.

In addition to the Tosone et al. (2010) study, Lambert and Lawson (2013) examined the association between the posttraumatic growth, professional resilience, and secondary trauma of professional counselors who assisted clients affected by Hurricanes Katrina and Rita. Researchers hypothesized finding higher levels of posttraumatic growth and professional resilience among participants who were not affected by the storms than among professional counselors who were affected. Several scales were used to collect data: the ProQOL-R-III, the Posttraumatic Growth Inventory, the K6+ (screen for severe mental illness), and a brief self-care

assessment. The ProQOL-R-III was used to measure professional resilience in this study. According to their findings, the individuals who responded to Hurricanes Katrina and Rita disasters reported that they experienced more than double the rate of CF than their counterparts. One study result revealed that mindfulness-based interventions can be used as a way of increasing an individual's resilience and well-being to cope with CF symptoms. Crowder and Sears (2017) investigated differences in practitioners' levels of stress, resilience, and burnout after a mindfulness-based intervention, compared to a wait-list group. This mixed-method study was conducted with 14 participants in Canada. Results suggested that the Mindfulness-Based Stress Reduction program is a promising approach to reducing stress in mental health providers and strengthening resilience through increasing self-compassion and reducing perceived stress, CF, and risk of burnout.

Kapoulitsas and Corcoran (2015) conducted a qualitative study using semi-structured interviews in Australia to attain a greater understanding of social workers' experience of working with distressed clients. Researchers examined what contributes to developing personal, professional, and organizational resilience and explored ways in which participants can be better protected from CF. After conducting interviews with six mental health providers, the researchers used thematic analysis and identified four major themes: (a) the complexities of social work, (b) supportive and unsupportive contexts, (c) promoting personal well-being/self-protection, and (d) resilience as a changing systemic and complex process. Researchers concluded that a supportive supervision played a vital role in developing resilience among participants.

The results of the Kapoulitsas and Corcoran (2015) study emphasize the importance of counselor resilience in coping with CF symptoms. However, these studies have been conducted in various cultures and used different approaches to examine the relation between resilience and

CF. For example, only one of these studies utilized a resilience scale to measure the concept of resilience, whereas others used related factors (e.g. self-compassion, quality of life, etc.) to measure it. Additionally, Skovholt and Trotter-Mathison (2016) wrote a book called *The Resilient Practitioner* to address the importance of resiliency preventing burnout and CF. Nevertheless, there is not sufficient empirical research results regarding the relation between resilience and compassion fatigue. Therefore, in this study, the researcher's goal was to fill this gap by using the Brief Resilience and ProQOL scales to assess participants' resilience and its association with CF.

Wellness

The term wellness originated in the mid-17th century and has subsequently been defined and reviewed by several scholars (Granello, 2013). Many conceptualizations of wellness, including the World Health Organization (2006)'s definition, emphasize that wellness is not the absence of illness or disease; it is a state of complete physical, mental, and social well-being. Roscoe (2009) reviewed components of nine different wellness theory models (e.g., Greenberg, 1985; Renger et al., 2000) and concluded that an integrated definition of wellness had not been created. However, some similarities were noted among definitions. Social, emotional, physical, intellectual, and spiritual dimensions of wellness were the ones which were commonly used to define wellness by all nine models/theories.

The concept of wellness also has a long history in the counseling field. Myers (1992) stated that wellness is the central paradigm for counseling and development. Further, the Wheel of Wellness was developed to identify essential components of wellness (Myers, Sweeney, Witmer, 2000). Five categories with subscales were determined as necessary to wellness: spirituality, self-direction, work and leisure, friendship, and love. The empirical research on

wellness continued to provide a better understanding of the multidimensional nature of holistic wellness. Thus, a new model, the Invisible Self Model of Wellness, emerged and included the following aspects: creative self, coping self, social self, essential self, and physical self (Myers & Sweeney, 2008; Myers, Sweeney, & Witmer, 2000).

The concept of wellness is also essential for positive psychological movement (Seligman, Steen, Park, & Peterson, 2005; Roscoe, 2009). Keyes (2007) stated that curing mental illness does not guarantee a mentally healthy population because focusing on the problem only reduces mental illness but does not promote mental health. Flourishing is a positive psychology concept and has been used as a measure of overall life well-being (Dunn & Dougherty, 2008; Fredricson & Losada, 2005; Seligman, 2011). Keyes (2007) identified 13 dimensions to describe flourishing under three main themes: (1) positive emotions, (2) positive psychological functioning, and (3) positive social functioning. Research on well-being and flourishing has evolved. Seligman (2011) developed a well-being theory in which he asserted that human flourishing consists of five elements, including positive emotion, engagement, relationship, meaning, and accomplishment.

The concepts of wellness and well-being have been used interchangeably, and several instruments were developed to measure these concepts. The Five Factor Wellness Inventory (5-F WEL) was developed to measure total wellness for research and clinical purposes (Lawson & Myers, 2011). The instrument has been used to measure wellness of counseling students (Roach, 2005; Stalnaker-Shofner & Manyam, 2014), professional counselors (Jang, Lee, Puig, & Lee, 2012), and counselor educators (Wester et al., 2009). Diener and colleagues (2010) developed the Flourishing Scale, which measures several identified universal human psychological needs related to well-being (e.g., meaning, engagement, optimism, etc.). The scale has been validated

in different cultures (Singh, Junnarkar, & Jaswal, 2016; Tang, Duan, Wang, & Liu, 2016; Villieux, Sovet, Jung, & Guilbert, 2016) and used with various concepts to measure the relationship between well-being and other variables (e.g., self-esteem, self-compassion, emotional self-efficacy, etc.) (Akin & Akin; 2015; Dogan, Totan, & Sapmaz, 2013). The PERMA-profiler is the most recent measurement of flourishing (Hone, Jarden, Schofield, & Duncan, 2014). Researchers have been using the PERMA-model in their studies to determine the applicability of the concept to different cultures (e.g., D'raven & Pasha-Zaidi, 2015; Solano & Cosentino, 2016).

Wellness and Compassion Fatigue in Research

Researchers have studied the prevalence of compassion fatigue among various populations, and, in some of them, the concept of wellness was used to explore its association with compassion fatigue. Researchers generally used three related concepts, including wellness, well-being, and self-care, to examine the relationship between wellness and CF. Some researchers studied the effectiveness of using mindfulness and self-care interventions to prevent CF.

Lawson and Myers (2011) conducted a study with a national sample of 506 professional counselors using the 5F-WEL and ProQOL instruments to address counselor wellness in relation to professional quality of life and career-sustaining behaviors. They found total wellness scores were negatively correlated with CF subscale scores. They also noted that counselors who scored higher on the 5F-WEL tended to have a lower percentage of high-risk clients and engaged in more career-sustaining behaviors.

Williams, Helm, and Clemens (2012) studied the personal wellness, childhood trauma, supervisory working alliance, and organizational factors on vicarious traumatization. A total of

131 participants included social workers, marriage and family therapists, professional counselors, psychologists, and unlicensed professionals from various community mental health centers in the Rocky Mountain region of the United States. Personal wellness was measured by the 5F-WEL scale while the vicarious traumatization was measured by the Trauma and Attachment Belief Scale. Results revealed that personal wellness had a significant effect on vicarious traumatization.

Killian (2008) was interested in designing a mixed method study of CF, burnout, and self-care in counselors working with trauma survivors. After conducting semi-structured interviews with 20 clinicians and a survey administration with 104 clinicians, Killian found that counselors' self-care practices included processing with peers/supervisor, spirituality, exercise, and spending time with family. However, specific self-care strategies were not significant factors in the multiple regression models on participants' CF scores.

In another study, a mindfulness-based intervention was utilized to reduce CF and improving emotional wellbeing in nurses (Craigie et al., 2016). The intervention included a one-day CF prevention workshop, followed by weekly mindfulness training seminars. A total of 21 participants completed measurements at three different times: pre, post, and one-month follow-up. Results revealed that the intervention was not significant in reducing CF scores or improving well-being among participants.

All the studies mentioned previously involved experienced practitioners. However, Beaumont and colleagues (2015) conducted research studies that involved CITs. Beaumont and colleagues (2015) assessed the relationship between self-compassion, CF, burnout, and well-being among a total of 54 student counselors and cognitive behavioral psychotherapists in their final year of study in United Kingdom. The ProQOL and short Warwick and Edinburgh Mental

Well-being Scale were used to measure CF and well-being respectively. Results revealed that participants who reported high on the well-being and self-compassion reported less CF and burnout.

As these findings suggest, the concept of wellness seems related to CF; however, there is a lack of research on this topic with CITs. Because research in this area is still relatively new, wellness may be conceptualized and measured differently in each study; therefore, there is still a need for further studies in the field of counseling. This study intends to enhance the literature by providing empirical data regarding the association between well-being and compassion fatigue among CITs.

Summary

Compassion fatigue is a byproduct of the helping professions; counselors are likely to develop CF from continual exposure to hearing painful stories and trauma narratives of clients. Novice counselors and CITs especially may be more vulnerable compared to experienced counselors because they may not yet have developed coping skills to overcome CF symptoms (Skovholt & Trotter-Mathison, 2016) In this study, the researcher explored the relationship between CF and its predictive factors, including empathy, supervisory working alliance, resilience, and wellness. These variables have been chosen to examine in relation to CF because these concepts are the ones that have been widely used in various studies across populations and cultures (Newell et al., 2016).

This chapter provided a theoretical orientation guiding the study along with an overall review of literature of CF. Specifically, the researcher reviewed the history of terminology and presented related study results regarding the concept of CF. Four main study variables—

empathy, supervisory working alliance, resilience, and wellness—were then introduced and their relationships with the concept of CF were reviewed by providing related study results.

