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The Prevalence and Impact of Burnout, Adverse Childhood Experiences, and Other Factors in Predicting Compassion Fatigue

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by

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Abstract

Counselors need to be aware of the signs, symptoms, and risk factors for compassion fatigue. Ethical codes including the ACA Code of Ethics state that counselors who are impaired should not see client and state that supervisors and counselor educators should monitor for impairment in supervisees and trainees (American Counseling Association, 2014). The sample included eighty-two counselors practicing in thirty states who completed a Qualtrics survey posted on counseling forums and listservs. This study utilized descriptive statistics to answer questions about the prevalence of burnout, compassion fatigue, and adverse childhood experiences in counselors. Multivariate regression models were used to predict compassion fatigue scores. All of the counselors in this study were at low to moderate risk of burnout, while approximately 80% of the sample was at moderate to extremely high risk of compassion fatigue. The average ACE score for participants including community ACEs was 7 and the average score excluding community ACES was 3.76. The combination of number of abusive/neglectful ACEs, number of community ACEs, number of household dysfunction ACEs, severity of ACEs, and total burnout score predicted approximately 53% of the variance in compassion fatigue scores. Counselors can be at risk for compassion fatigue even if they are not experiencing burnout. More research needs to be conduct on the impact of the severity of personal trauma on compassion fatigue.

Dedication

This dissertation is dedicated to my mother, Deanna Glover, who has always provided me with unwavering support and who believes in me even when I struggle to believe in myself.

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I would also like to thank the participants in my study. I appreciate their willingness to spend their time completing my survey and for their vulnerability in sharing deep, personal information with me.

Finally, I would like to thank my family and friends for helping me reach this goal. I know that I had to sacrifice time and memories with you all to complete this program. I appreciate your understanding and support.

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Chapter One: Predicting Compassion Fatigue: The Cost of Caring for Counselors

The following is a typical illustrative about a counselor's experience with burnout and compassion fatigue.

Loralai is a marriage and family therapist who has been working with traumatized clients over the past five years. She grew up in a disengaged family where she experienced abuse and neglect and decided to become a counselor to help improve family functioning and help families end the cycle of abuse. Loralai heard about burnout and compassion fatigue in her masters, but she hasn't given either much thought because her experiences sound similar to those of her colleagues.

Loralai works fulltime at an agency in town that provides free counseling to children and families and sees an average of twenty-five clients per week. Most of her clients were referred to the agency by Child Protective Services (CPS). All of Loralai's clients have a trauma history. Some of her clients perseverate on their trauma, while other clients avoid talking about or thinking about their traumatic experiences.

Loralai had weekly clinical supervision for the first two years of her practices; however, she has not attended clinical supervision for the past three years since she was fully licensed. Loralai attends a weekly staffing with her colleagues where she occasionally receives feedback on cases or is able to vent about her experiences. She tries to avoid thinking about her clients when she is not in session. When she encounters

circumstances that remind her of things her clients have disclosed, she immediately changes the subject or leaves the location.

Loralai wants to be helpful to her clients and genuinely cares about them; however, she finds herself exhausted much of the time. She assumes that exhaustion is a normal part of agency work and does her best to engage in self-care when she has the time or energy. Loralai feels comfortable working with clients who avoid talking about their trauma though she isn't sure how much progress they are making. When she works with clients who focus on their traumatic experiences, Loralai tries to get her clients to focus on the positive things that are happening in their lives and their hopes for the future. Some of her clients have learned that she is uncomfortable hearing about their traumatic experiences, while other clients enjoy working with her because they do not have to think about past traumas.

Loralai is experiencing symptoms of burnout and compassion fatigue. If assessed, she would be considered to be exhibiting more avoidant symptoms though she has some arousal symptoms including intrusive thoughts. Loralai's experiences are beginning to impact her work with her clients. She may not know enough about burnout or compassion fatigue to be able to identify her symptoms and assumes that her experience is typical of agency work.

Loralai's clinical director is not aware of her symptoms because she is not open or honest about them in staff meetings. Loralai's clinical

director tries to maintain professional boundaries and do not deeply inquire about their employees' personal lives or mental state per the American Counseling Association (ACA) Ethical Codes. The strict maintenance of professional boundaries has made it difficult for Loralai's clinical director to notice signs of burnout and compassion fatigue.

Background of the Problem

According to the American Psychiatric Association (2013), witnessing a traumatic event or having knowledge of the experience of a traumatic event experienced by a close friend or family member can be triggers for Post-Traumatic Stress Disorder (PTSD). In other words, an individual does not have to experience a traumatic event to experience symptoms of trauma. Having knowledge of a traumatic event can be traumatic (Figley, 2013).

Approximately 8.4% of Americans in 2008 reported being the victim of a violent personal crime (Bureau of Justice Statistics, 2008). Approximately 17%-25% of women experience a violent sexual assault, 17% of girls and 10% of boys experience childhood sexual abuse, and about 32 million individuals in America are child sexual abuse survivors (Healing Sexual Trauma, 2010; Heppner et al., 1995; Ratna & Mukergree, 1998).

Many individuals who experience violent crimes seek help from mental health professionals (National Center for Victims of Crime, 2010). Counselors who work at community agencies do not have control over organizational factors like caseloads may be more vulnerable to secondary traumatization (Pearlman & Saakvitne, 1995b). Counselors in community agencies cannot screen out clients due to the severity or nature

of the presenting problem and are thus more likely to be exposed to traumatized clients (Bride, 2004). Between 82% and 94% of clients at community mental health centers have experienced at least one traumatic event (Bride, 2004).

Secondary trauma or compassion fatigue is a predictor of work-related stress and fatigue (Figley, 2013). The term compassion fatigue was first described in a nursing magazine by Joinson (1992) in an article about nurses who worked with hospital emergencies daily and felt worn down. Kottler (1992) also described the importance of compassion when therapists are working with resistant or difficult clients. These researchers were the first to address why and how professionals lose compassion when they work with traumatized individuals (Figley, 2002a).

Statement of the Problem

Many stressors that counselors face may lead to impairment (Corey, Corey, & Callan, 2007). “Impairment is the presence of an illness or severe psychological depletion that is likely to block a professional from being able to deliver effective services and results in consistently functioning below acceptable practice standards” (Corey, Corey, & Callanan, 2007, p. 62).

Few studies have been conducted on the prevalence of burnout, adverse childhood experiences, and compassion fatigue in counselors. No studies have included the prevalence of community ACEs, the severity of ACEs, or the frequency of ACEs in counselors or other mental health workers.

The original study on adverse childhood experiences (ACE) included ten categories including: 1) physical abuse; 2) sexual abuse; 3) psychological abuse; 4) violence against mother; 5) living with mentally ill or suicidal individuals; 6) substance

use; 7) parental divorce or separation; 8) living in a household with criminal activity; 9) emotional neglect; and 10) physical neglect (Felitti et al., 1998). Esaki and Larkin (2013) found that 70% of mental health providers experienced at least one adverse childhood experience. La Mott and Martin (2019) in a study with mental health providers (48% psychologists, other participants included LCSWs and LMFTs but statistics were not reported) found that 82.5% of participants had experienced at least one adverse childhood experience, 36.7% had experienced one or two, and 45.8% had three or more adverse childhood experiences.

High caseloads, lack of resources, negative feedback from clients, and chronic workplace tedium are linked to burnout (Jenkins & Baird, 2002; Maslach, Schaufeli, & Leiter, 2001). Burnout often has a gradual onset and includes difficulty with job performance and feelings of hopelessness (Stamm, 2005). Burnout develops from exposure to challenging interpersonal and emotional situations over prolong periods of time, which lead to strain and insufficient professional support (Jenkins & Baird, 2002; Maslach, Schaufeli, & Leiter, 2001). La Mott and Martin (2019) found that mental health providers with a history of adverse childhood experiences had significantly higher burnout scores than those without a history of adverse childhood experiences.

Lee (1995) found that marriage and family therapist experience more compassion fatigue than medical students but less compassion fatigue than clients with PTSD (Lee, 1995). Lee (1995) found that 63% of clients seen by the marriage and family therapists in the study were traumatized. Therapists who have a history of childhood trauma may be more likely to experience compassion fatigue when working with traumatized clients.

Therapists with compassion fatigue may be more likely to be impaired and that impairment can have negative impacts on their clients.

The problem under investigation is the relationship that exists between compassion fatigue and counselors' personal history of childhood trauma, burnout, and professional variables. Research has shown that many individuals are at risk for compassion fatigue including counselors, family members, friends, and first responders. While research has shown that having personal history of trauma, burnout, and organizational factors are related to compassion fatigue, it has yet to be determined to what extent are specific traumatic events, the number, category, severity, and frequency of traumatic events in childhood, burnout, work setting, and licensure status are predictive of compassion fatigue in counselors. Additionally, there are no studies that examine the impact of community ACEs on compassion fatigue in counselors.

Purpose of the Study

Figley (2002a) stated that it is important for researchers to discover who is most vulnerable to compassion fatigue, under what conditions are they most vulnerable, and in what settings are professionals most vulnerable so that we can treat the condition. The purpose of this study was to explore the relationships between compassion fatigue, adverse childhood experiences (number, subcategory, frequency, and severity), age, and burnout in counselors. Participants were recruited from listservs of counselors, counselors-in-training, and counselor educators as well research forums on the website for the world's largest association that represents counselors exclusively.

Research Questions

The following research questions were used to guide this study:

1. What percentage of counselors are at low, moderate, and high risk for burnout?
2. What percentage of counselors are at extremely low, low, moderate, high, and extremely high risk for compassion fatigue.
3. What is the prevalence of adverse childhood experiences including frequency and severity in a sample of counselors?
4. Which of the four predictor variables (number of adverse childhood experiences, frequency of adverse childhood experiences, severity of adverse childhood experiences, and burnout) are most influential in predicting compassion fatigue in this sample? Are there any predictor variables that do not contribute significantly to the prediction model?
5. Which of the six predictor variables (number of abusive/neglectful ACEs, number of community ACEs, number of dysfunctional household ACEs, frequency of adverse childhood experiences, severity of adverse childhood experiences, and burnout) are most influential in predicting compassion fatigue in this sample? Are there any predictor variables that do not contribute significantly to the prediction model?
6. Which of the three predictor variables (severity of ACEs, burnout, and age) are most influential in predicting compassion fatigue in this sample? Are there any predictor variables that do not contribute significantly to the prediction model?

Significance of the Study

Counselors should be aware of the potential impact their childhood trauma can have on their emotions and memories so that they can be aware of triggers and changing beliefs (Williams, Helm, & Clemens, 2012). Counselors who are aware of changes can

take actions to mediate the effects of indirect trauma (Williams, Helm, & Clemens, 2012). The American Mental Health Counselors Association (AMHCA, 2010) states that counselors are responsible for recognizing when their mental or physical health compromises their effectiveness and that they should seek supervision and help when their competence is affected. The American Association for Marriage and Family Therapists (AAMFT, 2015) states that MFTs should seek help when their clinical judgment or performance may be impaired.

Green Albanese, Shapiro, and Aarons (2014) claim that the quality of care received by clients is negatively impacted when they receive services from someone experiencing burnout. Franco (2015) suggests that clinical supervisors of marriage and family therapists in agencies should be mindful about their supervisees' work and provide resources to help supervisees prevent and treat burnout. Franco (2015) suggests that supervisors should ask themselves if the work environment they have created for therapists promotes burnout. Burnout is a professional and ethical concern, because it may be difficult to overcome burnout (Franco, 2015). Corey, Corey, and Callana (2007) state that graduate programs should prepare students for both the positive experiences of the profession and the potential disappointments and stressors they are likely to face. Corey, Corey, and Callanan (2007) suggested that preventing counselor impairment requires counselors to view their wellness from a holistic perspective and commit to maintaining it.

This study adds to the existing literature on compassion fatigue and provides support that counselors who have a personal history of childhood trauma may be negatively affected by compassion fatigue. It determines if the type, number,

subcategory, frequency, and severity in combination with burnout and age can predict compassion fatigue in counselors as well as determine the prevalence of ACEs, burnout, and compassion fatigue in counselors.

This information helps clinicians become more aware of risk factors for compassion fatigue. The ACA Code of Ethics states that counselors should not see clients if they are impaired and that supervisors and counselor educators should monitor for impairment (American Counseling Association, 2014). Counselors, students, counselor educators, and supervisors need to be knowledgeable about compassion fatigue and burnout risk factors and symptoms in order to monitor for impairment. Knowledge of risk factors and symptoms of compassion fatigue and burnout can lead to prevention and early intervention for counselors who may be impacted by compassion fatigue.

