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COMPASSION FATIGUE, BURNOUT, OBJECTIVISM AND RELIGIOUS ACTIVITIES/BELIEFS IN PRACTITIONERS

by

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This dissertation is dedicated to the proposition that
all things are possible....through faith

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As major stakeholders in the helping profession, counselors and other mental health professionals are prepared to assist clients in coping with intensely painful and traumatic experiences. While assisting their clients in processing traumatic events (e.g., natural disasters, violent crimes, grief, accidents, terrorist attacks), however, some professional helpers may become overwhelmed themselves and thereby experience compassion fatigue and/or burnout. This study will evaluate whether certain personal and professional factors in counselors – including objectivism in decision-making and religious beliefs and activities – are related to their ability to avoid compassion fatigue and/or burnout.

Dissertation Committee Members: Dr. Kaethe P. Ferguson
Dr. Dr. Danica Hays

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COMPASSION FATIGUE, BURNOUT, OBJECTIVISM AND RELIGIOUS ACTIVITIES/ BELIEFS IN PRACTITIONERS

Chapter One

INTRODUCTION

This research study investigates compassion fatigue and burnout as related to religious activities/beliefs and objectivism in practitioners with a master's degree or above. Compassion fatigue has also been referred to as vicarious traumatization, secondary trauma, secondary traumatic stress, and secondary traumatic stress disorder, all of which are similar to the condition, Posttraumatic Stress Disorder (PTSD). Burnout is a process that gradually becomes progressively worse; it is not a fixed condition. Burnout can cause the following: job strain, erosion of idealism, and a lack of achievement (Figley, 1995). This study is being conducted because there is no known research that encompasses all of the variables that are being examined in this study. There are studies that suggest that spirituality is influenced by trauma. Decker claimed "that no matter what the psychological condition of the survivor, trauma will influence his or her spiritual development. He asserted that the survivor will become more focused on his or her search for meaning and purpose because trauma necessarily calls into question old perspectives, requiring a reexamination of values and beliefs" (as cited in Brady, Guy, Poelstra & Brokaw, 1999, p. 386). However, there is no study that addresses each variable of this research collectively. Compassion fatigue is relatively common in the research, but objectivism as related to compassion fatigue has not been examined. There are no studies found by this researcher that have examined whether the way individuals make decisions can reduce their risks for compassion fatigue/burnout. This study produces information that can potentially assist practitioners with identifying whether

they are experiencing compassion fatigue/burnout and provide suggestions for reducing the risk.

PTSD must be defined before any of the subparts can truly be examined. The text revision of the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR*; American Psychiatric Association, 2000) states, "Traumatic events that are experienced directly include, but are not limited to military combat, violent personal assault (sexual assault, physical attack, robbery, mugging), being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war or in a concentration camp, natural or manmade disasters, severe automobile accidents, or being diagnosed with a life-threatening illness. Sexually traumatic events in children may include developmentally inappropriate sexual experiences which may not include threatened or actual violence or injury" (pp. 463, 464).

When practitioners provide services to clients who have experienced a traumatic event, these mental health professionals are *exposed* to the trauma through the process of assisting their clients. The diagnostic criteria for PTSD from the *DSM* are presented as follows: (a) the person has been exposed to a traumatic event that involved actual or threatened death, serious injury, or a threat to physical being of self or others, which involved fear, helplessness or horror; (b) the traumatic event is persistently reexperienced causing a distressing recollections of the event through images, thoughts, perceptions or dreams, illusions, hallucinations, or dissociative flashbacks; (c) the intense psychological distress at the exposure to internal or external cues that symbolize or resemble an aspect of traumatic events; (d) the persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), such as, efforts to

avoid thoughts, feelings, activities, places, people, or conversations concerning the trauma; (e) the presence of two or more persistent symptoms, including, difficulty staying or falling asleep, concentrating, irritability or outbursts of anger, hypervigilance, and constant startle responses which were not present before the traumatic event ((*DSM-IV-TR*; American Psychiatric Association, 2000).

Trauma that clinicians experience can emulate the same symptoms as PTSD even though the trauma may be caused by secondary knowledge of the traumatic event.. "The essential feature of PTSD is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associates" (DSM-IV-TR, 2000, p. 463).

Effects of trauma exposure were first observed in the late 1970s in emergency and rescue workers who displayed symptoms similar to the trauma victims they helped (Moulden & Firesone, 2007). Many identify the publication of the American Psychiatric Association's third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-III*) in 1980 as a major milestone in the progress of this field of study (Figley, 1995). According to Figley, as cited in the latest revision of the *DSM* (APA, 2000), the symptom criteria were modified somewhat, and the popularity with professionals (including lawyers, therapists, emergency professionals, and researchers) working with traumatized people grew, as did accumulation of empirical research that validated the phenomenon. Secondary traumatic stress has been defined as "the natural, consequent

behaviors and emotions resulting from knowledge about a traumatizing event experienced by a significant other" (Bride, Robinson, Yegidis, & Figley, 2003, p. 2).

Compassion fatigue has the potential to inflict great harm on the vast number of practitioners who are susceptible to this phenomenon. Vicarious traumatization is an old problem with new exposure. The concept of the helper being traumatized as a result of helping has a framework and is a subcategory in a field of study known as *traumatology*. Traumatology is the study of the impact of trauma on humans, and the concept of traumatology can be traced back to the medical writings of Kunus Pyprus in Egypt circa 1900 B.C. (Figley, 1995).

While the study of trauma has been in existence for quite some time, the term, *vicarious traumatization*, is relatively new. The concept is receiving increasing attention and more researchers are slowly beginning to study this powerful and potentially damaging phenomenon. In recent years, with the occurrences of natural disasters, increased crime rates, killings in schools, and other traumatic experiences, the need for mental health services has increased dramatically and more victims of these traumatic experiences are seeking assistance. Practitioners are expected to utilize empathy to a degree such that the emotional well-being of the practitioner could be negatively affected. According to Dunkley and Whelan (2006), as clients describe the details of their trauma, practitioners can experience parallel states of fear, grief, and helplessness. Another name for the phenomenon of vicarious traumatization *is compassion fatigue*. In this study, the term *compassion fatigue* is used to indicate vicarious traumatization, secondary traumatic stress, and Secondary Traumatic Stress Disorder.

The concept of secondary stress occurring in the person who is attempting to help

a survivor of trauma is explored in this study. Some practitioners appear to be desensitized or are able to compartmentalize their feelings when treating clients who have been affected by trauma. Other practitioners, however, appear to be unable to compartmentalize their feelings, and are themselves traumatized from helping the actual survivors of trauma. Brady, Guy, Poelstra, and Brokaw (1999) stated that a practitioner's adaptation to secondary trauma will depend on the interplay between the characteristics of the situation and the person.

KEY CONSTRUCTS

Compassion Fatigue

Like soldiers on the front line in a battle, so are counselors on the front line in treating those who have been harmed in the mental and emotional battles of life, such as crisis situations and traumatic events. For many individuals, caring is a natural response to people who are hurting. Some people become emotional from watching a television show that displays painful events occurring with the cast on the show. Perhaps some practitioners are more susceptible to developing compassion fatigue than others. Practitioners are expected to listen to similar real-life sagas, day in and day out. Practitioners are responsible for caring for their clients and providing treatment to assist their clients with developing skills to manage issues and stressors that have a negative impact on their clients' lives.

As the awareness of practitioners' vicarious traumatization emerges, more terms are being developed to describe the experience. Although, much of the terminology being used to describe compassion fatigue has been in existence for some time, to a graduate student or a novice practitioner, terms such as *compassion fatigue*, *secondary trauma*, or

vicarious trauma may be new or unfamiliar terminology, and the experience itself may be an unexplored concept. Apparently, not all higher education institutions are providing a curriculum that teaches graduate students or future practitioners about compassion fatigue. *Burnout* may be the term that is discussed more often than compassion fatigue; however, many researchers view the two as separate, and they are treated as separate constructs in this study. The instrument that is used for this study differentiates between compassion fatigue and burnout.

Objectivism

Objectivism is one of the key constructs that will be examined in this study. The manner in which clinicians perceive, organize, and process information to make decisions may be related to whether they develop compassion fatigue. People differ not only in their cognitive abilities and in their styles of thinking, but also in the kinds of information upon which they base their judgments and beliefs (Leary, Shepperd, McNeil, Jenkins, & Barnes, 1986). An objective decision is a judgment that is based on data or facts that are empirical (observable by anyone in the same place at the same time), and an objective individual is one who seeks empirical information under conditions of uncertainty and attempts to process it in a rational and logical fashion (Leary et al.).

Practitioners are required to process large amounts of information during counseling sessions. The method in which practitioners make decisions could affect whether they develop compassion fatigue. According to Leary et al. (1986), among graduate students in psychology, objectivism correlated positively with ratings of research-oriented careers, but negatively with ratings of mental health careers. Highly objective students were more critical of nonobjective psychological assessment

techniques and placed greater importance on research. This research study assesses a component of the personality of practitioners based upon how counselors process information to make decisions. The concept of whether some counselors are more likely to experience compassion fatigue based upon their approach to decision making (their level of objectivism) is explored in this study.

Religious Beliefs

This research project also attempts to identify whether the religious activities or beliefs of practitioners are related to the development of compassion fatigue or burnout. According to Hill and Pargament (2003), religion and spirituality are connected to physical and mental health. Many of the religion and spirituality research findings, especially in relation to health, have emerged from either large epidemiological surveys of medical populations or large-scale sociological surveys of national populations (Hill & Pargament). Koenig et al. (as cited in Hill & Pargament, 2003) in their review of religion and physical health identified a growing literature investigating religion and spirituality (especially religion) in relation to factors such as heart disease, cholesterol, hypertension, cancer, mortality, and health behaviors in search of the impact of religion in the healing process.

Counselors who are exposed to trauma vicariously are confronted with spiritual challenges (Brady, Guy, Poelstra, & Brokaw, 1999). Neuman and Pearlman stated that trauma work affects mental health professionals most in the spiritual domain: "Perhaps more than any other realm...it is our spirituality which is deeply affected by doing trauma work" (as cited in Brady et al., 1999, p.387). Conducting therapy with trauma survivors' forces counselors to question their own sense of meaning and hope (Brady et al.).

Acknowledging the importance of the spiritual domain, this study further investigates the relevance of religion and spirituality in the lives of counselors who may experience compassion fatigue in their work with clients.

PURPOSE OF THIS STUDY

This purpose of this study is to explore whether practitioners' decision making skills, as well as their religious activities and beliefs, are factors that are associated with their ability to avoid developing compassion fatigue when counseling/assisting victims of traumatic events. Not only practitioners, but other helping professionals as well, could benefit from the results of this study. This study also examines whether the following traits of practitioners are associated with their development of compassion fatigue or burnout: (a) gender, (b) race, (c) years of experience at the master's level, (d) whether they are objective or subjective decision makers, (e) whether they engage in leisure activities, (f) their history of trauma, (g) their region (urban, rural, etc.), and (h) their religious activities and beliefs.

