THE COST OF COMPASSION: ASSESSING THE IMPACT OF ORGANIZATIONAL CULTURE & SELF-CARE ON COMPASSION FATIGUE & COMPASSION SATISFACTION IN COUNSELORS

by

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Liberty University

A Dissertation Presented in Partial Fulfillment of the Requirements for the Degree

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ABSTRACT

It is the responsibility of mental health counselors to provide compassion for broken and hurting populations. For counselors, the continuous strain of empathizing with distressed clientele can often result in physical and emotional exhaustion known as compassion fatigue (Figley, 1995a). Although providing continuous compassion for others may contribute to negative experiences such as compassion fatigue, counselors can also experience positive outcomes from showing compassion towards clients, known as compassion satisfaction (Figley, 2002b). While risk factors to compassion fatigue have been widely explored among various occupations within the literature, less has been researched regarding moderating effects between compassion fatigue and compassion satisfaction, specifically among counselors. The purpose of this quantitative study is to assess the moderating effects of organizational culture and self-care practices between counselor compassion fatigue and compassion satisfaction, using regression analysis. Participants include licensed and pre-licensed counselors. As expected, compassion fatigue and compassion satisfaction were negatively correlated (r = -.367, $p < .001$). Data analysis results indicated that organizational culture and self-care practices did not have a significant moderating effect between compassion fatigue and compassion satisfaction. However, peer support, supervisory support, personal self-care, and professional self-care transmitted a significant positive effect on compassion satisfaction. Limitations for this study and implications for future research are presented.

Keywords: mental health counselors, pre-licensed counselors, compassion fatigue, burnout, secondary traumatic stress, compassion satisfaction, organizational culture, peer support, supervisory support, systemic support, trauma training, self-care, personal self-care, professional self-care

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Dedication

I dedicate this dissertation, first and foremost, to my Lord and Savior, Jesus Christ. Without God's grace and blessing, I would not have been able to complete this research study. May this research glorify Him and further His Kingdom.

To my husband, Jamie Owen, thank you for constantly loving and supporting me. Your hard work and sacrifice have made it possible for me to pursue this degree in the first place. Thank you for enduring the late nights of me typing away on my computer, the never-ending reruns of *Clue*, and my constant need for hugs. I am forever grateful for your dedication, support, encouragement, and grace. How did I get so lucky?

To my son, Judah Owen, thank you for inspiring me to keep going. You may never know how important you have been to this journey; nevertheless, your influence has been vital. Thank you for choosing me to be your mom.

To my parents and grandma, thank you for your sacrificial love that has given me the chance to pursue this opportunity. I love you more! I win.

To the countless family and friends that have supported me during this journey, thank you for believing in me when I was struggling to believe in myself.

Lastly, this study is dedicated to the counselors that give their all for the betterment of those that they serve. You were the inspiration for this research.

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The completion of this dissertation research would not have been possible without the passion and dedication of the faculty and staff at Liberty University. Dr. Robyn Simmons, my dissertation chair, thank you for agreeing to meet me for coffee to hear my vision for this research project. Your constant encouragement and direction throughout this process has made this journey incredibly meaningful. Dr. Kristy Ford and Dr. Melvin Pride, my committee members, thank you for seeing the potential of this project and encouraging me to pursue it. Bonnie Gould and Chris Floyd, thank you for using your skills to enhance this dissertation and for your grace and flexibility in bearing with my shortcomings. Dr. Lisa Sosin, thank you for teaching me the importance of grace and truth. Dr. Mary Deacon and Dr. Patricia Kimball, thank you for your example of servant leadership, which has inspired me not only in academia but in my work as a counselor and supervisor as well. Dr. Fred Volk, thank you for your persistence and patience with me since my bachelor's. Thank you for pushing me to be a better student and a better researcher, even when I didn't want to be.

The support systems that I have had along the way have been nothing short of incredible. Thank you to my cohort for being available to answer my questions, hear my venting, and encourage me to keep persevering. Special thanks to Ann Gregory who has been my "go to" person for the last three years. Thank you to my coworkers and bosses at Hope for Tomorrow Counseling and Patrick Henry Family Services for giving me a chance to do what I love.

Finally, to the licensed and pre-licensed counselors who participated in this research study, thank you! I hope and pray that the results from this study will help in expanding current knowledge through your experiences in helping others.

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List of Abbreviations

American Counseling Association (ACA)

Compassion Fatigue (CF)

Compassion Satisfaction (CS)

Council for Accreditation of Counseling and Related Educational Programs (CACREP)

National Association of Social Work (NASW)

Professional Quality of Life (ProQOL)

Self-Care Practices Scale (SCPS)

Trauma Informed Organizational Culture Survey (TIOC)

Vicarious Traumatization Questionnaire (VTQ)

CHAPTER ONE: INTRODUCTION

Counselors are tasked with being present with clients in their pain and trauma while assisting them throughout the process of healing. Although this work is necessary, it often results in counselors experiencing *compassion fatigue* (CF; Figley, 1995a). The physical, behavioral, and emotional impact that CF has on counselors has the potential to negatively impact not only the counselors themselves but clients and organizations as well (Bride et al., 2007; Figley, 1996, 1999; Graystone, 2019; Lipsky, 2009; Mathieu, 2012; Rudolph et al., 1997).

Conversely, working within the helping profession can also result in feelings of *compassion satisfaction* (CS; Stamm, 2005). Like CF, CS also has the ability to impact the lives of counselors, clients, and organizations (Killian, 2008; Mathieu, 2012; Wei et al., 2018). Considering the effects that CF and CS have on the counseling profession, further research regarding ways to alleviate the effects of CF and promote CS in counselors would be beneficial.

Problem Statement

CF is the exhaustion and dysfunction that comes with prolonged exposure to the suffering of others (Figley, 1995a). According to Charles Figley (2002a), compassion means to bear suffering; as an individual views the world's suffering, they also suffer. The experience of CF can happen to anyone in a position of care, but CF is a normal response to hearing the pain and suffering of another (Figley, 1995b). Due to the nature of the helping profession, CF is almost inevitable (Conrad & Kellar-Guenther, 2006). As of 2007, the rate of CF among mental health clinicians was 39% (Sprang et al.). Condrey's study in 2017 confirmed this understanding when 38%-45% of surveyed mental health professionals showed similar results. Those who experience CF are not necessarily doing something wrong; in fact, it is because they care so much that it becomes burdensome. Mathieu (2012) stated, "we develop it (CF) because we care, or because

we *used* to care" (p. 9). Figley (1995a) believed that CF affects individuals who not only do their work but do their work well. This idea of caring until it hurts has plagued many individuals in the helping profession.

CF has been referred to as an occupational hazard (Adams et al., 2006; Bride, 2004; Bride et al, 2007). Counselors experiencing CF may be more susceptible to impaired clinical judgement and decision making, therefore putting organizations and clients at risk of harm (Eastwood & Ecklund, 2008). For example, CF has the potential to contribute to a toxic work environment, lower productivity, high turnover rates, lower quality of services, misdiagnoses, poor treatment planning, violation of client boundaries, or even client abuse (Bride et al., 2007; Figley, 1996, 1999; Graystone, 2019; Mathieu, 2012; Nelson, 2015; Rudolph et al., 1997).

Presumably, counselors can experience both CF and CS at the same time; however, when CF increases, it becomes more difficult to experience CS (Bride et al., 2007; Stamm, 2002). Currently, the literature indicates that organizational culture may influence CF and CS (Killian, 2008; Mathieu, 2012). Additionally, the implementation of self-care practices within the lives of employees has shown promising outcomes (Alkema et al., 2008; Craig & Sprang, 2010; Salloum et al., 2019). Unfortunately, the research describing potential influences on CS is scarce. Due to the prevalence of CF and the lack of research addressing influential factors moderating CF and CS, it is imperative to assess the moderating effects of organizational culture and self-care practices on these constructs.

Purpose & Significance of the Study

Although mental health counseling is not the only profession with high occurrences of CF, further research is needed to better understand the effects of CF and CS on counselors and

their organizations. There are three primary purposes for conducting this study: promoting counselor development, protecting client welfare, and providing organizational understanding.

First, establishing and refining counselor identity is a crucial standard in counselor development (CACREP, 2016). When counselor identity is threatened by CF, it is vital to mitigate this threat. Additionally, caring for oneself is essential to productivity in clinical work and even encouraged by the American Counseling Association's (ACA) *Code of Ethics* (2014). Understanding how self-care practices effect CF and CS aids counselors in better establishing their own counselor development and personal wellbeing.

Secondly, organizational culture and self-care practices have a strong impact on CF and CS, and therefore influence the treatment of clients. As previously explained, when counselors experience CF, their clinical judgement and decision making can become significantly impaired, thus placing clients at risk for harm. The ACA *Code of Ethics* (2014) clearly states that counselors must make every effort to do no harm in the treatment of their clients. Understanding the effects of organizational culture and self-care practices on CF and CS provides insight into how to better address the protection of clients.

Lastly, conducting this study provides further understanding of the role that organizations have on counselor CF and how organizations are affected by this phenomenon. As previously mentioned, CF can have a significant impact on organizational factors such as services rendered and turnover rates (Mathieu, 2012; Nelson, 2015). Additionally, the negative outcomes of CF can contribute to financial costs to the organization; for example, increased absences or lateness resulting in less clients being served, negative reputation resulting in less referrals, or even malpractice lawsuits resulting in legal costs (Smoot & Gonzolas, 1995; Stalker & Harvey, 2002). Understanding the impact of organizational culture and self-care practices on CF and CS helps

organizations know where they can better assist their employees, which in turn, helps the organization.

Research Design

This research study sought to better understand the relationship between organizational culture and self-care practices on CF and CS. This quantitative study views organizational culture and self-care practices as independent variables while CF and CS are the dependent variables. Once the data was collected, the researcher ran a regression analysis based on Andrew F. Hayes' PROCESS v3.3 SPSS Conceptual Model One (2017). The results determine the strength of the interaction between CF and CS when moderated by organizational culture and self-care practices. More details regarding research design, research questions, and hypotheses are discussed in Chapter 3.

Research Questions

The following research questions were examined in this study:

1. How does organizational culture moderate the relationship between CF and CS?
2. How do self-care practices moderate the relationship between CF and CS?

Hypotheses

Hypothesis 1: Positive organizational culture will attenuate the relationship between CF and CS in counselors (H1).

   a. Positive perceived peer support will attenuate the relationship between CF and CS (H1a).
   b. Positive perceived supervisory support will attenuate the relationship between CF and CS (H1b).

c. Positive perceived systemic support will attenuate the relationship between CF and CS (H1c).

d. Positive perceived trauma training will attenuate the relationship between CF and CS (H1d).

Hypothesis 2: The implementation of self-care practices will attenuate the relationship between CF and CS in counselors (H2).

a. The implementation of personal self-care practices will moderately attenuate the relationship between CF and CS in counselors (H2a).

b. The implementation of professional self-care practices will significantly attenuate the relationship between CF and CS in counselors (H2b).

c. The implementation of professional self-care practices will have stronger attenuating effects on the relationship between CF and CS than personal self-care practices (H2c).

Assumption

The following assumptions are held for this study:

1. Licensed and pre-licensed counselors acting as participants for this study are appropriately trained professionals; as such, they provide ethical and sound treatment for their clients.
2. CF is measured by assessing participants' levels of burnout and secondary traumatic stress.
3. Participants completed the provided survey honestly and appropriately based on their own experiences as professionals in the counseling field.

4. The instruments used in this study are valid and reliable instruments for measuring the independent and dependent variables.

Limitations

The following are limitations for this study:

1. Due to the nature of the recruitment process, the sample size is a concern. A larger sample size could provide a more accurate understanding of counselor experiences in this area.
2. This study only evaluated CF and CS as its dependent variables. There may be participants whose symptoms are better described as experiencing vicarious trauma.
3. Although it is assumed that participants answered the self-reported survey with honesty, it is difficult to assess whether participants' self-reporting is accurate to their lived experiences (Abel et al., 2014).
4. Universal terminology describing the effects of working in the helping profession are difficult to solidify. The terms compassion fatigue, burnout, secondary traumatic stress, and vicarious trauma are often used interchangeably when they are, in fact, different constructs. The same can be said for CS, vicarious posttraumatic growth, and self-care practices: other professionals may have an alternative understanding of these terms. Therefore, the results of this study may be conflictual to unanimous understanding of these experiences.

Definition of Terms

Licensed Counselors

For the duration of this research study, the term *licensed counselors* refer to licensed professional counselors and licensed marriage and family therapists. These individuals have

successfully completed the required educational coursework, practicum, internship, post-graduate residency, and examination for their respective states. Terminology referring to licensed professional counselors varies by state (i.e., licensed mental health counselor, licensed clinical mental health counselor, licensed professional clinical counselor, etc.; ACA, 2020). Similarly, marriage and family therapists are also known by a variety of titles across the U.S. (i.e., licensed marital and family therapist, licensed clinical marriage and family therapists, licensed independent marriage and family therapist, etc.; ACA, 2020). Regardless of their state board given title, these individuals are practicing mental health counselors providing therapeutic services to a variety of populations and bound by their respective code of ethics (ACA, 2014; AAMFT, 2015). Licensed school counselors were not included in this study.

Pre-licensed Counselors

Participants categorized as *pre-licensed counselors* have completed the required educational coursework, practicum, and internship of their graduate program and are pursuing licensure (LPC or LMFT) in their respective states. Terminology referring to pre-licensed counselors varies by state (i.e., resident counselor, associate, intern, etc.; ACA, 2020). Pre-licensed counselors provide therapeutic services to a variety of clients under the guidance of their registered supervisors.

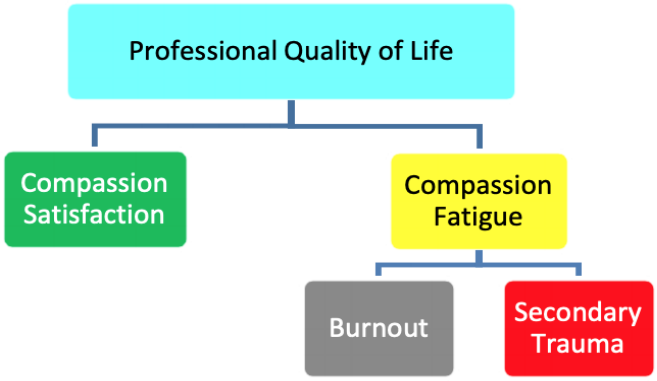
Professional Quality of Life

Stamm (2010) describes *professional quality of life* as "the quality one feels in relation to their work as a helper" (p. 8). The concept of professional quality of life is complex as it encompasses one's work environment, personal characteristics, and exposure to workplace primary and secondary trauma (Stamm, 2010). These factors can affect paid workers as well as volunteers (Stamm, 2010). Professional quality of life is assessed by measuring CS and CF. CF

is measured by assessing burnout and secondary traumatic stress as pictured in Figure 1. More details regarding the Professional Quality of Life scale (ProQOL) are described in Chapter 3.

Figure 1

Diagram of Professional Quality of Life (Stamm, 2010)



Compassion Fatigue

Originally introduced to the helping profession by Charles Figley (1995a), *compassion fatigue* (CF) refers to "a state of exhaustion and dysfunction— biologically, psychologically, and socially— a result of prolonged exposure to compassion stress and all that it evokes" (p. 253). Figley and Stamm's collaboration on CF resulted in the conclusion that CF is made up of two separate constructs: burnout and secondary trauma (Stamm, 2010). The exhaustion and frustration that derives from burnout in conjunction with the effects of work-related traumatic incidents from secondary traumatic stress result in employees experiencing CF. Symptomatology of CF can affect employees physically, behaviorally, and emotionally within their personal and professional lives.

Burnout

Burnout, one of the components to CF, is "associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively" (Stamm, 2010, p. 13). Burnout

is marked by exhaustion, cynicism, and inefficiency because of the state of one's work environment (Maslach et al., 2001). Employees experiencing burnout may feel that their work does not make a difference or impact. The onset of burnout is typically gradual (Stamm, 2010). As burnout progresses, the employee's physical and emotional exhaustion results in an array of negative outcomes such as apathy, irritability, lack of motivation, and poor work quality (Abassary & Goodrich, 2014; Mathieu, 2012; Nelson, 2015; Pross, 2006).

Secondary Traumatic Stress

Secondary traumatic stress, the second component of CF, is the "work-related, secondary exposure to people who have experienced extremely or traumatically stressful events" (Stamm, 2010, p. 13). Figley (1995b) described secondary traumatic stress as "the neutral and 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" (p. 7). Effects of secondary traumatic stress mirror symptoms of posttraumatic stress disorder (i.e., fear, sleep problems, intrusive thoughts/images, avoidance, etc.; Bride et al., 2007; Figley, 1995a, 2002b). Secondary traumatic stress is similar to vicarious trauma; however, the onset of secondary traumatic stress is typically rapid and associated with a particular event (Stamm, 2010).

Compassion Satisfaction

Compassion satisfaction (CS) refers to the positive outcomes that one experiences from helping others. Stamm (2010) describes it as "the pleasure you derive from being able to do your work well" (p. 12). This pleasure in the workplace can come from one's joy in working with colleagues or even satisfaction in helping people in need (Stamm, 2010). There is a sense of motivation and invigoration that assists in continuing to help others despite negative outcomes.

Employees experiencing CS believe they are making a difference with those that they serve (Stamm, 2010).

Organizational Culture

Organizational culture "supports the experience of belonging, understanding, and acceptance, defining insiders and outsiders: it provides a sense of 'home' and bounds the organizational identity" (Hormann & Vivian, 2005, p. 160). In order to do so, organizations must communicate a sense of safety, provide support, and promote trauma awareness for the betterment of the employee and the services provided (Handran, 2014). This is accomplished though peer support, supervisory support, systemic support, and trauma training.

Peer Support

Peer support is characterized by positive professional, social, and emotional support provided by coworkers (Bahraini, 2008; Nelson, 2015). Colleagues support each other by demonstrating care for one another (Figley & Roop, 2006). This may include using humor, being attuned to others' needs, offering help without being asked, and asking about each other's well-being when noticing mood changes (Figley & Roop, 2006). A sense of safety is developed within the collegial relationship that individuals can trust their coworkers with professional and personal information (Handran, 2014).

Supervisory Support

Supervisory support is defined as the "guidance and consultation that is provided by a superior who is competent, approachable, and knowledgeable" (Nelson, 2015, p. 17). While supervisory support includes guidance over clinical casework, an essential component also includes discussion of how cases affect the person of the counselor (Sommer, 2008). It is important to note that trauma-informed supervision is separate from administrative supervision

(Roche et al., 2007). Positive and trauma-informed supervisory support must convey to the supervisee that they are safe and respected within the workplace (Pearlman & McKay, 2008; Handran, 2014).