Definition of Terms

Burnout is a condition of "physical and emotional exhaustion, involving the development of negative self-concept, negative job attitudes, and loss of concern and feeling for clients" (Pines & Maslach, 1978, p. 234).

Compassion is the "feeling of deep sympathy and sorrow for another who is stricken by suffering or misfortune, accompanied by a strong desire to alleviate the pain or remove its cause" (Gilman, 1989, p.220).

Compassion Fatigue or Secondary Traumatic Stress is when an individual who cares for those who have experienced trauma or highly stressful events experiences similar symptoms to those experienced by the survivor of the trauma (Figley, 2013; Stamm, 1995).

Compassion Satisfaction is the term used to describe the pleasure an individual gets from helping others and doing their job (Stamm, 2005).

Compassion stress is the stress that results from an individual helping or wanting to help a traumatized person and/or having knowledge of the traumatic event (Figley, 2013).

Countertransference "occurs when there is inappropriate affect, when therapists respond in irrational ways, or when they lose their objectivity in a relationship because their own conflicts are triggered. In a broader sense, countertransference involves the therapist's total emotional response to a client (Corey, 2009, p. 72-73)." An example of countertransference would be a clinician who is annoyed while working with a client because they unconsciously remind them of their ex-partner.

Emotional Contagion is when "an individual observing another person experiences emotional responses parallel to that person's actual or anticipated emotions" (Miller, Stiff, & Ellis, 1988, p. 254).

Physical Abuse is "when a parent or caregiver commits an act that results in physical injury to a child or adolescent" (The National Child Traumatic Stress Network, n.d.).

Post-Traumatic Stress Disorder (PTSD) is "the development of characteristic symptoms following exposure to one or more traumatic events (American Psychiatric Association, 2013, p. 274)."

Sexual Abuse "is any interaction between a child and an adult (or another child) in which the child is used for the sexual stimulation of the perpetrator or an observer" (The National Child Traumatic Stress Network, n.d.).

Transference refers to the transferring emotional information that may not be expressible verbally from one individual to another (Valent, 2002). An example of transference may be when an individual interprets another individual's greeting as insincere because their parent used the same greeting and was often insincere.

Vicarious Traumatization occurs when a clinician's empathic engagement with the traumatic experiences of clients result in "significant disruptions in one's sense of meaning, connection, identity, and world view, as well as in one's affect tolerance, psychological needs, beliefs and self and other, interpersonal relationships, and sensory memory" (Pearlman & Saakvitne, 1995b, p. 151).

The "cost of caring" for someone in emotional pain has been described using a number of terms compassion fatigue (Figley, 2002a), secondary traumatic stress (Figley, 1983; Figley, 1985; Stamm, 1995; Stamm, 1997), and vicarious traumatization (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995b). Other topics that are related to the "cost of caring" include emotional contagion (Miller, Stiff, & Ellis, 1988), rape-related family crisis (Erikson, 1989; White & Rollins, 1981) and "proximity" effects found in the partners of war veterans (Verbosky & Ryan, 1988). While most of these concepts are closely related yet distinct, compassion fatigue and secondary traumatic stress disorder describe the same phenomenon and will be used interchangeably throughout this article giving preference compassion fatigue or the terminology used within the cited materials.

Chapter Two: Review of the Literature

Hilfiker (1985) stated, “all of us who attempt to heal the wounds of others will ourselves be wounded; it is, after all, inherent in the relationship” (p. 207). According to Valent (2002), people in the helping field may be attracted to working with clients who have gone through similar traumas and experiences as the helper’s repressed experiences. Helpers often recognize how their clients’ transference can lead to countertransference in themselves. We fail to acknowledge that helpers often transfer their issues onto their clients who experience countertransference, which compounds their clients’ trauma (Valent, 2002).

Valent (2002) stated, “when they are strained, or worse, when they fail, helpers may be the next dominoes who follow primary victims in suffering themselves” (p.17). Clinical social workers often share the emotional burden of traumatized clients in the facilitation of healing (Herman, 1992). Clinicians are often exposed to the awful and traumatic events of the world through their clients (Kassam-Adams, 1995; Pearlman & Saakvitne, 1995a). Clinicians are confronted with the traumatic events of the world may struggle with beliefs about vulnerability, the meaning we make in the world, and their self-perceptions (Janoff-Bulman, 1989).

Clinicians who treat traumatized clients help their clients process experiences, which usually involves asking clients to repeatedly remember traumatic events and this exposes clinicians to vivid imagery of the events. Indirect exposure to these traumatic events puts clinicians at risk of emotional, cognitive, and behavioral changes. Clinicians face the occupational hazards of vicarious traumatization, burnout, and compassion

fatigue when they work with traumatized clients (Adams, Boscarino, & Figley, 2006; Bride, 2004; Bride, 2007).

Conceptual Framework

Trauma

Trauma can include singular or multiple events that impact individuals differently (Center for Substance Abuse Treatment, 2014). The impact of trauma can range from subtle changes to clinically significant PTSD symptoms (Center for Substance Abuse Treatment, 2014). The way an individual is impacted by a traumatic event or experience is influenced by a number of factors including the following: individual characteristics, aspects of the event, development, the meaning of the trauma, and sociocultural factors (Center for Substance Abuse Treatment, 2014).

Researchers, while working with adults who were obese as children and examining the psychological aspects of obesity, found that many of these patients experienced abuse (psychological, sexual, and/or physical), neglect (emotional and/or physical), family dysfunction, and/or parental abandonment (Stevens, 2012). Researchers found that obese patients who experienced abuse or neglect as children required medical treatment at three times the rate of the rest of the population (Stevens, 2012). This foundational study with obese patients led to the discovery of adverse childhood experiences and their impacts on physical health, psychological health, and society.

Trauma is measured in a variety of ways. Bethell et al. (2017) compared fourteen different ACE assessment methods. All of the assessment measures, except one, were designed to be utilized as a self-report measure (Bethell et al., 2017). ACE instruments measure between six and twenty different constructs with all instruments assessing

parental incarceration, household substance use, household mental illness and suicide, domestic violence, and community trauma (Bethell et al., 2017). Bethell et al. (2017) found that all ACE measurements were similar and showed consistent associations with negative outcomes in adulthood when protective and resiliency factors were not present. The Yale-Vermont Adversity in Childhood Scale is specifically designed to assess the frequency and severity of ACEs (Holbrook, et al., 2015).

Burnout

Counseling as a profession comes with many sources of stress including professional expectations, the nature of the work, and individual dynamics (Corey, Corey, & Callanan, 2007). Many counselors are not warned about the amount of stress they are likely to face when they enter the counseling field (Corey, Corey, & Callanan, 2007). Many counselors get satisfaction from helping others; however, counselors also need to engage in self-exploration so they can help others explore themselves, a process which is not always easy (Corey, Corey, & Callanan, 2007). Effective counselors use their experiences and reactions to inform their understanding of their clients (Corey, Corey, & Callanan, 2007).

Many counselors join the helping profession because they have a desire to be needed, to feel important, to influence others, to impact others, and to be significant (Corey, Corey, & Callanan, 2007). These desires can often lead to irrational stress-inducing beliefs related to the need to help or fix others leading to experiences of burnout (Corey, Corey, & Callanan, 2007). Counselors who work in schools or managed care where they are expected to quickly "fix" clients may experience higher levels of burnout (Corey, Corey, & Callanan, 2007). In addition or personal beliefs, many work-related

stressors including caseload, work setting, and other professional responsibilities are linked to counselor burnout (Corey, Corey, & Callanan, 2007).

Burnout is measured with self-administered instruments. The Maslach Burnout Inventory was designed to assess burnout in individuals who work in education and human services (Maslach, Jackson, Leiter, Schaufeli, & Schwab, 1986). The internal consistency for the emotional exhaustion, depersonalization, and personal accomplishment subscales are .90, .79, and .71 respectively. There are a number compassion fatigue/secondary traumatic stress measurements with burnout subscales that are designed to assess burnout in a population exposed to secondary trauma. These instruments (including the Professional Quality of Life Scale) are discussed in further detail under compassion fatigue measurements.

Compassion Fatigue

Individuals who are highly empathic and have a high capacity for feeling tend to be at a higher risk for compassion stress (Figley, 2013). Compassion fatigue includes emotional and physical exhaustion from chronic use of empathy (Figley, 2002a; Rothschild & Rand, 2006). Figley (1995) found a wide range of symptoms related to compassion fatigue including higher mortality rates and serious illnesses.

Compassion fatigue can be masked by burnout, countertransference, dissatisfaction at work, and other related concepts (Figley, 1995). Figley (1997) described compassion fatigue as a type of burnout with family burnout being the interpersonal equivalent. Compassion fatigue is related to a professional's dissatisfaction with their caseload (Lee, 1995). A professional's cognitions related to general morale within their personal and professional life are strongly correlated to compassion fatigue (Lee, 1995).

Compassion fatigue is measured through a variety of self-administered instruments. The Compassion Fatigue Self Test (CFST), including all versions, is the most common instrument used to measure compassion fatigue (Bride, Radley, & Figley, 2007). The CFST was designed for practitioners to self-assess levels of job burnout and compassion fatigue with internal consistency for the CFST range from .86 to .94 (Bride, Radley, & Figley, 2007). The Compassion Satisfaction and Fatigue Self-Test was designed to include positive items related to compassion satisfaction with internal consistencies from .87 to .90 (Bride, Radley, & Figley, 2007). The Compassion Fatigue Scale-Revised was designed as a shorter version of the CFST; yet, it had questionable validity so it was revised again to create the Compassion Fatigue Short Scale (CF- Short Scale) with internal consistency for burnout, secondary trauma, and combined scales .90, .80, and .90 respectively (Bride, Radley, & Figley, 2007). The Professional Quality of Life Scale (ProQOL) was developed from modifying the CFST with internal consistencies for compassion satisfaction, burnout, and compassion fatigue .87, .72, and .80 respectively (Bride, Radley, & Figley, 2007).

The Secondary Traumatic Stress Scale was developed to examine the frequency of avoidance, arousal, and intrusive symptoms related to indirect trauma exposure with internal consistency for the combined score, intrusion subscale, avoidance subscale, and arousal subscale being .93, .80, .87, and .83 respectively (Bride, Radley, & Figley, 2007). The Impact of Event Scale (IES) and the Impact of Event Scale Revised (IES-R) were developed to measure direct trauma though some researchers have used it to assess compassion fatigue and have internal consistency scores form .82-.86 and .82-.89 respectively (Bride, Radley, & Figley, 2007). The Trauma and Attachment Belief Scale is

designed to assess changes in cognitive schemas and has an overall internal consistency of .98 (Bride, Radley, & Figley, 2007).

Review of Research

Background

Empathy and Therapeutic Relationship

Valent (2002) stated that empathy "is the vehicle whereby helpers make themselves open to absorption of traumatic information" (p. 20). Empathy allowed individuals to absorb information from another person then they often experience an impulse to respond to that person's emotions. A therapist's countertransference provided information to help them understand the transference information leading to their understanding of the experiences of their clients (Valent, 2002). Figley (2002a) stated that countertransference "explains the mechanism of producing helper symptoms. It was described as the unconscious attunement to and the absorption of victims' stresses and traumas" (p. 19).

Researchers believe that the therapeutic alliance including the ability to understand, help, and empathize with client is the key to effective therapy (Figley & Nelson, 1989). A client's ability to like and trust their therapist is essential to forming a therapeutic alliance (Figley, 2002a). A therapist's ability to demonstrate empathy and compassion are key to a client liking and trusting their therapist (Figley, 2002a).

It is vital for the therapeutic relationship for counselors to have an empathic connection with their client, yet this empathy is connected to affective vulnerability in counselors who work with traumatized clients (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995b). Counselors may identify with a client's traumatic experience through

empathic engagement. If they have difficulty making sense of their experience identifying with clients, they may feel unsafe or insecure in the world (Williams, Helm, & Clemens, 2012). Therapists, who do trauma work, are more vulnerable to the following impairments: burnout; compassion fatigue; countertransference; and vicarious traumatization (Bride, 2004; Pearlman & Saakvitne, 1995b).

PTSD and Secondary Trauma

Figley (1995) suggested that we should rename PTSD *primary posttraumatic stress* disorder and that symptoms experienced through contact with an individual who has experienced trauma should be called *secondary traumatic stress disorder (STSD).* Wilson, Lindy, and Raphael (1994) divided symptoms of compassion stress into two categories: intrusive-type countertransference and avoidance-type countertransference. These categories aligned with the arousal and avoidance symptoms of PTSD. Intrusive-type countertransference included boundary issues, becoming overinvolved, reciprocal dependency, and inappropriate bonding, while avoidance-type countertransference includes withdrawing, becoming numb, intellectualization, and denial (Wilson, Lindy, & Raphael, 1994).