CHAPTER III: RESEARCH DESIGN AND METHODOLOGY

In this study, I aimed to examine the relationship between empathy, supervisory working alliance, resilience, wellness, and compassion fatigue with CITs. An additional goal of this study was to examine the degree to which empathy, supervisory working alliance, resilience, and wellness predict levels of compassion fatigue among CITs. In this chapter, I present the following sections: research questions, research design, participants, data collection procedures, survey instruments, data analysis, assumptions, and limitations.

Research Questions

In the present study, I sought to answer the following research questions:

1. What is the level of compassion fatigue among CITs?
2. What are the relationships among empathy, supervisory working alliance, resilience, wellness, and compassion fatigue in CITs?
3. Do empathy, supervisory working alliance, resilience, and wellness significantly predict levels of compassion fatigue?

Research Design

A non-experimental correlational research design was employed to examine the relationship between the independent variables (empathy, supervisory working alliance, resilience, and wellness) and the dependent variable (compassion fatigue). A correlation analysis and hierarchical multiple regression analysis were conducted to examine the relationship among these variables.

Participants

Sample

The sample collected for this study consisted of master's level counseling students enrolled in an internship class at a U.S.-based college or university. Convenience sampling was utilized to recruit participants, 18 years of age or older, from counseling programs at public or private institutions across the country. Additionally, participation was voluntary and anonymous.

Data Collection

Prior to data collection, the researcher solicited and obtained permission from the Texas A&M University-Corpus Christi Institutional Review Board (IRB) to collect research data with human participants. After receiving IRB approval, data was collected from several counselor training departments during the 2017 summer and fall semesters. Participants were recruited from different institutions through the researcher contacting professional colleagues at various departments to disseminate the survey link to potential participants.

Through the online survey link, participants received a detailed information sheet regarding the study. In the information sheet, I invited volunteer students to participate in a study about compassion fatigue; participants were asked to review the information sheet prior to filling out survey instruments. Participants were informed their participation was completely voluntary and anonymous, and there were no right or wrong answers for any of the questions asked. Students with questions or concerns regarding the study were encouraged to contact me or my advisor directly. The survey link included an information letter, demographic form, and copies of the Brief Resilience Scale, the Flourishing Scale, the Interpersonal Reactivity Index, the Supervisory Working Alliance Inventory: Trainee Form, and the Professional Quality of Life Scale. The entire process took participants approximately 15-20 minutes to complete.

I also recruited participants through professional and program listservs. If required by the listserv administration, I obtained permission before emails were sent out on the listserv

requesting participation. After I received permission, an email containing a link to the website hosting the survey was sent out through listservs requesting voluntary participation in the study. Thus, listservs participants were also provided with the same informed consent and survey package through a secure website.

Instrumentation

I used self-administered surveys as the sources for obtaining information about the participants. I specifically used a demographic sheet and five instruments including the Professional Quality of Life Scale (ProQOL; Stamm, 2010), the Interpersonal Reactivity Index (Davis, 1983), Supervisory Working Alliance Inventory: Trainee Form (SWAI-T; Efstation et al., 1990), the Brief Resilience Scale (BRS; Smith et al., 2008), and the Flourishing Scale (FS; Diener et al., 2010).

Demographic Questionnaire

A demographic questionnaire was designed to collect data related to participants' age, gender, ethnicity, enrolled program (e.g. Clinical Mental Health Counseling, School Counseling, Addiction Counseling, etc.), program accreditation status (CACREP or not), internship site (e.g. school, community mental health setting, etc.), experience working with doctoral level student supervisor, and personal experience about previously seeking therapy.

Professional Quality of Life Scale (ProQOL)

The ProQOL is designed to measure positive and negative effects of working with people who have experienced extremely stressful events (Stamm, 2010). This Likert-type self-report assessment consists of 30 questions; each question includes five potential responses. Response options are *never, rarely, sometimes, often,* and *very often.* A sample item is "I feel depressed because of the traumatic experiences of the people I [help]." This assessment has 10 questions

per each of three main scales measuring separate constructs, while the compassion fatigue scale is distinct.

Figley originally developed the Compassion Fatigue Self-Test in the late 1980s; later collaborations with Stamm resulted in the adding of the compassion satisfaction subscale. There were several versions of the instrument until the measure shifted entirely to Stamm in the late 1990s, and the new name became the Professional Quality of Life Scale (ProQOL). The ProQOL was developed in English and then translated into other languages such as French, German, and Spanish (Stamm, 2010).

The ProQOL includes two main traits, the positive (compassion satisfaction) and the negative (compassion fatigue). Compassion satisfaction is about the pleasure you derive from being able to do your work well (Stamm, 2010). According to ProQOL screening results, the average score is 50; approximately 25% of people score higher than 57 and 25% of people score below 43 (Stamm, 2010). Higher scores on this scale symbolize a greater satisfaction related to individual's ability to be an effective caregiver in the job.

Compassion fatigue is comprised of two subscales: secondary traumatic stress (STS) and burnout (BO). STS is a negative feeling driven by fear and work-related trauma. Individuals develop problems due to exposure to others' trauma when they care for those who have experienced extremely stressful events (Stamm, 2010). According to ProQOL screening results, higher scores do not mean that an individual does have a problem; it is an indication that the individual may want to examine how she feels about her work and her work environment.

The second part of the compassion fatigue is BO, which is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively (Stamm,

2010). These feelings can be related to a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

There are three steps to calculate the scores on the ProQOL. The first step is to reverse some items (1, 4, 15, 17 and 29). The second step is to sum the items by subscale, and the third step is to convert the raw scores into a *t*-score. To calculate compassion fatigue scores, the researcher summed up the scores of STS and BO subscales. According to Stamm (2010), the ProQOL has a good construct validity as its efficacy has been reported in 200 published articles. Finally, the respective Cronbach's alpha values for the BO, STS, and CS scales were .75, .81, and .88 (Stamm, 2010).

Interpersonal Reactivity Index (IRI)

Davis (1983) developed the Interpersonal Reactivity Index to measure reactions of a person to the observed experiences of another individual. The IRI measure has four subscales: (a) perspective taking, (b) fantasy, (c) empathic concern, and (d) personal distress, with seven items in each subscale (Davis, 1983) Each subscale reports a separate score; there is no total score for the instrument. For the purpose of this study, only the empathic concern subscale was used to collect data regarding empathy scores of CITs and measure the construct of empathy. The higher scores on this subscale indicates the greater level of empathy.

Empathic concern is defined as assessing "other-oriented" feelings of sympathy and concern for unfortunate others on the IRI (Davis, 1983, p.114). The 7-item subscale is a self-report assessment with a 5-point Likert-type scale, ranging from "Does not describe me well" to "Describes me very well." Two out of seven items are reverse scored, and the scale scores are computed by summing the scores on all seven items. Sample questions include "I often have tender, concerned feelings for people less fortunate than me" and "I am often quite touched by

things that I see happen." Alpha coefficient for empathic concern subscale was reported .77 (Péloquin & Lafontaine, 2010).

Supervisory Working Alliance Inventory: Trainee Form (SWAI-T)

Efstation and colleagues (1990) developed the SWAI-T, which is a scale that includes 19 items and measures trainees' perceptions of the effective working relationship with their supervisors. The SWAI-T is a self-report assessment with a 7-point Likert-type scale. Responses range from *almost never* to *almost always*. A sample item is "My supervisor helps me talk freely in our sessions." The SWAI-T has two subscales: Client Focus and Rapport. Client focus is a 7-item subscale that measures the emphasis supervisors place on client issues, while the 12-item Rapport subscale measures the effectiveness of the supervisor in developing a rapport with the trainee (Efstation et al., 1990). Efstation et al. (1990) reported a Cronbach alpha coefficients of .77 and .90 for the Client Focus and Rapport scales, respectively. Some researchers found that these two subscales are highly correlated; thus, the researchers combined them in their studies (e.g., Ganske, 2007; White & Queener, 2003). Therefore, in this study, after conducting a correlation analysis with the subscale scores, I also chose to combine subscales as the results of subscale scores were highly correlated.

Brief Resilience Scale (BRS)

The BRS was designed to measure an individual's ability to overcome difficult situations (Smith et al., 2008). The BRS is a 6-item self-report assessment with a 5-point, Likert-type scale. Response options are *strongly disagree*, *disagree*, *neutral*, *agree*, and *strongly agree*. Possible scores range from six to 30, and high scores indicate greater resilience. Individuals respond to statements such as "I have a hard time making it through stressful events." The initial study

demonstrated strong convergent and discriminant predictive validity (Smith et al., 2008). Finally, Smith et al. (2008) reported internal consistency estimates ranging from .80 to .91.

Flourishing Scale (FS)

The FS was designed to measure individuals' self-perceived success in relationships, self-esteem, purpose, and optimism; it provides a single psychological well-being score (Diener et al., 2010). The FS is an 8-item self-report assessment with a 7-point, Likert-type scale (Diener et al., 2010). Response options are *strongly disagree*, *disagree*, *slightly disagree*, *neither agree nor disagree*, *slightly agree*, *agree*, and *strongly agree*. Possible scores vary from eight (lowest possible) to 56 (highest possible). Higher scores indicate an individual with many psychological strengths and resources (Diener et al., 2010). Individuals respond to statements such as "I am optimistic about my future." Several studies confirmed the validity and reliability of the FS with different populations (Dogan, Totan, & Sapmaz, 2013; Hone, Jardern, & Schofiled, 2014; Khodarahimi, 2013). Wirtz, Oishi, and Biswas-Diener (2010) reported moderately high reliability with a .87 Cronbach's alpha coefficient.

Data Analysis

Statistical Power Analysis

To determine the appropriate sample size for this study, an a priori power analysis using G*power was conducted. Based on an alpha of .05, a power level of .90, and four predictors (Faul, Erdfelder, Buchner, & Lang, 2009), the calculation revealed that 73 participants were required to find statistical significance with at least a moderate size effect (.15).