Figley (1995) stated that caring professionals who listen to clients' stories of fear, pain, and suffering may experience similar emotions or exemplify similar behaviors. The purpose of this research study is to determine whether practitioners' personal and professional characteristics are associated with their development of compassion fatigue and burnout.

RESEARCH QUESTIONS

The research questions in this study are as follows:

(1) What level of risk for compassion fatigue and level of risk for burnout exist in master's level and above practitioners (counselors, social workers,

and mental health clinicians) in the southeastern region of the United States?

(2) Are the following professional characteristics of practitioners associated with their levels of risk for compassion fatigue or their levels of risk for burnout: (a) the number of years that they have possessed a master's level degree; (b) their years of experience as a master's level or above practitioner; (c) the hours they currently counsel/assist trauma survivors, and (d) their years of experience in counseling/assisting trauma survivors?

(3) Are the following personal characteristics of practitioners associated with their levels of risk for compassion fatigue or to their levels of risk for burnout: (a) gender; (b) race; (c) whether they have been victims of trauma themselves; (d) type of community where they spent their childhood; (e) whether they regularly participate in leisure activities; (f) their level of objectivity in decision making and (g) their religious activities and beliefs?

LIMITATIONS AND DELIMITATIONS

The participants in this study were originally to be recruited from 1,020 Certified Clinical Mental Health Counselors (CCMHCs), from throughout the United States (National Board of Certified Counselors, personal communication, March 19, 2009). CCMHCs were to be surveyed in this study because they are counselors who have distinguished themselves by obtaining a voluntary credential reserved for counselors who have advanced preparation in the areas of psychopathology and who have practiced in a clinical setting (settings where more trauma victims may seek counseling). However, this researcher's permission to obtain a list from the National Board of Certified Counselors

was delayed and permission was not granted in a timely manner for the completion of this study.

The data for this project were obtained using a convenience sample. The population recruited encompassed counselors, social workers, and mental health clinicians from the southeastern region of the United States. This process is a threat to external validity because it represents a selection bias in that a subgroup of practitioners studied, and not generalizable to all practitioners. However, the focus of the study is to examine practitioners who assist victims of trauma.

Another threat to this study is subject effects. Subject effects occur when the participants of a study are reluctant to reveal that they may be affected by whatever variable is being researched. Subject effects could occur in this research project in that practitioners may respond in a way that they do not identify themselves as traumatized, when in fact, they are. To admit the presence of mental health problems in themselves may be embarrassing to some practitioners and may cause them to respond to survey items in a socially acceptable manner.

ASSUMPTIONS OF THE STUDY

It is assumed that the practitioners who complete the forms and surveys will be master's level practitioners with clinical experience. In addition, this researcher assumes that the practitioners in this study may have some hesitations about acknowledging that the risk for compassion fatigue/burnout may be prevalent in their lives. This hesitation may therefore, consciously or unconsciously influence their ability to answer honestly.

DEFINITIONS OF TERMS

Burnout: Physical or emotional exhaustion that is a direct result of unresolved stress that has been prevalent over an expanded period of time, not only as a result of caring, but also as a result of exposure to any unacknowledged or unaddressed issue (Figley, 1995).

Compassion Fatigue: When one becomes stressed or emotionally exhausted as a result of knowing or hearing about the trauma that someone else has experienced, it can lead to compassion fatigue.

Secondary Traumatic Stress: "The natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other – the stress resulting from helping or wanting to help a traumatized or suffering person (Figley, 1995, p. 7).

Stress: A basic reaction experienced by all humans. Tension that results from one's fundamental vulnerability to the environment, to one's own condition, to one's own impulses or needs, and to one's dependence on others (Kagan, Kagan, & Watson, 1995).

Trauma: Herman describe trauma as "an experience where

	the victim is rendered helpless and is overwhelmed by fear and loss of control" (as cited in Findling, Bratton, & Henson, 2006, p. 7).
Vicarious Trauma:	Symptoms similar to posttraumatic stress disorder and the disruption in cognitive schemas reported in practitioners who are exposed to the trauma material of their clients (Brady et al., 1999).
Countertransference	The distortion on the part of the therapist resulting from the therapist's life experiences and associated with her or his unconscious, neurotic reaction to the client's transference (Figley, 1995).
Empathy	A way of knowing and understanding another person that is a central concept in counseling (Lyons & Hazler, 2002).
Religion	An organized system of beliefs, practices, rituals, and symbols designed (a) to facilitate closeness to the sacred or transcendent (God, higher power, or ultimate truth/reality) and (b) to foster an understanding of one's relationship and responsibility to others in living together in a community (Koenig et al., 2001).
Religious beliefs	The basic level of religion that is often measured in terms of the orthodoxy of belief (Koenig et al.,

2001).

Spirituality	A term used to identify with a belief in a higher power that may or may not be God. It is the idea that something or someone serves as a higher power connected and interacting in the lives of humans. It is the personal, subjective, side of religious experiences (Hill & Pargament, 2003).
Objectivism	A theory that identifies the process that individuals use to make decisions based upon their method of thinking and processing information. Empirical data or facts are used to make decisions (Leary et al., 1986).
Subjectivism	A concept whereby an individual's feelings and intuitions are used to process information to make decisions (Leary et al., 1986).

Chapter Two

LITERATURE REVIEW

It has been suggested that a unique feature of some mental health practitioners' work is exposure through their role as practitioners to clients' descriptions of traumatic events and reactions to a trauma, and that these experiences may actually indirectly cause distress and traumatization to the therapist (Farell & Turpin, 2003). It is not an easy task for some counselors to listen to the problems, stories, and the traumatic events of clients on regular basis without experiencing some form of anguish.

There have been several attempts to identify the deleterious effects that helpers in the trauma field may experience (Sexton, 1999). Practitioners may not realize what is happening when they are being negatively impacted by exposure to trauma through the experiences of their clients. Bell (2003) found that when counselors of trauma victims were asked whether they were affected by the trauma experienced by their clients, "Forty percent of counselors felt that their work with trauma survivors had had a positive effect on them, feeling that they had become more compassionate, more grateful and less judgmental as a result. Only 10% of counselors felt that their work had a negative effect on them, making them feel more negative toward others. Forty-three percent of the counselors could name both positive and negative effects of their work or were unsure of its effect" (p. 516).

The purpose of this research study is to identify whether there are differences in practitioners who are negatively affected as a result of their work with trauma survivors and those who are not. The primary objective of this research project is to determine whether the practitioners' characteristics make them more or less susceptible to negative

effects as a result of providing mental health services to individuals who have been traumatized.

There is a paucity of studies that examine the affects of religion on compassion fatigue/burnout. Larson et al. (as cited in Hill & Pargament, 2003, p. 65), stated that four major psychiatric journals from 1978 to 1982 found that only 2.5% of the quantitative studies included a theme or religiosity. The lack of research on religion and the impact that religion may have on reducing the risk for compassion fatigue/burnout has not been examined extensively.

This researcher did not locate any research on objectivism impacting the risk for compassion fatigue/burnout. Objectivism helps to identify the cognitive style of the participants in this study. Goldstein & Blackman researched cognitive styles and investigated the individual differences that reflect ways of perceiving, organizing, and processing information (as cited in Leary et al., 1986, p. 32).

Dlugos & Friedlander (2001) found that the stress of being a mental health worker can negatively affect the career satisfaction of many individuals who entered the field with commitment, enthusiasm, and idealism. In spite of experiencing the same pressures, demands, and conflicts that confront all psychotherapists, some have managed not only to survive, but also to thrive, while maintaining a passion for their work that enhance rather than detract from their passion for other important life commitments. This statement supports the need for further research to investigate why some practitioners are more at risk for compassion fatigue/burnout than others.

TRAUMA AND SECONDARY TRAUMA

There are several types of trauma that exist. Some of the types of trauma have

been identified by Stamm (1999): "(a) Simultaneous trauma takes place when all members of the system are directly affected at the same time, such as a natural disaster; (b) Vicarious trauma happens when a single member is affected out of contact from the other members (e.g., war, coal mine accidents, hostage situations, distant disasters); (c) Intrafamilial trauma or abuse takes place when a member causes emotional injury to another member; (d) Chasmal or secondary trauma strikes when the traumatic stress appears to "infect" the entire system after first appearing in only one member. The latter phenomenon most closely parallels what we are now calling Secondary Traumatic Stress (STS) and Secondary Traumatic Stress Disorder (STSD)" (pp. 7-8). Stamm has discussed vicarious trauma as well: "Compassion fatigue, contact victimization, or secondary post traumatic stress reaction are terms which have been used to describe disruptive and painful psychological effects which sometime affect individuals in the mental health profession who work with survivors of traumatic events" (pp. 29-30). It is thought by some professionals in the field that countertransference and burnout are responses to characteristics of disclosed traumatic events which the therapist or counselor has not experienced directly.

Neuman and Gamble (1995) indicated that "often therapists' role responsiveness places them in the position of helpless witnesses to clients' suffering, either in the past, as the therapist listens to a graphic account of childhood abuse, or in the present, when a client engages in self-injurious behaviors" (p. 342). It has been suggested by some that novice practitioners are at a higher risk for countertransference. "Trauma work requires therapists to tolerate lengthy periods of feeling helpless and inadequate, shamed, attacked, and abandoned. Given these stressors, the new therapist needs supervision that

is grounded in a clear understanding of the transference – countertransference dynamics common to therapy (Neuman & Gamble, 1995, p. 343). This research study examines whether the years of experience have any bearing on the risk for compassion fatigue/burnout

Dunkley and Whelan (2006) concur with Newman and Gamble as they explain that according to constructivist self-development theory, trauma can disrupt a practitioner's cognitive schemata in one or more of the five fundamental need areas: safety (feeling safe from harm by oneself or others), trust/dependency (being able to depend on or trust others and oneself), esteem (feeling valued by others and oneself, as well as valuing others), control (being able to manage one's own feelings and behaviors, as well as managing others), and intimacy (feeling connected to others or to oneself).

COMPASSION FATIGUE

According to Brady et al. (1999), vicarious traumatization, a relatively new term found in the professional literature, describes the transformation mental health professionals undergo because of empathic engagement with clients' trauma material. While there has been some debate about how these concepts differ, for the purpose of this study, the term *compassion fatigue* is used to refer to post-traumatic stress reactions experienced by those who are indirectly exposed to traumatic events (Palm, Polusny, & Follett, 2004). Pearlman and Ian (1995) defined vicarious traumatization as the transformation that occurs within the therapist (or trauma worker) as a result of empathic engagement with clients' trauma experiences and their sequel. Vicarious trauma and compassion fatigue are used interchangeably in the professional literature.