Systemic Support

Systemic support, also known as organizational support, is "employees' perceptions concerning the extent to which the organization values their contributions and cares about their well-being" (Handran, 2014, p. 21). Systemic support is twofold, characterized by supportive tangibles and supportive empowerment (Handran, 2014). Supportive tangibles include factors such as fair compensation, vacation time, health benefits, ongoing supervision, diversity in responsibilities, and reasonable caseloads (Handran, 2014). An environment of positive communication, trust, respect, feedback, and inclusive decision making characterize supportive empowerment (Moore, 2007). Lastly, supportive organizations do not neglect the impact of CF on its employees; instead, organizations confront these issues and provide training, opportunities, policies, and procedures to effectively address CF symptoms (Handran, 2014). Organizational leaders are responsible for providing this supportive atmosphere to their employees (Handran, 2014).

Trauma Training

Trauma training involves three factors. First, organizations provide basic education on the symptomology and effects of trauma (Harris & Fallot, 2001). Secondly, organizations provide training opportunities for counselors to learn how to help survivors of trauma using evidence-based practices (Handran, 2014). Lastly, trauma training must include information regarding the importance of implementing self-care practices in order to address CF symptoms in employees (Handran, 2014).

Self-Care

Self-care is a process by which individuals implement practices to promote holistic wellbeing that encompasses wellness, resilience, and coping (Lee & Miller, 2013; Lee et al., 2019). These practices are often based upon an individual's preferences, beliefs, cultural background, social background, and employment (Lee & Miller, 2013; NASW, 2009). The implementation of self-care is foundational to ethical practice (ACA, 2014; NASW, 2009). This implementation is achieved through the interconnection of personal self-care practices and professional self-care practices (Lee & Miller, 2013).

Personal Self-Care Practices

Personal self-care is "a process of purposeful engagement in practices that promote holistic health and well-being of the self" (Lee & Miller, 2013, p. 99). Personal self-care includes practices such as physical activities, laughing, spiritual practices, sleep, accepting help from others, and meeting one's own emotional needs (Lee et al., 2019).

Professional Self-Care Practices

Professional self-care is "the process of purposeful engagement in practices that promote effective and appropriate use of the self in the professional role within the context of sustaining holistic health and well-being" (Lee & Miller, 2013, p. 99). Professional self-care includes the following practices: taking breaks throughout the work day, seeking professional development, taking vacations, acknowledging success, problem-solving, maintaining a work/life balance, seeking support, and implementing assertiveness skills (i.e., saying "no" when appropriate; Lee & Miller, 2019).

Theoretical Framework

Compassion Stress and Fatigue Model

The Compassion Fatigue Model, developed by Charles Figley, is a theoretical model based on the assumption that "empathy and emotional energy are the driving force in effectively working with (a) the suffering in general, (b) establishing and maintaining an effectively therapeutic alliance, and (c) delivering effective services including an empathetic response" (Figley, 1995a, 1997; Figley, 2002a, p. 1436). This etiological model holds to ten constructs that contribute to the cause and prevention of CF.

Figure 2 maps out the process by which CF is manifested under these ten constructs. Based on this map, exposure to clients, empathetic ability, and empathetic concern affect empathetic response. This empathetic response, in addition to counselor disengagement and satisfaction, contribute to the level of compassion stress the counselor may feel. The combination of compassion stress, prolonged exposure, traumatic memories, and degree of life disruption impact the degree to which a counselor experiences CF.

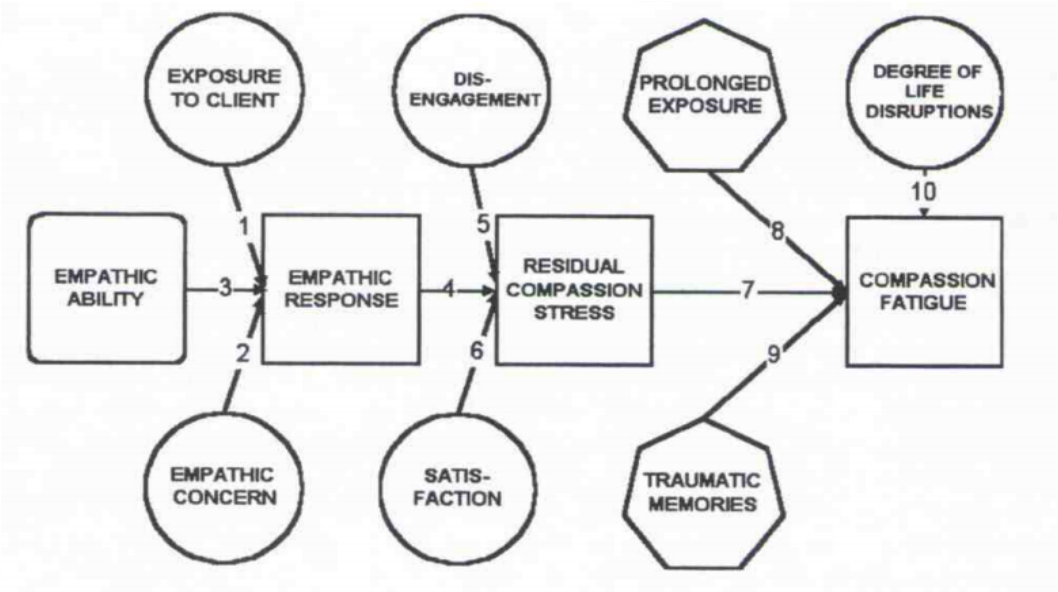
- *Empathetic ability* is the aptitude of empathy that counselors can provide to others. While empathy is an essential component of therapeutic treatment, it is also the main contributor to CF (Figley, 2002a).
- *Empathetic concern* is the motivation that counselors have to help those in need (Figley, 2002a).
- *Exposure to the client* is the direct contact with clients that requires expending emotional energy (Figley, 2002a). Many professionals move from direct client exposure (outpatient counseling, in-patient counseling, crisis counseling, etc.) to indirect exposure (supervisors, administrators, or teachers) due to the cost of direct exposure being too great.

- *Empathetic response* is the ability for the counselor to step into the shoes of the sufferer and gain insight on the sufferer's thoughts, feelings, and behaviors behind their suffering (Figley, 2002a). The ability to respond empathetically to clients' suffering contributes to powerful therapy yet can also contribute to overwhelming distress.
- *Compassion stress* is characterized by "the residue of emotional energy from the empathetic response to the client and is the ongoing demand for action to relieve the suffering of a client" (Figley, 2002a, p. 1437). If not addressed, compassion stress can intensify and lead to CF.
- *Sense of achievement*- Counselors experience a sense of achievement when they see the benefits of their efforts to help the sufferer and find success in such work (Figley, 2002a). This sense of achievement is a preventative factor to compassion stress.
- *Disengagement* is the counselor's ability to let go of their connection to the sufferer's pain in between sessions. Being able to disengage or distance oneself from the client's suffering helps to lower or prevent compassion stress (Figley, 2002a).
- *Prolonged exposure* is described as "the ongoing sense of responsibility for the care of the suffering, over a protracted period of time" (Figley, 2002a, p. 1438). When counselors are able to have time away from the responsibility of caring for others, they have time to recuperate from the stress of caring.

- *Traumatic recollections* are counselors' memories of particularly difficult clients or traumatic stories that invoke depression, anxiety, and/or PTSD like symptoms within the person of the counselor (Figley, 2002a).
- *Life disruption* such as a change in schedule or responsibilities under normal circumstances may be seen as inconvenient but tolerable; life disruptions combined with previously described constructs put counselors at a higher risk for experiencing CF (Figley, 2002a).

Figure 2

Compassion Stress and Fatigue Model (Figley, 1995a, 1997)



Creating Cultures of Trauma-Informed Care Approach

The Creating Cultures of Trauma-Informed Care Approach (CCTIC), presented by Fallot and Harris (2009), seeks to break the cycle of traumatization by focusing on healing and prevention within a system (Hardman, 2019). This trauma-informed care model encompasses five guiding principles: safety, trustworthiness, collaboration, choice, and empowerment (Fallot

& Harris, 2009). Each of the five guiding principles serves as a means to mitigate the negative effects of trauma and encourage healing (Wolf et al., 2014).

The origins of the CCTIC are based on a study conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA). Researchers conducted a study integrating the five principles of CCTIC in their work with women suffering from substance abuse, mental health disorder, and trauma histories (2004). They discovered that the implementation of trauma-informed care helped to increase the effectiveness of the services provided. Based on this study's findings, along with trauma research in the decades prior, Fallot and Harris (2009) summarized the trauma-informed care model with the following tenets:

- Trauma is pervasive.
- The impact of trauma is very broad and touches many life domains.
- The impact of trauma is often deep and life shaping.
- Violent trauma is often self-perpetuating.
- Trauma is insidious and preys particularly on the more vulnerable.
- Trauma affects the way people approach potentially helpful relationships.
- Trauma has often occurred in the service context itself.
- Trauma affects staff members as well as consumers in human services programs.

In understanding these theoretical assumptions, addressing the impact of organizational culture on CF and CS in counselors is vital. The overlap of the trauma-informed care approach is discussed further in Chapter 2.

Conceptual Framework for Self-Care

Lee and Miller's (2013) conceptual understanding of self-care, though originally focused on implementation with social workers, encompasses a well-rounded understanding of self-care

practices. This framework asserts that self-care is foundational to effective and ethical practice (NASW, 2009). Self-care is seen as two dimensional, incorporating personal self-care and professional self-care (Barnett et al., 2007; Hunter & Schofield, 2006; Lee & Miller, 2013). These dimensions, though separate, are inherently connected (Lee & Miller, 2013; Skovholt et al., 2001). The facilitation of personal and professional self-care can happen through the implementation of support systems. This construct fits well with the understanding that positive organizational culture incorporates an element of support, which is discussed in further detail in the literature review of organizational culture.

The conceptual framework for self-care states that proactive and intentional implementation of self-care is more effective than reactive self-care (Lee & Miller, 2013). The implementation of proactive self-care facilitates self-awareness and responsive engagement. Self-care incorporates an individual's preferences, beliefs, cultural background, social background, and employment (Lee & Miller, 2013; NASW, 2009). The intentional practice of self-care is believed to foster holistic health within the individual and has the power to facilitate change in an organization's culture (Lee & Miller, 2013). It is for these reasons that assessing the impact of self-care and organizational culture on CF and CS in counselors is so essential.

Organization of Remaining Chapters

Although briefly discussed in this chapter, Chapter 2 provides a more thorough understanding of the problem of CF, what constructs contribute to CF, the symptoms of CF, and current literature on ways to prevent and address CF. Furthermore, the literature review describes current research on CS, components of organizational culture, and self-care practices. Chapter 2 concludes with a rationale for the current study followed by areas in which the current literature is insufficient. Chapter 3 further discusses the research design, research questions, hypotheses,

participant recruitment, and construct measures. Chapter 4 provides details regarding the results of the data analysis. Chapter 5 explains the research findings as well as limitations and implications for future research.

Summary

The prevalence of CF in the lives of counselors is evident (Sprang et al., 2007; Condrey, 2017). The negative effects that CF can have on professionals, clients, and organizations should be concerning to those in the counseling profession. Additionally, little research has been conducted to further understand counselors' experiences of CS. This quantitative study sought to better understand the relationship between organizational culture and self-care practices on CF and CS in the lives of licensed and pre-licensed counselors.

CHAPTER TWO: LITERATURE REVIEW

Employees in the helping profession undoubtedly experience an array of positive and negative outcomes when working with distressed populations. Compassion fatigue (CF), marked by both burnout and secondary traumatic stress, can cause enervating symptoms for licensed and pre-licensed counselors (Mathieu, 2012). While employees may experience CF in their careers, the potential of experiencing compassion satisfaction (CS) is also prevalent. The current literature on mitigating CF and promoting CS varies; research suggests that components of a positive organizational culture and implementation of self-care practices could help moderate the relationship between CF and CS (Abassary & Goodrich, 2014; Aldridge, 2012; Alkema et al., 2008; Craig & Sprang, 2010; DePanfilis, 2006; Lang et al. 2016; Lizano et al., 2014; Nelson, 2015; Sillero & Zabalegui, 2018).

This chapter reviews the current literature on CF (including burnout and secondary traumatic stress), CS, organizational culture (including peer support, supervisory support, systemic support and trauma training), and self-care practices (both personal and professional). The chapter concludes with the rationale for this research study and areas in which the current research falls short of addressing this problem.

Compassion Fatigue

CF was first introduced by Joinson (1992) when discussing the emotional toll that nurses experience when caring for patients. Charles Figley later introduced the phenomenon in the lives of mental health professionals. Figley (1995) understood CF as "a state of exhaustion and dysfunction— biologically, psychologically, and socially— a result of prolonged exposure to compassion stress and all that it evokes" (p. 253). Klimeck and Singer (2012) further defined CF as "The willingness of an individual to place the needs of others above him- or herself to the

point of causing harm" (p. 368). Additionally, Figley (1995b) also described CF as the "cost of caring" (p. 1).

CF is a gradual erosion of connection with others and the self (Mathieu, 2012). This concept of CF (also known as emotional fatigue) is similar to burnout in that it negatively affects counselors (or any helper/caregiver) over an extended period; however, CF specifically occurs in those acting as an emotional buffer to persons/clients in crisis (Abassary & Goodrich, 2014; Dill, 2007). Risk factors of CF include, but are not limited to, the following considerations: history of childhood trauma, coping style, difficult life circumstances, working conditions, and excessive empathy (Mathieu, 2012). This research aligns with Figley's CF conceptual framework regarding the power of empathy on the counselor (Figley, 2002a). As a result, mental health counselors may be at a higher risk of developing CF.

Empathy, compassion, and caring, though essential in the counseling profession, can lead to CF (Figley, 1995a; Lawson et al., 2007; Pines & Maslach, 1978). Empathy is the ability to sit with another individual in their hurt and understand them with openness, vulnerability, and without judgement (Hojat, 2007). Although empathy plays a significant role in the therapeutic process, a great level of empathy also contributes to psychological distress on the part of the counselor (Figley, 2002a, 2002b). CF is associated with a "formal caregiver's reduced capacity or interest in being empathetic" (Adams et al. 2006, p. 103) when working with individuals who have experienced a traumatic event or distressing situation (Figley, 1995a; Figley, 2002a, 2002b). Continually empathizing with those in distress can cause a visceral reaction of increased numbness to the severity of the trauma narratives; in turn, resulting in decreased alertness and poorly executed services (Abassary & Goodrich, 2014; Dill, 2007; Figley, 2002b).

Development of Compassion Fatigue

Even though CF can happen to anyone working within the helping profession, there are certain circumstances that contribute to the development of CF. History of trauma, low social support, and difficulty coping with caregiving demands have been suspected to increase the likelihood of developing CF (Adams et al. 2006; Figley, 1995a, 2002b; Kassam-Adams, 1999). Furthermore, ignoring self-care implementation can leave counselors with feelings of anxiety, distress, burnout, and CF (Ray et al., 2013). A history of depression and/or anxiety also makes helpers more susceptible (Mathieu, 2012). Counselors experiencing any combination of these personal factors in addition to bearing the suffering of their clients could result in a higher risk for CF.

In addition to personal factors, professional components such as work environment, caseload, and trauma in the workplace (both primary and secondary trauma) may also have an impact on counselors' professional quality of life (Browning et al., 2019; Lawson & Myers, 2011; Stamm, 2010). Threat to safety, insufficient training, and isolation can also be contributing factors to CF (Mathieu, 2012). Further, high work demands, lower resources, and lower adaptive attitudes in an organization have been shown to lead to burnout (an essential component of CF; Alarcon, 2011).

Symptoms of Compassion Fatigue

Due to the complexity in presentation, the symptomology of CF can vary from person to person. In fact, it is believed that CF is on a continuum; at some point during one's career, its effects can be minimal while other times the effects can be debilitating (Mathieu, 2012). In accordance with Fallot and Harris' (2009) conceptual trauma-informed care model, the impact of trauma can be pervasive both personally and professionally in the following areas: physical, behavioral, and psychological (Mathieu, 2012; Saakvitne & Pearlman, 1996).

The internal struggle of caring for others can manifest itself into physical distress. The term *fatigue* in itself communicates a sense of tiredness or even exhaustion. This exhaustion is less about feeling tired and more about feeling depleted (Mathieu, 2012). Concerning sleep, insomnia or even hypersomnia have presented as physical symptoms of CF (Mathieu, 2012). Counselors are also likely to experience an increase in susceptibility to illness due to the body's inability to keep up with the demands of caring for others (Mathieu, 2012). They may be vulnerable to sickness more frequently and more severely. Additionally, headaches and migraines may become more persistent (Mathieu, 2012). In more severe cases, counselors may experience somatization or even hypochondriasis (Mathieu, 2012).

The impacts of CF are most evident through counselors' behavioral changes. CF causes a sense of detachment from others; typically, from family and friends first and later detachment from clients (Mathieu, 2012; Ronnestad & Skovholt, 2013). This detachment is evidenced by withdrawal and repression of emotions (Abassary & Goodrich, 2014; Figley, 2002b; Wilson & Lindy, 1994). They may begin to avoid social events, display more irritability/anger, demonstrate forgetfulness, and struggle in making decisions (Mathieu, 2012). In order to cope, they may begin to abuse alcohol, drugs, or develop other addictions (Mathieu, 2012). Bearing the weight of CF makes counselors more susceptible to projecting their frustrations onto others (clients, co-workers, family, and friends; Harr, 2013). These behaviors slowly begin to cause problems within counselors' relationships.

Just as CF is physically exhausting, it is also emotionally exhausting. Psychological symptoms of CF can be some of the most damaging for counselors (Mathieu, 2012). Counselors may feel angry, irritable, guilty, discouraged, anxious, depressed, and/or hopeless, further creating a sense of distancing between themselves and others. Additionally, they may become

cynical, bitter, and resentful, and may begin to have a negative view of themselves and others (Mathieu, 2012). Suffering from CF can make small tasks seem overwhelming (Merriman, 2015). They could experience an increased sense of personal vulnerability and helplessness. At times, a counselor may even experience intimacy difficulties with their significant other (Mathieu, 2012).

Symptoms within the Workplace

Counselors' professional behaviors can be negatively altered by CF. Counselors may begin to avoid their clients. They may take longer to return client phone calls and even ignore emotionally charged conversations in session (Mathieu, 2012). They may become so easily annoyed by clients in crisis that they avoid scheduling clients or demonstrate excessive absenteeism. When in a consistent routine of treating crisis cases, counselors can easily become numb to the severity of a client's pain. Alternatively, counselors may begin to believe that their clients cannot function without them; they feel an exaggerated sense of responsibility to their clients (Mathieu, 2012). Counselors may even develop the need to be needed, creating a codependency with clients and further perpetuating CF symptoms (Mathieu, 2012; van Dernoot Lipsky, 2009). Likewise, counselors can become so consumed by crisis that they assume every case they treat is high risk. When counselors are experiencing these behavioral symptoms, it becomes evident that their work/life balance is incongruent or even non-existent. Counselors may feel so embarrassed that they are experiencing any of these symptoms (Mathieu, 2012) that they find it difficult to seek the support that they need (Fallot & Harris, 2009).