According to Figley (2002a), PTSD can include the following avoidance symptoms: avoiding thoughts, feelings, or conversations related to the trauma; avoiding places, people, and activities that trigger memories of the trauma; inability to remember important details of the trauma; decreased interest or participation in activities; feeling detached or estranged from others; decreased affective range; and sense of foreshortened future. PTSD also can include the following arousal symptoms: difficulty with sleep

(falling asleep or staying asleep); anger outbursts or irritability; difficulty concentrating; hypervigilance; and exaggerated startle response (Figley, 2002a).

Figley (1997) found that PTSD spreads throughout families until coping strategies are developed because stress is both created and destroyed amongst family members. Lee, Gottfried, and Bride (2018) found that ten percent of their sample of social workers who work with traumatized clients met the criteria for PTSD, while approximately thirty percent of their sample reported mild secondary traumatic stress, approximately nine percent reported moderate secondary traumatic stress, and six percent reported high or severe secondary traumatic stress.

Compassion Stress

Lee, Gottfried, and Bride (2018) found that social workers who work with traumatized clients experience intrusive thoughts about clients, difficulty sleeping, irritability, and difficulty concentrating. Individuals with secondary traumatic stress experienced intrusive thoughts, nightmares, and generalized anxiety (Figley, 2013). Intrusive symptoms of secondary traumatic stress in social worker were most common followed by arousal symptoms and avoidance symptoms. Individuals' experiences with secondary traumatic stress may change the way they interact with the world, themselves, and their families (Figley, 2013).

Makadia, Sabin-Farrell, and Turpin (2017) found that exposure to trauma work in clinical psychologist trainees was a predictor of trauma symptoms. Individuals who are highly empathic and had a high capacity for feeling tended to be at a higher risk for compassion stress (Figley, 2013). Aid workers with a personal history of trauma were at higher risk of developing vicarious trauma and/or secondary traumatic stress than aid

workers without a personal history of trauma (Birinci & Erden, 2016). However, aid workers with a personal history of trauma were not at a higher risk for burnout than aid workers without a personal history of trauma.

Meyers and Cornille (2002) found a significant relationship between intrusive symptoms of secondary trauma and CPS workers with an enmeshed family of origin. These helpers reported experiencing more nightmares and intrusive thoughts and emotions than CPS workers who grew up with less enmeshed interaction patterns. Minuchin (1974) noted that enmeshed families tend to become intrusively involved with one another and that when one person in the family experiences stress it is immediately experienced by all family members.

Meyers and Cornille (2002) also found a significant relationship between avoidant symptoms of secondary trauma and CPS workers with a disengaged family of origin. These helpers reported experiencing more isolation, desire to withdraw, and schizoid lifestyles than CPS workers who grew up with less disengaged interaction patterns. Minuchin (1974) noted that individuals from extremely disengaged families become emotionally and behaviorally unaffected by the things that happen around them and they may lack feelings of belonging and loyalty.

Vicarious Traumatization

Birinci and Erden (2016) found burnout, secondary traumatic stress, and vicarious trauma are experienced differently despite appearing to have some similarities. Vicarious traumatization is a related; yet, distinct concept from compassion fatigue/secondary traumatic stress. A review of research on vicarious traumatization was presented to highlight the similarities and differences with compassion fatigue/secondary traumatic

stress research. According to one study, the prevalence of vicarious traumatization in counselors was approximately 45.9% (Dunkley & Whelan, 2006). Pearlman and Saakvitne (1995b) believed that a combination of personal, work, and supportive factors were related to the development of vicarious traumatization in mental health therapists.

The research on the relationship between vicarious traumatization and a history of childhood trauma was inconsistent. Some researchers found a positive relationship between vicarious traumatization and childhood trauma (Bride, 2004; Pearlman & Mac Ian, 1995; Williams, Helm, & Clemens, 2012), while others did not find a significant relationship between the two (Adams, Matto, & Harrington, 2001; Dunkley & Whelan, 2006; Schauben & Frazier, 1995). The existence of childhood trauma itself did not explain the development of vicarious traumatization although it appeared to contribute in some way (Williams, Helm, & Clemens, 2012).

In a study on mental health providers (only 8.4% marriage and family therapists) working with traumatized clients, Williams, Helm, and Clemens (2012) found that childhood trauma had a direct effect on the development of vicarious traumatization and that personal wellness partially mediates the relationship. Mental health providers who experienced more frequent occurrences of childhood trauma reported more symptoms (Williams, Helm, & Clemens, 2012). Mental health providers with a history of childhood trauma experienced a partially mediated effect based on the number of personal wellness activities that mental health providers engaged in (Williams, Helm, & Clemens, 2012). Therapists can use personal wellness to decrease symptoms of vicarious traumatization after developing them (Williams, Helm, & Clemens, 2012).

Organizational factors that were thought to impact the development of vicarious traumatization included the following: caseloads; workload; work environment; organizational culture; and organizational support (Bell, Kulkarni, & Dalton, 2003; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995b). Pearlman and Saakvitne (1995b) found that organizational factors directly impact a counselor's vulnerability and resilience to vicarious traumatization. Other researchers found that organizational factors strongly influence the development of vicarious traumatization (Bell, Kulkarni, & Dalton, 2003; Neumann & Gamble, 1995). Given that vicarious traumatization and compassion fatigue are closely related, these organizational factors may also impact the development of compassion fatigue and compassion satisfaction.

Mental health providers with a history of childhood trauma experienced more cognitive distortions that are associated with vicarious traumatization (Williams, Helm, & Clemens, 2012). Therapists can be reminded of their own trauma when they hear their clients' traumatic stories, which increases their vulnerability to cognitive distortions related to vicarious traumatization (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a; Williams, Helm, & Clemens, 2012). Therapists who recognize changes in cognitions related to vicarious traumatization should engage in mediating activities to improve their functioning (Williams, Helm, & Clemens, 2012).

Survival Strategies

Countertransference may explain how things are transmitted between clients and mental health professionals but does not explain why some symptoms are transferred and some are not nor does it explain the timing of the transmission of symptoms (Valent, 2002). Burnout may explain the transmission of a cluster of symptoms; yet, it fails to

explain other symptoms that are transmitted or why these symptoms are transmitted (Valent, 2002).

Survival strategies may explain the reason for the nature of symptoms. Survival strategies are "biopsychosocial templates that have evolved to enhance maximum survival within evolutionary social units" (Valent, 2002, p. 21). The manifestations of traumatic stress may include the contributions of the various (social, biological, psychological, adaptive, and maladaptive) components of survival strategies (Valent, 2002). Survival strategies may arise from the appraisal of stressors, while trauma and illnesses may result if stressors are not properly appraised; however, lack of memory of the event and other defenses mitigate these effects (Valent, 2002).

Valent (2002) proposes eight survival strategies than can be used as a framework for classifying, diagnosing, and generally making sense of the phenomena of compassion fatigue. Rescuing-Caretaking, Attaching, Asserting- Goal Achievement, Adapting- Goal Surrender, Fighting, Fleeing, Competing, and Cooperating are the eight survival strategies proposed by Valent (2002). The symptoms experienced by mental health professionals may be related to responding in a complementary fashion to a client's needs or survival strategies or identifying with a client's needs or survival strategies (Valent, 2002).

The appraisal of means of survival for the Rescuing-Caretaking survival strategy is "must save others" and includes the desire to protect and provide (Valent, 2002). The adaptive biological responses to the Rescuing-Caretaking survival strategy include an increase in estrogen, oxytocin, and opioids, while the maladaptive biological responses include sympathetic and parasympathetic nervous system arousal (Valent, 2002). The

adaptive psychological responses to the Rescuing-Caretaking survival strategy include care, empathy, and devotion, while the maladaptive psychological responses include burden, depletion, and self-concern (Valent, 2002). The adaptive social responses to the Rescuing-Caretaking survival strategy includes responsibility, nurture, preservation, while the maladaptive social responses include resentment, neglect, and rejection (Valent, 2002). The trauma responses related to the Rescuing-Caretaking survival strategy include anguish and compassion fatigue related death (Valent, 2002).

The appraisal of means of survival for the Attaching survival strategy is "must be saved by others" and includes the desire to be protected and provided for (Valent, 2002). The adaptive biological response to the Attaching survival strategy may include an increase in opioids, while the maladaptive biological response also includes the increase of opioids (Valent, 2002). The adaptive psychological responses to the Attaching survival strategy include held, cared for, nurtured, and looked after, while the maladaptive psychological responses include yearning, "need crave," and abandonment (Valent, 2002). The adaptive social responses to the Attaching survival strategy include: "close secure"; content; union; while the maladaptive social responses include "cry secure," deprived, and separation (Valent, 2002). The trauma responses related to the Attaching survival strategy include helplessness, "cast out," and "left to die" (Valent, 2002).

The appraisal of means of survival for the Asserting-Goal Achievement survival strategy is "must achieve goal" and includes the desire to combat and work (Valent, 2002). The adaptive biological responses to the Asserting-Goal Achieving survival strategy include an increase in estrogen, norepinephrine, and immunocompetence and a decrease in cortisol, while the maladaptive biological responses include too much

epinephrine and norepinephrine, depletion of epinephrine and norepinephrine, an increase in blood pressure, and potentially coronary heart disease (Valent, 2002). The adaptive psychological responses to the Asserting-Goal Achievement survival strategy include strength, control, and potency, while the maladaptive psychological responses include frustration, loss of control, and impotence (Valent, 2002). The adaptive social responses to the Asserting-Goal Achievement survival strategy includes will, high morale, and success, while the maladaptive social responses include willfulness, low morale, and failure (Valent, 2002). The trauma responses related to the Asserting- Goal Achievement survival strategy include exhaustion, burnout, and powerlessness (Valent, 2002).

The appraisal of means of survival for the Adapting survival strategy is "must surrender goal" and includes the desire to accept and grieve (Valent, 2002). The adaptive biological responses to the Adapting survival strategy include an increase in cortisol and parasympathetic nervous system arousal, while the maladaptive biological responses include an increase in cortisol and infections, a decrease in immunocompetence, and a potential increase in risk of cancer (Valent, 2002). The adaptive psychological responses to the Adapting survival strategy include acceptance, sadness, grief, and hope, while the maladaptive psychological responses include overwhelmed, depression, and despair (Valent, 2002). The adaptive social responses to the Adapting survival strategy include yielding, mourning, and "turn to new," while the maladaptive social responses include collapse, withdrawal, and giving up (Valent, 2002). The trauma responses related to the Adapting survival strategy include damaged, "given in," and succumbing (Valent, 2002).

The appraisal of means of survival for the Fighting survival strategy is "must remove danger" and includes the desire to defend and rid (Valent, 2002). The adaptive

biological responses to the Fighting survival strategy include an increase in norepinephrine, increase in blood pressure, and sympathetic nervous system arousal, while the maladaptive biological responses include a large increase in the sympathetic nervous system and a decrease in cortisol (Valent, 2002). The adaptive psychological responses to the Fighting survival strategy include threat, revenge, and frightened, while the maladaptive psychological responses include hatred, persecution, and killing (Valent, 2002). The adaptive social responses to the Fighting survival strategy includes deterrence, wounding, and riddance, while the maladaptive social responses include attack, eradication, and destruction (Valent, 2002). The trauma responses related to the Fighting survival strategy include horror, evil, and murder (Valent, 2002).

The appraisal of means of survival for the Fleeing survival strategy is "must remove oneself from danger" and includes the desire to run, hide, and save oneself (Valent, 2002). The adaptive biological responses to the Fleeing survival strategy include sympathetic and parasympathetic nervous system arousal, while the maladaptive biological responses include a depletion of norepinephrine and an increase in epinephrine and cortisol (Valent, 2002). The adaptive psychological responses to the Fleeing survival strategy include fear, terror, and deliverance, while the maladaptive psychological responses include phobia, paranoia, and engulfment (Valent, 2002). The adaptive social responses to the Fleeing survival strategy include retreat, flight, and escape, while the maladaptive social responses include avoidance, panic, and annihilation (Valent, 2002). The trauma responses related to the Fleeing survival strategy include "inescapable shock," being hunted, and killed (Valent, 2002).

In particular, the Rescue-Caretaking survival strategy is related to compassion fatigue and the Assertiveness-Goal Achievement survival strategy is related to burnout, while the Fighting and Fleeing survival strategies are related to arousal symptoms of PTSD. “When helpers’ survival strategies are insufficient to resolve victim stresses, helpers become secondarily stressed by carrying both maladaptive victim survival strategies with which they identify and their own maladaptive complementary survival strategies, which become insufficient” (Valent, 2002, p. 25). During traumatic situations, individual often attempt all survival strategies, so mental health professionals may experience all survival strategies to some degree through the rise of complementary survival strategies and identify with the reverberations from survival strategies (Valent, 2002). Mental health professionals are more likely to experience adaptive survival strategies, but all individuals experience both adaptive and maladaptive survival strategies (Valent, 2002).