Preliminary Analysis

I analyzed all data using the Statistical Package for the Social Science, Version 20 (SPSS; IBM Corporation, 2011). Prior to addressing research questions, I reversed the coding of the

needed items and checked data for possible entry errors and missing data. There were random missing values, and I replaced them using the series of mean function within the SPSS (IBM Corporation, 2011). Next, I calculated the Cronbach's alpha scores for each instrument to address internal consistency. Before performing the correlation and hierarchical regression analyses, I also tested necessary model assumptions.

Primary Analysis

Research Question 1: What is the level of compassion fatigue among CITs?

Descriptive statistics were calculated to organize the data by producing means, mode, median, standard deviations, and minimum and maximum scores for the study variables (Creswell, 2014). Specifically, descriptive statistics of compassion fatigue variable were reviewed, and results were reported to address the first research question. Descriptive statistics were also utilized to summarize the demographics of the participants.

Research Question 2: What are the relationships among empathy, resilience, wellness, supervisory working alliance, and compassion fatigue in CITs?

A correlation analysis was conducted to test for relationships between the study variables. These variables included the results of the instrumentation on empathy, supervisory working alliance, resilience, wellness, and compassion fatigue. The correlation analysis produced a Pearson product moment correlation coefficient that measured the strength and direction of relationship that exists between two variables (Dimitrov, 2013). Four main assumptions need to be met to produce a valid result: (a) variables should be measured on at least an interval scale, (b) there is a linear relationship between two variables, (c) there should be no significant outliers, and (d) the variables should be approximately normally distributed. To test all assumptions, the scatterplot was checked for significant outliers and a linear relationship between two variables.

Also, the Shapiro-Wilk test of normality was reviewed. Then the SPSS output about correlation was reported.

Research Question 3: **Do empathy, supervisory-working alliance, resilience and wellness significantly predict levels of compassion fatigue?**

A hierarchical multiple regression was conducted to answer this question. First, the following model assumptions were checked: (a) dependent variable should be measured on a continuous scale, (b) more than two independent variables should be either continuous or categorical, (c) independence of residuals, (d) linear relationship, (e) homoscedasticity, (f) multicollinearity, (g) no significant outliers, and (h) the residuals (errors) should be approximately normally distributed (Field, 2013). To test the assumption of independence of residuals, I used the Durbin-Watson test. Linearity and homoscedasticity were assessed through standardized residual plots. I checked for normality by inspecting histograms and descriptive statistics. To identify outliers, I examined boxplots. To assess for multicollinearity, I examined the correlation matrix of the variables. After determining that none of the model assumptions have been violated, a hieratical multiple regression analysis was conducted.

With hierarchical multiple regression, I entered variables into the regression equation one at a time, in an order determined by me in advance based on previous knowledge or theory (Can, 2017). Keith (2015) and Can (2017) stated that the change in variance accounted for by each independent variable depends on the order of entry of the variables in the regression equations. Because the order of entry makes a big difference in results, variables may be entered in order of actual time precedence, logic, or previous research results (Keith, 2015). In this study, the predictor variables were empathy, supervisory working alliance, resilience, and wellness. The criterion variable is the scores of compassion fatigue of the participants.

A three-step hieratical multiple regression analysis was performed to assess the relationship between variables among CITs (see Table 3). In the first step, empathy was entered as a predictor variable because Figley (1995), the developer of the concept of compassion fatigue, asserted that empathy is one of the main factors to lead compassion fatigue. In the second step, the supervisory working alliance was entered into the equation because many researchers addressed the importance of the supervisory support (e.g., Knight, 2010; Miller & Sprang, 2016). In the last step, the resilience and wellness scores of the participants were entered into the equation because there are limited empirical research findings on the relationship between these variables and CF (e.g., Beaumont et al., 2015; Kapoulitsas & Corcoran, 2015).

Table 3

Block Entry of Variables Predicting Compassion Fatigue (Criterion Variable)

Block	Predictor Variables
1	Empathy
2	Supervisory Working Alliance
3	Resilience & Wellness

Summary

In this explanatory, non-experimental, correlational design study, I aimed to examine the relationships between empathy, supervisory working alliance, resilience, wellness, and compassion fatigue among CITs. This chapter outlined the research questions, participants, instrumentation, data collection, and data analysis procedures. The instruments which were used to measure the study variables were the Brief Resilience Scale, the Flourishing Scale, the Interpersonal Reactivity Index, the Supervisory Working Alliance Inventory: Trainee Form, and the Professional Quality of Life Scale. Additionally, I computed descriptive statistics and

performed a correlation and a three-step hieratical multiple regression analysis to analyze the collected data.

CHAPTER IV: RESULTS

In this chapter, I present the results of statistical analyses examining the relationship between empathy, supervisory working alliance, resilience, wellness, and compassion fatigue with counselors-in-training (CITs). Prior to addressing the research questions established for this study, a description of the various preliminary analyses conducted is presented. This includes efforts made to clean the data set, address potential missing data, and evaluate model assumptions associated with planned statistical analyses. Next, demographic information pertaining to the sample used are presented along with psychometric data related to the instruments used among this sample. Finally, I address the three research questions and reported results to define the relationship between the study variables.

Data Cleaning Steps

A total of 114 CITs initially agreed to participate in this study. Prior to addressing the research questions, I inspected the data set for possible entry errors and missing data. The results of this inspection revealed that 28 participants failed to complete at least one entire scale included in the survey packet presented to participants. Consequently, these participants were excluded from all subsequent data analyses. This deletion resulted in a reduced sample of 86 CITs. Among this sample, a total of 20 missing values were noted in participants' responses to items across all scales used, resulting in a missing value percentage of .003% (20 of 6,020 items). Considering this small percentage (.003%), missing values were imputed using the series mean function found in the SPSS statistical software program (version 20) as recommended by Parent (2013).

Tests of Model Assumptions

Several statistical model assumptions needed to be tested before running the planned analyses addressing my stated research questions. The first assumption is normality. In the present study, the assumption of normality was tested through visual inspection of histograms (frequency distributions) and descriptive statistics. The histograms showed compassion fatigue data following a normal distribution while distributions for the empathy, supervisory working alliance, resilience, and wellness variables were abnormal. Specifically, compassion fatigue scores were positively skewed while score distributions for each of the other variables were negatively skewed. Additionally, compassion fatigue was more symmetric than others, with a skewness score of .19. Skewness scores for empathy and resilience were -.51 and -.74 respectively. For supervisory working alliance and wellness, I considered skewness to be more substantial. The distribution of scores for supervisory working alliance and wellness were highly skewed, with scores greater than one (-1.26 and -1.39) respectively. However, Ghasemi and Zahedias (2012) stated that violation of the normality assumption should not cause major problems with large enough sample sizes (greater than 30 or 40). In these cases, they contend that parametric procedures can be used even when data is not normally distributed. Given the sample in the present study consisted of 86 CITs, I deemed the sample to be sufficient for addressing research questions using parametric analyses.

Additional model assumptions specific to correlational designs also were tested. First, I assessed all variables to ensure they were being measured on at least an interval scale and no significant outliers were present. With no outliers identified and data appropriately scaled, I then inspected scatter plots to evaluate the assumption of linear relationships between variables. The

result of this visual inspection indicated no evidence suggesting the assumption had been violated. Therefore, I considered the dataset appropriate for correlational analysis.

Model assumptions specific to multiple linear regression also were tested. First, I examined study variables based on their types and concluded that all study variables were measured on a continuous scale. I then assessed the normality of the dependent variable by inspecting the results of a Shapiro-Wilk test. The Shapiro-Wilk test of normality ($W > .05$) indicated the data to be normally distributed for the dependent variable. To identify outliers, I examined boxplots. Although there were a few mild outliers, no extreme score was detected. Then, linearity and homoscedasticity were assessed through inspection of standardized residual plots. To assess for the assumption of multicollinearity, I examined the correlation matrix of the variables performed by scanning a correlation matrix including all predictor variables to determine if any correlated very highly. According to Field (2013), correlations above .80 are considered high and may indicate the presence of multicollinearity. In the present study, none of the correlation coefficients were above .80. Collectively, these findings indicated no evidence suggesting any of the model assumptions had been violated. As a result, the dataset was deemed appropriate for analysis using a hierarchical regression design.

Demographic Information

The sample was comprised of participants from diverse racial and ethnic backgrounds, including White (n = 48, 55.8%), Hispanic/Latino (n = 18, 20.9%), Black/African American (n = 12, 14.0%), Asian (n = 5, 5.8%), and other (n = 3, 3.5%). Regarding gender, the sample was composed of 78 female (90.7%) and eight male (9.3%) participants. The mean age of the participants was 32.89 years (SD = 9.72*; Mdn* = 29.50) with participants' ages ranging between 21 and 62 years. Two participants failed to respond to this demographic query. Participants

reported their program enrollment as follows: clinical mental health counseling program (*n* = 47, 54.7%); school counseling program (*n* = 23, 26.7%); marriage, couple, and family counseling program (*n* = 4, 4.7%); college counseling and student affairs program (*n* = 3, 3.5%); addiction counseling program (*n* = 2, 2.3%); and other programs (*n* = 7, 8.1%). Additionally, 84.9% of the participants (*n* = 73) reported enrollment in a CACREP accredited program compared to 15.1% of the participants (*n* = 13) who reported enrollment in a non-CACREP accredited program. Participants reported their internship sites as being school (*n* = 33, 38.8%), agency (*n* = 15, 17.6%), community mental health facility (*n* = 13, 15.3%), and hospital (*n* = 8, 9.4%) based. One participant failed to respond to this demographic query. Regarding working with a doctoral student supervisor, 55.8% of the participants (*n* = 48) did not work with a doctoral student supervisor while 44.2% of the participants (*n* = 38) reported working with at least one. Finally, the majority of participants (*n* = 65, 75.6%) had a personal experience seeking counseling. Table 4 provides a visual representation of the demographic data for this sample.