Psychological symptoms significantly affect counselors' professionalism. Counselors may begin to struggle to empathize and sympathize with their clients. They may experience a diminished sense of enjoyment in their work or even dread coming to work altogether (Mathieu,

2012). This outlook affects counselors' sense of achievement, thus perpetuating feelings of compassion stress (Figley, 2002b). Counselors' responses could range from hypersensitivity to insensitivity when hearing others discuss strong feelings or emotional traumas (Mathieu, 2012). Counselors could unknowingly redirect emotionally charged stories due to their inability to attend to the severity of the emotions being discussed (Gentry et al., 1997; Mathieu, 2012). If unaddressed, counselors may continue to display problematic behaviors that compromise the care given to clients (Mathieu, 2012). When plagued with CF for an extensive amount of time, counselors may cause harm to clients, leave the field temporarily, or even leave the profession permanently (i.e., attrition; Mathieu, 2012).

The culmination of physical, behavioral, and psychological symptoms can be incredibly debilitating, not only for counselors, but also for the organizations where they work and the clients that they serve. Saakvitne and Pearlman (1996) referred to CF as an occupational hazard. The bitterness and resentment that often comes from CF may result in a toxic work environment (Mathieu, 2012). CF affects the way in which clinical services are rendered, resulting in lower productivity, lower quality of care, and a disrespect for clients and their boundaries (Bride et al., 2007; Figley, 1996, 1999; Graystone, 2019; Mathieu, 2012). When impacted by CF, clinicians are more likely to make clinical errors such as misdiagnosis, poor treatment planning, or client abuse (Bride et al., 2007; Rudolph et al., 1997). It is important to note that the presence of some of these physical, behavioral, and psychological symptoms does not guarantee the presence of CF. Counselors must assess the nature of their symptoms in light of their work to determine if they are experiencing CF (Mathieu, 2012).

Over the course of the last three decades, researchers' understanding of CF has expanded and developed. CF has been frequently associated with similar terms such as burnout, secondary

traumatic stress, and vicarious traumatization (Rank et al., 2009). Though similar (Sprang et al., 2007), these terms cannot be seen as the same (Eastwood & Ecklund, 2008; Van Hook & Rothenberg, 2009). The most common understanding of CF is based on Figley's early concepts, with further development from Stamm and his work on the Professional Quality of Life scale (ProQOL). According to Stamm (2010), CF comprises both burnout and secondary traumatic stress. Though symptoms overlap, burnout, secondary traumatic stress, and CF are separate entities.

Burnout

Burnout has been described as a "persistent, negative, work-related state of mind in 'normal' individuals" (Schaufeli & Peters, 2000, p. 21). Burnout encompasses three main features: exhaustion, cynicism, and inefficiency (Maslach et al., 2001). Burnout is specifically linked to occupational based stressors; it is not limited only to those in the helping profession. The slow progression of a stressful work environment can cause in any employee. Typical characteristics of burnout can include distress, lack of motivation, and poor work attitude and behaviors, resulting in a decrease in the quality of work performance (Abassary & Goodrich, 2014). Burnout features both physical and emotional exhaustion due to various negative work factors (i.e., dissatisfaction with job, feelings of powerlessness in one's work, feeling overwhelmed with work tasks, etc.; Mathieu, 2012). Other symptoms include apathy, hopelessness, disillusionment, irritability, and an impersonal or uncaring attitude (Nelson, 2015; Pross, 2006). Burnout can be easily addressed. CF, on the other hand, is more difficult to resolve (Mathieu, 2012).

Research has shown various risk factors for burnout. Wilkerson and Bellini (2006) found that school counselors were at higher risk of experiencing burnout when they were more focused

on feelings and emotions when addressing problems and stressors. They suggested continually developing coping skills to combat this risk (Wilkerson & Bellini, 2006). Holdren and colleagues (2015) found that a poor work environment and heavy workload contributed to burnout in hospital nurses. Another study concluded that a lack of social support, lack of job satisfaction, and highly emotionally involved jobs may leave employees susceptible to burnout (Adams et al. 2006). African American and Caucasian social workers were shown to have a higher probability of experiencing burnout (Nelson, 2015). Burnout undoubtedly causes negative outcomes in those in the helping profession.

Burnout can have negative implications on workplace outcomes. Experiencing burnout can make counselors more susceptible to experiencing CF and vicarious traumatization (Mathieu, 2012). A general reduction in productivity, creativity, and compassion for others are common symptoms of employees experiencing burnout (Grosch & Olsen, 1994). Organizations may experience negative effects when their employees are burned out due to the cost of increased absences, tardiness, and reduced commitment to one's job (Smoot & Gonzolas, 1995; Stalker & Harvey, 2002). Unfortunately, burnout has been shown to lead to high turnover rates as well (Conrad & Kellar-Guenther, 2006).

Beitel et al. (2018) asserted that substance abuse treatment organizations have taken an interest in understanding the impact of burnout for a number of reasons. First, burnout can negatively impact the well-being of the counselor (Oyefeso et al., 2008). Additionally, burnout can affect organizational systems by effecting absenteeism, turnover rates, and productivity (Anagnostopoulous, 2010; Cropanzano et al., 2003). Beitel et al. (2018) suggested implementing organizational changes to alleviate burnout such as providing socialization opportunities, space

for counselors to support one another, more clinical supervision, and access to appropriate training.

A qualitative study conducted on female university counselors in Taiwan concluded that burnout can be brought about by work conflicts, family conflicts, changes on campus (i.e., their workplace), and changes within the counseling profession (Lin, 2012). The author specifically mentions that a negative work environment (i.e., work atmosphere, peer relationships, work systems) can contribute to symptoms of CF (Lin, 2012). In order to address this burnout, Lin (2012) asserts that an appropriate work/life balance is crucial.

Regarding combating these negative symptoms, Browning et al. (2019) found that gratitude and daily spiritual experiences were significant negative predictors for burnout, while hope was the only predictor of CS. They also discovered that older counselors were less likely to experience burnout (Browning et al., 2019). It has been noted that support systems (peer, family, and supervisor) are protectors against burnout, job stress, and CF (Barak et al., 2009; Bride et al., 2007; Ducharme et al., 2015; Knight, 2010; Knudsen & Roman, 2008; Kulkarni et al., 2013; Lloyd et al., 2002; Maslach et al., 2001).

One study assessing counselors-in-training discovered that resilience and wellness were significant predictors of CF; empathy and supervisory working alliance were not significant predictors of CF (Can & Watson, 2019). Ivicic and Motta (2017) and Williams et al. (2012) also found that supervisory working alliance was not significantly associated with CF in mental health professionals. Although not specifically addressing CF, Nelson (2015) found that peer support did not lower levels of vicarious trauma. More research is needed to understand the impact that organizational culture has on counselor CF and CS.

Secondary Traumatic Stress

Secondary trauma stress occurs in counselors when they hear (counseling session), read (reviewing case files), or see (movie or video clip) another's trauma story (Mathieu, 2012). Figley (1995) defined secondary traumatic stress as "the neutral and 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" (p. 7). Secondary traumatic stress is characterized by posttraumatic stress disorder symptomology (i.e., intrusive thoughts, intrusive images, avoidance, hyperarousal, distressing emotions, impairment in functioning); however, Secondary traumatic stress is developed via indirect contact with a traumatic experience (Bride et al., 2007; Figley, 1995a, 2002b; Figley & Roop, 2006).

The social work literature has an international focus on the experience of secondary traumatic stress. One study indicated that emotional separation and occupational stress were predictors of secondary traumatic stress in hospital social workers (Badger et al., 2008). Another study assessing masters-level social workers found that supervisory support, salary, caseload size, and personal anxiety were contributing factors to secondary traumatic stress. In particular, clinical supervisors who provided support via empathy, unconditional positive regard, congruence, etc. caused lower levels of secondary traumatic stress in their social work supervisees (Ji et al., 2019). Based on their findings on secondary traumatic stress in social workers, Ji et al. (2019) suggested that organizations would benefit from providing clinical supervision to their employees, opportunities for stress-relief activities, and access to programs such as the Employee Assistance Program (EAP).

Experiencing secondary traumatic stress results in counselors feeling a disruption in meaning, connection, and identity (Pearlman & Saakvitne, 1995). Secondary traumatic stress differs from CF in that the onset of secondary traumatic stress symptoms are typically rapid and

commonly associated with a particular event (Stamm, 2010), whereas CF symptoms emerge gradually after numerous events of caring for the wellbeing of others.

Compassion Satisfaction

The ability to empathize with another can be burdensome (Badger et al., 2008), but it can also be a source of motivation (Brockhouse et al., 2011; Harrison & Westwood, 2009). This motivation is known as CS. CS is "the pleasure you derive from being able to do your work well" (Stamm, 2010, p. 12). This is characterized by feelings of both satisfaction and success in one's job (Conrad & Kellar-Guenther, 2006). CF and CS are negatively correlated; as CF increases, CS decreases and vice versa (Collins & Long, 2003; Stamm, 2005).

The literature has assessed various professions regarding CS. One study focused on nurses (Wei et al., 2018) and showed that perceived caring behaviors in the workplace contributed to less CF, stress, and burnout as well as higher levels of job satisfaction and CS. While assessing student counselors and cognitive behavioral psychotherapists, researchers asserted that high levels of self-compassion (i.e., being kind to oneself mentally, emotionally, and physically) can result in higher levels of CS and lower levels of CF (Beaumont et al., 2016). Research conducted on camp counselors discovered burnout was linked to lower levels of CS, while the implementation of self-care practices and stress management contributed to positive CS (Stanfield & Baptist, 2019). Condrey (2017) ascertained organizational support to be a factor in resisting CF; this study assessed 16 organizations from varying occupations (i.e., medical professionals, social work, military, mental health professionals, banks, sales, and restaurants). This study did not specifically address CS.

The understanding of the impact of CF and CS in the workplace has developed over the years. Research has shown that high caseloads and lack of control in one's caseload are linked to

lower levels of CS (Killian, 2008; Mathieu, 2012). One study found that workplace social support was the most significant element for CS (Killian, 2008). Unfortunately, the literature is limited on its assessment of counselors' experiences of CS. More research is needed specifically addressing the influence of workplace practices on counselor CS.

Organizational Culture

The definition of organizational culture can range from basic norms or behaviors within an organization (Koberg & Chusmir, 1987) to shared beliefs by members of a social unit (O'Reilly et al., 1991), or a mix of both of these understandings (Erkutlu et al., 2011). A more comprehensive understanding of organizational culture includes "beliefs, values, attitudes, behaviors, and standards shared by the individuals and groups that make up an organization" (Bryant, 2013, p. 147). Organizational culture affects decision making, promotions, and expectations within an organization (Nelson, 2015). Handran (2014) suggested that an organization's culture must display safety, support, and trauma awareness, which all affect employees' well-being. With the influence that organizations have on their employees, it would be valuable to understand an organization's impact on counselor CF and CS.

One study concluded that organizational changes (such as better work conditions, schedule control, and quality supervision) were more effective in addressing CF than simply implementing individual self-care (Killian, 2008). Killian (2008) advocated for systemic change rather than just relying on individual change to address the effects of CF. In doing so, the blame for CF is not placed solely on the helper (Mathieu, 2012). Organizational leaders must take steps to change their organizational culture to allow employees to be more open and honest about their struggles, know that their organization is there to help them, and not punish or shame them for their struggles (Nelson, 2015). Promoting CS in the workplace has the potential to improve

employee wellness and services provided to clients (Kulkarni et al., 2013). Unfortunately, organizational culture can be difficult to change (Nelson, 2015; Patnaik, 2011; Schein, 1984).

Research has shown that organizational factors play a significant role in the successes and failures of the employees and services provided. A study conducted on nurses in Spain showed that organizational factors (i.e., leadership style, staffing, and support) increased the impact of job satisfaction and burnout (Sillero & Zabalegui, 2018). As previously mentioned, occupational stress has been identified as a predictor for secondary traumatic stress in hospital social workers (Badger et al., 2008). With this understanding in mind, Badger and colleagues (2008) noted that work environments needed to evaluate the environmental characteristics that contribute to occupational stress (e.g. workload, personal safety concerns, education about secondary traumatic stress, cultures that are unsupportive of the importance of self-care, etc.).

A study conducted on pediatric nurses and physicians sought to understand the mediating effects of secondary traumatic stress on perceived social support and burnout (Hamama et al., 2019). They found that secondary traumatic stress was a mediator between perceived social support (in the organization) and burnout (Hamama et al., 2019). Based on the concluding results, researchers recommended that organizations make systemic changes to decrease the effects of secondary traumatic stress. The significant premise of their recommendations was to cultivate an organizational culture that educated their employees on the potential for traumatic stress and provide appropriate interventions for coping with it (i.e., peer support and supervisory support; Hamama et al., 2019). Finally, researchers recommended that nurses and physicians participate in training opportunities and foster healthy, supportive social networks, particularly within the workplace (Hamama et al., 2019). Understanding the risks and potential interventions

for CF in other professions sparks interest in further research of the risks and interventions for the counseling profession as well.

After interviewing 29 staff members to investigate the effects that an organization has on employee secondary traumatic stress, Jirek (2020) identified various ways in which the organization provided an unhealthy atmosphere when it comes to addressing secondary traumatic stress in their employees. A common finding throughout the interviews suggested that the organization placed the responsibility of addressing secondary traumatic stress solely on the individual, thus perpetuating victim blaming when secondary traumatic stress affected clinical work. Additionally, employees were not given adequate resources and education necessary to practice appropriate self-care (Jirek, 2020). As a final finding, the organizational culture pressured their employees to maintain unrealistic expectations within the workplace, which further perpetuated secondary traumatic stress symptoms. This included unreasonable workloads and encouraging overextension within their work duties, which resulted in feelings of guilt for taking time off (Jirek, 2020). Understanding the impact of organizational culture should prompt organizational leadership to consider the effect that their choices have on their employees' wellbeing.

Various research indicates that occupational support can display a lessening effect of indirect trauma (i.e., compassion fatigue, secondary traumatic stress, and/or vicarious trauma) while the lack of support can pose a risk for such constructs (Bride et al., 2007; Brockhouse et al., 2011; Collins et al., 2010; Knight, 2013; Ortlepp & Friedman, 2002). Appropriate support from one's organization can significant influence an employee's choice to stay or leave the organization (Agbenyiga, 2009; Nelson, 2015). Organizational factors such as high turnover rates, lack of peer support, underqualified supervisors, and a lack of trauma awareness can

further inhibit the success of the organization and negatively influence wellbeing of its employees (Nelson, 2015). It is for these reasons that peer support, supervisory support, systemic support, and trauma training are crucial factors of a counseling organization's culture (Handran, 2013).

Peer Support

Peer support can be defined as workplace relationships with people who provide support professionally, socially, and emotionally (Bahraini, 2008; Nelson, 2015). Appropriate peer support allows for professionalism (Agnew et al., 2000; Nelson, 2015) alongside the freedom to ask questions (Nelson, 2015) and solve problems (Martin, 2010), while also providing an environment where employees do not feel intimidated or judged (Aldridge, 2012, Nelson, 2015). Peer support has been shown to have many benefits within an organization: a reduction in feelings of isolation, an increase in validation, and assistance in employees' decisions to stay or leave the organization (Aldridge, 2012; DePanfilis, 2006; Martin, 2010; Nelson, 2015).

Social support was identified as a contributor to CS, along with work hours and internal locus of control (Killian, 2008). A study assessing television journalists concluded that a moderately negative correlation existed between perceived peer cohesion and supervisor support on CF, burnout, and secondary traumatic stress; as cohesion and support declined, symptoms increased (Dworznik, 2018). Interestingly, Badger et al. (2008) did not find social support as a predictor against secondary traumatic stress in hospital social workers. Although much research indicates that peer support is helpful to employees, other research has seen little impact of peer support on constructs such as burnout, secondary traumatic stress, and vicarious trauma (DePanfilis et al., 2006; Martin, 2010; Nelson, 2015).

Supervisory Support

Support from a supervisor is characterized by "guidance and consultation that is provided by a superior who is competent, approachable, and knowledgeable" (Nelson, 2015, p. 17). Supervision is not limited to the guidance of clinical cases; it must also include time to discuss how these cases are affecting the counselor (Sommer, 2008). Adequate supervision can be a crucial influence in managing personal and professional experiences, especially for those working with crisis and trauma-focused cases (Abassary & Goodrich, 2014). Supervisors have a responsibility to be aware of the warning signs for conditions such as burnout, secondary traumatic stress, vicarious trauma, and CF in order to discuss the effects with their supervisees. Unfortunately, many employees do not share their experiences with their supervisors due to fear of being seen as weak or incompetent (Jankoski, 2010). Knight (2010) found that social work students were at a greater risk of CF if they felt that they could not talk to their supervisors. A recent mixed-method study conducted on workers who support refugees and asylum seekers in Australia concluded that frequent supervision and a positive supervisory alliance helped in reducing the risks of depression and secondary traumatic stress (Posselt et al., 2020). For this reason, supervisors must be diligent in cultivating an atmosphere of trust and respect (Hopkins, 2002; Nelson, 2015).

The role of supervisory support varies in the research. One study found that supervisory support played a significant role in reducing trauma (Chenot et al., 2009; Nelson, 2015; Westbrook et al., 2012). Another study showed that supervisory support was effective in moderating the relationship between conflict and burnout (Lizano et al., 2014). Nelson's (2015) study assessing vicarious traumatization in social workers discovered a significant association between perceived organizational supervisory support on burnout and secondary traumatic stress. However, other research suggests that supervisory support did not predict secondary

traumatization (Dagan et al., 2016). Continued research is needed to better understand the effects of supervisory support on counselor wellbeing, specifically as it pertains to CF and CS.

Systemic Support

Systemic support is defined as the support that one perceives from the organization where they are employed (Nelson, 2015). Systemic support has the ability to improve health and wellbeing (Ajala, 2013), affect services rendered (Glisson & Hennelgarn, 1998; Hopkins, 2002), and positively influence the effects of vicarious trauma (Nelson, 2015). Work environments have the ability to mitigate the effects of indirect trauma (i.e. compassion fatigue) by supporting their employees, or they can intensify indirect trauma by not supporting their employees (Knight, 2013).

When assessing CF and burnout in nurses, one study concluded that nurses are often judged by their employers for experiencing negative symptoms from their work (Contreras Sollazzo & Esposito, 2020). The researchers asserted that the systemic environment within the workplace, such as delivery, policies, and procedures, contributes to this reaction from employers. They suggested the implementation of self-care and advocacy on the part of the nurses, as well as incorporating various ways in which nurses' unions have attempted to reduce nurses' stress (i.e., eliminate threatening work conditions; adjustment of policies, procedures, and practices; safety and health education; workplace surveys; etc.; Contreras Sollazzo & Esposito, 2020).