Figley has been instrumental in identifying and defining terms used to describe

the phenomenon of clinicians being affected by compassion fatigue. Figley (2005) wrote "Traumatology, or the field of traumatic stress studies, has become a dominant focus of interest in the mental health fields only in the past decade" (p.iii). Vicarious traumatization is the cumulative transformation in the inner experience of the therapist that comes about as a result of empathic engagement with the client's traumatic material (Sexton, 1999).

Figley (2005) suggested that compassion fatigue is a natural process and a consequence of the counseling profession. Figley (1999) wrote that secondary traumatic stress has been defined as the "natural, consequent behaviors and emotions resulting from knowledge about a traumatizing event experienced by a significant other; it is the stress resulting from helping or wanting to help a traumatized or suffering person" (p.10). In *The Psychology of Dementia Praecox*, Jung identified one of the earliest references in the scientific literature regarding the cost of caring (as cited in Gentry, 2002, p. 6)., Jung (as cited in Gentry, 2002, p. 6) , described countertranference as being challenging for the therapist when reacting to clients. Countertransference occurs in all psychotherapists and is a temporary response to a particular client. Compassion fatigue or vicarious trauma is the result of an accumulation of experiences across many therapy situations (Sexton, 1999). Pearlman and Saakvitne (1995a) contended that compassion fatigue is an occupational hazard that will affect all trauma therapists, at least to some extent, during their career.

Stamm (1995) published a review of the literature examining the impact on mental health professionals who work with traumatized clients and she commented that the issue was not whether such a phenomenon existed but what it would be called. As

early as the late 1970s, the effects of trauma exposure were first observed in the medical field in emergency and rescue workers who displayed symptoms similar to the trauma victims they assisted. Follette et al. stated that the phenomenon of the transfer of trauma prompted the investigation of individuals working with victims in various capacities, such as disaster relief works, nurses and physicians, and crisis and hotline workers (as cited in Moulden & Firestone, 2007). Brady et al. (1999) suggested that "women psychotherapist who have more sexual abuse clients in their caseloads or see a high number of survivors over the course of their careers are more likely to exhibit trauma symptoms themselves" (p. 387). Follette et al. did a study with 225 mental health professionals and 46 law enforcement officers who were providing services to survivors of childhood sexual abuse and their study did not reveal whether a history of abuse could increase the risk for trauma in the practitioners (as cited in Pearlman & Ian, 1995, p. 559).

PRACTITIONER SUSCEPTIBILITY TO COMPASSION FATIGUE

Some of the gaps in the current research pivot on the definition of compassion fatigue as well as the type of practitioner that is more susceptible to secondary trauma. Some researchers view compassion fatigue and secondary trauma as parallel to vicarious traumatization, while others view vicarious traumatization and secondary trauma as being synonymous, with compassion fatigue being a separate entity. Figley (1995) said that "secondary traumatic stress has been called different names over the years" (p. 9). Bell (2003) indicated that practitioners who work with trauma survivors are susceptible to secondary trauma, a form of work-induced posttraumatic stress disorder. During the past 10 years, researchers have examined this experience using several similar terms: compassion fatigue, secondary traumatic stress, and vicarious trauma (Stamm,

1995/1999). Regardless of their theoretical frameworks, all of the terms used by various experts refer to negative reactions of helping professionals specific to their work with trauma survivors (Bell).

According to Pearlman and Ian (1995), previous personal history of practitioners may be a major contributing factor to the development of compassion fatigue in mental health professionals. They indicated that conducting trauma therapy can affect therapists negatively and that the effects of trauma therapy are different from those related to general psychotherapy. Pearlman and Ian suggested that the research implies that aspects of the therapist, such as personal history, gender, and personal stress, may interact with exposure to trauma material to contribute to trauma-related symptoms in therapists (1995). The impact of a counselor's personal history of trauma or his or her vulnerability to secondary trauma/compassion fatigue has been a major focus of research interest, but the findings are inconclusive (Bell, 2003).

It has been proposed that practitioners may be unaware that they have compassion fatigue because of their tendency to avoid self-evaluation. Norcross and Guy (2007) said that mental health professionals, by definition, study and modify human behavior. Psychological principles, methods, and research are rarely brought to bear on psychotherapists. However, there are symptoms that can identify compassion fatigue, making a counselor aware that he or she has been affected by a traumatic counseling session. These symptoms, analogous to post-trauma symptoms, can include sleep disturbance, intrusive images, and disruption to core schema about safety in the world, trust, intimacy and control (McLean, Wade, & Encel, 2003). Cunningham (2003) stated that acknowledging and addressing compassion fatigue can alleviate the negative effects

of trauma work for practitioners and help ensure quality services for the clients they treat. Practitioners must be cautious and approach each client's trauma with care, recognizing that the client's trauma could be contagious.

BURNOUT

Practitioners' reactions to trauma have historically been characterized as forms of either *burnout* or *countertransference* (Figley, 1995). The professional literature has more recently begun to use different terms, such as *vicarious trauma*, *compassion fatigue*, *secondary trauma* and *secondary traumatic stress*. Burnout and compassion fatigue are different in that burnout is described more as a result of the general psychological stress of working with difficult clients (Figley). Burnout occurs over the course of time while providing services. Compassion fatigue or vicarious traumatization is seen as a traumatic reaction to specific client-presented information (Tripanny, Kress, & Wilcoxon, 2004).

Initially, there were various opinions and debates over the constructs and how they differ. For example, Pearlman and Saakvitne (1995) contended that vicarious traumatization has its foundation in a constructivist personality theory and focuses on meaning and adaptation, whereas secondary traumatic stress disorder focuses on symptoms. According to Bell (2003), researchers have attempted to distinguish secondary trauma from earlier conceptualizations of counselor stress, such as burnout. Figley (1995) hypothesized that there may be similarities between burnout and compassion fatigue. Burnout, however, emerges gradually and is a result of emotional exhaustion, whereas compassion fatigue can emerge suddenly with little or no warning.

Burnout is different from compassion fatigue. Sexton (1999) concluded that burnout, "...is a syndrome of emotional exhaustion, depersonalization, and reduced personal

accomplishment that can occur among individuals who do people work of some kind" (p. 395). Although some researchers have equated burnout and secondary trauma, in this research project, these two constructs will be treated as separate and different constructs.

. While the two may cross in definitions, behaviors, or emotions, burnout occurs over time; however, compassion fatigue and vicarious traumatization could occur the first time that a counselor meets a client. Vicarious traumatization/compassion fatigue and burnout differ in that burnout is related to a feeling of being overloaded secondary to client problems of chronicity and complexity, while compassion fatigue reactions are related specifically to client related trauma (Trippany, Kress & Wilcoxon, 2004). Burnout is a process that an individual goes through over time in a particular position or role. There could be a variety of stressors that could produce burnout, which may include counseling victims of traumatic events. Traumatic events could include actual or threatened deaths or injuries to oneself or others, around which feelings of fear, helplessness, or horror were present. No person is immune to experiencing traumatic events; they can affect anyone regardless of age, race, sex, ethnicity, sexual orientation, religious affiliation, or educational level (Hesse, 2002). Theoretically, individuals working in the caring professions often attempt to alter the behaviors and emotions of their clients by providing emotional support (e.g., empathy), strategies for coping with emotions, or better cognitive management skills (Adams, Boscarino, & Figley, 2006)). However, as the practitioner attempts to rescue the client, the practitioner is placed in the tangible position of needing to be rescued from the very event that placed the client in a vulnerable position.

Burnout for mental health professionals has been extensively studied over a long

period of time (Maslach, 1976). Burnout occurs when professionals lose interest in their jobs because they work too hard over a period of time. They become tired or *worn out*. Burnout is included in this study to distinguish the construct from compassion fatigue. Norris and Guy (2007) indicated that avoiding burnout would be equivalent to discussing how to avoid catching a cold, how to avoid a bad marriage, or how to avoid an automobile accident. Research indicates that approximately 2-6% of psychotherapists experience burnout at any given time (Norris and Guy).

WELLNESS AND PRACTITIONER SELF-CARE

Myers, Sweeney, & Witmer (2000), recommend that a wellness model be incorporated throughout the clinical helping community. The challenge of incorporating wellness into all of clinical helping lies in the fact that wellness is a concept that we as counselors often focus on more readily for our clients than ourselves. Practitioners who are trained to care for others often overlook the need for personal self-care and often do not apply to themselves the techniques prescribed for their clients (O'Halloran & Linton, 2000). With the shift taking place today encompassing the increase of traumatic events in society, it is imperative that a shift occurs in the realm of clinical helping to incorporate practitioners embracing self-care. O'Halloran and Linton stated, "Following the advice Hippocrates might have made, 'Counselor heal thyself,' it is recommended that counselors prescribe self-care for themselves" (p. 355).

Once a practitioner has been traumatized, is the practitioner more vulnerable to future traumatization? If the answer to this question is *yes,* it is paramount that interventions become available to practitioners to avoid future occurrences. Phipps and Byrne (2003) declared that Cognitive Behavior Therapy (CBT) is an effective form of

treatment. However, they said that because CBT requires a high level of skills and training to offer to clients, researchers should seek interventions that can be utilized more readily, such as, critical incident stress debriefing (CISD).

Debriefing is an exposure-based therapy, and in the context of trauma, the facilitator may instruct the client to recall specific events, like safe environments (Phipps & Byrne, 2003). It is suggested that debriefing should take place during the time span of 48 to 72 hours after the event. This strategy is similar to action also taken by the military to stabilize a troop member who has encountered trauma. This intervention has been discussed as an option for not only counselors, social workers, and mental health clinicians, but also volunteers. Although the ethics of using volunteers to debrief victims of trauma may be questionable in times of crisis (e.g. natural disasters, terrorists' attacks), volunteers may be the only available helpers.

Phillips and Byrne (2003) developed a seven-phase debriefing technique: (a) Introduction (facilitator reviews symptoms and methods to prevent distress; (b) Expectation and Facts (facilitator encourages participants); (c) Thoughts and Impressions (facilitator asks participants to describe what they thought, saw, heard, or the different stages of the incident); (d) Emotional Reactions (facilitator enquires into the presence of acute stress reactions); (e) Normalization (facilitator emphasizes that the stressors of the events are normal); (f) Future Planning/Coping (facilitator discusses the availability of coping resources); and ((g) Disengagement (facilitator makes additional referrals, if needed). This debriefing intervention may not be appropriate for a practitioner who has been traumatized; however, the authors suggested that such debriefing not be dismissed altogether. Although the effectiveness of this intervention for practitioners of trauma

survivors has not been proven, it may be worth future exploration.