Table 4

Distribution of Demographic Variables

Variable		n	Frequency	Percentage
Age		84		
	20-29		42	50.0%
	30-39		22	26.2%
	40-49		15	17.8%
	50-59		4	4.8%
	60-69		1	1.2%
Gender		86		
	Female		78	90.7%
	Male		8	9.3%
Ethnicity		86		
	White		48	55.8%
	Hispanic/Latino		18	20.9%

Variable		n	Frequency	Percentage
Ethnicity				
	Black/African American		12	14.0%
	Asian		5	5.8%
	Other		3	3.5%
Program		86		
	Clinical Mental Health Counseling		47	54.7%
	School Counseling		23	26.7%
	Marriage, Couple, and Family Counseling		4	4.7%
	College Counseling and Student Affairs		3	3.5%
	Addiction Counseling		2	2.3%
	Other		7	8.1%
Internship Site		85		
	School		33	38.8%
	Agency		15	17.6%
	Community Mental Health Facility		13	15.3%
	Hospital		8	9.4%
	Other		16	18.8%
Program Accreditation Status		86		
	CACREP		73	84.9%
	Non-CACREP		13	15.1%
Experience Working with a Doctoral Supervisor		86		
	Yes		38	44.2%
	No		48	55.8%
Personal Experience Seeking Counseling		86		
	Yes		65	75.6%
	No		21	24.4%

Reliability

Cronbach alpha coefficients were calculated for the ProQOL, IRI, SWAI-T, FS, and BRS to assess their internal consistency when utilized with the current sample of CITs. For the three subscales of the ProQOL, alpha coefficients were computed as follows: BO α = .72, STS α = .79, and CS α = .87. The Cronbach alpha values for each subscale are slightly lower than those reported by Stamm (2010) with a difference of .03 for BO, .02 for STS, and .01 for CS. Internal

consistency for the IRI's emphatic concern subscale based on the present sample's responses is .80, slightly higher than the .77 reported by Péloquin and Lafontaine (2010). The Cronbach alpha values for the subscales of the SWAI-T are excellent (CF α = .90 and R α = .93). These values are higher than the values Efstation et al. (1990) reported in their study (CF α = .77 and R α = .90). The Cronbach alpha values for the FS and BRS are moderately high as follows: FS α = .86 and BRS α = .89, similar to the values Wirtz, Oishi, and Biswas-Diener (2010) reported in their study. Also, Smith et al. (2008) reported internal consistency estimates for the BRS ranging from .80 to .91, lower than the one calculated for the present study based on participants' responses.

Descriptive Statistics of Primary Study Variables

In this section, descriptive statistics are presented for the primary study variables of compassion fatigue, empathy, supervisory working alliance, resilience, and wellness (Table 5). Compassion fatigue is the dependent (outcome) variable of this study and was measured by using the ProQOL. Compassion fatigue scores of CITs represent the sum of scores of all items on the secondary traumatic stress (STS) and burnout (BO) subscales. According to the ProQOL administration manual (2010), individuals scoring below 22 may indicate little or no issues with BO and STS, whereas scores above 42 may be associated with increased levels of BO and STS. In the present study, participants' BO scores ranged from 12 to 32 with a mean of 21.34 (*SD* = 4.38), indicating an overall low risk of BO. In terms of STS, scores ranged from 10 to 38 with a mean of 20.14 (*SD* = 4.96), indicating low risk of STS.

Empathy, supervisory working alliance, wellness, and resilience represent the independent (predictor) variables used in this study. Empathy was measured utilizing the empathic concern subscale of the IRI. Empathy scores on the IRI can range from 0-28; however, neither a cut-off score nor set of norms to interpret scores are available (Konrath, 2013). In this

study, participants' total scores for empathy ranged between 9-28, with a mean of 21.86 (*SD* = 4.12).

Table 5

Descriptive Statistics of the Study Variables (n = 86)

			Range			
Variable	M	SD	Min	Max	Skew	α
Compassion Fatigue	41.48	8.03	22	60	.19	
BO	21.34	4.38	12	32	-	.72
STS	20.14	4.96	10	38	-	.79
Empathy	21.86	4.12	9	28	-.51	.80
Supervisory Working Alliance	5.82	.97	2.16	7	1.26	
CF	6.65	1.30	2.17	8.17	-	.90
R	5.8	.96	2.33	7	-	.93
Resilience	3.43	.79	1	4.67	-.74	.89
Wellness	47.58	6.23	27	56	-1.39	.86

Supervisory working alliance was measured by the SWAI-T scale. The SWAI-T has two subscales: rapport and client focus. To calculate the rapport and client subscale scores, items 1-12 were summed and then divided by 12; and items 13-19 were summed and divided by 7, respectively. In a previous study, Ganske (2007) found these two subscales to be highly correlated and chose to combine them. I followed this approach and conducted a correlation analysis to assess the relationship between the rapport and the client focus subscales. Results indicated there to be a strong positive correlation between rapport and client focus, r (84) = .81, p < 0.01, with rapport explaining 66% of the variance in client focus. Consistent with Ganske's (2007) approach, I combined the subscale scores of rapport and client focus creating an aggregate value representing participants' total supervisory working alliance scores. As a result,

while SWAI-T scores range from 1 – 7, in the present study participants' total scores ranged between 2.16 – 7 with a mean of 5.82 (*SD* = .97).

Wellness was measured utilizing the FS scale. The wellness scores on the FS scale range from 8 to 56 with high scores indicating a person with many psychological resources and strengths (Diener et al., 2010). In this study, participant's wellness scores ranged between 27 – 56 with a mean of 47.58 (*SD* = 6.23).

Resilience was measured using the BRS. Scores on the BRS can range from 1 – 5. Participants' scores were calculated by dividing the total sum by the total number of questions answered. Therefore, in this study, participants' resilience scores ranged between 1 – 4.67 with a mean of 3.43 (*SD* = .79).

Primary Analyses

In this section, I will address each research question and present related findings.

Research Question 1: What is the level of compassion fatigue among CITs?

The compassion fatigue scores of CITs were calculated by summing the standardized scores of STS and BO to be able interpret scores across various demographic categories. Stamm (2010) highlighted the importance of using standardized scores for improved interpretation across specific groups. Therefore, participants' subscale scores were converted to t-scores and BO scores ranged between 28.69 and 74.34 with a mean of 50 (*SD* = 10) while STS scores ranged between 29.95 and 85.99 with a mean of 50 (*SD* = 9.99). This step was conducted to facilitate comparison of scores from the present sample to those found by Stamm during the development and norming of the ProQOL. However, participants' raw scores were used in conducting the regression analysis planned to address Research Question 3. Stamm (2010) provided data from a data bank of 1289 cases created from multiple studies in the ProQOL

manual, including mean and standard deviation of these cases among age, gender, race, income group, and years at current employer. Comparing data from the present study with the data bank results from the ProQOL manual revealed the largest mean difference occurring between male BO scores and male STS scores. According to the manual, the mean BO score of male participants was 48.99 (*SD* = 9.75), while the mean BO score of male participants in the present study was 56.36 *(SD* = 12.94). Additionally, the mean score of STS of male participants was listed as 49.05 (*SD* = 9.75) in the manual whereas for participants in this study the mean STS score was found to be four points higher (*M* = 53.66, *SD* = 10.87). Although there is a difference between these mean scores, readers should be aware that there were only eight male participants in the current study. Additionally, among participants in this study, males above the age of 36 reported higher BO scores and males below the age of 36 lower STS scores than reported in the test manual.

As literature is lacking in regard to detailed information about CITs' compassion fatigue levels, the results of compassion fatigue score group differences in gender, age, program accreditation status, internship site, experience working with doctoral level supervisors, and seeking counseling were analyzed. Independent samples *t*-tests and one-way ANOVA tests results concluded that there were no statistically significant differences in the following pairs: gender, $t(84)=1.72$, $p = .69$; age, $t(82)=. 94$, $p = .32$; ethnicity, $F(4,81)= 1.13$, $p = .35$; enrolled program, $F(5,80)= 1.31$, $p = .27$; program accreditation status, $t(84)= -1.33$, $p = .43$; experience working with doctoral level supervisors, $t(84) = -1.67$, $p = .35$; and seeking counseling, $t(84) = .88$, $p = .65$. However, the only statistically significant difference was found among the compassion fatigue scores of participants from different internship sites, $F(4,80) = 3.13$, $p < .05$ (Table 6). Post hoc Tukey for multiple comparisons indicated that the mean difference between

compassion fatigue scores of participants from school and community mental health facility was 8.27 ($p < .05$).

Table 6

One-way Analysis of Variance of Internship Sites

Variable		Sum of Squares	df	Mean Square	F
Internship Sites	Between Groups	712.14	4	178.04	3.13*
	Within Groups	4359.91	80	57.00	
	Total	5272.06	84		

p<.05*

As a reminder to the reader, non-standardized CF, BO, and STS scores are listed and discussed under the primary variables section (Table 5). In sum, mean scores of CF, BO, and STS of CITs indicated low risk of BO and STS, as a result, low risk of CF. For more information, see the descriptive statistics of primary variables section and review the Table 5 providing the mean, standard deviation, range, and skewness scores of CF, BO, and STS.

Research Question 2: What are the relationships among empathy, resilience, wellness, supervisory working alliance, and compassion fatigue in CITs?

A correlation analysis was conducted to assess the relationships between empathy, resilience, wellness, supervisory working alliance, and compassion fatigue among a total of 86 CITs (Table 7). A moderate negative correlation was found between resilience and compassion fatigue, $r(84) = -.47$, $p < .01$, with resilience explaining 22% of the variation in compassion fatigue. There also was a moderate negative correlation between wellness and compassion fatigue, $r(84) = -.44$, $p < .01$, with wellness explaining 19% of the variation on compassion

fatigue. Additionally, wellness was found to positively correlate with both empathy and resilience. Finally, a small positive correlation was found between wellness and empathy, $r(84) = .26$, $p < .05$, with wellness explaining 6% of the variance in empathy, while there was a moderate positive correlation between wellness and resilience, $r(84) = .35$, $p < .01$, with wellness explaining 12% of the variation in resilience.