Stanfield and Baptist (2019) suggested that both the individual and the system surrounding the individual contribute to the manifestation of burnout. When assessing the items on the ProQOL, Stanfield and Baptist (2019) interpreted that systems have an influence on the atmosphere that contributes to burnout (i.e., heavy workload, resource mismanagement, staffing

issues, etc.). One study found a significant relationship between perceived organizational systemic support on burnout but not on secondary traumatic stress, at least in licensed social workers (Nelson, 2015). With this understanding, organizations must consider the role that they play in contributing to the visceral effects of working with hurting individuals. Unfortunately, the depth of influence of systemic support in the lives of counselors is limited in the research.

Trauma Training

Trauma awareness in the helping profession requires that all employees of the organization be trauma-informed through appropriate training (Fallott & Harris, 2008). Trauma training should include trauma awareness and self-care, as well as information on the prevention and treatment of symptoms related to CF and vicarious trauma (Fallott & Harris, 2008; Nelson, 2015). New counselors are particularly susceptible to experiencing CF due to their lack of experience in knowing how to cope with work-related exhaustion (Craig & Sprang, 2010; Figley, 1995a; Sheehy et al., 2009; Voss et al., 2011). Knight (2010) discovered that social work students and supervisors were at risk of indirect trauma if they identified as feeling educationally unprepared to handle the impact of their clinical work. In fact, few social workers (student or practitioner) had received any preparation or training on the effects of indirect trauma (Knight, 2010). Employees, especially those who are new to the field and are not appropriately trained to identify the symptoms and causes of CF or vicarious trauma, may begin to believe that these experiences are their fault (Nelson, 2015). This lack of awareness can lead to resistance in seeking help (Adams & Riggs, 2008), further affecting the clientele in a negative way (Courtois & Gold, 2009).

Continual efforts towards trauma awareness are not simply a suggestion but a necessity and an obligation, from both a practical standpoint as well as an ethical standpoint (ACA, 2014).

The implementation of trauma awareness can allow employees to experience a decrease in stress levels and an increase in empathy, comfort, and confidence (Nelson, 2015; Wolf et al., 2014). Additionally, consistent trauma training can increase retention and potentially decrease vicarious trauma (Nelson, 2015). In order to implement trauma-informed approaches, there must be "a sense of safety and collaboration in the workplace and ongoing training and workforce development provided for staff" (Salloum et al., 2019, p. 300). More research is needed specifically assessing the influence of support systems and trauma training on CF and CS.

Self-Care

Self-care can be broken down into two categories: personal self-care and professional self-care. This understanding of self-care is in alignment with Lee and Miller's (2013) conceptual framework for self-care. They described personal self-care as "a process of purposeful engagement in practices that promote holistic health and well-being of the self" (p. 99). Their definition of professional self-care is "the process of purposeful engagement in practices that promote effective and appropriate use of the self in the professional role within the context of sustaining holistic health and well-being" (Lee & Miller, 2013, p. 99). Although the subject of self-care has become increasingly utilized in the field, a standardized definition of self-care is not present (Lee et al., 2019). Regardless of one's definition, self-care should not be viewed as optional, but foundational to individuals in the helping profession (Lee & Miller, 2013).

Although self-care is a subjective experience, organizations have the potential to promote wellness within the individual counselors, thus affecting the quality of their clinical work (Nelson, 2015). In fact, both personal and professional self-care are key to being trauma-informed (Salloum et al., 2019). Research suggests that the implementation of personal self-care

can have a mediating effect between burnout, secondary traumatic stress, and mental health functioning (Alkema et al., 2008; Craig & Sprang, 2010; Salloum et al., 2019). Implementing personal self-care activities that promote appropriate work-life balance was crucial in these findings. Lang and colleagues (2016) found that assistance with self-care was important in the work environment. Further, Brady (2017) observed that the implementation of positive coping strategies such as adequate sleep and taking breaks at work (i.e. self-care) contributed to higher levels of CS and lower levels of secondary traumatic stress and burnout.

Hines (2019) conducted a study on nurses to determine the effects of self-care practices on stress and intent to leave (Hines, 2019). The results of this study indicate that increased self-care practices have the potential to lead to reduced stress and lower turnover rates (Hines, 2019). Based on these findings, Hines (2019) suggested that reducing stress can reduce employees' desire to leave; therefore, saving the organization in costs and protecting employee quality of life. With this in mind, organizations would do well to consider implementing stress-reducing habits (such as self-care practices) for the betterment of the organization and its employees.

While qualitatively assessing workers, who support refugees and asylum seekers in Australia, researchers identified physical or mental activities or practices (i.e., self-care practices) as a common theme among contributions to positive well-being (Posselt et al., 2020). Findings from another qualitative study on drug counselors suggested that various personal and professional self-care strategies have the potential to attenuate burnout (Beitel et al., 2018). From their interviews with drug counselors working at various opioid treatment programs, they discovered the following as useful practices in lowering the effects of burnout: socializing with friends, exercise, participating in supervision, utilizing paid time off, taking a break during work, and maintaining work-life balance (Beitel et al., 2018). Finally, Ji et al. (2019) discovered that

high anxiety was a contributing factor in the lives of masters-level social workers. They suggested that employees implement personal self-care strategies to reduce their anxiety, thus reducing the likelihood of experiencing secondary traumatic stress (Ji et al., 2019).

Although self-care has the potential to lessen the effects of burnout and secondary traumatic stress (Brady, 2017; Steinlin et al. 2017), some studies suggest otherwise. Bober and Regehr (2006) found that the implementation of self-care practices did not lead to a reduction in secondary traumatic stress. Killian revealed that the implementation of self-care practices was only moderately effective in addressing CF. Other research suggested that those in the helping profession are susceptible to experience CF, even if they are cautious to maintain an appropriate work/life balance and practice self-care (Mathieu, 2012). Due to the conflictual nature of the research findings on self-care, it would be valuable to further assess the nature of personal and professional self-care on mental health counselors' experience of CF and CS.

Rationale for Proposed Study

Research has indicated that CF not only exists, but has debilitating effects on counselors, both personally and professionally. Although studies vary, anywhere between 40%-85% of individuals in the helping profession experience some form of CF or traumatic symptoms (Mathieu, 2012). Left unaddressed, CF could lead to serious mental health concerns such as depression, anxiety, substance abuse, and suicidal ideations/behaviors (Mathieu, 2012). An environment that is unaware or neglectful in addressing the needs of its employees is subject to potentially causing CF in its workers (Adams et al., 2006; Nelson, 2015). Employees, especially those who are new to the field and not appropriately trained to identify the symptoms and causes of CF, may begin to believe that they are to blame for these symptoms. This lack of awareness can lead to resistance in seeking help (Adams & Riggs, 2008), thus impacting the clientele in a

negative way (Courtois & Gold, 2009). Continuous strain caused by unaddressed CF can lead to workers leaving the field temporarily or permanently.

Clinician effectiveness is heavily impacted by the clinician's ability to be authentic, provide unconditional positive regard, and show empathy towards clients (Truax, 1966; Figley, 2002b; Michalchuk & Martin, 2019). The hindrance of the capacity for empathy resulting in CF and vicarious trauma has the potential to lead to incomplete therapy and high employee turnover rates (Abassary & Goodrich, 2014; Sexton, 1999). Organizations with high turnover rates stunt the growth of their organization when they neglect to provide appropriate support systems (Nelson, 2015). With higher turnover rates, fewer clients are helped, the clients helped are potentially receiving lower quality services, and those still employed are at a higher risk for CF and vicarious trauma (Nelson, 2015). It is for these reasons that both counselors and organizations have an ethical responsibility to address the impacts of CF (ACA, 2014).

Lack of Research in Proposed Area of Study

Understanding the effect that CF has on employees and organizations, it is perplexing that little research has been done assessing the impact of organizational culture on mental health workers in general, much less on counselors. There appears to be a wealth of information on contributors to CF in the lives of health professionals such as nurses. One study found that one in four health care employees were planning to leave their hospital job due to wanting "greater control over work hours and more respect" (Duxbury et al., 2009, p. 89). Additionally, many employees missed work due to the "emotional and physical fatigue" (Duxbury et al., 2009, p. 56). If organizational factors can have these effects on nurses, it is valuable to understand how organizational factors have an effect on counselors' experience of CF and CS.

Current literature on CF is not solely limited to the healthcare profession; a portion of the literature has assessed the experience of social workers. One study evaluated the impact of organizational culture on vicarious trauma in social workers; however, the study did not assess CF or CS (Nelson, 2015). In another study on social workers, the supervisor played a significant role in whether a new social worker would continue in the field (Chenot et al., 2009; Westbrook et al., 2012). Although studies have shown the importance of social support and adequate supervision for the therapist's overall wellness and as a moderator for vicarious posttraumatic growth in alternate professions (Huddleston et al., 2006; Schauben & Frazier, 1995), there is little research evaluating the role of organizational support on counselors' experiences.

Lastly, the subject of CF has lacked conceptual clarity throughout the years (Adams et al., 2006; Jenkins & Baird, 2002). Research has attempted to better explain this phenomenon, especially in light of other terms; however, a disconnect still exists in the literature. The terms vicarious trauma, burnout, secondary traumatic stress, and CF overlap in many ways, yet each of them has defining characteristics that make them unique. It would be beneficial to solidify these terms moving forward. In doing so, counselors and organizations can better understand the effect that each of these experiences has on an individual and how best to mitigate those problems (Mathieu, 2012).

Summary

Based on the theoretical framework presented and the current literature related to the problem, more research is needed to further understand the impact of organizational culture and self-care on counselors' experiences of CF and CS. The problem of CF in the lives of employees in the helping profession is evident: The physical, behavioral, and psychological toll of CF has debilitating effects on counselors, clients, and organizations. Although a portion of the literature

shows organizational culture and self-care to be a productive means for mitigating the effects of CF, additional research states otherwise. Examining the moderating effects of organizational culture and self-care on counselor CF and CS is a valuable addition to the current state of the literature.

In the chapter to follow, the methodology for the current study is presented and explained. The research questions and hypotheses are discussed in light of current literature. The population for this study is presented along with the ways in which these participants were recruited. Finally, the three construct assessments are explained, including what these assessments measure, number of items, validity, and reliability.

CHAPTER THREE: METHODOLOGY

This quantitative study sought to better understand the relationship between the independent variables (organizational culture and self-care) and the dependent variables (CF and CS). Regression analysis was used in order to understand this relationship. For this study, the researcher ran the data analysis based on Andrew F. Hayes' PROCESS v3.3 SPSS conceptual model one (2017). Hayes' (2017) PROCESS Model 1 assesses the impact of the moderator (W) on the relationship between X and Y (2017). Two separate data analyses were ran using this model to individually assess each potential moderator. This data analysis determines the strength of the interaction between CF and CS in light of the two moderators: organizational culture and self-care practices. The conceptual understanding of these data analyses is pictured in Figure 3 and 4.

Figure 3

Current research study using Andrew F. Hayes' Conceptual Model 1: Organizational Culture

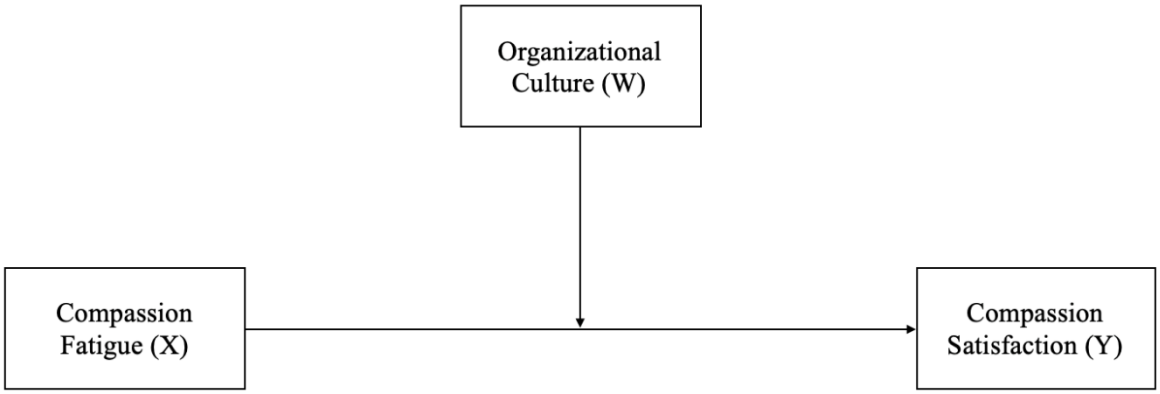
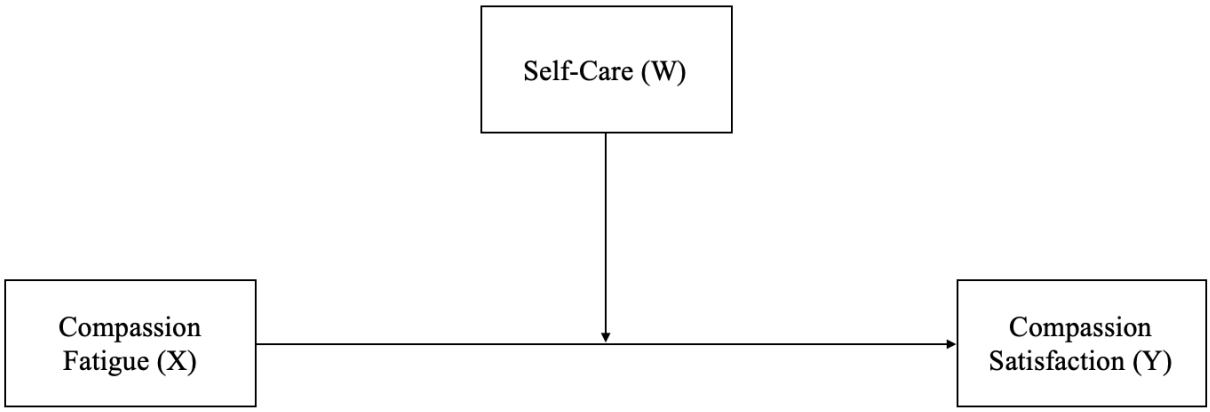


Figure 4

Current research study using Andrew F. Hayes' Conceptual Model 1: Self-Care



Research Questions & Hypotheses

Research Questions

1. How does organizational culture moderate the relationship between CF and CS?
2. How do self-care practices moderate the relationship between CF and CS?

Hypothesis One: Organizational Culture

Hypothesis 1: It is hypothesized that positive organizational culture will attenuate the relationship between CF and CS in counselors (H1).

a. It is hypothesized that positive perceived peer support will attenuate the relationship between CF and CS (H1a).
b. It is hypothesized that positive perceived supervisory support will attenuate the relationship between CF and CS (H1b).
c. It is hypothesized that positive perceived systemic support will attenuate the relationship between CF and CS (H1c).
d. It is hypothesized that positive perceived trauma training will attenuate the relationship between CF and CS (H1d).

The literature suggests that organizational culture has the potential to influence the quality of services provided to clients, job satisfaction, employee retention, and employee

wellness (CF and CS; Agbenyiga, 2009; Killian, 2008; Kulkarni et al., 2013; Sillero & Zabalegui, 2018). Unfortunately, studies on counselors' experience of organizational culture on CF and CS are lacking. Additionally, current research on the impact of support and trauma training is conflictual. Much of the research indicates that support and trauma training are significantly beneficial in decreasing CF constructs and increasing CS (Chenot et al., 2009; Killian, 2008; Lizano et al., 2014; Westbrook et al., 2012). Other studies however, have seen minimal impact on these constructs (Dagan et al., 2016; DePanfilis et al., 2006; Martin, 2010). Based on the literature assessing an array of helping professionals, it is hypothesized that positive organizational culture will have an attenuating influence on the relationship between CF and CS in counselors (H1a-H1d).

Hypothesis Two: Self-Care Practices

Hypothesis 2: It is hypothesized that the implementation of self-care practices will attenuate the relationship between CF and CS in counselors.

a. It is hypothesized that the implementation of personal self-care practices will moderately attenuate the relationship between CF and CS in counselors (H2a).
b. It is hypothesized that the implementation of professional self-care practices will significantly attenuate the relationship between CF and CS in counselors (H2b).
c. It is hypothesized that the implementation of professional self-care practices will have stronger attenuating effects on the relationship between CF and CS than personal self-care practices (H2c).

Current research indicates that the implementation of personal self-care practices has the potential to decrease CF and increase CS (Alkema et al., 2008; Brady, 2017; Craig & Sprang, 2010; Salloum et al., 2019). Hypothesis 2a anticipated similar results. However, some research

suggests that systemic/organizational change (i.e. better work conditions, schedule control, and quality supervision, etc.) would be more effective in addressing CF (Killian, 2008). While the impact of organizational culture (support and trauma training) is addressed in Hypothesis 1, it is also hypothesized that the more frequent implementation of professional self-care practices will result in greater attenuation of the relationship between CF and CS than personal self-care practices (H2b and H2c).

Participants

Licensed counselors, licensed marriage and family therapists, and pre-licensed counselors are the target population for this study. Data was not collected from licensed school counselors for this study. Seventy-five (75) participants started the study, eleven (11) of which did not complete the survey, leaving the remaining sixty-four (64) participants' surveys to be analyzed. The participants were employed within various roles (i.e., outpatient, in-patient, school-based, crisis counseling, etc.) and organizations (i.e., private practice, non-profit, community services board, hospital, schools, universities/colleges, etc.) across several states in the US. Participants ranged in age, gender, race, caseload, and years of experience. In order for their data to be included in the study, participants must have had at least worked consistent part-time hours (1-29 hours a week) within their respective counseling roles over the last 30 days prior to completing the survey.

Recruitment of Participants

Details regarding the research study and access to the survey were provided on an electronically distributed flyer. Surveys included information about the study, a consent form, demographic questions, three assessment measures, and conclusion information. Surveys were accessible through an electronic medium (Qualtrics).

Numerous counseling agencies and organizations were contacted via email in order to gain permission to send out this research survey. In addition to counseling agencies and organizations, the survey was provided to doctoral students in a Counselor Education and Supervision (CES) program as well as a CES listserv. Lastly, flyers were posted on social media (Facebook, Instagram, Linkedin, etc.) platforms in order to further recruit participants. Participants who completed the survey in its entirety had the option to be entered into a gift card raffle.

Constructs

To better understand the relationship between organizational culture and self-care practices on CF and CS, counselors completed four assessment measures in the survey provided. First, the ProQOL measures the dependent variables (CF and CS). In order to assess the independent variables, the following assessment measures were used: The Trauma Informed Organizational Culture Survey (TIOC) and the Self-Care Practices Scale (SCPS). A set of five questions were pulled from the Vicarious Traumatization Questionnaire (VTQ) to detect potential cognitive shifts in worldview when working with trauma cases. The culmination of these four assessments resulted in the survey containing 83 total items, not including demographic questions. The following demographic information was asked of the participants: age, gender, race, caseload, average weekly work hours, location, type of organization, type of counselor role (including whether licensed or pre-licensed), and years of experience.