Compassion fatigue results when professionals identify with the maladaptive aspects of a client’s survival strategies or the traumatic aspects of their own survival strategies through the process of countertransference with the professional’s complementary survival strategies insufficient to meet the needs of the client (Valent, 2002). Maladaptive stress responses leading to compassion fatigue may arise as mental health providers identify with the survival strategies or their clients or have survival strategies that complement their client’s (Valent, 2002). Countertransference allows professionals to become attuned to and reverberate the needs and signals of their clients (Valent, 2002). Mental health professionals who are able to read the reverberations from their clients are better able to understand the experiences of their clients (Valent, 2002).

Mental health professions should use the signals they receive from their clients to match adaptive survival strategies with the maladaptive survival strategies being presented by their client (Valent, 2002). It is common for the survival strategies of mental health professionals to be the adaptive equivalent or adjacent reciprocal to their client's maladaptive survival strategies. For example, a client experiencing abandonment as a maladaptive response to the Attaching survival strategy may be met with nurture, which is an adaptive response to the Rescue-Caregiving survival strategy (Valent, 2002).

Main Concepts

Trauma

Adverse childhood experiences are characterized by experiences of childhood abuse (psychological, physical, or sexual), neglect (emotional or physical), and household dysfunction (substance abuse, mental illness, or mother treated violently) (Felitti et al., 1998). According to Felitti et al. (1998), children exposed to adverse childhood experiences are more likely to develop ischemic heart disease, cancer, emphysema, cardiovascular disease, chronic bronchitis, skeletal fractures, hepatitis, and jaundice. Adverse childhood experiences are linked to a number of health and behavioral risk factors (Felitti et al., 1998). Children exposed to four or more adverse childhood experiences were likely to begin smoking by the age of fourteen, were 12.2 times more likely to attempt suicide, were 7.4 times more likely to become alcoholics, and were 10.3 times more likely to inject drugs (Felitti et al., 1998).

Brown et al. (2009) found that individuals with an ACE score of six or higher died an average of twenty years earlier than individuals with an ACE score of zero. Whitfield, Dube, Felitti, and Anda (2005) found that a significant graded relationship

exists between individuals with a history of hallucinations not related to substance use and a history of adverse childhood experiences. Individuals with an ACE score of seven or higher were five times more likely to report hallucinations that individuals with an ACE score of zero.

Dong et al. (2004) found that individuals with an ACE score of seven or more were 3.6 times more likely to experience ischemic heart disease than individuals with an ACE score of zero. Psychological risk factors related to ACES including anger and depressed affect more strongly mediate the relationships between ACEs and ischemic heart disease than traditional risk factors for ischemic heart disease including smoking, obesity, hypertension, diabetes, and physical activity (Dong et al., 2004). Anda et al. (2008) found that individuals with an ACE score of five or higher were 2.6 times more likely to experience Chronic Obstructive Pulmonary Disease (COPD), two times more likely to experience COPD related hospitalizations, and 1.6 times more prescriptions than individuals with an ACE score of zero. There is an inverse relationship between average age of COPD related hospitalizations and ACE scores (Anda et al., 2008).

Chapman et al. (2004) found that women with a history of childhood emotional abuse were 2.7 times more likely to experience lifetime depressive disorders and men were 2.5 times more likely to experience lifetime depressive disorders. A dose-response relationship exists between ACE scores and lifetime and recent depressive disorders (Chapman et al., 2004). Dube et al. (2001) found a strong graded relationship between ACE score and suicide attempts. All ACE categories are associated with risk of suicide attempts at an increase of two to five times (Dube et al., 2001). Individuals with an ACE

score of seven or more were 31.1 times more likely to have ever attempted suicide than individuals with an ACE score of zero (Dube et al., 2001).

Anda et al. (2010) found that all ACE categories were related to an increase of risk and prevalence of frequent headaches. The risk and prevalence of frequent headaches doubled in individuals with an ACE score of five or more (Anda et al., 2010).

La Mott and Martin (2019) found in a survey of mental health providers (48% psychologists) that 43% experienced verbal abuse, 21.7% experienced physical abuse, 31.9% experienced sexual abuse, 40.4% experienced feeling unloved/unwanted, 10.2% experienced neglect, 31.8% had parents who separated or divorced, 11.9% experienced domestic violence in the home, 30.8% experienced substance abuse in the home, 44.5% experienced a family member with a mental illness, and 4.9% experienced a family member who went to prison before the age eighteen. There is a significant relationship between the number of adverse childhood experiences endured by a mental health provider and their burnout and secondary traumatic stress scores (La Mott & Martin, 2019).

Mental health providers who felt unloved/unwanted prior to age eighteen or grew up in a house with a family member who had a mental illness had higher burnout and secondary traumatic stress scores, but not all adverse childhood experiences were correlated with burnout or secondary traumatic stress (La Mott & Martin, 2019). Esaki and Larkin (2013) found that having a member of the household with a mental illness was the most common adverse childhood experience of child service providers, and La Mott and Martin (2019) found it was the most common adverse childhood experience of mental health providers.

Burnout

Valent (2002) noted that common symptoms of burnout include the following: difficulty sleeping, headaches, irritability, aggression, exhaustion, pessimism, callousness, cynicism, difficulty managing professional relationships, and decreased work performance.

Burnout includes the following components: inefficacy; exhaustion; and cynicism (Harr, 2013; Maslach, Schaufeli, & Leiter, 2001). Burnout is an organizational issue even though symptoms may appear on an individual level (Nelson-Gardell & Harris, 2003). Approximately half of trauma therapists are at risk for developing burnout (Rudolph, Stamm, & Stamm, 1997). Mental health providers are at higher risk for burnout than any other profession (Newell & MacNeil, 2010). Mental health workers in the public sector are at higher risk of burnout than those in the private sector (Craig & Sprang, 2010).

Burnout can result from inability to achieve work goals, frustration, and powerlessness (Valent, 2002). Symptoms of burnout can include difficulty sleeping, irritability, headaches, aggression, physical exhaustion, and mental exhaustion (Valent, 2002). Additional symptoms can include the following: pessimism, difficulty in work relationships, callousness, decreased work performance, and cynicism (Valent, 2002).

Franco (2015) stated that burnout amongst therapist can result from not meeting productivity standards at work. Individuals who work in environments with long hours and low compensation, including many agencies providing therapy, may be more prone to developing burnout (Freudenberger, 1974). Thomas, Kohli, and Jong (2014) found that the most significant predictor of burnout in human service workers was caseload size. Rosenberg and Pace (2006) suggested that self-care and support from colleagues

may prevent negative impacts of burnout. Franco (2015) suggested that clinical supervisors boost collegial support through team-building exercises and treatment planning team meetings. Supervisors should support and work with supervisees who are struggling to meet productivity goals rather than disciplining them (Franco, 2015).

Female marriage and family therapists (MFTs) report more exhaustion and personal life deterioration than male MFTs (Chen, et al., 2019). Marriage and family therapists who are working towards becoming fully licensed report more exhaustion than fully licensed marriage and family therapists (Chen, et al., 2019). Marriage and family therapists who have children reported less levels of devaluing clients, exhaustion, and perceptions of recently experiencing burnout than marriage and family therapists without children (Chen et al., 2019).

Marriage and family therapists who work in agencies exhibit higher rates of burnout than MFTs in private practice (Rosenberg & Pace, 2006). MFTs in agencies experience more exhaustion, negative work environments, and personal life deterioration than MFTs in private practice (Chen, et al., 2019). Negative work environments may impact marriage and family therapists in agencies more than marriage and family therapists in private practice (Chen, et al., 2019). Marriage and family therapists who work in agencies often have to balance responsibilities to the agency (expectations, policies, rules, caseloads, and administrative duties) and their responsibilities to their clients (Rosenberg & Pace, 2006).

Compassion Fatigue

According to Figley (2002a), compassion fatigue can include the following avoidance symptoms: avoiding thoughts, feelings, or conversations related to the a

client's trauma; avoiding places, people, and activities that trigger memories of a client's trauma; difficulty conceptualizing and treating trauma; decreased interest or participation in activities; feeling detached or estranged from others; decreased affective range; and sense of foreshortened future. In other words, the avoidance symptoms of compassion fatigue are nearly identical to the avoidance symptoms of PTSD. He also noted that compassion fatigue can include the same arousal symptoms as PTSD (Figley, 2002a). Therapists who have experienced compassion fatigue have reported experiencing sadness, depression, sleeplessness, general anxiety, and additional suffering (Figley, 2013).

Overall psychological well-being is a factor in the development of compassion fatigue (Figley, 1995). Limited social support increases the risk of compassion fatigue (Harr, 2013). Inadequate self-care increases the risk of compassion fatigue (Harr, 2013; La Mott & Martin, 2019). Inability to maintain healthy boundaries increases the risk of compassion fatigue (Harr, 2013).

A personal history of trauma increases the risk for compassion fatigue (Baird & Kracen, 2006; Harr, 2013; La Mott & Martin, 2019). A history of adverse childhood experiences, in particular, is linked to negative compassion outcomes (Bride, 2004; Jordan, 2010; La Mott & Martin, 2019; Nelson-Gardell & Harris, 2003; Pearlman & MacIan, 1995). Mental health providers with a history of adverse childhood experiences had significantly higher secondary traumatic stress than those without adverse childhood experiences (La Mott & Martin, 2019).

One study found that approximately one-third of trauma therapists have a high risk of developing secondary traumatic stress (Rudolph, Stamm, & Stamm, 1997).

Conrad and Keller-Guenther (2006) found symptoms of compassion fatigue in about half of mental health providers who worked with traumatized clients.

Individuals' experiences with secondary traumatic stress may change the way they interact with the world, themselves, and their families (Figley, 2013). Therapists with compassion fatigue that specialize in childhood trauma risk making poor professional judgments including abuse of clients, misdiagnoses, and poor treatment planning (Bride, Radey, & Figley, 2007). Therapists with compassion fatigue may be more irritable and have poor professional relationships (Inbar & Ganor, 2003). The impairment of therapists with compassion fatigue is an ethical problem (Harr, 2013).

Treatment and Prevention

Self-Care

Self-care may mitigate symptoms of both vicarious traumatization and compassion fatigue (McCann & Pearlman, 1990; O'Halloran & Linton, 2000; Sansbury, Graves, & Scott, 2015). Self-care was also recommended in the treatment of compassion fatigue (Figley, 2002b). McCann and Pearlman (1990) found that the relationship between childhood trauma and vicarious traumatization is mediated by personal wellness and self-care. Pearlman and Saakvitne (1995b) believed that holistic wellness can both prevent and alleviate symptoms of vicarious traumatization; yet, this theory has not been researched. Research has shown that consistently engaging in wellness activities decreases an individual's vulnerability to vicarious traumatization (Bober, Regehr, & Zhou, 2006; Brady, Guy, Polestra, & Brokaw, 1999; Bride, 2004; Hunter & Schofield, 2006; Schauben & Frazier, 1995).

Self-care is believed to an effective way to cope (Jones, 2005; Knight, 2013). Professional self-care is when people use skills and strategies that attend to their spiritual, emotional, and personal needs while attending to their clients' needs (Figley, 2002b). Self-care can mitigate symptoms of compassion fatigue (O'Halloran & Linton, 2000; Sansbury, Graves, & Scott, 2015), secondary traumatic stress (Cappuccio, D'Elia, Strazzullo, & Miller, 2010; Dombo & Gray, 2013; Sansbury, Graves, & Scott, 2015), and burnout (Hughes, 2014; Maslach, 1982; Sansbury, Graves, & Scott, 2015; Sherman, 1996; Skovholt, 2001). Kraus (2005) found that there was not a direct relationship between self-care and burnout or secondary traumatic stress; however, there was a direct relationship between self-care and compassion satisfaction.

La Mott and Martin (2019) found that mental health providers who engaged in more instances of self-care had higher scores on compassion satisfaction and lower scores on burnout and secondary traumatic stress. Mental health providers with a history of adverse childhood experiences who engaged in higher levels of self-care had lower levels of burnout. Mental health providers without a history of adverse childhood experiences who engaged in lower levels of self-care had higher scores on burnout than mental health providers with a history of adverse childhood experiences who engaged in lower levels of self-care (La Mott & Martin, 2019).