Table 7

Summary of Intercorrelations for Scores on the ProQOL-CF, IRI-EC, SWAIT-T, BRS, and FS

	Variable	1	2	3	4	5
1.	ProQOL-CF	-				
2.	SWAIT-T	.04	-			
3.	IRI-EC	-.06	.04	-		
4.	BRS	-.47**	-.09	-.11	-	
5.	FS	-.45**	.12	.25*	.35**	-

Note. N = 86 ProQOL = Professional Quality of Life [Compassion Fatigue (CF) score is presented]; IRI = Interpersonal Reactivity Index [Empathic Concern (EC) subscale score is presented]; SWAI-T: Supervisory Working Alliance Inventory: Trainee Form; BRS: Brief Resilience Scale; FS = Flourishing Scale.
** p < .01. * p < .05.

Research Question 3: Do empathy, supervisory-working alliance, resilience, and wellness significantly predict levels of compassion fatigue?

A three-step hierarchical multiple linear regression analysis was performed to evaluate the relationship between empathy, supervisory working alliance, wellness, resilience, and compassion fatigue. In the first step, empathy scores were entered to the model as a predictor variable as Figley (1995) stated that empathy is one of the main factors contributing to compassion fatigue. However, among this sample, empathy was not found to be a significant predictor of compassion fatigue, $F(1, 84) = .2$ $p = .66$, $R^2 = .002$ (adjusted $R^2 = -.01$). Supervisory working alliance scores were added to the model in the second step, as both Knight

(2010) and Miller and Sprang (2016) emphasized the importance of supervisory support for mental health practitioners. Results revealed that the second step of this model also was not significant, $F(2, 83) = .16$ $p = .85$, $R^2 = .004$ (adjusted $R^2 = -.02$). In the third step, resilience and wellness scores were entered to the model to determine whether these variables significantly improved the amount of explained variance in compassion fatigue. Results showed that this combination of variables significantly predicted 26% of the variance in compassion fatigue, $F(4, 81) = 8.57$, $p < .001$, $R^2 = .30$. Overall, results indicated that CITs with greater resilience and wellness perceived themselves as having less compassion fatigue. A complete listing of the three-step hierarchical multiple regression results is presented in Table 8.

Table 8

Summary of Hierarchical Regression Analysis for Variables Predicting Compassion Fatigue

Variables		B	SEB	β	R^2	ΔR^2
Step 1					.002	-.01
	Empathy	-.09	.21	-.05		
Step 2					.004	-.02
	Empathy	-10	.21	-.05		
	SWA	.33	.91	.04		
Step 3					.30*	.26
	Empathy	-.03	.19	-.02		
	SWA	.36	.78	.04		
	Wellness	-.39	.14	-.30*		
	Resilience	-3.66	1.05	-.36*		

Note. SWA=Supervisory Working Alliance
*p < .05.

Summary

This chapter included results addressing each of the research questions included in this study. Results of analyses addressing the first research question indicated that CITs reported

themselves as having a low risk of compassion fatigue. Addressing the second question, findings revealed significant negative correlations between compassion fatigue, wellness, and resilience respectively. Significant positive correlations were found between wellness, empathy, and resilience. Finally, a hierarchical regression analysis was conducted to address the third research question with results indicating wellness and resilience significantly predicting compassion fatigue among CITs. However, there is no significant relationship between compassion fatigue with empathy and supervisory working alliance.

CHAPTER V: DISCUSSION

In this chapter I discuss the implications of the results obtained in this study. The chapter starts with a summary of the study then provides a discussion of the results of each research question. Theoretical and practical implications of the findings are provided. Additionally, I present assumptions, limitations of the study, recommendations for future research and concluding remarks.

Summary of the Study

Compassion fatigue results from continual exposure to hearing about or supporting clients suffering from a traumatic event or events (Skovholt & Trotter-Mathison, 2016). Counselors listening to clients' suffering, fear, and pain may feel similar emotions because they care (Figley, 1995). As a result, compassion fatigue may create emotional and professional problems for counselors, such as feelings of helplessness and being isolated from their support network. This experience may also make regeneration and renewal difficult for counselors after engaging with clients who are trauma survivors. These counselors may also experience an inability to participate successfully in the re-creation phase of the Cycle of Caring (Skovholt & Trotter-Mathison, 2016); and without practicing self-care in this phase, moving through in the work of the Cycle of Caring can be challenging.

Counselors-in-training (CITs) are inexperienced beginning counselors in the mental health field; however, they may need to work with trauma survivors before developing necessary coping skills to offset compassion fatigue. The current study was conducted to better understand both the prevalence of compassion fatigue and the relationship between it and potential protective factors for CITs in the United States. The findings regarding each research question addressed in this study are discussed in the following section.

Discussion of Findings

Research Question 1: What is the level of compassion fatigue among CITs?

In this present study, the ProQOL was utilized to measure compassion fatigue among CITs; results revealed that a total of 86 CITs reported having a low risk of compassion fatigue. When I examined BO and STS scores, the main contributors of CF (Stamm, 2010), outcomes did not change, indicating participants stated having a low risk of BO and STS. This finding was like results found by Beaumont and colleagues (2016) in their study of compassion fatigue among student counselors and student cognitive behavioral psychotherapists.

Overall, there is a lack of knowledge regarding CF among CITs. In one of the few studies conducted, Star (2013) examined the relationship between compassion fatigue among counselors and CITs. Star investigated whether recent life changes, age, sex, race, years of experience, education level, and work/internship setting impacted counselors' and CITs' self-reports of compassion fatigue, burnout, compassion satisfaction, and self-care. According to Star, recent life changes impacted compassion fatigue scores of counselors and CITs, with female participants reporting experiencing a higher level of compassion fatigue than male participants. Other researchers also have stated that female professionals are more likely to exhibit compassion fatigue (Ivicic & Motto, 2017; Rossi et al., 2012; Sprang et al., 2007). However, in this present study, it was the male participants who reported experiencing higher compassion fatigue than their female peers. This finding must be interpreted cautiously, though, as there were only eight male participants in this study. Further, a total of six male participants reported enrollment in a clinical mental health counseling program where they might be working with difficult clinical cases at their internship sites. The compassion fatigue score of this limited

number of male participants may explain the difference between current and previous study results.

Research Question 2: What are the relationships among empathy, supervisory working alliance, resilience, wellness, and compassion fatigue in CITs?

As I presented in Chapter 2, there are several variables that have been examined regarding their relationship with compassion fatigue. Empathy, supervisory working alliance, wellness, and resilience are the focus of this present study. The second research question specifically focused on the relationship among empathy, supervisory working alliance, resilience, wellness, and compassion fatigue in CITs. According to results, a significant negative correlation between wellness and compassion fatigue among CITs exists. This finding was consistent with previous research (Beaumont et al., 2015; Lawson & Myers, 2011) indicating wellness is negatively correlated with compassion fatigue.

The current study also suggested that there is a significant negative correlation between resilience and compassion fatigue. Researchers provided promising evidence reducing compassion fatigue in mental health providers with resilience (Wood et al., 2017). Wood et al. (2017) conducted a study to examine the effectiveness of a mobile resilience application among 30 mental health providers. After using the application for a month, participants' level of compassion fatigue significantly decreased. Crowder and Sears (2017) reported similar findings regarding the relationship between resilience and compassion fatigue by conducting a mixed-method, exploratory study among 14 social workers in Canada; however, researchers used self-compassion to measure resilience. Although the current and previous studies' results appear similar, the way researchers measured the construct of resilience was different, and the present

study contributed the literature by providing resilience scores utilizing an established resilience scale as a proxy for this construct.

Results also evidenced a significant positive correlation between wellness and empathy. In a study by Wagaman et al. (2015), the relationship between empathy, burnout, STS, and compassion satisfaction was explored among social workers. They concluded that empathy might be a contributing factor to the maintenance of individuals' well-being. Present study results also revealed a significant positive correlation between wellness and resilience. Current study findings also support Kapoulitsas and Corcoran's (2015) qualitative study findings regarding exploration of contributing factors of resilience and ways to be protected from compassion fatigue with six social workers in Australia. Additionally, Skovholt and Trotther-Mathison (2016) highlighted the need for more self-care at times of personal crisis and excessive stress.

Finally, the results showed there to be no correlation between empathy and compassion fatigue, which is similar to O'Brien and Haaga's (2015) study in which they compared trait empathy and empathic accuracy with compassion fatigue after showing a videotaped trauma-self-disclosure among therapist trainees and non-therapists. Their findings indicated no significant correlation between participants' level of compassion fatigue and empathy. Moreover, Thomas and Otis (2010) reported similar findings after examining relationships of mindfulness, empathy, and emotional separation to several aspects of professional quality of life, including compassion fatigue, using a random sample of social workers. Conversely, additional researchers reported a significant relationship between empathy and compassion fatigue (Figley, 2002a; MacRitchie & Leibowitz, 2010; Wagaman et al., 2015). I discuss the relationship between these variables and compassion fatigue further in the following section.

Research Question 3: Do empathy, supervisory-working alliance, resilience, and wellness significantly predict levels of compassion fatigue?

One of the goals of this study was to seek an answer for whether empathy, supervisory-working alliance, resilience, and wellness significantly predict compassion fatigue. A hierarchical multiple regression analysis was chosen because scholars highlighted the essential relationship between empathy, supervision, and compassion fatigue (Figley, 2002a; MacRitchie & Leibowitz, 2010). With this present study, I examined whether wellness and resilience explain a statistically significant amount of variance in compassion fatigue among CITs after accounting for empathy and supervisory working alliance. However, the findings from this analysis were not in line with previous findings, indicating a significant relationship between empathy, supervisory working alliance, and compassion fatigue.