PREPARING PRACTITIONERS TO AVOID COMPASSION FATIGUE

Compassion fatigue is a topic that higher education institutions need to address world-wide in their curriculum, as it is an important area that needs more exploration. Traumatic events are occurring more frequently in contemporary life, and counselors need to develop greater awareness so that they can intervene early to detect and treat the symptoms of compassion fatigue, should they arise.

It is suggested that empathy can also lead to secondary trauma – a phenomenon referred to as, *empathetic stress*. "Empathy is a key factor in the induction of traumatic material from the primary to the secondary victim" (Figley, 1995, p.15). "Empathy is important in assessing the problem and formulating a treatment approach, because the perspectives of the clients-including the victim's family members - must be considered. Thus the process of empathizing with a traumatized person helps us to understand the person's experience of being traumatized, but, in the process, counselors may be traumatized as well" (Figley, p. 15). As much as higher education institutions attempt to produce well prepared future practitioners, empathy, can produce undesired results, and could indirectly cause practitioners to become traumatized.

Empathy has been identified as a tool to be utilized by helping professionals that allows them to understand clients' problems without becoming overwhelmed. On the other hand, sympathy has been described as an emotion that is expressed between family members, and it is not to be used in the professional realm. There is evidence that emotional empathy is related to clinical helping skills and other variables indicative of effective counseling (Trusty, Ng, & Watts, 2005). It is not certain as to how a practitioner

can elect to use one skill over the other. If in fact being empathetic - rather than sympathetic - is a skill that it is developed over time, a question arises as to why experienced practitioners sometimes develop compassion fatigue. How do practitioners manage their emotions and determine how they are going to respond to any given traumatic experience? Do practitioners become drained by caring too much for the clients that they counsel? All of these questions suggest that the phenomenon of compassion fatigue should be further explored.

This study is not only vital to the counseling community, but it is also important for social workers, firefighters, physicians, police officers, nurses and other clinical professionals who work with trauma survivors and their families. The research results could be helpful to the counseling profession by providing information that will assist practitioners in preventing the development of compassion fatigue.

RELIGION AND COMPASSION FATIGUE

In researching compassion fatigue, the effects of *religious beliefs* in practitioners who are able to avoid compassion fatigue have not been examined. However, research does exist which examines the effects of spirituality on healing. Brady et al. (1999) indicated that compassion fatigue (vicarious traumatization) and spirituality are directly linked and that damage to one's spiritual life is one of the possible outcomes of compassion fatigue and is considered by some to be the most dangerous threat to trauma therapists' well-being. For the purpose of this study, it is necessary to separate *spirituality* from *religion.* In a health-care setting, the term, *spirituality* is used to describe individuals who identify their beliefs or feelings as a personal, subjective side of religious experience. Koenig (2001) identified spirituality as the personal quest for understanding

answers to ultimate questions about life. In contrast, *religion* is often viewed as a separate entity that includes personal spirituality. Koenig suggested that religion is an organized system of beliefs and practices that incorporate a belief in a higher power.

According to Mottram (2007), "A religion can usually be identified by name, for example, Christian, Jewish, Hindu, Islamic, etc., whereas spirituality concerns practices that are person-specific and individualistic in nature" (p. 70). Mottram has explained, "Like other factors that promote health (e.g., exercise), religious involvement and spirituality likely enhance resistance to disease through the interaction of multiple beneficial mediators" (p. 72). With this concept in mind, the impact of religious activities in counselors will be explored to determine if what is believed to be important to the healing of the body can also be beneficial to the healing of the mind.

One goal of this study is to help determine whether there is a relationship between religious activities and/or beliefs of practitioners and their development of compassion fatigue and burnout.

GENDER AND COMPASSION FATIGUE

It is unclear if gender has any bearing on whether or not a practitioner becomes vicariously traumatized or develops compassion fatigue. Freedman, Gluck, Tuval-Mashiach, Brandes, Peri, and Shalev (2002) have suggested that there may be a gender difference. Men are more frequently exposed to combat, mugging, or beatings. Women are more frequently exposed to rape and sexual assault. While the authors did not discuss how practitioners respond to these types of trauma, they definitely concluded that gender has an effect on whether practitioners are more susceptible to certain types of trauma. Women have an increased sensitivity to traumatic stress. Freedman et al. (2002)

conducted a study with 197 participants (93 men and 104 women). The study examined gender differences in response to motor vehicle accidents, burglary, rape and sexual assault, physical injury, death and combat issues. It was determined that there were no differences in gender found" (p. 411). However, Breslau et al found that PTSD was more likely to become chronic in women (as cited in Freedman et al., 2002, p. 407).

PRACTITIONER RESIDENCE AND COMPASSION FATIGUE

In studies of community violence, exposure rates of both victims and witnesses to violence are high (Cunningham, 2004). The manner in which a community responds to traumatic events may identify the resilience of the community. Norris and Stevens (2007) examined how the capacities thought to underlie "community resilience" likewise promote safety, calmness, efficacy, hope, and connectedness (the five essential elements of mass trauma interventions)" (p. 321). Collaboration and traditional values both emphasize social support as a way to create opportunities for collective sharing of ideas, stories, and resources" (Stamm, 1999, p. 149). The concept of community resources linking together to aid the phenomenon of trauma prompted this researcher to examine whether the concept of the same type of social collaboration reduces the risk for compassion fatigue and/or burnout. This researcher was unable to obtain literature that supports or denies whether there is any relationship between compassion fatigue and the community where practitioners are reared.

COUNSELOR OBJECTIVITY AND COMPASSION FATIGUE

In a study examining the resiliency of some practitioners, Bell (2003) suggested that "Counselors who are less stressed had creative and resilient ways of looking at and dealing with the difficult situations at home and at work, such as, (1) having a sense of

competence about coping (This competence is identified as self-efficacy which refers to a belief in the capacity to exercise control over self and environment); (2) maintaining an objective motivation (The most common motivation mentioned had to do with personal experiences, either as a victim of a traumatic event or being cast in the role of a caretaker by their family of origin); (3) resolving personal traumas (Practitioners who resolved their trauma had less stress); (4) drawing on positive role models of coping (Early positive role models of coping emerged as strengths for some practitioners); and (5) having buffering personal beliefs (personal beliefs were a source of strength for some practitioners) " (pp. 518-519).

SUMMARY OF THE LITERATURE

It is not an easy task for some practitioners to listen to the problems, stories, or issues of their clients each day without bearing some form of anguish. Sometimes, as practitioners assist clients, they pay the ultimate price of having the very problems that their clients are struggling with trickle over into their lives. When practitioners have difficulty separating their personal lives from their professional lives, they may fail to utilize empathy. If the information that the clients have relayed to them is of such a great magnitude, the practitioners may become vicariously traumatized by their clients' pain, thereby developing compassion fatigue.

As noted by Fox and Cooper (1998), practitioners are not immune to painful images, thoughts, and feelings that are presented by clients. This study explores the phenomenon of compassion fatigue development in relationship to objectivism and religious activities and beliefs.

Chapter Three

METHODOLOGY

This chapter identifies the methodology that was used in this study. Included in this chapter are the following components: research design, research questions and hypotheses, variables of interest, participants, instrumentation, data analysis plan, and threats to validity.

RESEARCH DESIGN

This project consisted of a descriptive research study Practitioners were surveyed via e-mail. Nonparametric tests were used to analyze the data. Levels of risk for compassion fatigue and burnout in subjects were determined. In addition, their levels of risk for compassion fatigue and burnout were examined for differences based on their levels of objectivism, their religious activities and beliefs, and their selected personal and professional traits. This research design incorporated composite variables. Five composite dependent variables created were included: (1) compassion fatigue, (2) burnout, (3) self, (4) client and families, and (5) work environment. All of these dependent variable groupings were drawn from the *Compassion Fatigue Self-Test for Psychotherapists* instrument. Items on the Compassion Fatigue Self-Test for Psychotherapists are divided into three sections: self, client/families, and work environment. For the purpose of this research, the instrument was scored according to the developer's instruction; however, each section of the instrument (self, client/families, and work environment) was examined, which helped to create the five composite variables. Each composite variable was examined to determine whether any significant differences occurred.

RESEARCH QUESTIONS AND HYPOTHESES

Research Question 1

What levels of risk for compassion fatigue and level of risk for burnout exist in master's level and above practitioners (counselors, social workers, and mental health clinicians) in the southeastern region United States?

Hypothesis 1

Varying levels of risk for compassion fatigue and burnout are present in master's level and above practitioners in the southeastern region in the United States.

Research Question 2

Are the following professional characteristics of practitioners associated with their levels of risk for compassion fatigue or with their levels of risk for burnout: (a) the number of years that they have possessed a master's level degree; (b) their years of experience as a master's level or above practitioner; (c) the hours per week they currently counsel/assist trauma survivors; and (d) their years of experience in counseling/assisting trauma survivors?

Hypothesis 2

One or more of the following professional characteristics of practitioners may in part predict their levels of risk for compassion fatigue and burnout: (a) the number of years that they have possessed a master's level degree; (b) their years of experience as a master's level or above practitioner; (c) whether they currently counsel/assist trauma survivors; and (d) their years of experience in counseling/assisting trauma survivors.

Research Question 3

Are the following personal characteristics of practitioners associated with their levels of risk for compassion fatigue and/or with their levels of risk for burnout: (a) gender; (b) race; (c) whether they are trauma survivors themselves; (d) the type of community where they spent their childhood; (e) whether they regularly participate in leisure activities; (f) their level of objectivity in decision making; and (g) their religious activities and beliefs?

Hypothesis 3

One or more of the following personal characteristics of practitioners are associated with the levels of compassion fatigue and levels of risk for burnout in practitioners: (a) gender (b) race; (c) whether they are trauma survivors themselves; (d) the type of community where they spent their childhood; (e) whether they regularly participate in leisure activities; (f) their level of objectivity in decision making; and (g) their religious activities and beliefs.

VARIABLES

The primary variable of interest in this study was the risk for compassion fatigue in practitioners. The risk for compassion fatigue was determined by the scores of participants on the *CF Self Test for Psychotherapists*. Scores on this instrument for compassion fatigue ranged from 23 or less to 115, with higher scores indicating higher risks for compassion fatigue (Figley, 1995).

A second variable of interest in this study was the risk for burnout in practitioners. The risk for burnout is determined by the scores of participants on the *CF Self Test for Psychotherapists*. The higher scores, the higher the risks for burnout.

The independent variable, objectivism of practitioners (their tendency to base their judgments and beliefs on empirical information and rational considerations), was measured by the *Objectivism Scale*. Scores on this scale ranged from 11 to 55, with higher scores indicating participants were more objective in decision making (Leary et al., 1986).