Professional Quality of Life Scale (ProQOL)

The dependent variables (CF and CS) were measured using the ProQOL-Version 5. The ProQOL (Stamm, 2005) is a revised version of Figley's Compassion Fatigue Self-Test (1995a). CF is characterized by two factors: burnout and secondary traumatic stress (Stamm, 2005). This

assessment measure is divided into three subscales: CS, burnout, and secondary traumatic stress (Stamm, 2005).

The ProQOL is a self-reported assessment consisting of 30-items available in over ten languages. Each item is ranked on a 5-point Likert scale (1= never, 2= rarely, 3= sometimes, 4= often, and 5= very often). Participants are asked to rate each question based on their experience in the last 30 days. Five of the items must be reverse scored before calculating the overall total score (items 1, 4, 15, 17, and 29). Each subscale has a mean of 50 and standard deviation of 10 (Stamm, 2010). CS scores of 42 or higher indicated high levels of pleasure and satisfaction that one derives from doing their job well (Stamm, 2010). When assessing the burnout subscale, a score of 22 or below depict positive feelings about one's work. A burnout score of 42 or above indicates that the individual may be experiencing high levels of burnout; therefore, the participant may not feel effective in his/her work as a helper. In assessing the secondary traumatic stress subscale, scores above 44 indicate that the participant may be experiencing problematic symptoms of secondary traumatic stress.

Based on over 200 published articles, the ProQOL scale has shown good construct validity. In regard to the CF scale, "the inter-scale correlations show 2% shared variance (r=-.23; co-σ = 5%; n=1187) with Secondary Traumatic Stress and 5% shared variance (r=.-.14; co-σ = 2%; n=1187) with Burnout" (Stamm, 2010, p. 13). Together the shared variance is 34% (r=.58; co-σ = 34%; 14 n=1187; Stamm, 2010). The internal consistency reliability estimates as follows: CS (.88), burnout (.75), and secondary traumatic stress (.81; Stamm, 2010). Access to the ProQOL was provided by The Center for Victims of Torture (www.ProQOL.org).

Trauma Informed Organizational Culture Survey (TIOC)

The TIOC was developed by Joni Handran in her dissertation research at Colorado State University. This instrument was developed by Handran because no such assessment measured perceptions of organizational culture up until that point in time (Handran, 2013). The TIOC is a 30-item measure assessing perceptions of an organization's support, safety, and trauma awareness using a 5-point Likert scale. TIOC consists of the following subsets: perceived organizational peer support, perceived organizational supervisory support, perceived organizational systemic support, and perceived organizational trauma training, as well as factoring burnout and secondary traumatic stress (Handran, 2013; Nelson, 2015).

To date, only two research studies have been conducted using the TIOC (Handran, 2013; Nelson, 2015). A pilot study was conducted, and changes were made to the original assessment based on recommendations from the pilot study (Handran, 2013). Cronbach's alpha was completed indicating a strong internal reliability ranging from .80-.91 (Handran, 2013). The alpha reliability of the TIOC is as follows: perceived peer support (α =.82), perceived supervisory support (α =.88), perceived systemic support (α =.90), and perceived trauma training (α =.82). The internal consistency was .91 for all 30 items of the TIOC. The Cronbach alphas for the TIOC used by Nelson (2015) ranged from .714 to .884. Unfortunately, due to the newness of this study, the validity of the TIOC has yet to be determined. Handran (2013) expressed that continued research using this instrument would help to increase understanding of its construct validity. In using the TIOC, the final results of this study increase current literature understandings of the assessment's construct validity.

Self-Care Practices Scale (SCPS)

The SCPS measures frequency of engagement in personal and professional self-care practices (Lee et al., 2020). The original SCPS consisted of 71 items, later narrowed down to 38

items (Lee et al., 2016). The latest revision narrowed down the assessment to 18 items: Half of the questions allocated to personal self-care practices while the other half addressed professional self-care practices (Lee et al., 2020). Using a five-point Likert scale (0= never, 1= rarely, 2= sometimes, 3= often, 4= very often), individuals are asked to rate the frequency of the described self-care practices.

This version's pilot study resulted in the following internal reliability: personal self-care (α =.865), professional self-care (α =.91), total scale (α =.93; Lee, Miller, & Bride, 2016). After revising the assessment to 18 items, reliability coefficients remained internally consistent: personal self-care (α =.81), professional self-care (α =.78), total scale (α =.87; Lee et al., 2020). Since reliability was maintained, the shorter version of this measure was used for data collection.

Vicarious Traumatization Questionnaire (VTQ)

In order to assess for vicarious trauma, a set of 5 questions was used from the VTQ (Culver et al., 2011). These five questions from the VTQ were meant to assess the potential cognitive shift in worldview due to working with trauma cases.

Summary

This study utilized Andrew F. Hayes' PROCESS Conceptual Model 1 in SPSS to perform a regression analysis on the data collected (2017). The data analysis provided information regarding the impact of the moderators, organizational culture (W) and self-care practices (Z), on the relationship between CF (X) and CS (Y). It is hypothesized that positive organizational culture (support and trauma training) and the implementation of self-care practices (personal and professional) will attenuate the relationship between CF and CS. The ProQOL was used to assess CF (burnout and secondary traumatic stress) and CS (Stamm, 2010).

The TIOC was used to assess perceived support (peer, supervisory, and systemic) and perceived trauma training (Handran, 2013). The SCPS was used to assess the frequency of personal and professional self-care practices (Lee et al., 2020). Five questions from the VTQ were used to understand the participants' cognitive shift in worldview (Culver et al., 2011). The results and discussion of the data analysis are described in the following chapters.

CHAPTER FOUR: RESULTS

This research study sought to better understand the moderating effects of organizational culture and self-care practices on compassion fatigue (CF) and compassion satisfaction (CS) in the lives of licensed and pre-licensed counselors. The three primary purposes for conducting this research study are to promote counselor development, protect client welfare, and provide organizational understanding. In this chapter, the process of data collection is explained, and the results of the data analysis are presented. Figures and tables are provided.

Sample Collection and Information

In order to recruit participants, the research survey was distributed online to one university, 18 community service boards, 19 counseling agencies, 11 counseling association divisions, six counseling association branches, three social media platforms, and one listserv. Using SPSS syntax, the dataset was screened to examine missing cases. Seventy-five participants started the study, 11 of which did not complete the survey. The remaining 64 participants consented to the survey and completed all of the necessary questions to qualify for data analysis.

Participant Demographic Information

There were 64 qualified surveys completed from licensed and pre-licensed counselors across the United States. The data was collected from January 2021 to February 2021. Of the 64 participants, 71.9% (*N*=46) were licensed professional counselors (LPC), 7.8% (*N*=5) were licensed marriage and family therapists (LMFT), 25.0% (*N*=16) were pre-licensed counselors, and 4.7% (*N*=3) indicated that they held both licenses (LPC and LMFT). Regarding gender, 79.7% (*N*=51) participants were female, 18.8% (*N*=12) participants were male, and 1.6% (*N*=1) participants preferred not to answer. Participants indicated the following regarding ethnicity: 4.7% (*N*=3) Hispanic/Spanish/Latinx, 9.4% (*N*=6) Black/African American, 3.1% (*N*=2) Asian

or Asian American, 1.6% (*N*=1) American Indian and Alaska Native, 87.5% (*N*=56) White or Caucasian, 6.3% (*N*=4) indicated "other". In terms of higher education, 81.3% (*N*=52) held a master's degree while 18.8% (*N*=12) held a doctoral degree. Table 1 presents further details regarding demographic information.

Table 1

Participant Demographic Information

Baseline characteristics	*n*	%
Licensure*		
LPC	46	71.9
LMFT	5	7.8
Pre-licensed Counselor	16	25.0
Both LPC & LMFT	3	4.7
Age		
20 to 29	13	20.3
30 to 39	28	43.8
40 to 49	9	14.1
50 to 59	11	17.2
60 to 69	2	3.1
70 to 79	1	1.6
Gender Identify		
Male	12	18.8
Female	51	79.7
Prefer Not to Answer	1	1.6
Ethnicity*		
Hispanic, Latinx, or Spanish	3	4.7
Black or African American	6	9.4
Asian or Asian American	2	3.1
American Indian or Alaska Native	1	1.6
White or Caucasian	56	87.5
Other	4	6.3
Marital Status		
Married	45	70.3
Divorced	6	9.4
Unmarried	13	20.3
Highest Education Completed		
Master's Degree	52	81.3
Doctoral Degree	12	18.8
Religious Affiliation		
Hinduism	1	1.6

Christian (Catholic, Protestant or any other Christian Denomination)	53	82.8
Other	3	4.7
I am not religious	7	10.9
Annual Income		
Less than $20,000	4	6.3
$20,000 to $29,000	3	4.7
$30,000 to $39,000	2	3.1
$40,000 to $49,000	9	14.1
$50,000 to $59,000	8	12.5
Above, $60,000	38	59.4

**Note.* Some of the demographic variables were singular questions (e.g., "Are you Hispanic, Latinx, or Spanish origin?") or gave participants the option to give more than one response to a single question (e.g. LPC, LMFT, Pre-licensed). In these cases, some participants indicated more than one option.

Participant Employment Information

Regarding employment information, 4.7% (*N*=3) of participants averaged 1-10 work hours per week, 1.6% (*N*=1) of participants averaged 11-20 work hours per week, 14.1% (*N*=9) of participants averaged 21-30 work hours per week, 24.4% (*N*=22) of participants averaged 31-40 work hours per week, and 45.3% (*N*=29) of participants averaged 41+ work hours per week. Participants ranged in the amount of time spent directly with clients: 25.0% (*N*=16) of participants work directly with clients for 1-10 hours per week, 20.3% (*N*=13) of participants work directly with clients for 11-20 hours per week, 37.5% (*N*=24) of participants work directly with clients for 21-30 hours per week, 14.1% (*N*=9) of participants work directly with clients for 31-40 hours per week, 1.6% (*N*=1) of participants work directly with clients for 41+ hours per week, and 1.6% (*N*=1) of participants indicated that they spend no time working directly with clients. The amount of time spent working directly with trauma clients ranged as well: 51.6% (*N*=33) of participants work directly with trauma clients for 1-10 hours per week, 18.8% (*N*=12)

of participants work directly with trauma clients for 11-20 hours per week, 21.9% (*N*=14) of participants work directly with trauma clients for 21-30 hours per week, and 7.8% (*N*=5) of participants reported no hours working directly with trauma clients.

Data indicated that 43.8% (*N*=28) of participants work at an organization that requires that they maintain a certain number of caseload hours (by number of client and/or billable hours) while the remaining 56.3% (*N*=36) of participants did not have a caseload requirement. In terms of the years of experience practicing in the mental health field, 3.1% (*N*=2) had less than one year of experience, 25.0% (*N*=16) had 2-5 years of experience, 32.8% (*N*=21) had 6-10 years of experience, 15.6% (*N*=10) had 11-15 years of experience, 4.7% (*N*=3) had 16-20 years of experience, 9.4% (*N*=6) had 21-25 years of experience, 6.3% (*N*=4) had 26-30 years of experience, and 3.1% (*N*=2) had 31-35 years of experience. Of the licensed participants, 14.1% (*N*=9) of participants had been licensed for less than one year, 34.4% (*N*=22) had been licensed 1-5 years, 14.1% (*N*=9) had been licensed 6-10 years, 3.1% (*N*=2) had been licensed for 11-15 years, 7.8% (*N*=5) had been licensed for 16-20 years, 6.3% (*N*=4) had been licensed for 21-25 years, and 3.1% (*N*=2) had been licensed for 26-30 years.

Participants were employed in various types of organizations, some of which could be categorized under multiple descriptions. Based on the data, 43.8% (*N*=28) of participants worked at a private practice, 26.6% (*N*=17) worked at a non-profit agency, 23.4% (*N*=15) worked at a university or college, 14.1% (*N*=9) worked at a community service board, 14.1% (*N*=9) worked at a for-profit agency, 7.8% (*N*=5) were self-employed, 7.8% (*N*=5) indicated “other”, 3.1% (*N*=2) worked at a church/religious organization, and 1.6% (*N*=1) worked at a hospital. Participants' roles at their place of employment varied as well: 81.3% (*N*=52) indicated that they were outpatient counselors, 4.7% (*N*=3) were in-patient counselors, 9.4% (*N*=6) were school-

based counselors, 10.9% (*N*=7) were crisis counselors, and 20.3% (*N*=13) indicated "other". For clarification, school-based counselors in this study are not the same as guidance counselors or licensed school counselors. Table 2 presents further details regarding employment information.

Table 2

Participant Employment Information

Baseline characteristics	*n*	%
Average work hours a week		
1 to 10 hours	3	4.7
11 to 20 hours	1	1.6
21 to 30 hours	9	14.1
31 to 40 hours	22	24.4
40+ hours	29	45.3
Average hours a week working directly with clients		
None	1	1.6
1 to 10 hours	16	25.0
11 to 20 hours	13	20.3
21 to 30 hours	24	37.5
31 to 40 hours	9	14.1
40+ hours	1	1.6
Average hours a week working directly with trauma clients		
None	5	7.8
1 to 10 hours	33	51.6
11 to 20 hours	12	18.8
21 to 30 hours	14	21.9
Does your place of employment require you to maintain a certain caseload number?		
Yes	28	43.8
No	36	56.3
Average clients seen per week		
1 to 10	20	31.3
11 to 20	18	28.1
21 to 30	17	26.6
31 to 40	8	12.5
41+	1	1.6
Average Number of Total Active Clients on Caseload		
1 to 10	17	26.6
11 to 20	11	17.2
21 to 30	17	26.6
31 to 40	9	14.1

41+	10	15.6
Years Practicing in the Mental Health Field		
Less than 1 year	2	3.1
2 to 5 years	16	25.0
6 to 10 years	21	32.8
11 to 15 years	10	15.6
16 to 20 years	3	4.7
21 to 25 years	6	9.4
26 to 30 years	4	6.3
31 to 35 years	2	3.1
Number of years holding counseling license		
Less than 1 year	9	14.1
2 to 5 years	22	34.4
6 to 10 years	9	14.1
11 to 15 years	2	3.1
16 to 20 years	5	7.8
21 to 25 years	4	6.3
26 to 30 years	2	3.1
Not Applicable	11	17.2
What best describes the type of organization you work for?*		
For Profit	9	14.1
Non-Profit	17	26.6
Private Practice	28	43.8
Community Service Board	9	14.1
Hospital	1	1.6
University/College	15	23.4
Church/Religious Organization	2	3.1
Self-Employed	5	7.8
Other	5	7.8
Role(s)/Position(s) at Place of Employment*		
Outpatient Counselor	52	81.3
In-Patient Counselor	3	4.7
School-Based Counselor	6	9.4
Crisis Counselor	7	10.9
Other	13	20.3

Note. Some of the employment variables gave participants the option to give more than one response to a single question (e.g. type of organization, roles/positions at place of employment). In these cases, some participants indicated more than one option.

Data Analysis

The initial dataset was transferred from Qualtrics to SPSS. Using the SPSS syntax function, the scales and subscales were computed according to the scoring sheet for each measure. Reversed coded items were reversed coded before computing the totals and subscales. For each variable, Cronbach's Alpha was assessed for internal consistency (Table 3). Next, a Pearson's *r* correlation was conducted to examine whether the present study's variables were correlated in expected ways (Table 4). In order to test the hypotheses, a moderation analysis was conducted; four models (Hayes Model 1) for each organizational culture subscale (TIOC Peer, Supervisory, Systemic, and Trauma Training; Tables 5-8) and two models (Hayes Model 1) for each SCPS subscale (personal self-care and professional self-care; Tables 9-10).

Cronbach's Alpha

Each variable was assessed for internal consistency. As demonstrated in Table 3, each variable showed sufficient internal consistency except for TIOC Systemic. The impact of this subscale's reliability on this research study's findings is discussed in further detail in Chapter 5.

Table 3

Cronbach's Alpha for ProQOL, TIOC, and SCPS Subscales

Measure/Subscale	*Items*	α
ProQOL Compassion Satisfaction	10	.920
ProQOL Burnout	10	.741
ProQOL Secondary Traumatic Stress	10	.873
ProQOL Compassion Fatigue	20	.866
TIOC Peer	5	.813
TIOC Supervisory	11	.863
TIOC Systemic	4	.160
TIOC Trauma Training	3	.815
SCPS Global	18	.867
SCPS Personal	9	.798
SCPS Professional	9	.795

Pearson's Correlation

A Pearson's *r* correlation test was conducted to assess the relationship between participants' scores on each of the study's variables (see Table 4). As expected, the data showed that CF and CS were significantly negatively correlated ($r = -.367$, $p < .001$). That is, findings suggested that as scores on CF increases, scores on CS decreases. Likewise, as CS increases, CF decreases. This finding is important as it is the fundamental assumption for each of the proposed models.

In assessing the subscales for TIOC, CF was significantly negatively correlated with supervisory support ($r = -.253$, $p < .05$). CF was not significantly correlated with systemic support, peer support, or trauma training (see Table 4). Additionally, findings suggested that CS was significantly positively correlated with supervisory support ($r = .425$, $p < .01$) and peer support ($r = .308$, $p < .05$). However, CS was not found to be associated with systemic support or trauma training (see Table 4).

While assessing the subscales for SCPS, CF was significantly negatively correlated with global self-care practices ($r = -.254$, $p < .01$) and personal self-care practices ($r = -.313$, $p < .05$). However, CF was not found to be significantly correlated with professional self-care practices scores ($r = -.146$, $p > .05$). Finally, CS was significantly positively correlated with global self-care practices ($r = .451$, $p < .01$), personal self-care practices ($r = .469$, $p < .01$), and professional self-care practices scores ($r = .342$, $p > .01$). More details regarding the implications of these findings are discussed in Chapter 5.

Table 4

Pearson's r, Means, and Standard Deviations

	1	2	3	4	5	6	7	8	9
(1) Compassion Fatigue	1								
(2) Compassion Satisfaction	-.367**	1							
(3) Systemic Support	-.010	.180	1						
(4) Supervisory Support	-.253*	.425**	.414**	1					
(5) Peer Support	.010	.308*	.220	.386**	1				
(6) Trauma Training	-.040	.243	.492**	.603**	.275*	1			
(7) Global Self-Care	-.254**	.451**	.419**	.359**	.435**	.260*	1		
(8) Personal Self-Care	-.313*	.469**	.358**	.383**	.319*	.227	.894**	1	
(9) Profession Self-Care	-.146	.342**	.393**	.263*	.461**	.239	.901**	.611**	1
Mean	20.555	41.563	14.000	41.188	19.406	9.938	48.406	24.859	23.547
SD	4.544	5.809	1.911	7.222	3.284	3.070	9.168	5.033	5.182
Cronbach's α	.920	.866	.160	.863	.813	.815	.867	.798	.795

*Correlation is significant at the .05 level (2-tailed).
**Correlation is significant at the .01 level (2-tailed).