Compassion Satisfaction

Compassion satisfaction is believed to protect against burnout and compassion fatigue (Stamm, 2005). Compassion satisfaction includes professional success and an individual's belief that they are supported in their job (Zerach, 2013). Although there is an inverse relationship between compassion fatigue and compassion satisfaction, it is

possible to experience both at the same time (Bride, Radey, & Figley, 2007). Mental health providers with a history of adverse childhood experiences have significantly higher compassion satisfaction scores than those without adverse childhood experiences (La Mott & Martin, 2019).

Current Study

Counselors have an ethical responsibility to recognize personal impairment (ACA, 2014). Counselors should be aware of risk factors for impairment including history of trauma, burnout, and compassion fatigue. Counselors and supervisors should be aware of potential risk factors, symptoms of triggers for impairment, specifically those related to history of trauma, burnout, and compassion fatigue. Given the paucity of published research specific to considering counselors, this study examines the prevalence of ACEs including community ACEs in combination with burnout and age to predict compassion fatigue in a sample of counselors.

Chapter Three: Method

Participants

The final sample included 82 participants (N=82). One hundred participants (N=100) engaged in this research study. Eighteen participants were removed from the study because they did not complete one or more subscales in the survey. G*Power was used to calculate the estimated sample size needed to determine the following: alpha (.05), power (.80), and a medium effect size (.30). It was determined that the sample needed to include at least 68 participants. Convenience sampling was used to recruit participants as the first available data sources were utilized (Saunders, Lewis, & Thornhill, 2012). One of the largest listservs for counselor educators as well as listservs and forums for the world's largest association for counselors were used to recruit counselors who work with traumatized clients. To participate in the study, participants had to self-report that they were trained as a counselor and are currently working with traumatized clients.

Instruments

Independent Variables

The independent variables were the number of total adverse childhood experiences, number of abusive/neglectful ACEs, number of community ACEs, number of dysfunctional household ACEs, frequency of adverse childhood experiences, severity of adverse childhood experiences, burnout, gender, and age. The number, subcategories, frequency, and severity of adverse childhood experiences was assessed using the Yale-Vermont Adversity in Childhood Scale (Y-VACS) (Hudziak & Kauffman, 2014).

Burnout was assessed through the Professional Quality of Life Scale (ProQOL) (Stamm, 2010). Age was assessed in the demographic survey.

Dependent Variable

The dependent variable was compassion fatigue. Compassion fatigue was assessed through the Compassion Fatigue Self-Test for Practitioners (Figley, 1996).

Demographic Questionnaire

A demographic questionnaire was used to gather background information about the participants (Dillman, Smyth, & Christian, 2014). The questionnaire included age, gender, race/ethnicity, sexual orientation, marital status, average number of direct hours worked per week, licensure status, work environment, length of time working with traumatized clients, graduate program specialty area, graduate program accreditation status, states counselors were currently practicing in, and length of current employment. The following demographic questions were left open-ended for the sake of brevity and inclusion: age and states counselors were practicing in (Hughes, Camden, & Yangchen, 2016). The following demographic questions included multiple options to choose from for accuracy in coding: gender, race/ethnicity, sexual orientation, marital status, length of time working with traumatized clients, hours worked per week, average number of direct hours worked per week, length of current employment, work environment, licensure status, graduate program specialty areas, and graduate program accreditation status (Hughes, Camden, & Yangchen, 2016; Dillman, Smyth, & Christian, 2014). The demographic questionnaire was placed at the end of the questionnaire to help keep the participants interested in the instruments and avoid discomfort (Dillman, 2007).

Yale-Vermont Adversity in Childhood Scale (Y-VACS)

The Yale-Vermont Adversity in Childhood Scale (Y-VACS) is designed for adults to self-report about the type, frequency and severity of adverse childhood experiences. The Y-VACS includes nineteen questions about natural disasters, war/terrorism, medical trauma, death of family members and friends, community violence, bullying, child abuse, neglect, and household dysfunction. The Y-VACS includes nine questions about natural disasters, community, and health-related experiences and ten questions about family-related experiences.

A sample question is “Was a parent or other adult in the household ever arrested or incarcerated?”. To complete the questionnaire, participants respond to the frequency and severity of each question. Frequency scores for each question range from Never “0” to More Than Once “2”. Severity scores for each question range from N/A “0” to Severe “3”.

Scoring for the Y-VACS includes finding the sum scores for frequency and severity of experiences. Total number of ACEs was calculated by adding one for every ACE each participant provided a score for frequency and/or severity. Total number of abusive/neglectful ACEs was calculated by adding one for each of the following ACEs the participant provided a frequency/severity score for: nonfamilial sexual abuse, physical neglect, emotional abuse, physical abuse, and sexual abuse by a member of the household. Total number of household dysfunction ACEs was calculated by adding one for each of the following ACEs the participant provided a frequency/severity score for: parental divorce/separation, witnessing domestic violence, arrest/incarceration of household member, problematic alcohol/drug use by household member, and intentional

harm/suicidality of household member. Total number of community ACEs was calculated by adding one for each of the following ACEs the participant provided a frequency/severity score for: natural disaster, serious fire, armed conflict, serious car accident, death of loved one, medical trauma, witnessing community violence, and bullying. Holbrook et al. (2015) compared the ACE Questionnaire and the Y-VACS and found both had cronbach alphas for internal consistency of .95. The internal consistency for the frequency scale with the current sample was α=0.699. The internal consistency for the severity scale with the current sample was α=0.756.

Professional Quality of Life Scale (ProQOL) Version 5

The Professional Quality of Life Scale (ProQOL) has been used in over two-hundred publications (Stamm, 2010). The ProQOL (Stamm, 2010) was developed to assess compassion satisfaction, burnout, and compassion fatigue in individuals helping people who have experienced trauma or suffering. The ProQOL uses a 5-point Likert scale (1 = rarely; 5 = very often) with 30 multiple-choice questions.

This instrument includes three subscales, compassion satisfaction, burnout, and secondary traumatic stress. The compassion satisfaction subscale contains 10 items, the burnout subscale contains 10 items, and the secondary traumatic stress subscale contains 10 items. Scoring the ProQOL involves reverse scoring five items then adding the scores to obtain a subscale score.

Scores of 22 or below on the burnout subscale indicate low risk for burnout. Scores between 23 and 41 indicate moderate risk for burnout, Scores of 42 or above indicate high risk for burnout. Validity studies for the ProQOL have not been published

yet (Bride, Radey, & Figley, 2007; Stamm, 2010). Cronbach's alpha for this study was 0.819 for the burnout subscale.

Compassion Fatigue Self Test for Practitioners

The Compassion Fatigue Self Test is the most common instrument used to measure compassion fatigue (Bride, Radey, & Figley, 2007). The Compassion Fatigue Self Test for Practitioners (Figley, 1996) was developed to assess burnout and compassion fatigue in individuals helping people who have experienced trauma or suffering. The Compassion Fatigue Self Test for Practitioners has forty items and includes two subscales: burnout and compassion fatigue. The Compassion Fatigue Self Test for Practitioners uses a 5-point Likert scale (1 = rarely/never; 5 = very often) in which individuals indicate if a characteristic is true for their situation or themselves.

Scores below 27 on the compassion fatigue subscale indicate extremely low risk. Scores between 27 and 30 indicate low risk for compassion fatigue. Scores between 31 and 35 indicate moderate risk for compassion fatigue, Scores between 36 and 40 indicate high risk for compassion fatigue, and scores above 40 indicate extremely high risk for compassion fatigue.

Factor analysis indicate one factor with depressed mood in relation to work, fatigue, disillusionment, and worthlessness (Figley, 1995). Internal consistencies reported in previous research range from .86 to .94. Cronbach's alpha for this study was 0.852 for the compassion fatigue subscale.

Procedure

Qualtrics was used to collect data. Participants received a link via email to participate in the study. The emails included the time required to complete the survey,

nature of the study, confidentiality, and the right to end participation at any time. Participants were asked to review the informed consent, which included risks and benefits to participating in the study.

Research Design

A series of regression models were used to predict scores of compassion fatigue using a number of predictor variables including: the number of total adverse childhood experiences, number of abusive/neglectful ACEs, number of community ACEs, number of dysfunctional household ACEs, frequency of adverse childhood experiences, severity of adverse childhood experiences, burnout, and age.

"Bivariate regression utilizes the relationship between the independent and dependent variables to predict the score of the dependent variable from the independent variable" (Mertler & Reinhart, 2016, p. 14.) According to Mertler and Reinhart (2016), multiple regression is used when there are multiple independent variables as an extension to the simple bivariate regression.

Descriptive statistics were used to determine the prevalence of burnout, compassion fatigue, and adverse childhood experiences. These statistics included the percentage of counselors who were at low, moderate, or high risk for burnout; the percentage of counselors who were at extremely low, low, moderate, high, or extremely high risk for compassion fatigue; and the number and types of adverse childhood experiences reported by this sample of counselors.

Research Questions

The following research questions were used to guide this study:

1. What percentage of counselors are at low, moderate, and high risk for burnout?

2. What percentage of counselors are at extremely low, low, moderate, high, and extremely high risk for compassion fatigue?
3. What is the prevalence of adverse childhood experiences including frequency and severity in a sample of counselors?
4. Which of the four predictor variables (number of adverse childhood experiences, frequency of adverse childhood experiences, severity of adverse childhood experiences, and burnout) are most influential in predicting compassion fatigue in this sample? Are there any predictor variables that do not contribute significantly to the prediction model?
5. Which of the six predictor variables (number of abusive/neglectful ACEs, number of community ACEs, number of dysfunctional household ACEs, frequency of adverse childhood experiences, severity of adverse childhood experiences, and burnout) are most influential in predicting compassion fatigue in this sample? Are there any predictor variables that do not contribute significantly to the prediction model?
6. Which of the three predictor variables (severity of ACEs, burnout, and age) are most influential in predicting compassion fatigue in this sample? Are there any predictor variables that do not contribute significantly to the prediction model?

Data Analysis

To examine the research questions, a series of regression models were conducted to assess if a combination of the number of total adverse childhood experiences, number of abusive/neglectful ACEs, number of community ACEs, number of dysfunctional household ACEs, frequency of adverse childhood experiences, severity of adverse

childhood experiences, burnout, and age can predict compassion fatigue. In the current study, the independent variables include the number of total adverse childhood experiences, number of abusive/neglectful ACEs, number of community ACEs, number of dysfunctional household ACEs, frequency of adverse childhood experiences, severity of adverse childhood experiences, burnout, and age. The dependent variable is compassion fatigue.

Data was scanned for missing data and/or errors. Participants who were missing one or more subscales and thus did not complete the survey were removed from the study. Remaining data was screened for accuracy and missing data. No patterns existed in the remaining missing data. The research calculated the means for the sample and replaced any remaining missing data with the mean.

Descriptive statistics were used to determine the percentage of participants who experienced each type and subcategory of adverse childhood experiences. Descriptive statistics were used to determine the percentage of participants who fell in the following risk categories for burnout: low risk, moderate risk, and high risk. Descriptive statistics were used to determine the percentage of participants who fell in the following risk categories for compassion fatigue: extremely low risk, low risk, moderate risk, high risk, and very high risk.

The following assumptions of multiple regression were analyzed: linearity, homoscedasticity and multicollinearity. Multiple regression evaluates linear relationships, so linearity assumptions were checked by examining scatter plots to determine if the predictor variables and the criterion variable have a straight-line relationship. Homoscedasticity assumptions were checked by examining scatter plots to determine if

scores were normally distributed. Multicollinearity assumptions were checked if the predictor variables are distinct.

The enter method of standard multiple regression was used to predict the value of compassion fatigue from a weighted linear combination of predictor variables. The following report options were chosen: coefficients for the regression equation, the analysis of variance report, normality testing, regression diagnostics, and multicollinearity reports.

The enter method of standard multiple linear regression was used. All independent variables, or predictor variables, are entered into the model simultaneously. The enter method is the standard used except when theory suggests a different method. Predictor variables were evaluated to determine what they add to the prediction of compassion fatigue compared to other variables. The F-test was used to determine if the predictor variables collectively predicted compassion fatigue. R-squared was reported and used to amount of variance in compassion fatigue that was accounted for by the independent variables. The magnitude of the predictor variables was evaluated using beta coefficients. Significant predictors indicated that as the predictor variable increased by one unit, the criterion variable increased by the number of unstandardized beta coefficients.

Results

Demographic Information

Participants in this study ranged in age from 22 to 69. 73.5% of participants identified as female, 19.5% identified as male, and 2.4% identified as nonbinary. 76.8% of participants identified as White, 12.2% identified as Black or African American, 1.2% identified as Asian, and 7.3% identified as Hispanic or LatinX. Seventy-eight percent of participants identified as heterosexual, 7.3% identified as homosexual, 6.1% identified as bisexual, 2.4% identified as pansexual, and 1.2% identified as asexual. 47.6% of participants reported that they were married, 7.3% reported that they were divorced, 1.2% reported that they were separated, and 40.2% reported that they had never been married.