The present study results indicated that there was no significant relationship found between compassion fatigue with empathy and supervisory working alliance. Regarding empathy and compassion fatigue relation results, Figley's hypothesis was not supported by the findings of this study. This result was also inconsistent with Wagaman and colleagues' (2015) results indicating a significant relationship between empathy and compassion fatigue among social work practitioners. However, current results aligned with those studies found no correlation between empathy and compassion fatigue (O'Brien & Haaga, 2015; Thomas &Otis, 2010). An explanation of the variability between this inquiry and previous studies might be the difference between participants' field of study and measurement differences. None of the previous studies used CITs solely as their sample, nor used the similar way to measure the construct of empathy. Also, the other explanation might be related to the difficulty regarding empirical measurement of the construct of empathy (Lawrence, Shaw, Baker, Baron-Cohen, David, 2004)

Although scholars addressed the importance of supervision and supervisory working alliance to help prevent compassion fatigue (Kapoulitsas & Corcoran, 2015; Ling, Hunter, & Maple, 2013; Marriman, 2015a), this study's results indicated there is no relationship between supervisory working alliance and compassion fatigue among CITs. Similar to current results, Williams and colleagues (2012) found no statistically significant relationship between supervisory working alliance and compassion fatigue among mental health therapists by using the SWAI-T scale. Ivicic and Motta (2017) also found no relationship between quality of supervision and compassion fatigue (secondary traumatization) among mental health professionals. It is interesting to note that these studies highlighting the importance of supervision and supervisory relationship are qualitative in design, and participants did not consist solely of beginning counselors. Additionally, their results emphasized the importance of supervision as support to counter the negative impact of trauma exposure (Kapoulitsas & Corcoran, 2015; Ling, Hunter, & Maple, 2013). According to current study results, CITs did not report experiencing a high level of compassion fatigue; this could be interpreted as beginning counselors not yet feeling the need of supervisory support.

Results also indicated resilience and wellness predicting compassion fatigue among CITs. In other words, CITs with greater resilience and wellness reported lower scores of compassion fatigue. The results were consistent with previous research findings. Tosone et al. (2010) examined the relationship between attachment classification, resiliency, and compassion fatigue in mental health providers after 9/11 and found that secure attachment and resilience were predictive factors of compassion fatigue. Regarding a wellness and compassion fatigue relationship, Beaumont and colleagues (2016) investigated the associations between self-compassion, compassion fatigue, well-being, and burnout in student counselors and student

cognitive behavioral psychotherapists. Results showed that individuals who reported high measures of self-compassion and well-being reported less compassion fatigue and burnout. Thomas and Morris (2017) also asserted the importance of self-care and well-being not only for preventing and helping to manage the potentially damaging impact of practice but also for facilitating the counselor's personal and professional growth.

Implications

This section provides theoretical and practical implications of the present study results.

Theoretical Implications

The concept of compassion fatigue emerged in the social work literature and subsequently has been used in various fields. Although the term has been used for over 20 years, there is still lack of clarity among related concepts, including compassion fatigue, secondary traumatic stress, and vicarious traumatization (Newell et al., 2016; Thomas, 2013). Although these terms have some overlaps (Ivicic & Motta, 2016), using them interchangeably prevents developing a common professional knowledge regarding study participants. Therefore, the lack of clarity among these concepts creates an explicit need for a better definition of compassion fatigue.

Additionally, new measures should be developed to assess compassion fatigue. According to Turgoose et al. (2017), most researchers studying compassion fatigue in relation to a variety of psychosocial factors in mental health professionals utilized a version of the ProQOL to measure compassion fatigue. In the ProQOL manual, compassion fatigue is described as the combination of burnout and secondary traumatic stress. However, many researchers reported the secondary traumatic stress scores as compassion fatigue scores instead of combining the scores of burnout and secondary traumatic stress to provide compassion fatigue scores (e.g., Ray et al.,

2013; Star, 2013; Thomas & Otis, 2010; Thompson et al., 2014). This instability creates difficulties for researchers interpreting and comparing study results. Further, this confusion creates problems in describing the prevalence of compassion fatigue among different groups. Unlike most other studies, the current study reported secondary traumatic stress and burnout scores of the ProQOL, generating compassion fatigue scores as a combination of these two scales among CITs. Providing all three scores may help future researchers better understand the prevalence of compassion fatigue among CITs. Additionally, Stamm (2010) suggested converting the ProQOL subscale scores into standard scores to make them accessible to compare present study results with existing data consisting of more than 1000 cases in the ProQOL manual. Reporting standard scores may also help future researchers make easier comparisons among various demographic scores, such as gender, age, race, income group, and years at current employer.

Practical Implications

The research findings provide data-driven results regarding compassion fatigue among CITs that have meaningful practical implications for counselor educators and supervisors. Present study results revealed that CITs reported having a low risk of compassion fatigue. However, raising awareness on this issue may still help CITs become more aware of compassion fatigue symptoms and more prepared to cope with possible compassion fatigue experience in the future. To address this issue, counselor educators may consider reviewing current training program curriculum used nationwide and enhance their own by adding required discussion topics of compassion fatigue and its empirically predictive factors such as wellness and resilience in various courses. Roach and Young (2007) conducted a study with a total of 204 master's level counseling students at three points in their training program and measured their wellness using

the Five Factor Wellness Evaluation of Lifestyle scale. Researchers found that students taking a wellness course reported statistically higher levels of total wellness. Roach and Young (2007) also stated that Group Counseling, Practicum I and II, Techniques of Counseling, Legal and Ethical Issues, and Social and Cultural Foundations were the courses reported by participants as contributing most to their knowledge and skills regarding wellness. Therefore, counselor educators might use different assignments including personal journals, in-class discussions, group projects, and role-playing exercises to introduce the concept of compassion fatigue and its relationship with wellness in these courses. Counselor educators may also create an assignment about the ProQOL scale, a widely used measure of compassion fatigue, in an assessment and testing course, informing CITs about how to use this instrument when an individual feels the need.

Supervisors may also find ways to raise awareness of compassion fatigue and its protective factors among CITs. Counselors-in-training should be made aware of the emotional and psychological risks involved in working with trauma survivors. During internship experience, supervisors may develop site training including compassion fatigue awareness for CITs. Beginning counselors should also be encouraged to advocate for themselves when they notice symptoms of compassion fatigue. Supervisors may also consider administration of the ProQOL scale on a regular basis to assess both organizational and individual risks (Newell & MacNeil, 2010). Additionally, supervisors may use the ProQOL scale with their supervisee to start a conversation about compassion fatigue. Although the ProQOL is not a diagnostic test, the 30-item self-report scale readily can be utilized as a conversation starter.

The current study results suggested that empathy and supervisory working alliance are not significantly related in contributing to CITs' compassion fatigue level. However, wellness

and resilience are significantly related to contributing to it. Therefore, both counselor educators and supervisors may consider finding ways to enhance CITs' resilience and wellness. For example, Miller and Sprang (2016) developed a component-based practice and supervision model for reducing compassion fatigue. The five components of this model are experiential engagement, managing rumination, intentional narrative, reducing emotional labor, and parasympathetic recovery strategies. These skills are derived from evidence in psychological treatment and neurophysiology literature regarding the management of difficult emotional states. Miller and Sprang (2016) stated that this model, a skill-based approach, can be used in training, supervision, and clinical practice.

Additionally, an integrative training framework developed by Hernández, Engstrom, and Gangsei (2010) including key concepts in trauma work such as compassion fatigue, resilience, vicarious trauma, and post-traumatic growths can be used with CITs as a training tool. They offered a training/supervision exercise to assist counselors in addressing the complex and systemic relationships of trauma work affecting counselors in both positive and negative manners. Further researchers stated that this tool was developed to enhance a counselor's resilience. Reim, Ifrach and Miller (2016) studied the effectiveness of a social action art therapy session to address symptoms of stress and compassion fatigue in counselors working with domestic violence and sexual assault survivors. Participants were asked to create art for a peace pool as a symbol of peace and safety. Results showed the intervention was effective in reducing stress levels for all participants, regardless of levels of or presence of compassion fatigue. Finally, Christopher and Maris (2010) reviewed five qualitative mindfulness studies for CITs and asserted that mindfulness training might enhance the physical and psychological well-being of beginning counselors. Considering these studies, counselor educators and supervisors help CITs

start their professional careers better prepared by teaching them strategies of self-care as a preventative measure against compassion fatigue from its early-onset.

Limitations and Delimitations

The results of this study provide greater clarity regarding predictive factors of compassion fatigue among CITs. However, interpretations of these results should take into consideration the limitations that emerged due to uncontrollable influences and choices I made. The study was limited in its ability to represent all CITs throughout the United States as convenience sampling was utilized. Because convenience sampling has biases related to its lack of random sampling, the sample is unlikely to be completely representative of the population being studied. Additionally, I gathered the data through self-report questionnaires. It is possible data might include elements of response bias. While I assumed that participants answered each question honestly, participants might not have been honest in their responses because of the fear of being seen as weak or less competent. It is important to note that being in an internship class might also increase participants' interest in the profession as they currently are engaged in the practice of counseling. Therefore, participants might have had a higher level of enthusiasm and reported less compassion fatigue. Also, individuals who suffer from compassion fatigue might have preferred not to respond to these items.

The sample and the instrumentation are delimitations of this study. The sample was determined as CITs and results were limited to this population. Therefore, other populations might be utilized in further studies. There are different instruments to measure each of the study variables; however, I chose to use the Brief Resilience Scale, the Flourishing Scale, the Interpersonal Reactivity Index, the Supervisory Working Alliance Inventory: Trainee Form, and the Professional Quality of Life Scale. Further researchers might use other related instruments to

measure the same constructs and crosscheck the results to contribute the literature of compassion fatigue.