Hypothesis 1: Organizational Culture

Hayes' (2017) Process Macro (Version 3.5) was utilized to test Hypothesis 1 (H1). This analysis was used to produce regression coefficients, *p*-values, and confidence intervals (5,000 bias-corrected bootstrap samples) for each of the necessary regressions. It was hypothesized that positive organizational culture would have an attenuating effect on the relationship between CF and CS in counselors (H1). In looking at the subscales of organizational culture, it was hypothesized that perceived peer support (H1a), supervisory support (H1b), systemic support (H1c), and trauma training (H1d) would moderate the effect of CF on CS. In the following figures, solid lines between variables indicate significance, dashed lines indicate no significance.

Peer Support. As seen in Figure 5 and Table 5, findings indicated that CF had a significant negative effect on CS when running the data analysis for peer support (*b* = -.502, SE = .143, CI = [-.788 to -.216]). Contrary to H1a, peer support did not have a significant moderating effect on the relationship between CF and CS (*b* = .074, SE = .047, CI = [-.021 to .168]). As such, the data failed to reject the null hypothesis for H1a. Interestingly, peer support,

on its own, did transmit a significant positive effect on CS (b = .653, SE = .207, CI = [.239 to 1.066]; see Table 5).

Figure 5

Peer Support Moderation Model

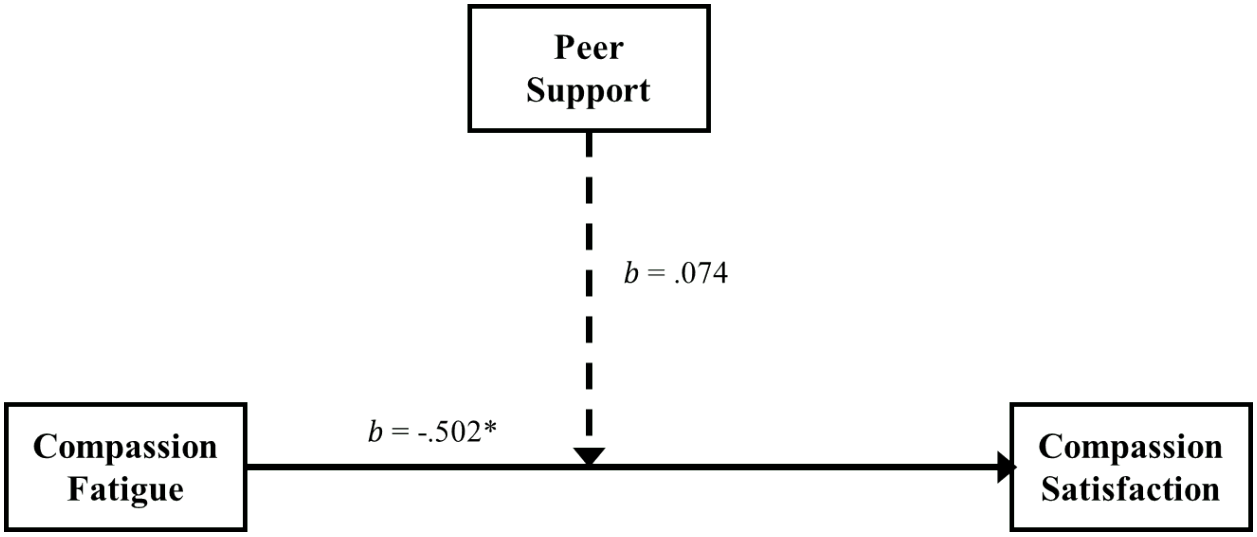


Table 5

Moderation Results for Peer Support

Source	*b*	*se*	*t*	*p*	*LLCI*	*ULCI*
Compassion Satisfaction: $R = .512$, $R^2 = .262$, $MSE = 26.151$, $F(3, 60) = 7.096$, $p < .001$						
Compassion Fatigue	-.502	.143	-3.509	<.05	-.788	-.216
Peer Support	.653	.207	3.158	<.05	.239	1.066
Fatigue X Peer	.074	.047	1.560	.124	-.021	.168

Supervisory Support. As seen in Figure 6 and Table 6, findings indicated that CF had a significant negative effect on CS when running the data analysis for supervisory support (*b* = -.4, SE = .152, CI = [-.699 to -.089]). Similar to the results on peer support, supervisory support did

not have a significant moderating effect on the relationship between CF and CS (*b* = .018, SE = .019, CI = [-.020 to .056]). Based on these findings, the data failed to reject the null hypothesis for H1b. However, supervisory support, on its own, did transmit a significant positive effect on CS (b = .276, SE = .093, CI = [.091 to .461]; see Table 6).

Figure 6

Supervisory Support Moderation Model

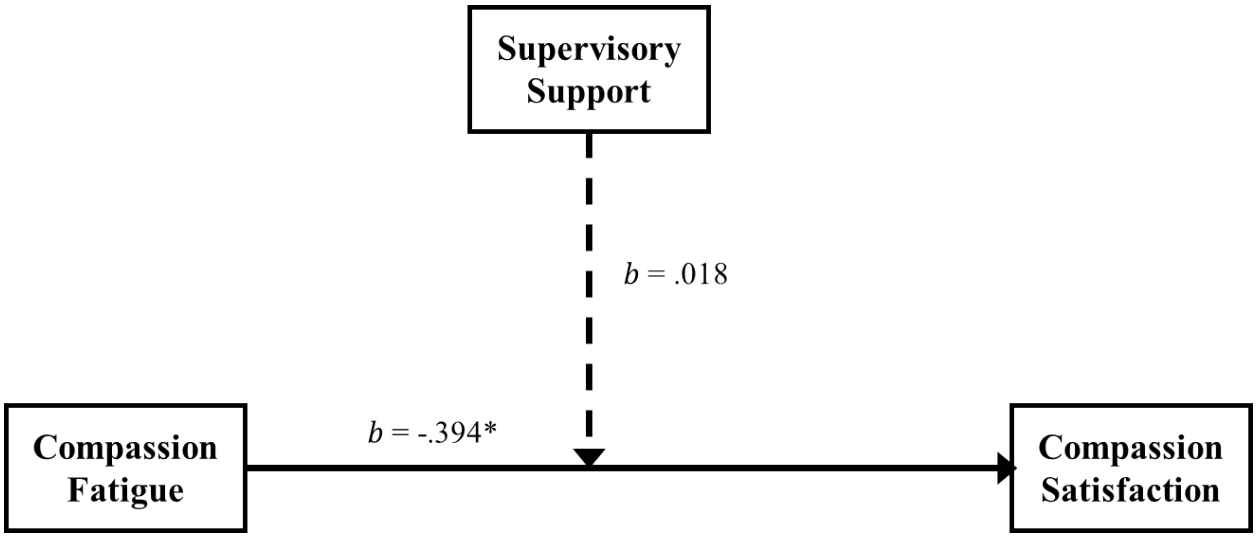


Table 6

Moderation Results for Supervisory Support

Source	*b*	*se*	*t*	*p*	*LLCI*	*ULCI*
Compassion Satisfaction: $R = .513$, $R^2 = .263$, $MSE = 26.107$, $F(3, 60) = 7.142$, $p < .001$						
Compassion Fatigue	-.394	.152	-2.586	<.05	-.699	-.089
Supervisory Support	.276	.093	2.978	<.05	.091	.461
Fatigue X Supervisory	.018	.019	.938	.352	-.020	.056

Systemic Support. As seen in Figure 7 and Table 7, findings indicated that CF had a significant negative effect on CS when running the data analysis for systemic support (b = -.511, SE = .157, CI = [-.825 to -.197]). In alignment with previous subscales, systemic support did not have a significant moderating effect on the relationship between CF and CS (b = .053, SE = .057, CI = [-.061 to .167]). It is for this reason that we failed to reject the null hypothesis for H1c. Unlike the previous constructs, systemic support, on its own, did not transmit a significant effect on CS (b = .428, SE = .375, CI = [-.321 to 1.178]; see Table 7). More details regarding potential explanations for these findings will be discussed in Chapter 5.

Figure 7

Systemic Support Moderation Model

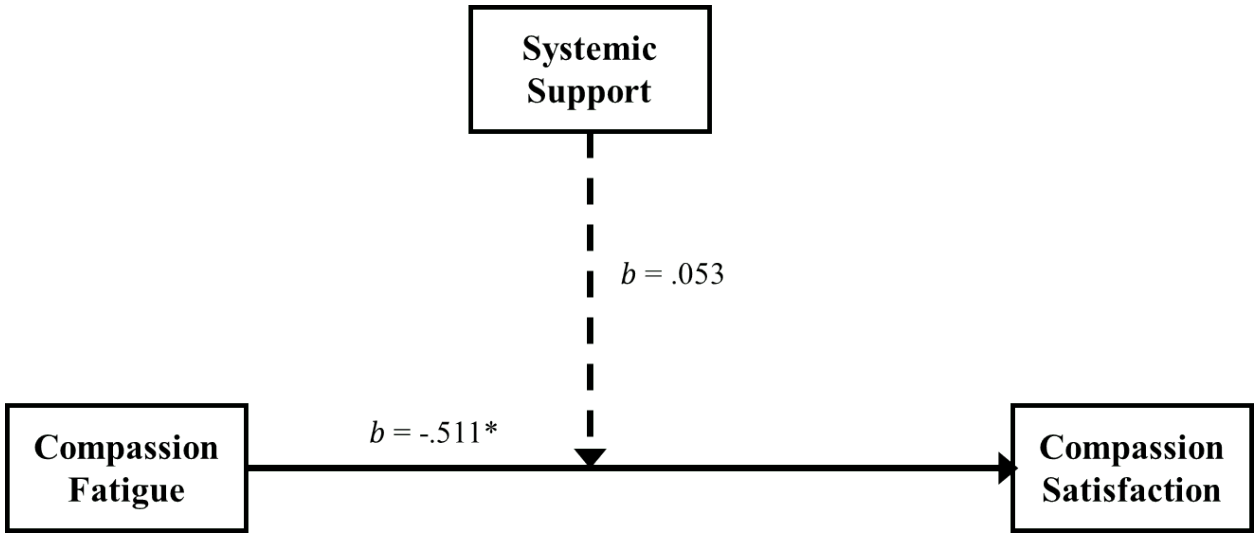


Table 7

Moderation Results for Systemic Support

Source	*b*	*se*	*t*	*p*	*LLCI*	*ULCI*
Compassion Satisfaction: $R = .422$, $R^2 = .178$, $MSE = 29.133$, $F(3, 60) = 4.322$, $p < .05$						
Compassion Fatigue	-.511	.157	-3.255	<.05	-.825	-.197
Systemic Support	.428	.375	1.142	.258	-.321	1.178
Fatigue X Systemic	.053	.057	.928	.357	-.061	.167

Trauma Training. As seen in Figure 8 and Table 8, findings indicated that CF had a significant negative effect on CS when running the data analysis for trauma training (b = -.482, SE = .158, CI = [-.797 to -.166]). In alignment with the previous subscale's findings, trauma training did not have a significant moderating effect on the relationship between CF and CS (b = .021, SE = .046, CI = [-.071 to .113]). Therefore, we failed to reject the null hypothesis for H1d. Lastly, trauma training, on its own, did not transmit a significant effect on CS (b = .439, SE = .220, CI = [-.002 to .880]; see Table 8). More details regarding potential explanations for these findings will be discussed in Chapter 5.

Figure 8

Trauma Training Moderation Model

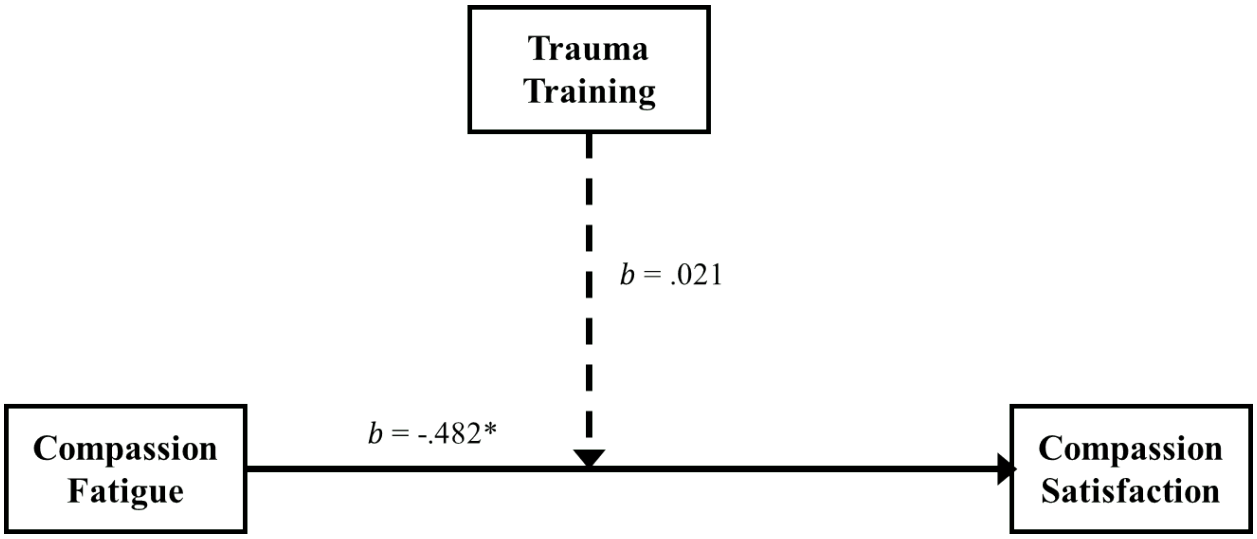


Table 8

Moderation Results for Trauma Training

Source	*b*	*se*	*t*	*p*	*LLCI*	*ULCI*
Compassion Satisfaction: $R = .436$, $R^2 = .190$, $MSE = 28.700$, $F(3, 60) = 4.689$, $p < .05$						
Compassion Fatigue	-.482	.158	-3.054	<.05	-.797	-.166
Trauma Training	.439	.220	1.992	.051	-.002	.880
Fatigue X Trauma Training	.021	.046	.456	.650	-.071	.113

Hypotheses 2: Self-care Practices

Hayes' (2017) Process Macro (Version 3.5) was utilized again to test Hypothesis 2. It was hypothesized that the implementation of self-care practices would have an attenuating effect on the relationship between CF and CS in counselors (H2). In looking at the subscales of self-care, it was hypothesized that both personal self-care practices (H2a) and professional self-care

practices (H2b) would moderate the effect of CF on CS. Lastly, it was hypothesized that professional self-care practices would have a stronger moderating effect than personal self-care practices (H2c), indicating that it accounted for more significant variance. In the following figures, solid lines between variables indicate significance, dashed lines indicate no significance.

Personal Self-Care. As seen in Figure 9 and Table 9, findings indicated that CF had a significant negative effect on CS when running the data analysis for personal self-care practices (b = -.312, SE = .148, CI = [-.608 to -.016]). In contrast to what was hypothesized (H2a), personal self-care practices did not have a significant moderating effect on the relationship between CF and CS (b = .011, SE = .024, CI = [-.036 to .059]). Thus, the data failed to reject the null hypothesis for H2a. On its own, personal self-care practices did transmit a significant positive effect on CS (b = .450, SE = .134, CI = [.182 to .717]; see Table 9).

Figure 9

Personal Self-Care Practices Moderation Model

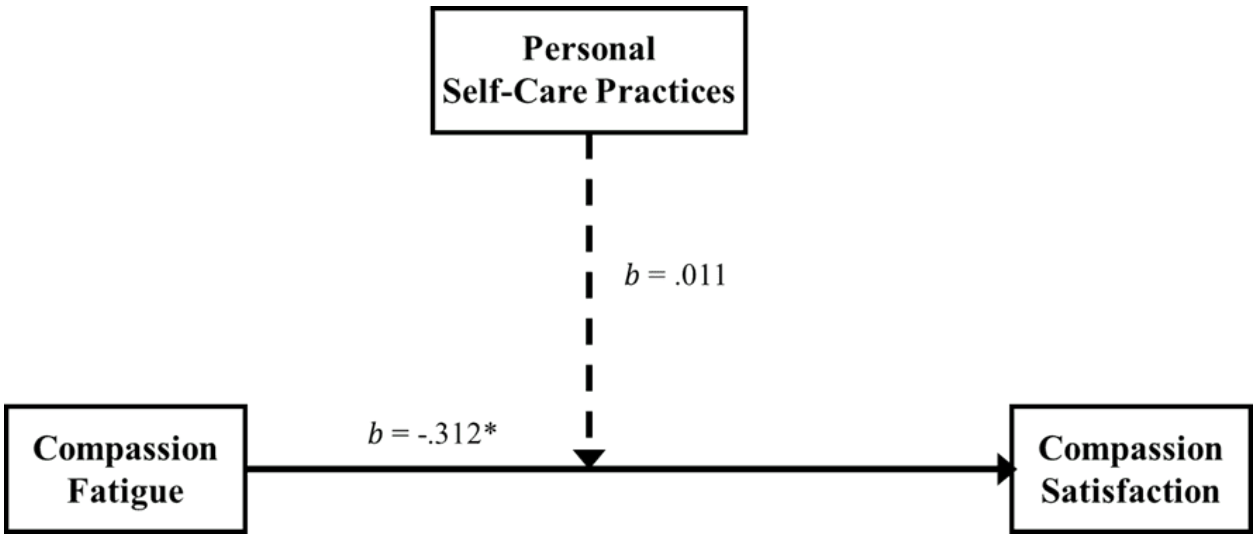


Table 9

Moderation Results for Personal Self-Care Practices (SCPS-Personal)

Source	*b*	*se*	*t*	*p*	*LLCI*	*ULCI*
Compassion Satisfaction: $R = .525$, $R^2 = .276$, $MSE = 25.646$, $F(3, 60) = 7.630$, $p < .001$						
Compassion Fatigue	-.312	.148	-2.110	<.05	-.608	-.016
SCPS-Personal	.450	.134	3.336	<.05	.182	.717
Fatigue X SCPS-Personal	.011	.024	.479	.634	-.036	.059

Professional Self-Care. As seen in Figure 10 and Table 10, findings indicated that CF had a significant negative effect on CS when running the data analysis for professional self-care practices (b = -.423, SE = .153, CI = [-.729 to -.116]). In contrast to what was hypothesized (H2b), professional self-care practices did not have a significant moderating effect on the relationship between CF and CS (b = .005, SE = .024, CI = [-.043 to .052]). Therefore, the data failed to reject the null hypothesis for H2b. On its own, professional self-care practices did transmit a significant positive effect on CS (b = .335, SE = .131, CI = [.073 to .597]; see Table 9).