Participants in this study reported currently practicing in thirty different states and two countries. 11.0% of participants reported that they were currently students in a counseling graduate program, 26.8% reported that they had an associate/intern license, and 58.5% reported that they were fully licensed. 81.7% of participants graduated from a CACREP accredited graduate program, 1.2% graduated from a COAMFTE accredited graduate program, and 14.6% of participants graduated from a program that was not accredited by either.

Table 1 shows the amounts of experience counselors in this study have working with traumatized clients.

Table 1

Experience Working with Traumatized Clients

	Time Working with Traumatized Clients

	n	%
1-6 Months	4	4.9%
7-12 Months	5	6.1%
1-2 Years	12	14.6%
3-4 Years	10	12.2%
5-6 Years	14	17.1%
7-8 Years	5	6.1%
9-10 Years	5	6.1%
11-15 Years	12	14.6%
16-20 Years	5	6.1%
21-25 Years	3	3.7%
26-30 Years	0	0.0%
31+ Years	5	6.1%

The largest percentage of counselors in this study had five to six years of experience working with traumatized clients. The smallest percentage of counselors in this study had twenty-one to twenty-five years of experience working with traumatized clients.

Table 2 shows the amount of time counselors in this study have spent in their current employment.

Table 2

Time Working at Current Employment

	Time at Current Employment	
	n	%
1-6 Months	9	11.0%
7-12 Months	9	11.0%
1-2 Years	26	31.7%
3-4 Years	14	17.1%
5-6 Years	5	6.1%
7-8 Years	5	6.1%
9-10 Years	3	3.7%

11-15 Years	2	2.4%
16-20 Years	3	3.7%
21-25 Years	0	0.0%
26-30 Years	1	1.2%
31+ Years	3	3.7%

The largest percentage of counselors in this study had one to two years at their current place of employment. The smallest percentage of counselors in this study had twenty-six to thirty years at their current place of employment.

Table 3 shows the average amount of time that counselors spend working directly with clients each week.

Table 3

Average Direct Hours Worked Per Week

	Direct Hours	
	n	%
0-5 Hours	9	11.0%
6-10 Hours	17	20.7%

11-15 Hours	13	15.9%
16-20 Hours	14	17.1%
21-25 Hours	13	15.9%
26-30 Hours	7	8.5%
31-35 Hours	2	2.4%
36-40 Hours	5	6.1%

The largest percentage of counselors in this study spend six to ten hours a week working directly with clients. The smallest percentage of counselors in this study spend thirty-one to thirty-five hours a week working directly with clients.

Table 4 shows the types of work environments for counselors in this study.

Table 4

Work Environment

	Agency		School		Private Practice		Majority Agency		Majority School		Majority Private Practice	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%
Work Environment	30	36.6%	13	15.9%	19	23.2%	6	7.3%	6	7.3%	6	7.3%

The largest percentage of counselors in this study work at an agency setting. The smallest percentages of counselors in this study work in multiple settings with a majority of their time in an agency setting, a school setting, or a private practice setting.

Table 5 shows the graduate program specialty areas/emphasis for counselors in this study. Many participants reported having been trained in multiple specialty areas.

Table 5

Graduate Program Emphasis/ Specialty Area

Emphasis		
	n	%
Addiction Counseling	16	19.5%
Career Counseling	4	4.9%
Clinical Mental Health Counseling	70	85.4%
Clinical Rehabilitation Counseling	2	2.4%
College Counseling and Student Affairs	7	8.5%
Marriage, Couples, and Family Counseling	9	11.0%
School Counseling	10	12.2%

Rehabilitation Counseling	3	3.7%

Percentages add up to more than one hundred percent, because some counselors were trained in multiple specialty areas. The majority of the counselors in this study were trained in Clinical Mental Health Counseling. Clinical Rehabilitation Counseling was specialty area with the least counselors from this study.

Prevalence of Burnout

To examine the first research question, descriptive statistics were used to determine the percentage of counselors who were at low risk, moderate risk and high risk for burnout. Table 6 shows the percentages of counselors in this study that fall in to the following risk factors for burnout: Low, moderate, and high risk.

Table 6

Prevalence of Burnout

Burnout	Burnout Total			Low Risk		Moderate Risk		High Risk	
	n	M	SD	*n*	%	*n*	%	*n*	%
	82	21.40	5.584	57	69.5%	25	30.5%	0	0.0%

Most of the counselors in this study were at low risk for burnout, while none of the counselors in this study were at high risk for burnout.

Prevalence of Compassion Fatigue

To examine the second research question, descriptive statistics were used to determine the percentage of counselors who were at extremely low risk, low risk, moderate risk, high risk, and extremely high risk for compassion fatigue. Table 7 shows the percentages of counselors in this study that fall in to the following risk factors for

compassion fatigue: extremely low, low, moderate, high, and extremely high risk. The sample included 82 participants (n=82) with a mean of 40.13 and a standard deviation of 10.927.

Table 7

Prevalence of Compassion Fatigue

Compassion Fatigue	Extremely Low Risk		Low Risk		Moderate Risk		High Risk		Extremely High Risk	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
	7	8.5%	9	11.0%	17	20.7%	14	17.1%	35	42.7%

The largest percentage of counselors in this study were at extremely high risk for compassion fatigue, while the lowest percentage of counselors in this study were at extremely low risk for compassion fatigue. 80.5% of counselors in this study were at moderate to extremely high risk for compassion fatigue.

Prevalence of Adverse Childhood Experiences

To examine the third research question, descriptive statistics were used to determine the prevalence of adverse childhood experiences including frequency and severity. Table 8 shows the frequency of adverse childhood experiences including overall statistics as well as the number and percentages for each response.

Table 8

Frequency of Adverse Childhood Experiences

Adverse Childhood Experience	Frequency	Never	One Time	More Than Once

	n	M	SD	*n*	%	*n*	%	*n*	%
Natural Disaster	82	.71	.809	42	51.2%	22	26.8%	18	22%
Serious Fire	82	.11	.315	73	89%	9	11%	0	0%
War, Armed Conflict, or Terrorism	81	.26	.543	64	78%	13	15.9%	4	4.9%
Car Accident with Serious Injury of Death	82	.17	.466	71	86.6%	8	9.8%	3	3.7%
Death of Someone Outside of Immediate Family	82	1.22	.832	21	25.6%	22	26.8%	39	47.6%
Hospital Care	82	1.01	.778	24	29.3%	33	40.2%	25	30.5%
Witness Community Violence	82	.34	.707	65	79.3%	6	7.3%	11	13.4%
Bullied	82	1.55	.772	14	17.1%	9	11.0%	59	72%
Sexual Abuse by Someone Outside the Household	82	.55	.804	53	64.4%	13	15.9%	16	19.5%
Parent Divorce or Separation Without Contact	82	.70	.796	42	51.2%	23	28.0%	17	20.7%

to One or Both Parents									
Hearing Adults in Household Having Serious Fights	81	1.17	.959	31	37.8%	5	6.1%	45	54.9%
Adults in Household Arrested or Incarcerated	82	.10	.404	77	93.9%	2	2.4%	3	3.7%
Physical Neglect	82	.32	.718	68	82.9%	2	2.4%	12	14.6
Adult in Household Misusing Drugs or Alcohol	82	.88	.974	44	53.7%	4	4.9%	34	41.5%
Adult in Household Attempt Suicide or Intentionally Harm Self	82	.28	.653	68	82.9%	5	6.1%	9	11.0%
Emotional Abuse by Adult in Household	82	1.05	.967	36	43.9%	6	7.3%	40	48.8%
Physical Abuse by Adult in Household	82	.91	.919	38	46.3%	13	15.9%	31	37.8%

Sexual Abuse by Adult in Household	82	.34	.707	65	79.3%	6	7.3%	11	13.4%	

The most common adverse childhood experience for counselors in this study was being bullied with 82.9% of the sample having experienced bullying at least one. The least common adverse childhood experience for counselors in this study was the arrest or incarceration of a parent or household member with only 6.1% of the sample having experienced it. The most common community ACE was bullying. The most common household dysfunction ACE was witnessing domestic violence with 62.2% of the sample having witnessed domestic violence at least once. The most common abusive/neglectful ACE was emotional abuse with 56.1% of the sample having experienced emotional abuse by a parent or household member at least once.

Table 9 shows the severity of adverse childhood experiences including overall statistics as well as the number and percentages for each response.

Table 9

Severity of Adverse Childhood Experiences

Adverse Childhood Experience	Severity Mean			Mild or Suspected		Moderate		Severe		N/A	
	n	M	SD	*n*	%	*n*	%	*n*	%	*n*	%
Natural Disaster	82	.87	.991	16	19.5%	20	24.4%	5	6.1%	41	50.0%

Serious Fire	82	.24	.746	2	2.4%	3	3.7%	4	4.9%	73	89.0%
War, Armed Conflict, or Terrorism	82	.43	.861	7	8.5%	8	9.8%	4	4.9%	63	76.8%
Car Accident with Serious Injury of Death	82	.24	.658	6	7.3%	4	4.9%	2	2.4%	70	85.4%
Death of Someone Outside of Immediate Family	82	1.46	1.068	14	17.1%	32	39.0%	14	17.1%	22	26.8%
Hospital Care	82	1.28	1.057	24	29.3%	21	25.6%	13	15.9%	24	29.3%
Witness Community Violence	82	.40	.844	4	4.9%	10	12.2%	3	3.7%	65	79.3%
Bullied	82	1.51	.959	25	30.5%	30	36.6%	13	15.9%	14	17.1%

Sexual Abuse by Someone Outside the Household	82	.68	1.053	11	13.4%	9	11.0%	9	11.0%	53	64.6%
Parent Divorce or Separation Without Contact to One or Both Parents	82	1.09	1.239	5	6.1%	18	22.0%	16	19.5%	43	52.4
Hearing Adults in Household Having Serious Fights	82	1.29	1.160	11	13.4%	25	30.5%	15	18.3%	31	37.8%
Adults in Household Arrested or Incarcerated	82	.13	.539	0	0.0%	4	4.9%	1	1.2%	77	93.9%

Physical Neglect	82	.26	.625	8	9.8%	5	6.1%	1	1.2%	68	82.9%
Adult in Household Misusing Drugs or Alcohol	82	1.04	1.232	7	8.5%	15	18.3%	16	19.5%	44	53.7%
Adult in Household Attempt Suicide or Intentionally Harm Self	82	.34	.864	4	4.9%	3	3.7%	6	7.3%	69	84.1%
Emotional Abuse by Adult in Household	82	1.10	1.151	13	15.9%	19	23.2%	13	15.9%	37	45.1%
Physical Abuse by Adult in Household	82	.89	.981	21	25.5%	17	20.7%	6	7.3%	38	46.3%

Sexual Abuse by Adult in Household	82	.39	.828	5	6.1%	9	11.0	3	3.7%	65	79.3%

The adverse childhood experience with the highest mean severity scores for counselors in this study bullying with a mean score of 1.51. The adverse childhood experience with the lowest mean severity score for counselors in this study was the arrest or incarceration of a parent or household member with a mean score of 0.13. The community ACE with the highest mean severity score was bullying. The household dysfunction ACE with the highest mean severity score was witnessing domestic violence with a mean score of 1.29. The abusive/neglectful ACE with the highest mean severity score was emotional abuse with a mean score of 1.10.

Table 10 shows the number, mean and standard deviation for the total number of ACEs and each subtype of ACE.

Table 10

Adverse Childhood Experiences and Subtypes Descriptive Statistics

Adverse Childhood Experience	Descriptive Statistics		
	n	M	SD
Total ACEs	82	7.11	2.98
Abusive/ Neglectful ACEs	63	1.93	1.49
Household Dysfunction ACEs	69	1.80	1.30
Community ACEs	70	3.39	1.53

The average ACE score for counselors in this study was 7.11. This study includes community ACEs, which were not part of the original ACE study. The average ACE score for counselors in this study without the community ACEs was 3.73.

Table 11 shows the total number of ACEs, number of abusive/neglectful ACEs, number of household dysfunction ACEs, and community ACEs reported by counselors in this study.