Future Directions for Research

Additional research should be conducted to expand and clarify current research findings of compassion fatigue among CITs. Future researchers may focus on exploring the relationship between similar or different variables with compassion fatigue. Variables such as empathy and supervisory working alliance are both difficult constructs to measure. The literature also includes conflicting results regarding the relationship between these variables and compassion fatigue (Ivicic & Motta, 2017; Kapoulitsas & Corcoran, 2015; O'Brien & Haaga, 2015). As the concept of compassion fatigue has been used across different countries such as Australia, South Africa, Italy, England, and China (Beaumont et al, 2016; Craigie et al, 2016; Mashego et al., 2016; Rossi et al., 2012; Yu et al., 2016), future researchers may design studies with the same variables as an attempt to determine the generalizability of results to CITs in different locations. Also, using different variables such as emotional separation, support, supervision hours, and self-care activities might help to expand current research results.

The current study results included CITs in the U.S. concluded that CITs have a low risk for compassion fatigue; however, it is recommended that the study is replicated with novice counselors. Novice counselors are individuals who are in their first few years as counselors after graduation, and for most novice counselors, these years are experienced as intense (Skovholt & Trotter-Mathison, 2016). In the novice professional phase, there are many challenges to master and many choices to be made without the guidance of counselor educators and supervisors. Therefore, future research exploring novice counselors' experiences with compassion fatigue will help supervisors better understand when counselors may start developing compassion

fatigue symptoms as well as how they cope with the symptoms. The findings of the current study suggest that wellness and resilience are significant predictors of compassion fatigue. Therefore, future researchers may explore the effectiveness of specific self-care, wellness, and resilience interventions aimed at preventing the development of compassion fatigue symptoms.

A phenomenological study using qualitative research method is recommended to expand the results of this present study. Future researchers may use the ProQOL scale to assess CITs level of compassion fatigue and then conduct interviews with the volunteer participants reporting a higher level of compassion fatigue to better understand CITs experience with compassion fatigue and its contributing factors. The results of this qualitative study can be utilized to provide greater insight into the phenomenon of compassion fatigue among CITs.

Conclusion

Compassion fatigue has been defined as an occupational hazard for mental health providers (Figley, 2002b; Merriman, 2015a). Beginning counselors may experience struggles working with clients due to a lack of experience, skillset, or support (Skovholt & Trotter-Mathison, 2016). Using data-driven research results to provide education to CITs on compassion fatigue and its protective factors can be beneficial in preventing compassion fatigue symptoms from developing as CITs can take precautionary measures to ensure they remain enthused and energized by the work they do.

In this study, I aimed to investigate the prevalence of compassion fatigue among CITs as well as the relationship between empathy, supervisory working alliance, resilience, wellness, and compassion fatigue. I found that CITs reported having a low risk of compassion fatigue. The research findings also revealed that CITs with higher levels of resilience and wellness reported a lower level of compassion fatigue, indicating wellness and resilience predict compassion fatigue.

Wellness and resilience are also negatively correlated with compassion fatigue, while wellness is positively correlated with empathy and resilience.

The findings of the current study not only contribute to the literature but also provide theoretical and practical implications for counselor educators, supervisors, and future researchers. Counselor educators may consider reviewing their current training program curriculum and include discussion topics on compassion fatigue in various courses to help CITs to become more aware of compassion fatigue symptoms and more prepared to cope with possible compassion fatigue experience in the future. Supervisors may include resilience and wellness strategies and interventions in supervision sessions with CITs to prevent compassion fatigue from its early-onset. Future researchers may explore the effectiveness of these wellness and resilience interventions and design a qualitative study including interviews to explore CITs compassion fatigue experiences in depth to expand the results of this present study. I believe the findings of this study expand the literature on compassion fatigue among CITs and have the potential to serve as a building block for future researchers. I am also hopeful that the implications of current study will help CITs to start their professional career better prepared to provide their clients with the best care they need throughout the counseling relationship.

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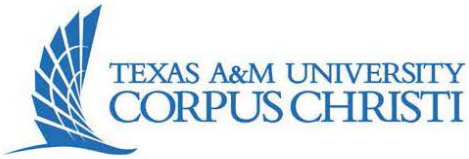
APPENDICES

Appendix A: IRB Approval Letter



OFFICE OF RESEARCH COMPLIANCE
Division of Research, Commercialization and Outreach

6300 Ocean Drive, Unit 5844
Corpus Christi, Texas 78412
O 361.825.2497 • F 361.825.2755

Human Subjects Protection Program	Institutional Review Board

APPROVAL DATE:	July 18, 2017
TO:	Nesime Can
CC:	Dr. Joshua Watson
FROM:	Office of Research Compliance Institutional Review Board
SUBJECT:	Notification of Exemption

Protocol Number:	HSRP #99-17
Title:	Caring for Beginning Counselors: The Relationship between Empathy, Supervisory Working Alliance, Resilience, Wellness, and Compassion Fatigue among Counselors-In-Training (CITs)
Review Category:	Qualifies for Exemption

Approval determination was based on the following Code of Federal Regulations:

Eligible for Exemption (45 CFR 46.101)

Criteria for exemption has been met (45 CFR 46.101) - The criteria for exemption listed in 45 CFR 46.101 have been met (or if previously met, have not changed).

(2) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless: (i) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

Provisions:	
Comments:	The TAMUCC Human Subjects Protections Program has implemented a post-approval monitoring program. All protocols are subject to selection for post-approval monitoring.

This research project has been granted the above exemption. As principal investigator, you assume the following responsibilities:

1. Informed Consent: Information must be presented to enable persons to voluntarily decide whether or not to participate in the research project unless otherwise waived.
2. Amendments: Changes to the protocol must be requested by submitting an Amendment Application to the Research Compliance Office for review. The Amendment must be approved before being implemented.
3. Completion Report: Upon completion of the research project (including data analysis and final written papers), a Completion Report must be submitted to the Research Compliance Office.
4. Records Retention: All research related records must be retained for three years beyond the completion date of the study in a secure location. At a minimum these documents include: the research protocol, all questionnaires, survey instruments, interview questions and/or data collection instruments associated with this research protocol, recruiting or advertising materials, any consent forms or information sheets given to participants, all correspondence to or from the IRB or Office of Research Compliance, and any other pertinent documents.
5. Adverse Events: Adverse events must be reported to the Research Compliance Office immediately.

6. Post-approval monitoring: Requested materials for post-approval monitoring must be provided by dates requested.

Appendix B: Recruitment Scripts

Dear Sir/Madam,

My name is Nesime Can, and I am a doctoral candidate in the Department of Counseling and Educational Psychology at Texas A&M University- Corpus Christi. I am conducting a research study entitled "Caring for Beginning Counselors: The Relationship Between Empathy, Supervisory Working Alliance, Resilience, Wellness, And Compassion Fatigue Among Counselors-In-Training." I am conducting this study to fulfill the degree requirements for the Counselor Education doctoral program.

I am kindly requesting you to share the email below with your master's level counseling students, 18 years of age or older, enrolled in an internship course within the counselor training program, where you currently work. The email can be directly sent to students' email addresses or shared via department list-serv.

The purpose of this study is to examine the relationship between compassion fatigue and its protective factors among counselors-in-training. This survey will take 15-20 minutes to complete, and participation is voluntary. Students may decide not to participate or to withdraw their participation at any time without current or future relations with their university being affected.

The risks associated in this study are minimal and are not considered to be greater than risks ordinarily encountered in daily life. Participant's information will be kept anonymous. If you have any questions or concerns regarding the study, I can be reached at (267) 231-8567 or ncan@islander.tamucc.edu. If you have additional questions, you can also contact the chair of my dissertation committee, Dr. Joshua C. Watson at Joshua.Watson@tamucc.edu or (361) 825-2739.

Thank you for your time and consideration.
Best Regards,

Nesime Can
Doctoral Candidate
Department of Counseling and Educational Psychology
Texas A&M University- Corpus Christi

Invitation to Participate in a Dissertation Study

Dear counseling students:

My name is Nesime Can, and I am a doctoral candidate in the Department of Counseling and Educational Psychology at Texas A&M University- Corpus Christi. I am conducting a research study entitled "**Caring for Beginning Counselors: The Relationship Between Empathy, Supervisory Working Alliance, Resilience, Wellness, And Compassion Fatigue Among Counselors-In-Training.**" I am conducting this study to fulfill the degree requirements for the Counselor Education doctoral program and inviting you to participate in my dissertation study. To be eligible to participate, you must be **a master's level counselor-in-training, 18 years of age or older, enrolled in an internship course in a counselor training program across the U.S during Fall 2017 and/or Spring 2018 semesters**.

The purpose of this study is to examine the relationship between compassion fatigue and its protective factors among counselors-in-training. This survey will take 15-20 minutes to complete, and your participation is voluntary. You may decide not to participate or to withdraw your participation at any time without your current or future relations with your university being affected.

The risks associated in this study are minimal and are not considered to be greater than risks ordinarily encountered in daily life. Your information will be kept anonymous. If you have any questions, I can be reached at (267) 231-8567 or ncan@islander.tamucc.edu. If you have additional questions about the study, you can also contact the chair of my dissertation committee, Dr. Joshua C. Watson at Joshua.Watson@tamucc.edu or (361) 825-2739.

This research study has been reviewed by the Institutional Review Board and/or the Office of Research Compliance at Texas A&M University-Corpus Christi. If you have questions about your rights as a participant, please contact the Office of Research Compliance, (361) 825-2497, or via email sent to IRB@tamucc.edu.