The independent variable, religious activities and beliefs of practitioners, was measured using a researcher designed scale adapted from the Duke University Religious Index (DUREL); the DUREL. While the DUREL questions were used, only one of the Likert scales was used for all of the questions; therefore, throughout this research study, the DUREL will be referred to as the adapted DUREL. There were two subscales used from this instrument, Subscale 2 (which consists of item 2 on the index) and Subscale 3 (items 3 – 5 on the index). A religious activity score from Subscale 2, ranged from 1 to 6, with lower scores indicating less religious activity, and higher scores indicating that more religious activities were present in the lives of the practitioners. Subscale 1, which identified religious attendance, was not utilized in this project. Subscale 2 and Subscale 3 were reverse scored as recommended by DUREL's instructions (using an adapted Likert scale) and this researcher's recoded scores so that the higher numbers represented more. The scores were grouped into 3 levels, low religious activities, medium religious activities, and high religious activities.

The remaining variables were examined through the responses of participants on the Personal and Professional Information instrument developed for the purpose of this study. Participants' years of experience as master's level and above practitioners were self-reported on the instrument. Whether participants currently counsel/assist trauma

victims were determined by their responses on the instrument and were limited to either *yes* or *no*. Participants' levels of experience in counseling/assisting trauma victims were determined by their responses on the instrument. The number of hours per week that practitioners' counseled/assisted clients was requested and examined. Participants' gender was determined by their responses on the instrument and the responses were limited to *male* or *female*. Participants' race was determined by their responses on the instrument and included the following categories that are used by the United States Census Bureau: American Indian or Alaska Native; Asian; African-American (Black); Hispanic Origin; Native Hawaiian or Other Pacific Islander; Caucasian (White, not Hispanic); or Mixed (Biracial). Participants' age was determined by their responses given on the instrument. Whether participants had survived trauma themselves was determined by their responses on the instrument and the responses were limited to three categories *serious trauma, mild trauma*, or *no trauma*. The communities where participants spent their childhood were determined by their responses on the instrument and included the following categories: rural community; small town; urban community; suburban community; or mixture of communities. The variable of whether participants regularly participated in leisure activities was determined by their responses on the instrument and responses were limited to *yes* and *no*.

PARTICIPANTS

This study collected information from master's level and above practitioners in the southeastern region of the United States. Master's level and above practitioners are more educated and are able to acquire credentials that will allow them to actively work in the areas of trauma, crisis situations, or grief and loss counseling than are helping

professionals with bachelor's degrees. This does mean that some bachelor's level practitioners are not trained to work with trauma survivors; however, for the purpose of this study, master's level and above practitioners were selected. The opportunity to participate in this study was extended to referred practitioners and practitioner's supervisors who have an earned master's degree in social work, counseling, education, or psychology, as well as licensed social workers (LCSWs), licensed counselors (LPCs) and PhD level practitioners working in agencies in the southeastern region of the United States.

PROCEDURE

A convenience sample was used to conduct this study. An e-mail list was obtained from Virginia Beach Social Services, Virginia Beach Community Services Board, regional private counseling practices, Norfolk General Social Work Trauma Burn Unit, Chesapeake Community Services Board, Chesapeake Social Services, Portsmouth Behavioral Center, and other clinical agencies/universities. Once administrators, supervisors, directors, and other helping professionals were contacted via email, they were asked to recommend participants based on the criteria for participants. These recommendations were sent in the form of e-mail addresses. Potential participants were then contacted via e-mail with a request that they participate. In addition, if participants were aware of others with the credentials that this researcher was requesting, he/she referred the e-mail address of other qualified individuals. Instructions were included explaining the details of the research project. A copy of the instructions can be found in at the end of this document, Appendix F. Practitioners who agreed to participate were instructed to select the survey link that opened the instruments, and each participant was

instructed to respond to each question on the survey. Participants also had the opportunity to opt out of the study.

Permissions were granted by Dr. Charles Figley to use the *Compassion Fatigue Self-Test for Psychotherapists*, by Dr. Mark Leary to use the *Objectivism Scale*, and by Dr. Harold G. Koenig to use and adapt the scoring of the *Duke Religion Index* in this research study.

INSTRUMENTATION

Four instruments were used to collect data: The Personal and Professional Information instrument; the Objectivism Scale, the researcher designed scale that was adapted from the Duke University Religion Index (DUREL), and the *Compassion Fatigue Self Test for Psychotherapists (CF Self Test.* These instruments were used to determine whether compassion fatigue or burnout were identifiable in the practitioners' processed information (primarily using feelings or empirical data), and whether the religious activities and beliefs of the practitioners could be contributors to compassion fatigue or burnout.

Personal and Professional Information Instrument

This researcher developed an information sheet to obtain demographic data, as well as to obtain personal and professional information about the practitioners. The questions on the Personal and Professional Information Instrument are as follows: (1) Number of years since you earned your master's degree? (2) Number of years you have been a clinician, social worker, or counselor? (3) Race/ethnicity? (4) Gender? (5) What type of community did you live in during the majority of your childhood, ages 3-19? (6) Do you currently counsel (or work with in a professional setting) clients who have

experienced trauma or have you counseled (or worked in a professional setting) such clients in the past? (7) How many hours a week do you counsel (or work with a professional setting) clients who have experienced trauma (on an average) or have you counseled (or work with in a professional setting) such clients in the past? (8) Number of years you have counseled (or worked with in a professional setting) clients who have experienced trauma? (9) Have you ever been a direct victim of trauma yourself? and (10) Leisure activity? This instruction sheet was posted on Survey Monkey (Appendix F), along with all of the surveys for this research. Survey Monkey is an online software program that is used to create surveys, collect data, and analyze data.

Objectivism Scale

The *Objectivism Scale* is an 11-item self-report instrument that measures individual differences in objectivism – the tendency to base one's judgments and beliefs on empirical information and rational considerations (Leary et al., 1986). According to the validity data, people who placed in the low range on the *Objectivism Scale* vary from the people who scored high in that higher scorers indicated that the subjects had greater objectivity, enjoyed thinking more, relied more on observable facts when making decisions, and placed less emphasis on subjective and intuitive styles of decision making (Leary et al.). The *Objectivism Scale* requires its subjects to respond to each of the 11 items using a 5-point scale labeled as follows: *not at all*, *slightly*, *moderately*, *very*, and *extremely characteristic of me* (Leary et al.). The *Objectivism Scale* is an instrument that can be self-administered, self-scored and self-interpreted, as the instructions were provided with the instrument. In this study, the instruments were scored using *Statistical Package for the Social Sciences (SPSS), Graduate Pack 15.*

The *Objectivism Scale's* 11 items are as follows: (1) I seek as much information as possible before making decisions; (2) I think the answers to most questions in life can be found through careful, objective analysis of the situation; (3) I do not like to be too objective in the way I look at things; (4) Trying to be highly objective and rational does not improve my ability to make good decisions; (5) I see myself as a rational and objective person; (6) After I make a decision, it is often difficult for me to give logical reasons for it; (7) I gather as much information as possible before making decisions; (8) The solution to many problems in life cannot be found through an intellectual examination of the facts; (9) I try to employ a cool-headed, objective approach when making decisions about my life; (10) I am only confident of decisions that are made after careful analysis of all available information; and (11) I tend not to be particularly objective or logical in my approach to life (Leary et al., 1986). Items 3, 4, 6, 8, and 11 are reversed scored. Scores could range from 11 to 55 with higher scores indicating more objectivism.

In a study by Leary, to establish construct validity data, 416 undergraduate students were given the Objectivism Scale, along with the following measures: the *Need for Cognition Scale*, the *Myers-Briggs Type Indicator*, the *Objectivity-Subjectivity Scale*, and the *Self-Consciousness Scale* (Leary et al., 1986). The summary of the research suggested that correlations with other measures provided convergent evidence for the validity of the *Objectivism Scale* (Leary et al.). There were individual results; however, collective results were displayed. The results of the *Need for Cognition*, the *MBTI* (thinking, sensing, and judging), and the public self-consciousness were correlated positively; while feeling, intuition, and perceiving scores on the *MBTI* and with the ad

hoc measure of subjectivism revealed negative correlations (Leary et al.).

The *Need for Cognition* is a 30-item test. The test was designed to measure the level of its participants' ability to engage and enjoy thinking. Compared to people who scored low on the scale, high scorers indicated that they enjoyed thinking, were more likely to enjoy thought provoking jobs, and preferred tasks of a complex nature rather than simple cognitive tasks (Leary et al., 1986). Therefore, this instrument, as expected, correlated positively with Objectivism, $r = .47$, $p < .001$ (Leary et al.).

The *Myers-Briggs Type Indicator* measured the manner in which individuals use judgments and perceptions, as well as individual differences in people. There were eight subscales and 16 discrete types; however, for the purpose of this study, each subscale score was correlated with objectivism (Leary et al., 1986). The subscales were *thinking – feeling; sensing – intuition*; *judging-perceiving*, and *extraversion – introversion*. *Objectivism* correlated positively with the following: *thinking*, *sensing*, and *judging*; however, *Objectivism* did not correlate positively with the following: *feeling*, *intuition*, *perceiving*, *extraversion*, or *introversion* (Leary et al.).

The Adapted Duke Religious Index (DUREL)

The *DUREL* is a five-item survey consisting of the following: (1) How often do you attend church or other religious meetings; (2) How often do you spend time in private religious activities, such as prayer, mediation or *Bible* study; (3) In my life, I experience the presence of the Divine (i.e. God); (4) My religious beliefs are what really lie behind my whole approach to life; (5) I try hard to carry my religion over into all other dealings in my life (Koenig, 1996). Questions from this instrument were adapted to obtain frequency information about whether practitioners have religious beliefs and

whether practitioners engage in religious activities. While the original Likert for the DUREL was not used (due to data entry error), the developer suggested that the data can still produce information if coded appropriately. This researcher followed the coding suggestions, and frequency information was examined, as well as responses, using the three groupings: *low*, *moderate*, and *high* degree of participation and degree of belief.

The original *DUREL* is a brief self-administered measure that was designed to assess the religious involvement of its users. This instrument has been used in a variety of research studies and it has proven construct validity. Storch, Strawser and Storch (2004) investigated a 2-week test-retest reliability of the *DUREL* (the 5-item self-report questionnaire that assesses organizational, nonorganizational, and intrinsic religiosity). In this study, the sample consisted of 20 undergraduate college students, of which 11 of the participants were women and their mean age was 24.7 years (SD=5.0 yr). The findings demonstrated test-retest reliability of the *DUREL* with an intraclass correlation coefficient of .91 (Storch, Strawser, & Storch). The researcher used questions from the original DRUEL to design an instrument to measure religiosity. The adapted version was used to determine whether participants have religious beliefs and engage in religious activities.