Table 11

Total Adverse Childhood Experiences and Subtypes

Adverse Childhood Experience	Total ACEs		Abusive/Neglectful ACEs		Household Dysfunction ACEs		Community ACEs	
	n	%	*n*	%	*n*	%		
Zero ACEs	0	0.0%	19	23.2%	13	15.9%	3	3.7%
One ACE	0	0.0%	16	19.5%	25	30.5%	6	7.3%
Two ACEs	5	6.1%	14	17.1%	20	24.4%	12	14.6%
Three ACEs	4	4.9%	22	26.8%	16	19.5%	24	29.3%
Four ACEs	9	11.0%	8	9.8%	5	6.1%	17	20.7%
Five ACEs	9	11.0%	2	2.4%	3	3.7%	13	15.9%
Six ACEs	9	11.0%	1	1.2%	0	0.0%	6	7.3%
Seven ACEs	7	8.5%	0	0.0%	0	0.0%	1	1.2%
Eight ACEs	13	15.9%	0	0.0%	0	0.0%	0	0.0%
Nine ACEs	11	13.4%	0	0.0%	0	0.0%	0	0.0%

Ten ACEs	5	6.1%	0	0.0%	0	0.0%	0	0.0%
Eleven ACEs	2	2.4%	0	0.0%	0	0.0%	0	0.0%
Twelve ACEs	4	4.9%	0	0.0%	0	0.0%	0	0.0%
Thirteen ACEs	2	2.4%	0	0.0%	0	0.0%	0	0.0%
Fourteen ACEs	2	2.4%	0	0.0&	0	0.0%	0	0.0%

The largest percentage (15.9%) of counselors in this study had eight ACEs. The smallest percentages (2.4%) of counselors in this study had eleven, thirteen, or fourteen ACES. None of the counselors in this study had less than two ACEs. The largest percentage (26.8%) of counselors in this study had three abusive/neglectful ACEs. 76.8% of the counselors in this study experienced at least one type of abuse or neglect prior to age eighteen. The largest percentage (30.5%) of counselors in this study had one household dysfunction ACE. 86.1% of the counselors in this study experienced at least one type of household dysfunction prior to age eighteen. The largest percentage (29.3%) of counselors in this study had three community ACEs. 96.3% of the counselors in this study experienced at least one type of community ACE prior to age eighteen.

Predictors of Compassion Fatigue

To examine the fourth research question, a multiple regression model was designed to examine the relationship between compassion fatigue and the following predictor factors: total number of ACEs, frequency of ACEs, severity of ACEs, and total burnout score. The following assumptions were tested: linearity, multicollinearity, and homoscedasticity. The assumptions for linearity and homoscedasticity were met. The assumption of multicollinearity was not met for frequency of ACEs and number of ACEs meaning that the predictor factors were not distinct, so it was determined that this

regression model was not a good fit and regression statistics were not analyzed. Severity of ACEs and burnout scores were included in the fifth and sixth research questions.

To examine the fifth research question, a multiple regression model was designed to examine the relationship between compassion fatigue and the following predictor factors: number of abusive/neglectful ACEs, number of community ACEs, number of household dysfunction ACEs, frequency of ACEs, severity of ACEs, and total burnout score. The following assumptions were tested: linearity, multicollinearity, and homoscedasticity. The assumptions for linearity and homoscedasticity were met. The assumption of multicollinearity was not met for frequency and severity of ACEs meaning the predictor factors were not distinct. Frequency of ACEs was dropped from the predictor model. After dropping frequency of ACEs from the model, the assumptions of linearity, multicollinearity, and homoscedasticity were met.

A multiple linear regression was calculated to predict compassion fatigue based on the following predictor factors: number of abusive/neglectful ACEs, number of community ACEs, number of household dysfunction ACEs, frequency of ACEs, severity of ACEs, and total burnout score. A significant regression equation was found ($F(5,76) = 17.424$, $p < .000$), with an R^2 of .534. Participants' predicted compassion fatigue score is equal to 7.028 - 0.425 (abuseACE) – 1.389 (communityACE) – 1.499 (dysfunctionACE) + 0.766 (severityACE) + 1.298 (burnout), where abusive/neglectful ACEs were measured with a score of 1 for each type reported, community ACEs were measured with a score of 1 for each type reported, household dysfunction ACEs were measured with a score of 1 for each type reported, the severity of ACEs were coded with 0= N/A, 1= Mild or

Suspected, 2= Moderate, 3= Severe, and burnout scores were coded as 1=Never, 2=Rarely, 3=Sometimes, 4=Often, and 5=Very Often .

Community ACEs, burnout score, and severity of ACEs were each significant predictors of compassion fatigue. Meaning that there was a negative association between community ACEs and compassion fatigue scores, a positive association between burnout scores and compassion fatigue scores, and a positive association between severity of ACE scores and compassion fatigue scores. Abusive/neglectful ACES and household dysfunction ACEs were not significant predictors of compassion fatigue. Compassion fatigue decreased 0.425 points for each additional abusive/neglectful ACE, decreased 1.389 points for each additional community ACE, decreased 1.499 points for each additional household dysfunction ACE, increased 0.766 points for each additional ACE severity score, and increased 1.298 points for each additional burnout score. Fifty-three percent of the variance of compassion fatigue was accounted for in this model.

To examine the sixth research question, a multiple regression model was designed to examine the relationship between compassion fatigue and the following predictor factors: severity of ACEs, burnout score, and age. The following assumptions were tested: linearity, multicollinearity, and homoscedasticity. The assumptions of linearity, multicollinearity, and homoscedasticity were met.

A multiple linear regression was calculated to predict compassion fatigue based on the following predictor factors: severity of ACEs, burnout scores, and age. A significant regression equation was found ($F(3,70) = 20.277$, $p < .000$), with an R^2 of .465. Participants' predicted compassion fatigue score is equal to 10.148 + 0.420 (severityACE) + 1.208 (burnout) – 0.89(age), where the severity of ACEs were coded

with 0= N/A, 1= Mild or Suspected, 2= Moderate, 3= Severe, burnout scores were coded as 1=Never, 2=Rarely, 3=Sometimes, 4=Often, and 5=Very Often, and age was measured in years.

Severity of ACEs and burnout were each significant predictors of compassion fatigue. Meaning that there was a positive association between severity of ACE scores and compassion fatigue scores and a positive association between burnout scores and compassion fatigue scores. Age was not a significant predictor of compassion fatigue. Compassion fatigue increased 0.420 points for each additional ACE severity score, increased 1.208 points for each additional burnout score, and decreased 0.89 points for each additional year. Forty-seven percent of the variance of compassion fatigue was accounted for by this model. It was determined that the second regression model was the best fit for this study.

Discussion

Summary

Research Question #1

The first research question examined the prevalence of burnout in a sample of counselors. Approximately 70% of the counselors' scores in this study indicated a low risk for burnout, while 30% of the counselors' scores in this study indicated a moderate risk for burnout. None of the counselors' scores in this study indicated a high risk for burnout. According to Morse, Salyers, Rollins, Monroe-Devita, and Pfahler (2012), the prevalence of mental health workers who may be experiencing high levels of burnout is between twenty-one and sixty-seven percent. According to Stamm (2005), the average burnout score for the ProQOL is 22, and the average score for this sample was 21.4. While the burnout scores for this sample were slightly lower than the norm average, none of the counselors' scores in this sample indicated a high risk for burnout inconsistent with previous studies on the prevalence of burnout in mental health workers.

Research Question #2

The second research question examined the prevalence of compassion fatigue in a sample of counselors. Approximately 19.5% of counselors' scores in this study indicated an extremely low or low risk for compassion fatigue. Approximately 20% of the counselors' scores indicated a moderate risk and about 60% of the counselors' scores indicated a high or extremely high risk for compassion fatigue. This finding appears to be much higher than Rudolph, Stamm, and Stamm (1997), who found that one-third of therapists who frequently worked with trauma were at high risk for compassion fatigue,

and Conrad and Keller-Guenther (2006) reported that approximately half of mental health providers had symptoms of compassion fatigue.

Research Question #3

The third research question examined the prevalence of adverse childhood experiences in this sample of counselors. Every counselor in this study had an ACE score of at least two, and the average ACE score was seven. The Y-VACS instrument provides a frequency and a severity score rather than a traditional ACE score. ACE scores were calculated by hand for each response with a frequency of once or more than once, so the average ACE score utilizing the Y-VACS is still unknown. This was the first known study that included community ACEs in the examination of the prevalence of ACEs in counselors. After removing community ACEs, the average ACE score was 3.76 out of a possible 10 ACEs.

Merrick, Ford, Ports, and Guinn (2018) found that approximately eighty-six percent of individuals who participated in state-based random-digit-dial telephone surveys had three or less ACEs. According to the CDC (2020), women and racial/ethnic minorities are at higher risk for ACEs. Given that approximately three-quarters of this sample were female and approximately a quarter of this sample identified as a racial/ethnic minority, it follows that the ACE scores would be higher than average. Another explanation for the high number of ACEs in this study is that the instrument to assess adverse childhood experiences had different wording than the BRFSS. The Y-VACs asks if experiences ever happened, while the BRFSS has several questions that ask if the experiences “often” happen. Finally, a third explanation for the higher number of

ACEs is that counselors may be more comfortable disclosing personal history of trauma than the average American.

The prevalence of many ACEs (*m*= 3.76) was higher for this sample of counselors than a previous study on a sample of mental health workers. La Mott and Martin (2019) found that approximately 43% of mental health workers experienced emotional abuse as a child compared to about 56% of counselors in this sample. Approximately 62% of this sample of counselors witnessed domestic violence as a child compared to 13% of mental health workers reported by La Mott and Martin (2019). La Mott and Martin (2019) found that approximately 22% of mental health workers experienced physical abuse as a child compared to about 54% of counselors in this sample. La Mott and Martin (2019) found that approximately 10% of mental health workers experienced physical neglect as a child compared to about 17% of counselors in this sample. Approximately 47% of this sample of counselors had parents who were separated or divorced as a child compared to 32% of mental health workers reported by La Mott and Martin (2019). La Mott and Martin (2019) found that approximately 31% of mental health workers grew up in a household with an adult with problematic substance use compared to about 46% of counselors in this sample. Approximately 6% of this sample of counselors grew up with an adult in the household that was arrested or incarcerated compared to 5% of mental health workers reported by La Mott and Martin (2019).

Somewhat surprisingly, more than three quarters of the counselors in this study experienced some type of abuse or neglect as a child. At least one type of household dysfunction was experienced by about 86% of the counselors in this study. At least one type of community ACE was experienced by more than 95% of counselors in this study.

Previous studies found that 70%-83% of mental health workers had an ACE score of at least one (Esaki & Larkin, 2013; La Mott & Martin, 2019).

The most commonly experienced ACE in this sample was bullying (community ACE) which was experienced by approximately 83% of participants. No other known studies on mental health workers have looked at the prevalence of community ACEs, so this data cannot be compared to previous studies of on the prevalence of ACEs in mental health workers.

The prevalence of a few ACEs was lower for this sample of counselors than a previous study on a sample of mental health workers. Approximately 21% of this sample of counselors experienced sexual abuse as a child compared to 32% of mental health workers reported by La Mott and Martin (2019). La Mott and Martin (2019) found that approximately 45% of mental health workers grew up in a house with a family member with a mental illness. Sixteen percent of the counselors in this study grew up in a house someone who attempted suicide or intentionally harmed themselves.

In terms of severity, approximately sixteen percent of the sample reported the bullying as severely traumatic, thirty-seven percent of the sample reported the bullying as moderately traumatic, and thirty percent of the sample reported that the bullying was mildly traumatic. Approximately eighteen percent of the sample reported that the domestic violence was severely traumatic, thirty percent of the sample reported that the domestic violence was moderately traumatic, and thirteen percent of the sample reported that the domestic violence was mildly traumatic. Approximately sixteen percent of the sample reported that the emotional abuse was severely traumatic, twenty-three reported that the abuse was moderately traumatic, and sixteen percent reported that the abuse was

mildly traumatic. All participants who experienced the arrest/incarceration of an adult in the household reported it as either moderately or severely traumatic. No other known studies have looked at the severity of ACEs in mental health providers.

Research Question #4

The fourth research question examined the total number of ACEs, the frequency and severity of ACEs, and the total burnout score associated with (as predictors of) compassion fatigue. The assumptions for multivariate regression were not met. The variables in this prediction model were too similar and determined to not be distinct enough to run the regression statistics. Variables were removed from the model one at a time, but the assumption of multicollinearity was still not met. It was determined that this regression model was not a good fit.

Research Question #5

The fifth research question examined the number of abusive/neglectful ACEs, the number of community ACEs, the number of household dysfunction ACEs, the frequency and severity of ACEs, and the total burnout score as predictors of compassion fatigue. Frequency of ACEs was dropped from the prediction model after it was determined that the variable was not distinct from the severity of ACEs. While abusive/neglectful ACEs and household dysfunction ACEs did not significantly contribute to the model, community ACEs, severity of ACEs, and burnout score all significantly contributed to the model. Consistent with predictions, as the severity of ACEs score and the total burnout score increased, the total compassion fatigue score also increased. This regression model accounted for approximately fifty-three percent of the variance in compassion fatigue scores and was determined to be the best fit for this study.