Figure 10

Professional Self-Care Practices Moderation Model

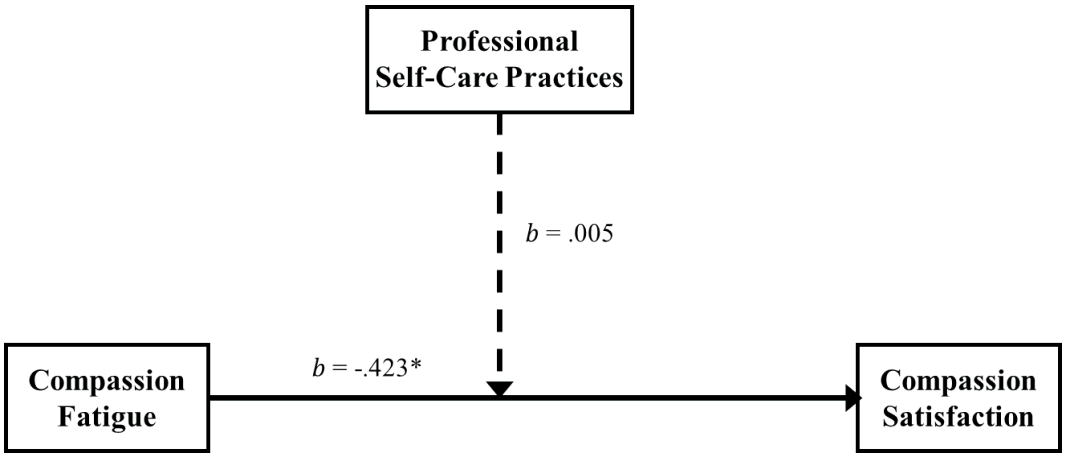


Table 10

Moderation Results for Professional Self-Care Practices (SCPS-Professional)

Source	*b*	*se*	*t*	*p*	*LLCI*	*ULCI*
Compassion Satisfaction: $R = .470$, $R^2 = .221$, $MSE = 27.614$, $F(3, 60) = 5.660$, $p < .05$						
Compassion Fatigue	-.423	.153	-2.759	<.05	-.729	-.116
SCPS-Professional	.335	.131	2.561	<.05	.073	.597
Fatigue X Professional	.005	.024	.202	.841	-.043	.052

Professional Self-Care vs. Personal Self-Care. The findings from this study determined that both personal self-care (b = .011, SE = .024, CI = [-.036 to .059]) and professional self-care practices (b = .005, SE = .024, CI = [-.043 to .052]) did not have a significant moderating effect on the relationship between CF and CS. Therefore, since neither self-care subscale showed any moderating effect, professional self-care did not show more significance than personal self-care. Since neither subscale demonstrated a moderating effect, the data failed to reject the null hypothesis for H2c.

Summary

After transferring the dataset from Qualtrics to SPSS, syntax was used to compute each scale appropriately with the scoring information for each measure. After screening for missing cases, 64 participants' surveys remained for data analysis. While there were various differences in demographics, a large portion of the participants fell under similar categories (e.g. LPC, age 30-39, female, white, married, Christian, high annual income). While most measures maintained internal consistency, the Cronbach's Alpha for TIOC systemic support subscale did not show to be reliable (a = .160). A Pearson's Correlation test indicated that CF had a significant negative

effect on CS. Meaning that when one increases, the other decreases. This was an important finding as it is a fundamental assumption in relation to the proposed hypotheses.

Contrary to hypotheses H1 and H2, the results of the moderation analysis indicated that organizational culture (peer support, supervisory support, systemic support, and trauma training) and self-care practices (personal and professional) did not have an attenuating effect on the relationship between CF and CS in counselors. However, when assessed individually, peer support, supervisory support, personal self-care, and professional self-care all transmitted a significant positive effect on CS. Systemic support and trauma training did not show this effect on CS. While the data analysis did not support the proposed hypotheses, there is much that can be discussed in terms of explanation of findings and implications for practice and future research. Chapter 5 will conclude by discussing these results in further detail.

CHAPTER FIVE: SUMMARY & DISCUSSION

The phenomenon of compassion fatigue (CF) is one that has plagued many counselors in the mental health field. In order to combat this, the current research study sought to better understand ways in which counselors can work towards greater compassion satisfaction (CS). Current literature indicates various factors that can contribute towards lower levels of CF (burnout and secondary traumatic stress; Alkema et al., 2008; Bride et al., 2007; Brockhouse et al., 2011; Beaumont et al., 2016; Brady, 2017; Chenot et al., 2009; Collins et al. 2010; Craig & Sprang, 2010; Killian, 2008; Knight, 2013; Lizano et al., 2014; Nelson, 2015; Ortlepp & Friedman, 2002; Posselt et al., 2020; Salloum et al., 2019; Wei et al., 2018; Westbrook et al., 2012) and greater levels of CS (Alkema et al., 2008; Beaumont et al., 2016; Brady, 2017; Chenot et al., 2009; Craig & Sprang, 2010; Killian, 2008; Lizano et al., 2014; Salloum et al., 2019; Stanfield & Baptist, 2019; Wei et al., 2018; Westbrook et al., 2012). Support from one's organization and the implementation of self-care practices were contributing factors in this research.

Despite some research indicating organizational culture and self-care as positive contributing factors, other literature suggests otherwise (Badger et al., 2008; Bober & Regehr, 2006; Dagan et al., 2016; DePanfilis et al., 2006; Ivicic & Motta, 2017; Martin, 2010; Nelson, 2015; Williams et al., 2012). With this in mind, this quantitative research study sought to understand the moderating effects of organizational culture and self-care practices on CF and CS in licensed and pre-licensed counselors. After conducting Hayes' (2017) Process Macro (Version 3.5) using data from 64 licensed and pre-licensed counselors, it was determined that positive organizational culture and the frequent implementation of self-care practices did not attenuate the relationship between CF and CS.

Summary of Findings

When evaluating factors that affect employee wellbeing, the literature was clear in indicating that the employee's work environment played a significant role in positive and negative employee wellness. Poor work environment, heavy caseload, lack of social support, and insufficient training have influenced the growth of CF, burnout, secondary traumatic stress, and vicarious trauma in employees across varying helping professions (Adams et al., 2006; Browning et al., 2019; Holden, 2015; Lawson & Myers, 2011; Mathieu, 2012; Stamm, 2010). Understanding that CF and CS are negatively correlated (Collins & Long, 2003; Stamm, 2005), hypotheses H1 and H2 sought to understand whether positive organizational culture and frequent self-care practices had an attenuating effect on the relationship between CF and CS. After reviewing the data analysis, these constructs did not show moderating effects between CF and CS.

Hypotheses 1: Organizational Culture

It was hypothesized that positive organizational culture would attenuate the relationship between CF on CS in counselors (H1). Four components of organizational culture were assessed: perceived peer support (H1a), perceived supervisory support (H1b), perceived systemic support (H1c), and perceived trauma training (H1d). In accordance with previous research (Collins & Long, 2003; Stamm, 2005), CF and CS were shown to be negatively correlated in this study's findings. Contrary to what was hypothesized (H1a-d), none of the organizational culture components demonstrated moderating effects. Unfortunately, there is little research assessing the moderating effects of organizational culture, none of which specifically addresses CF and CS. Therefore, it is difficult to conclude whether these findings are out of the ordinary. A possible reason that the components of organizational culture did not affect the relationship between CF

and CS is because there is such a strong and consistent negative correlation between the two. As previously mentioned, CF and CS have been shown to be negatively correlated (Collins & Long, 2003; Stamm, 2005). It has even been proposed that CF is almost inevitable (Conrad & Kellar-Guenther, 2006). Mathieu (2012) suggested that those in the helping profession are susceptible to experience CF, regardless of cautions to thwart its effects. Although unexpected, based on this understanding of CF and CS, these findings are not surprising.

Peer Support. Although there was no evidence that peer support lessened the effects of CF on CS, peer support did transmit a significant positive effect on CS. These findings support Killian's (2008) results that workplace social support was the most significant factor in impacting CS in clinicians working with trauma survivors. Similarly, various studies have seen where support systems are protective factors against burnout, job stress, and CF (Barak et al., 2009; Bride et al., 2007; Ducharme et al., 2015; Knight, 2010; Knudsen & Roman, 2008; Kulkarni et al., 2013; Lloyd et al., 2002; Maslach et al., 2001). Understanding this, counselors must consider how their peer support, or lack thereof, may be affecting their overall experiences of CS.

Supervisory Support. While there was no evidence of moderating effects, supervisory support did transmit a significant positive effect on CS. Previous research concluded that clinical supervisor support resulted in lower levels of STS in social work supervisees (Ji et al., 2019). Abassary and Goodrich's (2014) suggested implementing adequate supervision in order to manage personal and professional experiences when working with crisis and trauma-focused cases. Additionally, a mixed-method study also found supervision to help reduce the risk of secondary traumatic stress in workers who support refugees and asylum seekers in Australia (Posselt et al., 2020). Finally, Nelson's (2015) research on social workers discovered a

significant association between perceived organizational supervisory support on components of CF (i.e, burnout and secondary traumatic stress). While there were some studies that did not see a significant association between supervisory support and CF (Can & Watson, 2019; Dagan et al., 2016; Ivicic & Motta, 2017; Williams et al., 2012), the current research found this facet of organizational culture a significant influencer on experiences of CS.

Systemic Support. Research findings indicated that systemic support did not attenuate the relationship between CF and CS, nor did it have an effect on CS when assessed on its own. An important potential contributor to this was that the TIOC subscale measuring systemic support did not exhibit internal consistency. The Cronbach's Alpha (.160) for TIOC-Systemic was too low indicating that the measure was unreliable. The problem may be due to the number of items or a lack of inter-item correlation between the subscales' four items. It is important to note that in Nelson's (2015) version of the TIOC assessment, some questions asking about organization support (i.e., "I feel like my organization does not support me", "My organization values me as a person", "My organization values people who have different types of skills", "My organization encourages me to take care of myself", etc.) were categorized under supervisory support rather than organizational support. Additionally, three other questions asking about compensation, benefits, and resources were not factored into the TIOC- Systemic subscale that could have been added to the TIOC subscale assessing systemic support. The four questions categorized under systemic support focused more on safety within the workplace (i.e., "I feel safe at my job", "My organization has policies in place to ensure my safety", etc.). Including some of those organization-focused questions in the TIOC-Systemic subscale may have affected the Cronbach's Alpha as well as the data analysis findings.

These results on systemic support contradict a large portion of the literature that suggests that the impact of supportive organizational systems demonstrate less CF and more CS. Workplace behaviors and support have contributed to CF (burnout and secondary traumatic stress) and CS within professions such as social work (Ji et al., 2019), nursing (Sillero & Zabalegui, 2018; Wei et al., 2018), medicine, military, mental health, banking, sales, and restaurants (Condrey, 2017). A possible explanation for these results, aside from the reliability of the measure, is that counselors' understanding of a supportive system may differ across participants. While some counselors may find tangibles (e.g., fair compensation, vacation time, health benefits, reasonable caseload, etc.; Handran, 2014) as supportive, this may not be seen as a support to others. For example, part-time employees may not receive these tangible supports and it is unknown how this may impact their perceptions of systemic support.

Trauma Training. The implementation of trauma training did not have a moderating effect on CF and CS, nor did it have an effect on CS when assessed alone.

These results contradict the current literature which suggests that trauma training can have an impact on decreasing the experience of undesirable experiences (stress, vicarious trauma) and increase positive factors (empathy, comfort, confidence; Nelson, 2015; Wolf et al., 2014). A potential explanation for these contradictory findings could be that this study assessed perceived trauma training rather than actual trauma training. It is possible that counselors perceive that they have adequate training to address trauma experiences when they in fact do not.

Hypotheses 2: Self-Care

It was hypothesized that the implementation of personal self-care practices would moderately attenuate the relationship between CF and CS (H2a) while the implementation of professional self-care practices would significantly attenuate the relationship between CF and CS

in counselors (H2b). Subsequently, it was hypothesized that the implementation of professional self-care practices would have a stronger attenuating effect than personal self-care practices (H2c). Similar to the findings on organizational culture, personal and professional self-care practices did not show moderating effects between CF and CS. As explained previously, potential explanations for these findings are due in part to the significant negative correlation between CF and CS and the unavoidable nature of the CF experience.

Personal Self-care. Personal self-care practices were not found to have significant moderating effects. However, when assessed alone, personal self-care practices did transmit a significant positive effect on CS. Interestingly, Bober and Regehr (2006) found that the implementation of self-care practices did not lead to a reduction in secondary traumatic stress. Additionally, one study found the implementation of self-care practices as only moderately significant (Killian, 2008). On the other hand, a large portion of research suggests that the implementation of self-care practices can have a significant role in addressing experiences of CF and its components: burnout and secondary traumatic stress (Alkema et al., 2008, Beaumont et al., 2016; Beitel et al., 2018; Brady, 2007; Craig & Sprang, 2010; Ji et al., 2019; Salloum et al., 2019; Stanfield & Baptist, 2019). Perhaps a reason for these inconsistencies is that there is not a unified understanding of what self-care is, or clarification that self-care can be categorized as personal and professional.

Professional Self-care. Professional self-care practices did not display a moderating effect between CF and CS but did transmit a significant positive effect on CS when assessed individually. Some literature suggests professional self-care practices (such as participating in supervision, using paid time-off, taking breaks at work, and maintaining work/life balance) can attenuate burnout, lower levels of secondary traumatic stress, and contribute to higher levels of

CS (Beitel et al., 2018; Brady, 2017). Therefore, these results indicating the positive effect on CS are expected.

Discussion

Organizational Support

This study's findings concluded that the four components of organizational support (peer, supervisor, systemic, and trauma training) did not have an attenuating effect on the relationship between CF and CS. While findings assessing moderation were not significant, peer support and supervisory support transmitted a significant positive effect on CS. Based on these findings, there are multiple implications that counselors and organizations must consider in addressing experiences of CF and CS within themselves and their employees.

Peer Support. Counselors and organizations should consider the state of their peer support. Counselors should consider whether their coworkers are likable, supportive, and trustworthy. Likewise, counselors must consider whether they display these qualities within themselves towards their coworkers. Organizations must consider whether they are creating an atmosphere that promotes and facilitates regular and healthy communication among employees. Based on this study's findings, counselors and organizations can conclude that surrounding oneself with healthy peer support can have a positive effect on one's own experiences of CS.

Supervisory Support. Regarding supervisory support, counselors would benefit from finding a supervisor with whom they feel comfortable, values alternative opinions, is able to meet regularly, and is supportive and trustworthy. At times, counselors are assigned a supervisor they know very little about. In these cases, counselors must evaluate whether this assigned supervisor is supportive, encouraging, and trustworthy to work with. Counselors could also consider finding an outside supervisor they can trust and confide in. Organizations should be

diligent and intentional when hiring supervisors to ensure that their supervisors are able to foster a supportive and trustworthy atmosphere. In doing so, counselors could benefit from potentially experiencing an increase in CS. In turn, when organizations have employees who are experiencing CS, clients are positively affected.

Systemic Support. This study's findings were in contrast to previous research which indicates numerous benefits of having systemic support at one's organization. Potential reasons for this inconsistency are (1) the unreliability of the TIOC Systemic measure and (2) potential differences in defining what a supportive system looks like. Regardless, there is no known evidence that positive systemic support could create or influence negative outcomes such as CF, burnout, secondary traumatic stress, or vicarious trauma. Previous studies have found many benefits of a supportive organizational system: it affects quality of services rendered (Glisson & Hennelgarn, 1998; Hopkins, 2002), alleviates burnout (Beitel et al., 2018; Sillero & Zabalegui, 2018; Wei et al., 2018), decreases the effects of secondary traumatic stress (Hamama et al., 2019), mitigates CF (Condrey, 2017; Knight, 2013; Wei et al., 2018), positively impacts the effects of vicarious trauma (Nelson, 2015), elevates job satisfaction (Sillero & Zabalegui, 2018; Wei et al., 2018), increases CS (Wei et al., 2018), and improves overall health and wellbeing (Ajala, 2013). Killian (2008) even suggested that organizational changes would be more effective in addressing CF than a counselor's personal efforts to alleviate these symptoms by implementing individual self-care practices.

Understanding the wide range of benefits that could come from systemic support, counselors would benefit from reflecting on the experiences they have had with their organization and consider the impact that their employers' systems have had on their own wellness. If counselors find that their organization does not provide supportive tangibles or

supportive empowerment, they may want to consider talking with their supervisor about possible changes to become more supportive. If counselors are unable to do this, they could also consider switching their place of employment to one that is more supportive. The leadership teams for organizations can provide support through tangible means such as fair compensation, paid vacation days, health benefits (including mental health benefits), consistent supervision, evenly distributing responsibilities, realistic expectations for caseloads, and appropriate training (Handran, 2014). Organizations also must consider how they are providing supportive empowerment through positive communication, trust, respect, feedback, and inclusive decision making (Handran, 2014; Moore, 2007). Organizations should not be placing the responsibility of addressing CF solely on the employees, but consider how the system itself can play a part in combating these negative experiences and promoting CS (Jirek, 2020; Killian, 2008). In providing these supportive measures, organizations position themselves to better assist their counselors who experience CF. Even though the present study cannot make the assertion that systemic support is beneficial in these ways, there is an array of other evidence-based research indicating its benefits.

Trauma Training. This study's findings were also in contrast to previous research which indicates trauma training as beneficial to those in the helping profession. Since the TIOC subscale only measures perceived trauma training, it is possible that participants perceive that they have adequate trauma training when they might not. Regardless, previous research is clear in showing the risks of not providing training as well as the benefits of participating in trauma training. Employees who are not adequate trained could be more susceptible to experiencing CF (Craig & Sprang, 2010; Figley, 1995a; Knight, 2010, Sheehy et al., 2009; Voss et al., 2011), start self-blame for experiencing CF or vicarious trauma (Nelson, 2015), display resistance in seeking

help for CF (Adams & Riggs, 2008), and even negatively impacting clients (Courtois & Gold, 2009). Research has shown that the implementation of trauma training has the capacity to decrease stress levels; increase retention; increase empathy, comfort, and confidence; and potentially decrease vicarious trauma (Nelson, 2015; Wolf et al., 2014).

Understanding the potential impact that trauma training can have on counselors, counselors and organizations should consider ways in which to incorporate more trauma specific training. Since counselors are required to complete a designated amount of continued education hours each year to maintain licensure, they should consider taking trauma specific training that provides continued education credits. These trauma trainings should not only cover presentation and treatment of client trauma but also trainings that provide information on CF, burnout, secondary traumatic stress, and CS. Organizations should regularly provide trauma training to keep counselors informed on evidence-based practices to effectively address client trauma as well as counselor CF, burnout, and secondary traumatic stress.

Self-Care Practices

This study's findings concluded that the two components of self-care (personal self-care practices and professional self-care practices) did not have an attenuating effect on the relationship between CF and CS. While there was no evidence of a moderating effect, both forms of self-care transmitted a significant positive effect on CS. Based on these findings, there are multiple implications that counselors and organizations must consider.

Counselors should first be aware of different types of self-care practices and which category they fall under (personal or professional). Once they are aware of what self-care practically looks like, counselors should take some time to reflect on their current use of those self-care practices. The Self-Care Practices Scale (SCPS; Lee & Miller, 2013) used for this study

is a helpful assessment tool that counselors can use to reflect on the frequency of their current self-care practices. After reflecting on their current implementation of self-care practices, counselors could create a wellness plan to start implementing more self-care practices into their lives. In creating a wellness plan, they could pick one specific self-care goal that they would like to achieve, make the goal measurable and attainable, and work towards achieving that self-care goal. Counselors should consider whether there are any barriers toward achieving more frequency in self-care practices, and take steps to address such barriers. A significant barrier that may arise is that counselors may find that they view self-care practices as optional, when they should be viewing them as foundational (Lee & Miller, 2013).