CF Self Test for Psychotherapists

The *CF Self Test* was used to evaluate whether participants were at risk for developing compassion fatigue or burnout. The *CF Self Test* is being used in numerous studies across multiple disciplines, including mental health, education, and health care (Figley & Stamm, 1996). The *CF Self-Test for Psychotherapists* is an instrument that is self-administered, and can be self-scored. The instrument could be interpreted by the

individual taking the test, as scoring instructions were also provided with the testing material (Figley, 1995a). In this study, the instrument was scored by the researcher using SPSS. The test listed items that were designed to obtain information about the test taker's experiences and feelings concerning counseling/assisting victims of trauma. The phenomenon of burnout was explored through a series of questions that focuses on the work environment of the practitioner. The estimated time to complete the test was about 3 to 5 minutes.

Often the terms compassion fatigue and burnout are used interchangeably; however, they are not identified as the same according to the professional literature. In contrast to burnout, which emerges gradually and is a result of emotional exhaustion, compassion fatigue can emerge suddenly with little warning (Figley, 1995). The *Self Test for Psychotherapists* was designed to help therapists differentiate between burnout and secondary trauma (Figley).

The inventory consisted of 40 items. The *CF Self Test* required that the test taker responded to items according to a Likert scale, with 1 = Rarely/Never; 2 = At Times; 3 = Not Sure; 4 = Often, and 5 = Very Often. "Compassion fatigue scores were as follows: 26 or less = Extremely low risk; 27 to 30 = Low risk; 31- 35 = Moderate risk; 36 to 40 = High risk; 41 or more = Extremely high risk. The scores for 'burn out' were as follows: 17 – 36 or less = Extremely low risk; 37 – 50 = Moderate risk; 51 – 75 = High risk and 76 – 85 = Extremely high risk" (Figley, 1995, p. 14). This instrument consisted of two subscales, where one subscale identified compassion fatigue, and the other subscale identified burnout. The following items identified compassion fatigue scores: items 1-8; 10-13; 17-26; and 29. The remaining items of the 40- item instrument identified whether

burnout was present in counselors: items 9; 14-16; 27-28; and 30-40. The scores for this instrument were obtained by adding together identified items for each subscale. The scores were grouped into three levels, *low/extremely low risk, moderate risk* and *high/extremely high risk.* The scores for low and extremely low were combined. The scores for high and extremely high were combined.

The *CF Self-Test for Psychotherapists* was developed in 1992. Psychometric properties have been established for this instrument as it has been used in a number of research studies since its conception. The psychometric properties were reported in 1993, and the results yielded favorable results. There is a range of 94 to 96 for the Alpha reliability scores. There was one stable factor that was yielded according to the structural analysis which is characterized by depressed mood in relationship to work accompanied by feelings of fatigue, disillusionment, and worthlessness. The Structural Reliability (stability) of this factor, as indicated by Tucker's Coefficient of Congruence (cc), is 91 (Figley, 1995).

ANALYZING THE DATA

This study was analyzed utilizing the *Statistical Package for the Social Sciences (SPSS), Graduate Package 15.* The independent variables of this study were drawn from the Personal and Professional Information instrument, the researcher designed index adapted from the *Duke Religious Index* (to measure religious activities and beliefs), and from the *Objectivism Scale* (to determine the level of objectivity in decision making of practitioners). The dependent variables were drawn from the *Compassion Fatigue Self Test for Psychotherapists (CF Self Test).* The *CF Self Test* determined whether the risk for compassion fatigue or the risk for burnout was present in the participants. Descriptive

data were reported using Nonparametric Tests to measure the differences and correlations between the dependent variables and the independent variables. All collected data were measured using ordinal data.

The correlation between the independent variables from items in the personal information instrument, the researcher adaption of the *DUREL*, and the *Objectivism Scale* and the dependent variables from items in the *CF Self Test* were observed, using the appropriate correlation coefficient statistical tests. Overall scores using composite variables were created for the researcher adaption of the *DUREL*, the *Objectivism Scale*, and the *CF Self-Test* for each participant. In examining where relationships exist between the independent and dependent variables, the Mann Whitney, the Kruskal Wallis, the Spearman R Correlation Coefficient, and additional appropriate correlation coefficient were used to determine whether the risk for compassion fatigue and the risk for burnout were more prevalent with the presence of different identified independent variables.

INTERNAL AND EXTERNAL VALIDITY THREATS

There were two types of validity threats in this research project: external validity threats and internal validity threats. The ability to generalize the results of an experiment to individuals in a population outside of the experimental setting is considered to suggest external validity (Ocher, 2005). A circumstance that limits the ability to generalize is considered as a threat to external validity (Orcher).

Internal validity was important to this study because it helped with identifying whether the following components were attributed to the practitioner's abilities to reduce their risks of developing compassion fatigue or burnout: (a) gender (b) race; (c) previous trauma, (d) the community where they spent their childhood; (e) leisure activities; (f)

their level of objectivity in decision making; or (g) their religious activities and beliefs. Internal validity is basically the extent to which all extraneous influences, other than the variable(s) under study, have been accounted for (controlled) and the observed effect can be attributed to this variable (s) (also called the independent or experimental variable) (Drew, Hardman & Hosp, 2008). Internal validity determined the credibility of the study.

The populations in this study were master's level and above practitioners in the southeastern region in the United States. The practitioners who decided to complete and return the survey may be different from those who do not, but there was no way to make that determination. As a result, only tentative generalizations regarding the results may be made to the entire population. In addition, practitioners are somewhat unique clinicians in that they practice in various clinical settings, and they serve clients in different capacities. As a result, only tentative generalization of the results was made to other clinical practitioners throughout the southeastern region of United States. The results of this study implicated that a national study would be valuable to the clinical helping profession.

A threat to this study was subject effects. Subject effects may have occurred in this research, meaning practitioners may have responded in a way such that they are not identified as being traumatized. Practitioners view themselves as professionals and to admit that they are having problems with "*professional separation,*" may be embarrassing to some practitioners. The term professional separation means, the ability of a practitioner to separate professional matters from personal matters.

Chapter 4

RESULTS

This study examined whether the following traits of practitioners are associated with their development of compassion fatigue or burnout: (a) gender, (b) race, (c) years and type of clinical experience, (d) how many hours/week they counsel/assist trauma survivors, (e) whether they are objective or subjective decision makers, (f) whether they engage in leisure activities, (g) history of trauma (childhood/adult), (h) region (urban/rural) of upbringing, and (i) religious activities and beliefs. This chapter reports the results of the study, beginning with a summary of demographic information about the study practitioners. The results for each of the instruments used in this research are presented, to include the ten items listed in the Personal and Professional Instrument, the Compassion Fatigue Self-Test for Psychotherapist, the Objectivism Scale, and the researcher adaption of the Duke University Religion Index. Results of the statistical analyses used to test the hypotheses associated with each of the research questions are then presented in answer to each of the research questions. Pertinent information from the analyses is presented in tabular form and figures.

DEMOGRAPHICS

Responses for Personal and Professional Information Instrument

The surveyed population for this study consists of a convenience collection of master's level and above practitioners in a southeastern region of the United States. The practitioners in this study consist of counselors, social workers, and mental health clinicians who have earned a master's degree in counseling (mental health and school counseling), social workers (senior workers, supervisors, and directors), licensed counselors (LPCs), licensed social workers (LCSWs), and PhD level practitioners,

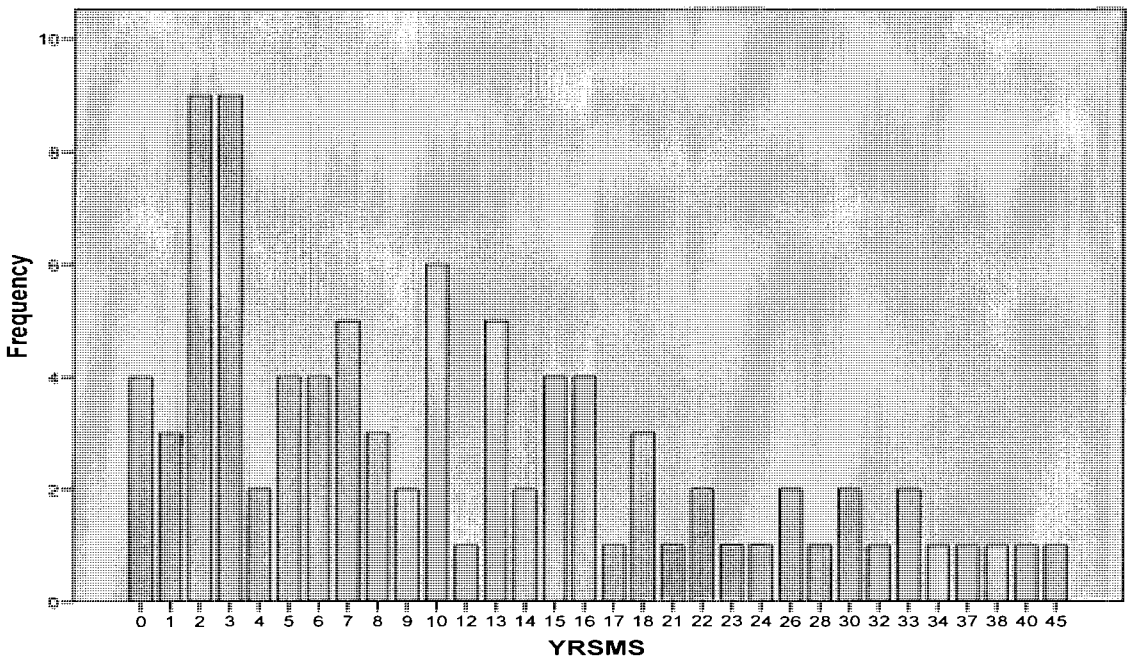
referred to as practitioners throughout this chapter.

A convenience sample was drawn from 113 regional master's level and above practitioners. Of the 113 e-mailed invitations, eighty-nine practitioners completed the survey in the allotted time (ten days), which equates to 78.76%.

Because this was a convenience sample, respondents were not necessarily representative of the demographics of the overall population of practitioners. Therefore, the results of this study may not be generalizable to the population of master's level and above practitioners. However, this research does provide information that can be used to help practitioners, and may indicate potential implications for further study using a broader sampling pool.