Please click on the link below or copy and paste the link into your internet browser to access the survey if you are interested in participating.

https://tamucc.co1.qualtrics.com/jfe/form/SV_erEbIDLqmnAMbgF

Thank you for taking the time to complete this survey.
Regards,
Nesime Can
Doctoral Candidate

Department of Counseling and Educational Psychology
Texas A&M University- Corpus Christi

Appendix C: Information Sheet

INFORMATION SHEET

Caring for Beginning Counselors: The Relationship Between Empathy, Supervisory Working Alliance, Resilience, Wellness, And Compassion Fatigue Among Counselors-In-Training

Introduction
The purpose of this form is to provide you information that may affect your decision as to whether or not to participate in this research study. By filling out a survey, providing responses to questions, etc. you are consenting to participate in the study. By participating in this study, you also are certifying that you are 18 years of age or older. Please do not fill out the survey, provide responses to questions, etc. if you do not consent to participate in the study.

You have been asked to participate in a research project studying the relationship between empathy, supervisory working alliance, resilience, wellness, and compassion fatigue among counselors-in-training. The purpose of this study is to evaluate compassion fatigue levels and potential protective factors among CITs. You were selected to be a possible participant because you are identified as counselor-in-training who is enrolled a practicum or internship course. This study is being funded by the Texas Counseling Association Educational Endowment Fund.

What will I be asked to do?
If you agree to participate in this study you will be asked to complete a brief demographic questionnaire, the Brief Resilience Scale, the Flourishing Scale, the Interpersonal Reactivity Index, the Supervisory Working Alliance Inventory: Trainee Form, and the Professional Quality of Life Scale. The entire process will take approximately 15-20 minutes to complete.

What are the risks involved in this study?
The risks associated with this study are minimal, and are not greater than risks ordinarily encountered in daily life.

What are the possible benefits of this study?
You will receive no direct benefit from participating in this study; however, participants of this study will have an opportunity to question their understanding about the topic of compassion fatigue and its protective factors including empathy, supervisory working alliance, resilience, and wellness. Additionally, the results of this study will help counselor educators to better train counselors-in-training regarding compassion fatigue and its protective factors, allowing clients in society to receive the quality care they need.

Do I have to participate?
No. Your participation is voluntary. You may decide not to participate or to withdraw at any time without your current or future relations with Texas A&M University-Corpus Christi being affected.

Who will know about my participation in this research study?
No identifiers linking you to this study will be included in any sort of report that might be published. Research records will be stored securely and only Nesime Can, M.S.Ed, and Joshua C. Watson, Ph.D. will have access to the records.

Whom do I contact with questions about the research?
If you have questions regarding this study, you may contact Nesime Can at ncan@islander.tamucc.edu, (267) 231-8561 or Joshua C. Watson at Joshua.Watson@tamucc.edu, (361) 825-2739.

Whom do I contact about my rights as a research participant?
This research study has been reviewed by the Institutional Review Board and/or the Office of Research Compliance at Texas A&M University-Corpus Christi. To report a problem or for questions regarding your rights as a research participant, contact the Research Compliance and Export Control Officer at (361) 825-2497.

Appendix D: Demographic Form

1. Age: ___

2. Gender:
   ___Female
   ___Male

3. Ethnicity:
   ___Asian
   ___Black/African American
   ___Hispanic or Latino
   ___White
   ___Other

4. Enrolled course
   ___Practicum
   ___Internship-I
   ___Internship-II

5. Enrolled program
   ___Clinical Mental Health Counseling
   ___School Counseling
   ___Marriage, Couple, and Family Counseling
   ___Addiction Counseling
   ___Rehabilitation Counseling
   ___Other

6. Program accreditation status
   ___CACREP
   ___Non-CACREP

7. Practicum/internship site
   ___School
   ___Community Mental Health Facility
   ___Agency
   ___Hospital
   ___Other

8. Experience working with doctoral level student supervisor
   ___Yes
   ___No

9. Personal experience about seeking therapy before
   ___Yes
   ___No

Appendix E: Professional Quality of Life Scale (ProQOL)

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

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

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

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

Appendix F: Supervisory Working Alliance Inventory - Trainee Form

Instructions: Please indicate the frequency with which the behavior described in each of the following items seems characteristic of your work with your supervisee. After each item, check (X) the space over the number corresponding to the appropriate point of the following seven-point scale:

1	2	3	4	5	6	7
Almost Never						Almost Always

I feel comfortable working with my supervisor.

___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7

My supervisor welcomes my explanations about the client's behavior.

___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7

My supervisor makes the effort to understand me.

___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7

My supervisor encourages me to talk about my work with clients in ways that are comfortable for me.

___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7

My supervisor is tactful when commenting about my performance.

___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7

My supervisor encourages me to formulate my own interventions with the client.

___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7

My supervisor helps me talk freely in our sessions.

___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7

My supervisor stays in tune with me during supervision.

___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7

I understand client behavior and treatment technique similar to the way my supervisor does.

___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7

I feel free to mention to my supervisor any troublesome feelings I might have about him/her.

___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7

My supervisor treats me like a colleague in our supervisory sessions.

___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7

In supervision, I am more curious than anxious when discussing my difficulties with clients.

___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7

In supervision, my supervisor places a high priority on our understanding the client's perspective.

___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7

My supervisor encourages me to take time to understand what the client is saying and doing.

___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7

My supervisor's style is to carefully and systematically consider the material I bring to supervision.

___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7

When correcting my errors with a client, my supervisor offers alternative ways of intervening with that client.

___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7

My supervisor helps me work within a specific treatment plan with my clients.

___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7

My supervisor helps me stay on track during our meetings.

___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7

I work with my supervisor on specific goals in the supervisory session.

___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7

Supervisory Working Alliance from: Efstation, J. E, Patton, M. J., & Kardash, C. M. (1990). Measuring the working alliance in counselor supervision. *Journal of Counseling Psychology, 37*, 322-329.

Appendix G: Interpersonal Reactivity Index – Empathic Concern Subscale

The following statements inquire about your thoughts and feelings in a variety of situations. For each item, indicate how well it describes you by choosing the appropriate letter on the scale at the top of the page: A, B, C, D, or E. When you have decided on your answer, fill in the letter next to the item number. READ EACH ITEM CAREFULLY BEFORE RESPONDING. Answer as honestly as you can. Thank you.

ANSWER SCALE:

A	B	C	D	E
DOES NOT DESCRIBES ME WELL				DESCRIBES VERY WELL

1. I often have tender, concerned feelings for people less fortunate than me.
2. Sometimes I don't feel very sorry for other people when they are having problems.
3. When I see someone being taken advantage of, I feel kind of protective towards them.
4. Other people's misfortunes do not usually disturb me a great deal.
5. When I see someone being treated unfairly, I sometimes don't feel very much pity for them.
6. I am often quite touched by things that I see happen.
7. I would describe myself as a pretty soft-hearted person.

Davis, M. H. (1980). A multidimensional approach to individual differences in empathy. *JSAS Catalog of Selected Documents in Psychology, 10*, 85.

Appendix H: Brief Resilience Scale

Please respond to each item by marking <u>one box</u> per row		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
BRS 1	I tend to bounce back quickly after hard times	1 □	2 □	3 □	4 □	5 □
BRS2	I have a hard time making it through stressful events.	5 □	4 □	3 □	2 □	1 □
BRS3	It does not take me long to recover from a stressful event.	1 □	2 □	3 □	4 □	5 □
BRS4	It is hard for me to snap back when something bad happens.	5 □	4 □	3 □	2 □	1 □
BRS5	I usually come through difficult times with little trouble.	1 □	2 □	3 □	4 □	5 □
BRS6	I tend to take a long time to get over set-backs in my life.	5 □	4 □	3 □	2 □	1 □

Smith, B. W., Dalen, J., Wiggins, K., Tooley, E., Christopher, P., & Bernard, J. (2008). The brief resilience scale: assessing the ability to bounce back. *International journal of behavioral medicine, 15*(3), 194-200.

Appendix I: Flourishing Scale

Below are 8 statements with which you may agree or disagree. Using the 1–7 scale below, indicate your agreement with each item by indicating that response for each statement.

- 7 - Strongly agree
- 6 - Agree
- 5 - Slightly agree
- 4 - Neither agree nor disagree
- 3 - Slightly disagree
- 2 - Disagree
- 1 - Strongly disagree

____ I lead a purposeful and meaningful life
____ My social relationships are supportive and rewarding
____ I am engaged and interested in my daily activities
____ I actively contribute to the happiness and well-being of others
____ I am competent and capable in the activities that are important to me
____ I am a good person and live a good life
____ I am optimistic about my future
____ People respect me

Appendix J: Figure Copyright

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Licensed content date	Mar 3, 2016
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Format	Print, Electronic
Portion	chart/graph/table/figure
Number of charts/graphs/tables/figures	1
Title or numeric reference of the portion(s)	Chapter 3, Figure 3.1, The figure called "the Cycle of Caring"
Title of the article or chapter the portion is from	The cycle of caring: Core of the helping professionals
Editor of portion(s)	N/A
Author of portion(s)	Thomas M. Skovholt & Michelle Trotter-Mathison
Volume of serial or monograph.	N/A
Page range of the portion	18
Publication date of portion	2016
Rights for	Main product
Duration of use	Life of current edition
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With minor editing privileges	no
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In the following language(s)	Original language of publication
With incidental promotional	no

use	
The lifetime unit quantity of new product	Up to 499
Made available in the following markets	Counseling professionals
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Order reference number	
Author/Editor	Nesime Can
The standard identifier of New Work	Doctoral dissertation
The proposed price	-
Title of New Work	Caring For Beginning Counselors: The Relationship Between Empathy, Supervisory Working Alliance, Resiliance, Wellness, And Compassion Fatigue Among Counselors-In-Training
Publisher of New Work	The author will publish
Expected publication date	Dec 2017
Estimated size (pages)	150
Total (may include CCC user fee)	0.00 USD
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