Inconsistent with predictions, as the number of community ACEs increased the total compassion fatigue score decreased indicating that individuals who experienced community adverse childhood experiences may be at lower risk for compassion fatigue. One explanation is that community ACEs impact large numbers of individuals, so there may be some inherent protective factors related to these experiences. There may be a sense that "we're all in this together" and/or other resiliency factors related to community ACEs that act as protective factors against compassion fatigue (Weinstein, 2020, March 14).

Contradictory to past research, this implies that individuals with a history of some types of childhood trauma may be less likely to develop compassion fatigue. Previous research indicated that compassion fatigue increased along with increases in ACEs (Bride, 2004; Jordan, 2010; La Mott & Martin, 2019; Nelson-Gardell & Harris, 2003; Pearlman & MacIan, 1995). One explanation is that La Mott and Martin (2019) found that not all ACEs are correlated with compassion fatigue, so it's possible that including all ACEs may skew the results. Another explanation is that counselors who have a history of childhood trauma have learned ways to cope with trauma that those who didn't experience childhood trauma did not learn. Another possibility is that counselors who have a history of childhood trauma derive more meaning or satisfaction from their work with traumatized clients, which acts as a protective factor for them (Stamm, 2005). Finally, La Mott and Martin (2019) found that counselors with a high number of ACEs may have lower levels of burnout if they have high levels of self-care. Self-care may be acting as a mitigating factor between compassion fatigue and childhood trauma.

Research Question #6

The sixth research question examined severity of ACEs, the total burnout score, and age as predictors of compassion fatigue via a regression model. While age did not significantly contribute to the model, severity of ACEs and burnout score significantly contributed to the model as indicated in research question 5. Consistent with predictions, as the severity of ACEs score and the total burnout score increased, the total compassion fatigue score also increased. With the addition of age, this regression model accounted for approximately forty-seven percent of the variance in compassion fatigue scores, and it was determined that the second regression model was a better fit for this study than this regression model.

Implications

Counselors are expected to monitor themselves for impairment (AMHCA, 2010; AAMFT, 2015; ACA, 2014). While all of the counselors in this study were at low to moderate risk for burnout, approximately eighty percent of counselors in this study were at moderate to extremely high risk for compassion fatigue. More surprisingly, approximately sixty percent of counselors in this study were at high or extremely high risk for compassion fatigue. The second and third regression models in this study indicated that burnout scores and severity of ACEs scores are positively correlated to compassion fatigue scores. The impact of the severity of ACEs needs to be explored further to determine how it impacts the high levels of compassion fatigue in this study. Counselors need to be aware that they can be experiencing compassion fatigue even if they are not experiencing burnout. Counselors should monitor how their work with traumatized clients is impacting them personally and professionally.

La Mott and Martin (2019) surveyed mental health providers about self-care, prevalence of ACEs, burnout, secondary traumatic stress, and compassion satisfaction. They reported that all of their participants were licensed mental health providers including clinical psychologists (48% of the sample), LCSWs, and LMFTs but did not report the percentages of counselors or mental health workers other than psychologists in this study. La Mott and Martin (2019) utilized the Adverse Childhood Experience Questionnaire to assess the prevalence of ACEs. The wording of this ACE instrument is different from the one used in this sample. The Y-VACS asks if an experience ever occurred, while the ACE Questionnaire asks if some experiences "often" occurred. The differences in wording may explain why participants in this sample reported more ACEs than the La Mott and Martin (2019) study. Another explanation for the differences is that this study was promoted as a study on compassion fatigue while the La Mott and Marin (2019) study was exploring self-care; participants often self-select to participate in studies with topics that interest or impact them.

Unexpectedly counselors in this study had higher compassion fatigue scores associated with higher burnout and severity of ACEs. The consequences of burnout and compassion fatigue include irritability, poor professional judgment, misdiagnoses, mental and physical exhaustion, difficulty sleeping, and aggression. Counselors experiencing compassion fatigue may engage in inadequate self-care (Harr, 2013; La Mott & Martin, 2019) and struggle to maintain healthy boundaries (Harr, 2013). Compassion fatigue changes the way a counselor interacts with themselves, others, and the world (Figley, 2013). Counselors may risk making poor judgments including judgments about the abuse of clients, misdiagnoses, and poor treatment planning when they experience compassion

fatigue (Bride, Radey, & Figley, 2007). Counselors experiencing compassion fatigue may be more irritable and engage in poor professional relationships (Inbar & Ganor, 2003).

It follows that burnout and compassion fatigue may be addressed by increasing self-care and/or monitoring and reducing Rescue-Caretaking survival strategies with clients. Self-care may mitigate the impacts of compassion fatigue (Figley, 2002b; McCann & Pearlman, 1990; O'Halloran & Linton, 2000; Sansbury, Graves, & Scott, 2015). The relationship between personal trauma and compassion fatigue may be mitigated by personal wellness and self-care (McCann & Pearlman, 1990). The lower levels of burnout in comparison to the high levels of compassion fatigue reported in this study are consistent with Valent's (2002) theory on survival strategies. Valent (2002) proposed that individuals who engage in Rescue-Caretaking survival strategies are likely to exhibit higher levels of empathy, devotion, responsibility, nurture, and preservation; however, they are also likely to experience more feelings of burden, depletion, self-concern, resentment, neglect, rejection, and anguish and high levels of compassion fatigue. According to Valent (2002), burnout is associated with the Asserting-Goal-Achievement survival strategies. The counselors in this study may be more likely to engage in Rescue-Caretaking survival strategies than Asserting-Goal Achievement survival strategies with clients. Counselors with a history of childhood trauma may have more countertransference, which leads to engaging in more Rescue-Caretaking survival strategies (Valent, 2002).

This study's finding about increased community ACEs associated with decreased compassion fatigue may be an important one. Bellis et al. (2018) found that, while negative outcomes increase with number of ACEs reported, childhood community

resilience assets including being treated fairly, supportive friendships, having someone to look up to, and opportunities to utilize your abilities were associated with positive outcomes. Weinstein (2020, March 14) wrote that a “we and not just me” attitude has helped humans be resilient and survive all kinds of tragedies. There may be a number of resiliency factors link to community ACEs that are negatively associated with compassion fatigue.

Counselor educators should incorporate planned discussions about trauma via ACEs, burnout, and compassion fatigue as well as self-care in to their curriculum, perhaps in the clinical coursework of practicum and internship. CACREP should consider adding compassion fatigue to their requirements in their next revision. Counselors in training may be more familiar with burnout and self-care than they are with compassion fatigue. The lower levels of burnout in this study may indicate that counselors actively monitor burnout levels and engage in activities to decrease burnout. Therefore, compassion fatigue may be less familiar to counselors in training and thus they may be unsure how to monitor for or mediate the impacts of compassion fatigue. In addition, given the prevalence of compassion fatigue and ACEs in counselors found in this study and the potential mitigating factors of self-care, it is important for counselor educators to include planned discussions of trauma, burnout, compassion fatigue, and self-care throughout their curriculum.

Potential Limitations

One potential limitation to this study is the issue of causation due to this study being a nonexperimental, descriptive statistics design. This means that causation cannot be assumed due to a lack of control and manipulation of variables. Descriptive statistics

are commonly used in counseling research. The study can, however, address questions of prevalence and correlation.

The issue of generalizability or coverage error is another concern (Dillman, Smyth, & Christian, 2014). This study sampled participants from the largest association of counselors and a national listserv of counselor educators. Participants in this study are currently practicing in thirty different states and have varying degrees of experience and training.

Another limitation is that this study uses self-report data. Self-report data needs to be carefully examined. Response bias may influence the way participants answer questions (Dillman, Smyth, & Christian, 2014). Other individuals may not feel comfortable disclosing personal information, in particular, it may be very difficult to disclose a personal history of childhood trauma. The survey was carefully developed including the wording and types of questions utilized to decrease response bias (Dillman, Smyth, & Christian, 2014). The survey included a tailored design to reduce survey error by customizing the procedures for this topic and adding reverse-scored items (Dillmam, Smyth, & Christian, 2014). One more thing to consider is that participants often self-select to participate in studies that interest or impact them.

A final limitation to this study is that the data was collected at the beginning of a global pandemic. Prior research states that individuals experience burnout and compassion fatigue at higher rates during times of crisis (Creamer & Liddle, 2005; Boscarino, Figley, & Adams, 2004; Roberts, Flannelly, Weaver, & Figley, 2003). However, this study also found that community ACEs can work to decrease compassion fatigue, so further research needs to be conducted to determine the impact of community

ACEs. It is unknown if and to what degree the participants were impacted by this crisis. The results of this study could provide great information about the early impacts of crises on counselors.

Further Research

This study should be recreated after the global pandemic subsides and a new sense of normalcy has emerged to determine if the scores were impacted by the crisis. Researchers should conduct further research on the prevalence and impact of community ACEs on counselors. This was the first known study to examine this aspect of childhood trauma in counselors. Researchers should further examine the prevalence and impact of the severity of traumatic experiences in childhood. More information is needed to determine if it is the experience trauma itself or the severity of the trauma that leads to negative outcomes as adults.

Future research could also include compassion satisfaction and self-care in the prediction model. Kraus (2005) found a direct relationship between self-care and compassion satisfaction, yet also found that self-care was indirectly related to burnout and secondary traumatic stress. La Mott and Martin (2019) found an inverse relationship between compassion satisfaction and compassion fatigue.

The impact of various systemic and community factors in the prediction of compassion fatigue should be examine. Other factors might include: location, place of work, size of agency, funding, licensure status, gender identity, and marital status. It is still unclear which factor increase or decrease risk and which factors may increase risk under some circumstances and decrease risk under others.

This study should be replicated with other sample populations that may be vulnerable to burnout and compassion fatigue. Other samples my include teachers, physicians, nurses, volunteers, and first responders. It is important to determine who is at risk from compassion fatigue and whether the risk is extremely low, extremely high, or somewhere in the middle.

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Appendix A

(Yale-Vermont Adversity in Childhood Scale not published in the appendix because permission from the authors is required for use).

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

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

1. I am happy.
2. I feel connected to others.
3. I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].
4. I feel trapped by my job as a [helper].
5. I have beliefs that sustain me.
6. I am the person I always wanted to be.
7. My work makes me feel satisfied.
8. I feel worn out because of my work as a [helper].
9. I feel overwhelmed because my case [work] load seems endless.
10. I feel "bogged down" by the system.
11. I am a very caring person.

Consider each of the following characteristics about you and your situation. Write in the number for the best response. Use one of the following answers:

1=Rarely/Never 2=At Times 3=Not Sure 4=Often 5=Very Often

1. ___ I force myself to avoid certain thoughts and feelings that remind me of a frightening experience.
2. ___ I find myself avoiding certain activities or situations because they remind me of a frightening experience.
3. ___ I have gaps in my memory about frightening events.
4. ___ I feel estranged from others.
5. ___ I have difficulty falling or staying asleep.

6. ___ I have outbursts of anger or irritability with little provocation.
7. ___ I startle easily.
8. ___ While working with a victim, I have thought about violence against the person or perpetrator.
9. ___ I have had flashbacks connected to my clients and families.
10. ___ I have had first-hand experience with traumatic events in my adult life.
11. ___ I have had first-hand experience with traumatic events in my childhood.
12. ___ I have thought that I need to "work through" a traumatic experience in my life.
13. ___ I am frightened by the things traumatized people and their families have said or done to me.
14. ___ I experience troubling dreams similar to a client of mine and their family.
15. ___ I have experienced intrusive thoughts of interactions with especially difficult clients and their families.
16. ___ I have suddenly and involuntarily recalled a frightening experience while working with a client or their family.
17. ___ I am preoccupied with more than one client and their family.
18. ___ I am losing sleep over a client and their family's traumatic experiences.
19. ___ I have thought that I might have been "infected" by the traumatic stress of my clients and their families.
20. ___ I remind myself to be less concerned about the well-being of my clients and their families.
21. ___ I have felt trapped by my work as a helper.

22. ___ I have felt a since of hopelessness associated with working with clients and their families.
23. ___ I have been in danger working with some clients and their families.

Please complete the following demographic information.

Age:

Gender:

Race/Ethnicity:

Sexual Orientation:

Relationship Status:

Length of Time Working with Traumatized Clients:

Hours Worked per Week:

Length of Current Employment:

Please Choose One of the Options for the following questions.

Which best describes your current licensure status? Fully Licensed, Associate/Intern License, Graduate Student-in-Training

Which best describes the work environment you are in the most? Agency, School, Private Practice, Majority Private Practice, Majority Agency, Majority School