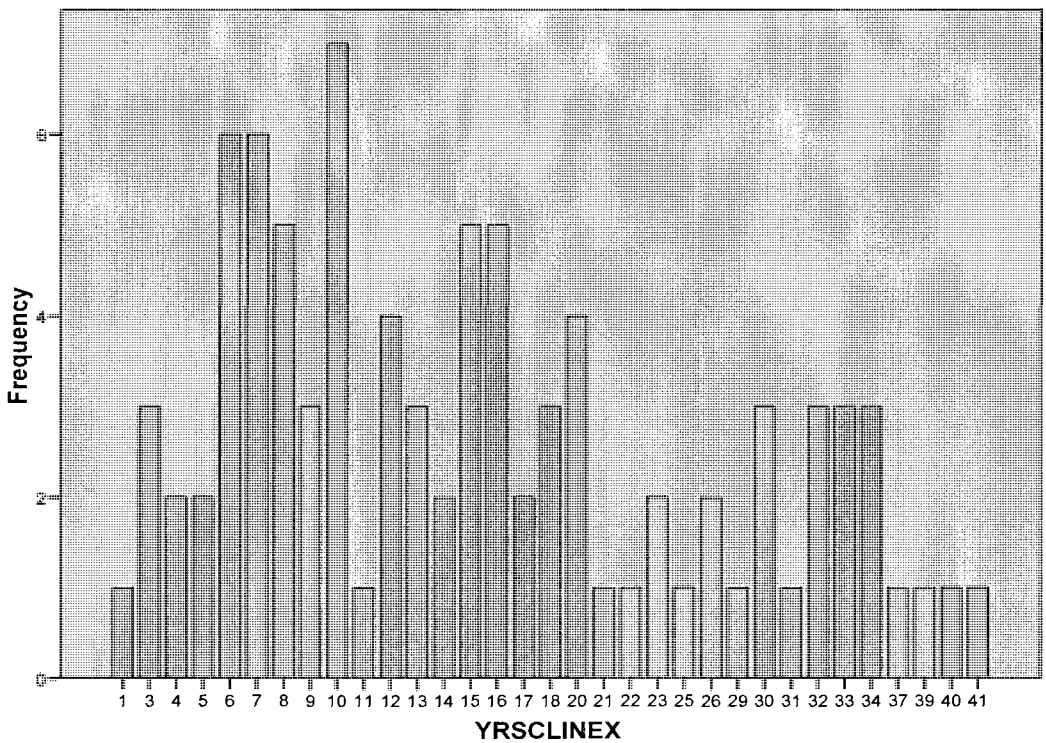
Practitioners were asked to indicate the number of years in which they have held a master's degree. Descriptive data for practitioner's educational levels are presented in Figure 1.

Figure 1
Number of Years with Master's Degree



Practitioners reported the number of years that they have held a master's degree. This researcher is interested in whether or not the seasoned practitioners (more years with a master's degree) are more or less at risk for compassion fatigue/burnout than novice practitioners (new to the helping profession). Most practitioners reported zero to 16 years (highest frequencies are two and three years) of experience. Descriptive data for practitioners' clinical experience are presented in Figure 2.

Figure 2
Years of Clinical Experience



The results indicate that clinical experience range from one to 41 years. The most frequently reported number of years of experience was 10 (7.9 %). There were more people with 10 years of clinical experience. Most practitioners reported between six and 16 years of clinical experience.

Practitioners were asked to identify their ethnicity as Asian, Black, Hispanic, Native Hawaiian or Other Pacific Islander, White (not Hispanic), Biracial and Other. No practitioners identified themselves as Native Hawaiian, Other Pacific Islander or Other. Descriptive data for practitioners' responses are presented in Table 1.

Table 1
Race/Ethnicity of Practitioners

Response	Frequency	Percent
Asian	3	3.4
Black	43	48.3
Hispanic	1	1.1
White (not Hispanic)	41	46.1
Biracial	1	1.1
Total	89	100.0

These results indicate that 48.3% of the practitioners in this study were Black (African American) and 46.1% were White (not Hispanic). These two populations represent almost 94% of the population.

Practitioners reported their gender; the options were *male* or *female*. This researcher was interested in examining whether an individual's gender is associated with the risk for practitioners to encounter compassion fatigue/burnout.

Descriptive data for practitioners' gender are presented in Table 2.

Table 2
Gender of Practitioners

Response	Frequency	Percent
Male	21	23.6
Female	68	76.4
Total	89	100.0

Over three fourths of the practitioners in this study were females. There were 21 males who participated in this study.

The practitioners identified the type of community in which they lived from ages three to 19 years. The community choices were rural, small town, urban, suburban, and mixed. The largest group of practitioners, 40 (44.9%), lived in urban communities. The second largest group, 20 (22.5%), of practitioners lived in suburban communities. Descriptive data for practitioners' responses are presented in Table 3.

Table 3
Type of Community from Ages 3-19

Response	Frequency	Percent
Rural	11	12.4
Small Town	12	13.5
Urban	40	44.9
Suburban	20	22.5
Mixed	6	6.7
Total	89	100.0

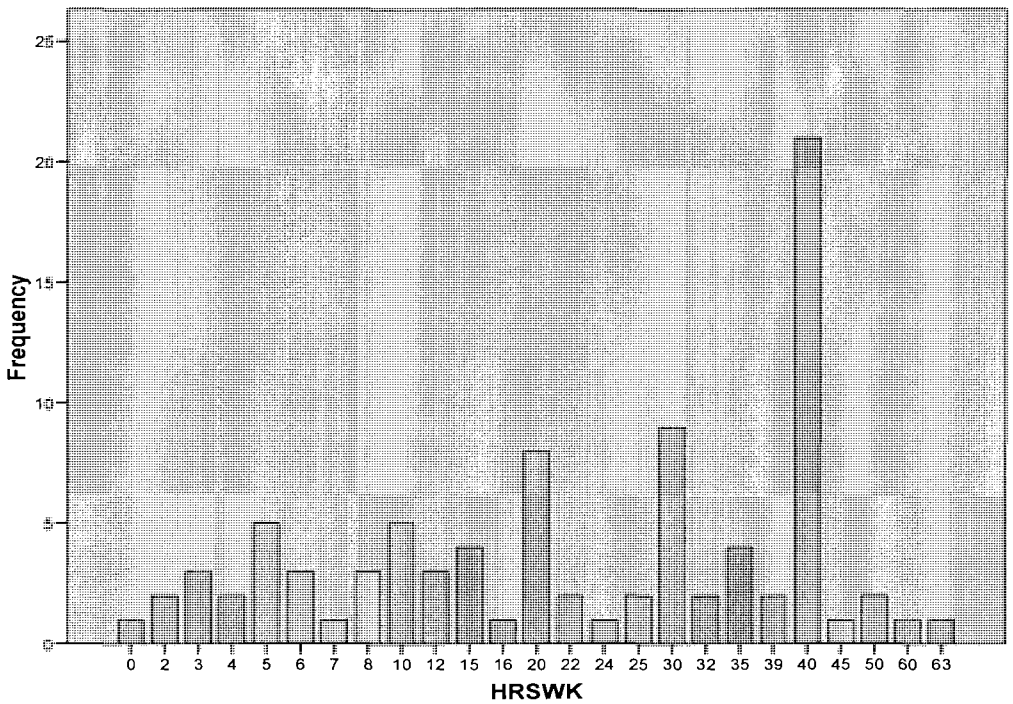
The practitioners reported whether or not they worked with trauma survivors. Although the survey package was intentionally sent to at least master's level and above practitioners with trauma clinical experience, two (2.2 %) reported that they had no experience in working with trauma survivors; the remaining practitioners consisted of 87 (97.8%) individuals who responded yes to having experience working with trauma survivors. Descriptive data for practitioners' responses are presented in Table 4.

Table 4
Experience Working With Trauma Survivors

Response	Frequency	Percent
Yes	87	97.8
No	2	2.2
Total	89	100.0

Practitioners reported the number of hours each week spent counseling/assisting trauma survivors. Descriptive data for practitioners' responses are presented below in Figure 3.

Figure 3
Hours per Week Working with Trauma Survivors

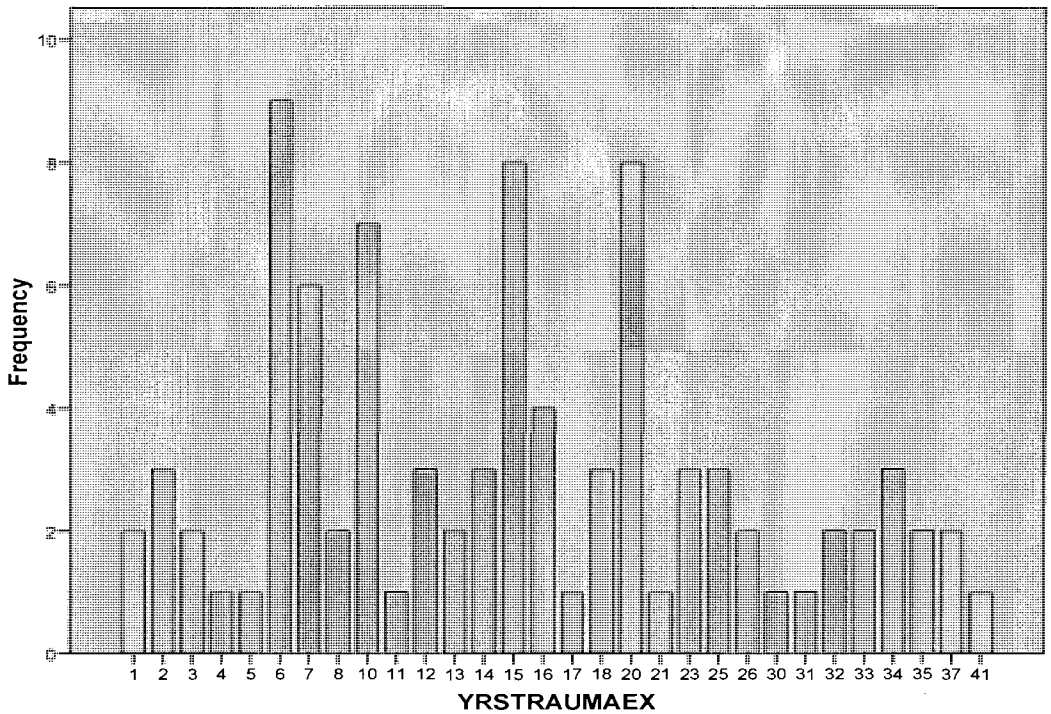


The highest frequency occurred among practitioners who worked 40 hours per week, 21 (23.6%), helping trauma survivors. The highest range occurred between 20 and 40 hours per week. Additional data for this variable can be viewed in Table 3.

Practitioners reported the number of years of trauma experience in order to examine whether there is any difference between practitioners with more years of trauma experience and those with fewer years of trauma experience.

Descriptive data for practitioners' responses are presented in Figure 4.