While self-care practices are primarily individualistic, organizations can play a significant role in promoting self-care to their employees. Organizations should reflect on the written and unwritten culture and expectations surrounding the idea of self-care implementation. If the organization's culture communicates a sense of unimportance toward self-care, leaders should consider practical ways to change this dynamic to one that is more supportive of employee self-care. Regular discussions about employee self-care within a non-judgmental environment are essential in creating a workplace that is conducive to appropriate and essential self-care. Organizational leaders could provide space and time at work to implement specific professional self-care practices such as offering development opportunities, encouraging the use of vacation days, acknowledging employee successes, and respecting employee boundaries (Lee & Miller, 2013). Organizational leaders could model appropriate self-care practices and implement a self-care wellness training which educates employees on how they can best take care of themselves. In doing so, organizations model and promote the importance of maintaining a healthy work-life balance.

Limitations

There were a number of limitations that were presented in this research study. First, the sample was a concern for this study. The small sample size may not have adequately determined effects and may limit the generalizability of the findings. A larger sample size could provide a more accurate understanding of counselors' experiences with CF, CS, organizational culture, and self-care practices. Additionally, the sample was biased to certain populations. A large portion of the participants identified as female (79.7%), white (87.5%), married (70.3%), Christian (82.8%), and with an annual income of over $60,000 (59.4%). Since there was no statistically representative sample, it is difficult to suggest that the general population of counselors would have the same type of experience of CF and CS.

Another limitation was that participants were tasked with self-reporting. As with any survey assessing subjective experiences, participants' answers are vulnerable to inaccurate interpretation. Self-reporting issues can be a concern on various levels with this research. First, it is possible that participants could complete the survey without being honest in their responses. This could manifest itself in participants knowingly providing false information in their responses. Participants could also misinterpret the meaning of the question and provide an answer that is inaccurate to their lived experience. Additionally, the TIOC assessment scale specifically asks about the participants "perceived" experiences. When questions are left to the participants' discretion for interpretation, it is possible that the response is not accurate to what is actually taking place. For example, a participant can perceive that they have had appropriate trauma training when they have not.

Unfortunately, the Cronbach's Alpha for the TIOC subscale assessing systemic support was far too low. This indicated that the measure was unreliable in assessing systemic support.

Due to this, there is less confidence in the statistics' claim regarding systemic support's moderating effects as well as its connection with CS.

It is important to note that terminology used to describe the negative effects of working in the helping profession at times appears inconsistent, making it difficult to differentiate between terms. CF, burnout, secondary traumatic stress, and vicarious trauma have often been used interchangeably when they should not be. Due to this inconsistency and confusion in terminology, some participants in this study may have symptoms that are better described as vicarious trauma rather than CF. At the beginning of this research study, it was proposed that vicarious trauma would be assessed as a covariate and those participants' surveys would be eliminated from the data analysis, leaving the remaining participants with CF to be analyzed. Vicarious trauma was to be analyzed using five questions from the Vicarious Traumatization Questionnaire assessing "disruption in worldview and perceptions of others" (Culver, 2011, p. 40). However, what was discovered was that a large portion of participants indicated some form of cognitive shift in worldview (a significant symptom for vicarious trauma). After consultation, it was decided that participants experiencing this disruption in worldview associated with vicarious trauma could not be eliminated from the participant pool.

Implications for Future Research

This study's findings concluded that CF is negatively correlated with CS on a consistent basis. With this in mind, one may assert that CF is not something that can be fully prevented. Instead, CS should be promoted. This study found that peer support, supervisory support, personal self-care, and professional self-care transmitted a significant positive effect on CS; further research could explore what this may look like practically for counselors.

Further efforts can be made to broaden the current understanding of the impact of organizational culture and self-care practices on CF and CS. Even though organizational culture and self-care practices did not show moderating effects, it would be valuable to assess the mediating role that CF may have between organizational culture/self-care and CS.

Additionally, it would be interesting to conduct a study focusing on the demographic and employee factors that may contribute to CF and CS. Although this study collected demographic information and employee information, there were not enough participants to make any general assumptions about an overarching population. In looking at the demographic areas and employee areas, additional research could gain a better understanding of potential contributors towards CF and CS.

Regarding measurements, it would be valuable to reevaluate the TIOC subscale for systemic support. In order to effectively measure this construct, there must be consistent reliability. Perhaps by altering this measure to obtain this internal consistency, researchers could better use this tool to assess the impact of systemic support more accurately.

Lastly, future research is needed in distinguishing the differences between CF, burnout, secondary traumatic stress, and vicarious trauma. The literature continues to show inconsistencies in defining these terms. It is difficult for professionals to know what they are experiencing if the literature is not clear on the foundations of each term.

Conclusion

While organizational culture and self-care practices did not show moderating effects between CF and CS, this study still discovered interesting findings in the data. As expected, those who experience more CF experience less CS. Likewise, those who experience less CF

experience more CS. Additionally, peer support, supervisory support, personal self-care, and professional self-care all demonstrated a significant positive effect on CS. Understanding these findings, counselors must consider how their current organizational support and self-care practices are affecting their compassion towards those that they help. Similarly, organizations must consider how their actions affect the way in which their employees experience CF and CS. Promoting healthy organizational support and regular self-care practices can serve as a way to create an atmosphere of growth and wellbeing for compassionate counselors.

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Appendix A: Dissertation Research Survey

The Cost of Compassion: Organizational Culture and Self-Care as Moderators between Compassion Fatigue and Compassion Satisfaction in Counselors

Jennifer L. Owen, LPC, NCC; Liberty University

Invitation to be Part of a Research Study
You are invited to participate in a research study. In order to participate, you must be a licensed professional counselors (LPC), licensed marriage and family therapists (LMFT), or a pre-licensed counselor (registered with the state counseling board in pursuit of LPC and/or LMFT). You can be employed within various roles (i.e., outpatient, in-patient, intensive in-home, school-based, etc.) and organizations (i.e., private practice, non-profit, community services board, hospital, public schools, universities/colleges, etc.) across various states in the US. You must have at least worked part-time hours (1-29 hours a week) or more within your respective counseling role(s) consistently over the last 30 days prior to completing the survey.

Taking part in this research project is voluntary. Please take time to read this entire form and ask questions before deciding whether to take part in this research project

What is the study about and why is it being done?
The purpose of this study is to understand how organizational culture and self-care practices affect the relationship between compassion fatigue and compassion satisfaction in counselors. Understanding this impact has the potential to help promote counselor development, protect client welfare, and provide organizational understanding.

What will happen if you take part in this study?
If you agree to be in this study, I would ask you to do the following: Complete a brief demographic survey (20 questions) including the following: age, gender, race, caseload, average weekly work hours, location, type of organization, type of counselor role, years of experience, etc.). Complete a 78-item survey assessing compassion fatigue, compassion satisfaction,

organizational culture, and self-care practices. The demographic information and survey should take approximately 20 minutes to complete.

How could you or others benefit from this study?
Participants should not expect to receive a direct benefit from taking part in this study. Benefits to society include greater understanding of how organizations can assist their employees, which in turn may promote healthier employees and improved quality of services for clients.

What risks might you experience from being in this study?
The risks involved in this study are minimal. Participants may experience uncomfortable feelings/realizations while completing the questions in this survey.

How will personal information be protected?
The records of this study will be kept private. Research records will be stored securely, and only the researcher and faculty committee will have access to the records unless deemed appropriate to share with other researchers for future research studies. Participant responses will be anonymous. Data will be stored on a password-locked computer and may be used in future presentations. After three years, all electronic records will be deleted

How will you be compensated for being part of the study?
Participants will not be compensated for participating in this study. However, as an incentive to complete the survey, participants will be given the option to email a password to the researcher at the conclusion of the survey to be entered into a drawing to win a $50 gift card.

Does the researcher have any conflicts of interest?
Due to the data collection being anonymous, there is no conflict of interest.

Is study participation voluntary?
Participation in this study is voluntary. Your decision whether to participate will not affect your current or future relations with Liberty University. If you decide to participate, you are free to not answer any question or withdraw at any time prior to submitting the survey without affecting those relationships.

What should you do if you decide to withdraw from the study?
If you choose to withdraw from the study, please exit the survey and close your internet browser. Your responses will not be recorded or included in the study.

Whom do you contact if you have questions or concerns about the study?
The researcher conducting this study is Jennifer Owen under the supervision of her dissertation chair, Dr. Robyn Simmons. You may ask any questions you have now. If you have questions

later, you are encouraged to contact her at jlashebatista2@liberty.edu. You may also contact the researcher's faculty sponsor, Dr. Robyn Simmons, at rsimmons30@liberty.edu.

Whom do you contact if you have questions about your rights as a research participant?
If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, you are encouraged to contact the Institutional Review Board, 1971 University Blvd., Green Hall Stu. 2845, Lynchburg, VA 24515 or email irb@liberty.edu.

Your Consent
Before agreeing to be part of the research, please be sure that you understand what the study is about. You can print a copy of the document for your records. If you have any questions about the study later, you can contact the researcher/study team using the information provided above. By clicking the button below, you consent to participate in this study.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

○ Yes, I consent to participate in the study.

Q3 Are you a licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), or a pre-licensed counselor (registered with the state counseling board in pursuit of LPC and/or LMFT)?

*Please Note: The term LPC and LMFT may be called by a different name in your respective state. If you hold a similar position in a state that uses different terminology, you may still qualify as a participant for this study.

- [ ] Licensed Professional Counselor (LPC)
- [ ] License Marriage & Family Therapist (LMFT)
- [ ] Pre-licensed Counselor

Q4 What is your current age?

- ○ 20-29
- ○ 30-39
- ○ 40-49
- ○ 50-59
- ○ 60-69
- ○ 70-79
- ○ 80-89
- ○ 90-99

Q5 What is your gender? / What gender do you identify as?

- ○ Male
- ○ Female
- ○ Prefer Not to Answer

Q6 Are you of Hispanic, Latinx, or Spanish origin?

- ○ Yes
- ○ No

Q7 Race/Ethnicity [Check all that apply.]

- ☐ Black or African American
- ☐ Asian
- ☐ American Indian and Alaska Native
- ☐ Native Hawaiian and Other Pacific Islander
- ☐ White
- ☐ Other

Q8 What is your highest qualification (completed)?

- ○ Master's Degree
- ○ Doctoral Degree

Q9 What is your marital status?

- ○ Married
- ○ Divorced
- ○ Separated
- ○ Widowed
- ○ Unmarried

Q10 What religion or spiritual affiliation do you identify yourself most closely to?

- ○ Hinduism
- ○ Buddhism
- ○ Sikhism
- ○ Judaism
- ○ Muslim
- ○ Christian (Catholic protestant or any other Christian denominations)
- ○ Other
- ○ I am not religious

Q11 What annual income group do you personally fall under?

- ○ Less than $20,000
- ○ $20,000 - $29,000
- ○ $30,000 - $39,000
- ○ $40,000 - $49,000
- ○ $50,000 - $59,000
- ○ Above $60,000

Q13 What state do you live in?

_____

Q14 On average, how many hours a week do you work?

- ○ None
- ○ 1-10 hours
- ○ 11-20 hours
- ○ 21-30 hours
- ○ 31-40 hours
- ○ 41+ hours

Q15 On average, how many hours a week do you work directly with clients?

- ○ None
- ○ 1-10 hours
- ○ 11-20 hours
- ○ 21-30 hours
- ○ 31-40 hours
- ○ 41+ hours

Q16 On average, how many hours a week do you work directly with trauma clients?

- ○ None
- ○ 1-10 hours
- ○ 11-20 hours
- ○ 21-30 hours
- ○ 31-40 hours
- ○ 41+ hours

Q17 Does your place of employment require you to maintain a certain caseload number (by number of clients and/or billable hours)?

- ○ Yes
- ○ No

Q18 On average, how many clients do you see per week?

- ○ 1-10 clients
- ○ 11-20 client
- ○ 21-30 clients
- ○ 31-40 clients
- ○ 41+ clients

Q19 On average, how many total active clients do you have on your caseload?

- ○ 1-10 clients
- ○ 11-20 client
- ○ 21-30 clients
- ○ 31-40 clients
- ○ 41+ clients

Q20 How many years have you been practicing in the mental health field?

- ○ Less than 1 year
- ○ 2-5 years
- ○ 6-10 years
- ○ 11-15 years
- ○ 16-20 years
- ○ 21-25 years
- ○ 26-30 years
- ○ 31-35 years
- ○ 36-40 years
- ○ 40+ years

Q21 If licensed, how many years have you held that counseling license?

- ○ Less than 1 year
- ○ 1-5 years
- ○ 6-10 years
- ○ 11-15 years
- ○ 16-20 years
- ○ 21-25 years
- ○ 26-30 years
- ○ 31-35 years
- ○ 36-40 years
- ○ 40+ years
- ○ Not Applicable/ Not yet licensed

Q22 What best describes the type of organization you work for? [Check all that apply.]

- [ ] For profit
- [ ] Non-profit
- [ ] Private Practice
- [ ] Community Services Board
- [ ] Hospital
- [ ] Public/Private School
- [ ] University/College
- [ ] Church/Religious Organization
- [ ] Self-Employed
- [ ] Other

Q23 What role(s)/position(s) do you have at your place of employment? [Check all that apply.]

- ☐ Outpatient Counselor
- ☐ In-patient Counselor
- ☐ In-home Counselor
- ☐ School-based Counselor (not the same as a guidance counselor or licensed school counselor)
- ☐ Crisis Counselor
- ☐ Other

Q43 Vicarious Traumatization Questionnaire	Not at all	Very little	Mild amount	Neutral	Moderate amount	A great deal	A significant amount
1. To what extent have you been personally impacted as a result of your work with trauma victims?	○	○	○	○	○	○	○
2. To what extent have your perceptions of yourself been altered as a result of your work with trauma victims?	○	○	○	○	○	○	○
3. To what extent have your perceptions of others been altered as a result of your work with trauma victims?	○	○	○	○	○	○	○
4. To what extent have your perceptions of the world been altered as a result of your work with trauma victims?	○	○	○	○	○	○	○

5. To what extent have you experienced any negative psychological effects as a result of your work with trauma victims?	○	○	○	○	○	○	○

Q24 Professional Quality of Life Scale (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.

Q25 ProQOL	Never	Rarely	Sometimes	Often	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.	○	○	○	○	○

Q26 Trauma Informed Organizational Culture Survey
Please rate the following statements.

Q27 TIOC	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1. I feel safe at my job.	○	○	○	○	○
2. I witness violence at my job.	○	○	○	○	○
3. My organization has policies and procedures in place to ensure my safety.	○	○	○	○	○
4. I am asked to do things at my job that I do not feel safe doing.	○	○	○	○	○
5. My organization values people who have different types of skills.	○	○	○	○	○
6. My organization values me as a person.	○	○	○	○	○
7. My organization offers adequate health insurance to employees that include confidential mental health services.	○	○	○	○	○

8. My organization compensates me or provides comp time when I work long hours or overtime.	○	○	○	○	○
9. My organization encourages me to take care of myself.	○	○	○	○	○
10. My work day is filled with different types of activities.	○	○	○	○	○
11. I feel like I do not have enough work time to get my job done during a normal business day.	○	○	○	○	○
12. I feel like I do not have enough resources to succeed at my job.	○	○	○	○	○
13. I feel like my organization does not support me.	○	○	○	○	○
14. I feel comfortable talking to my supervisor about work related problems.	○	○	○	○	○

15. My supervisor asked me for suggestions or about my opinions.	○	○	○	○	○
16. I receive regularly scheduled supervision for my job.	○	○	○	○	○
17. My supervisor encourages me to take care of myself.	○	○	○	○	○
18. I trust my supervisor.	○	○	○	○	○
19. My supervisor supports my decisions.	○	○	○	○	○
20. I trust my co-workers.	○	○	○	○	○
21. My co-workers know at least a few personal things about me. (for example birthday, partner's name, favorite type of food or hobby)	○	○	○	○	○
22. I generally like my co-workers.	○	○	○	○	○

23. I feel comfortable discussing work related problems with my co-workers.	○	○	○	○	○
24. I feel comfortable discussing personal problems with my co-workers.	○	○	○	○	○
25. I have received training through my current job to help me effectively work with individuals who have experienced trauma.	○	○	○	○	○
26. I have received information at my current job on the importance of self-care.	○	○	○	○	○
27. I have received information at my current job on compassion fatigue.	○	○	○	○	○
28. I work in a stressful environment.	○	○	○	○	○

29. When something upsetting happens at my agency workers are given time to process and heal.	○	○	○	○	○
30. I work in an agency that supports my self-care efforts.	○	○	○	○	○

Q28 Self-Care Practices Scale (SCPS)

This part of the survey asks questions about possible self-care practices. The first section relates to personal self-care practices. Keep in mind there are no right or wrong answers. When filling out this part of the scale, please indicate how frequently you engage in each of the following.

	Never	Rarely	Sometimes	Often	Very Often
1. I engage in physical activities.	○	○	○	○	○
2. I laugh.	○	○	○	○	○
3. I engage in spiritual practices.	○	○	○	○	○
4. I get adequate sleep for my body.	○	○	○	○	○
5. I spend quality time with people I care about.	○	○	○	○	○
6. I participate in activities that I enjoy.	○	○	○	○	○
7. I accept help from others.	○	○	○	○	○
8. I engage in physical intimacy.	○	○	○	○	○
9. I take action to meet my emotional needs.	○	○	○	○	○

Q36 This second section relates to professional self-care practices. Remember, there are no right or wrong answers. When filling out this part of the scale, please indicate how frequently you engage in each of the following.

	Never	Rarely	Sometimes	Often	Very Often
1. I take small breaks throughout the workday.	○	○	○	○	○
2. I seek out professional development opportunities.	○	○	○	○	○
3. I take vacations.	○	○	○	○	○
4. I acknowledge my successes at work.	○	○	○	○	○
5. I problem solve when I have challenges at work.	○	○	○	○	○
6. I reserve work tasks for designated work hours (e.g., paperwork, emails, work-related colleague contact).	○	○	○	○	○
7. I attend to feelings of being overwhelmed with my work.	○	○	○	○	○
8. I seek out colleagues I find supportive.	○	○	○	○	○
9. I am able to say “no” when appropriate.	○	○	○	○	○

Appendix B: Social Media Post for Recruitment

RESEARCH PARTICIPANTS NEEDED

- Are you a counselor?
- Are you interested in contributing to the current literature on counselors' experiences of compassion fatigue?
- Are you interested in winning a $50 gift card?

Follow the link provided (QR code) to complete the research survey:

Please contact Jennifer L. Owen at [redacted] or jlashebatista2@liberty.edu for more information.