Figure 4
Years of Experience Working With Trauma Survivors



The years of trauma experience reported range from one to 41. Most practitioners reported between six and 20 years of experience.

Practitioners reported whether or not they had been victims of trauma. A total of 21 (23.6%) of the 89 practitioners reported experiencing "serious trauma," 29 (32.6%) experienced "mild trauma," and 39 (43.8%) reported "no trauma." These findings were used to identify whether trauma in a practitioner's history increases the risk for compassion fatigue or the risk for burnout. Descriptive data for practitioners' responses are presented below in Table 5.

Table 5
Victims of Trauma

Response	Frequency	Percent
Serious Trauma	21	23.6
Mild Trauma	29	32.6
No Trauma	39	43.8
Total	89	100.0

Practitioners reported whether or not they incorporate leisure into their weekly schedule. Seventy (78.7%) practitioners reported that they incorporate leisure into their weekly schedule. As shown in Table 6, only 19 (21.3%) of the 89 practitioners do not incorporate leisure into their weekly schedule. Descriptive data for practitioners' responses are presented below in Table 6.

Table 6
Incorporates Leisure into Schedule

Response	Frequency	Percent
Yes	70	78.7
No	19	21.3
Total	89	100.0

Scoring Responses for the Objectivism Scale

Practitioners completed an 11- item Likert instrument, *Objectivism Scale*. The *Objectivism Scale* measures individual differences in objectivism, which identifies the

manner in which practitioners make decisions. The Objectivism Scale requested practitioners respond to the following items: (1) I seek as much information as possible before making decisions; (2) I think the answers to most questions in life can be found through careful objective analysis of the situation; (3) I do not like to be too objective in the way I look at things; (4) Trying to be highly objective and rational does not improve my ability to make good decisions; (5) I see myself as a rational and objective person; (6) After I make a decision, it is often difficult for me to give logical reasons for it; (7) I gather as much information as possible before making decisions; (8) The solution to many problems in life cannot be found through an intellectual examination of the facts; (9) I try to employ a cool-headed, objective approach when making decisions about my life; (10) I am only confident of decisions that are made after careful analysis of all available information, and (11) I tend not to be particularly objective or logical in my approach to life. Descriptive data for each item on the Objectivism Scale are presented below in Table 7.

Table 7
Descriptive Results- Responses for Objectivism Scale

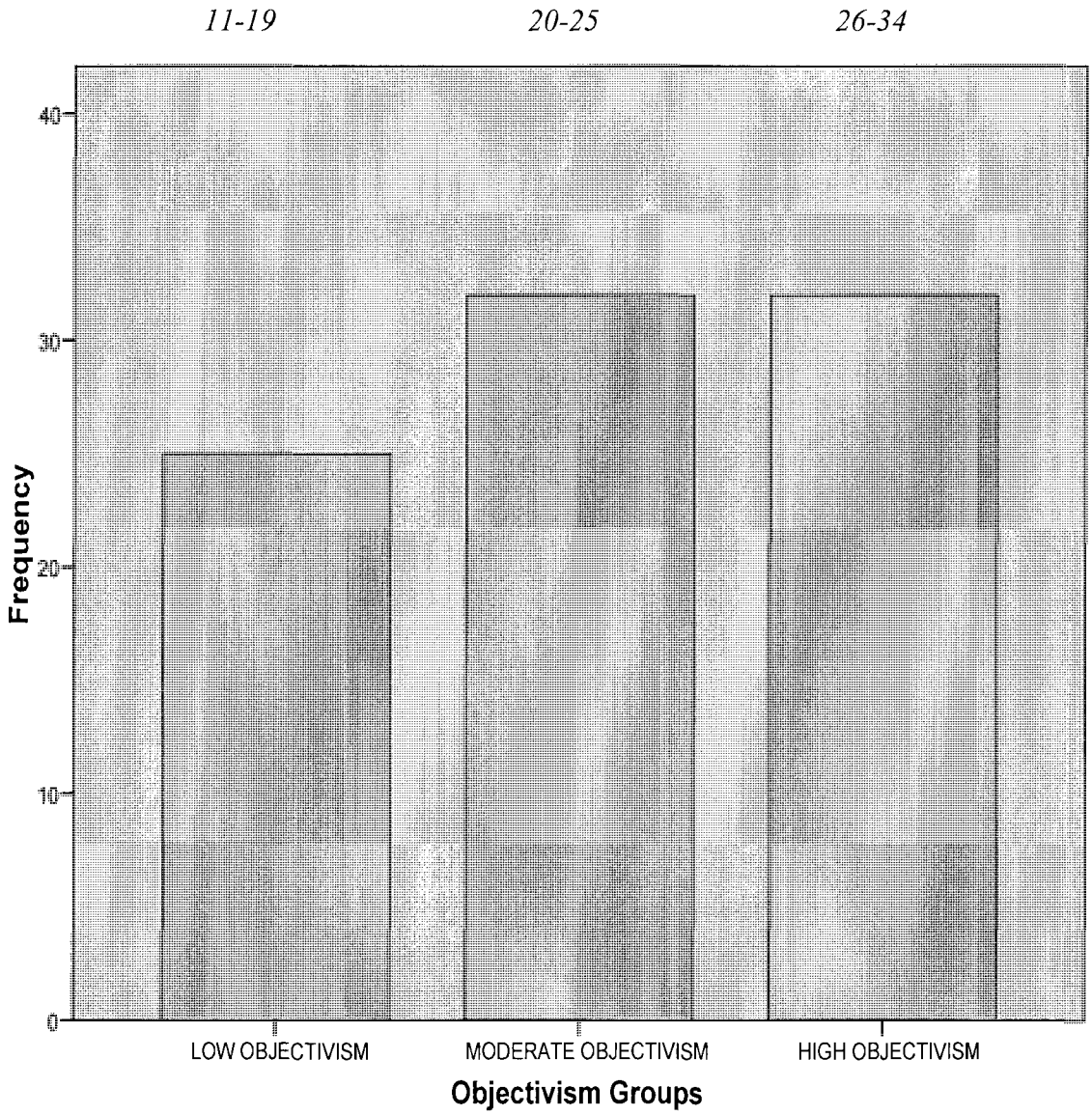
Item #	Not At All	Slightly	Moderately	Very	Extremely
1			16 (18.0%)	38 (42.7%)	35 (39.3%)
2		3 (3.4%)	28 (31.5%)	39 (43.8%)	19 (21.3%)
3	21 (23.6%)	25 (28.1%)	27 (30.3%)	11 (12.4%)	5 (5.6%)
4	39 (43.8%)	18 (20.2%)	27 (30.3%)	2 (2.2%)	3 (3.4%)
5		3 (3.4%)	17 (19.1%)	42 (47.2%)	27 (30.3%)
6	60 (67.4%)	19 (21.3%)	8 (9.0%)	1 (1.1%)	1 (1.1%)
7			17 (19.1%)	36 (40.4%)	36 (40.4%)
8	19 (21.3)	19 (21.3)	31 (34.8%)	15 (16.9)	5 (5.6%)
9		1 (1.1%)	17 (19.1%)	42 (47.2%)	29 (32.6%)
10	2 (2.2%)	11 (12.4%)	28 (31.5%)	33 (37.1%)	15 (16.9%)
11	38 (42.7%)	16 (18.0%)	24 (27.0%)	9 (10.1%)	2 (2.2%)

The highest frequency occurred in item six (67.4%); practitioners reported that they do not have a difficult time giving a logical reason when making decisions.

Objectivism scores were grouped into three levels, *low objectivism*, *moderate*

objectivism and *high objectivism*. Descriptive data of practitioners' responses are presented below in Figure 5

Figure 5
Frequencies of Three Level Groups



Moderate objectivism and high objectivism are equal in frequencies, 32 (36%). Twenty-five (28.1%) practitioners scored in the low range on the objectivism scale.

Scoring Responses for the Researcher Adaption of the DUREL

The Practitioners completed an adapted version of the DUREL. The researcher

designed adaptation of the DUREL was used to measure individual differences of responses to items which identifies religious activities (adapted Subscale 2) and religious beliefs (adapted Subscale 3). The researcher adaption requested practitioners respond to the following items: (1) How often do you attend church or other religious meetings; (2) How often do you spend time in private religious activities, such as prayer, meditation or Bible study; (3) In my life, I experience the presence of the Divine (i.e. God); (4) My religious beliefs are what really lie behind my whole approach to life; and (5) I try hard to carry my religion over into all other dealings in life.

Descriptive data for item two on the researcher adaption of the DUREL are presented in Table 8.

Table 8
How often do you spend time in private religious activities, such as prayer, meditation or Bible Study?

Responses	Frequency	Percent
More than once a week	52	58.4%
Once a week	4	4.5%
A few times a month	7	7.9%
A few times a year	9	10.1%
Once a year or less	9	10.1%
Never	19	21.3%
Total	89	100.0

Fifty-two (58.4%) practitioners reported "more than once a week;" four (4.5%) reported "once a week;" seven (7.9%) reported "a few times a month;" nine (10.1%) reported "a few times a year;" nine (10.1%) reported "once a year or less;" and 19 (21.3%) reported never.

Descriptive data for item three on the adapted DUREL are presented in Table 9.

Table 9
In my life, I experience the presence of the Divine (i.e., God).

Responses	Frequency	Percent
More than once a week	60	67.4%
Once a week	7	7.9%
A few times a month	4	4.5%
A few times a year	9	10.1%
Once a year or less	2	2.2%
Never	7	7.9%
Total	89	100.0

Sixty (67.4%) practitioners reported "more than once a week;" seven (7.9%) reported "once a week;" four (4.5%) reported "a few times a month;" nine (10.1%) reported "a few times a year;" two (2.2%) reported "once a year or less;" and seven

(7.9%) reported "never."

Descriptive data for item four on the adapted DUREL are presented in Table 10.

Table 10
My religious beliefs are what really lie behind my whole approach to life.

Responses	Frequency	Percent
More than once a week	61	68.5%
Once a week	3	3.4%
A few times a month	5	5.6%
A few times a year	4	4.5%
Once a year or less	3	3.4%
Never	13	14.6%
Total	89	100.0

Sixty-one (68.5%) practitioners reported "more than once a week;" three (3.4%) reported "once a week;" five (5.6%) reported "a few times a month;" four (4.5%) reported "a few times a year;" three (3.4%) reported "once a year or less;" and 13 (14.6%) reported "never."

Descriptive data for item five on the adapted DUREL are presented below in Table 11.

Table 11
I try hard to carry my religion over into all other dealings in life.

Responses	Frequency	Percent
More than once a week	55	61.8%
Once a week	2	2.2%
A few times a month	7	7.9%
A few times a year	4	4.5%
Once a year or less	2	2.2%
Never	19	21.3%
Total	89	100.0

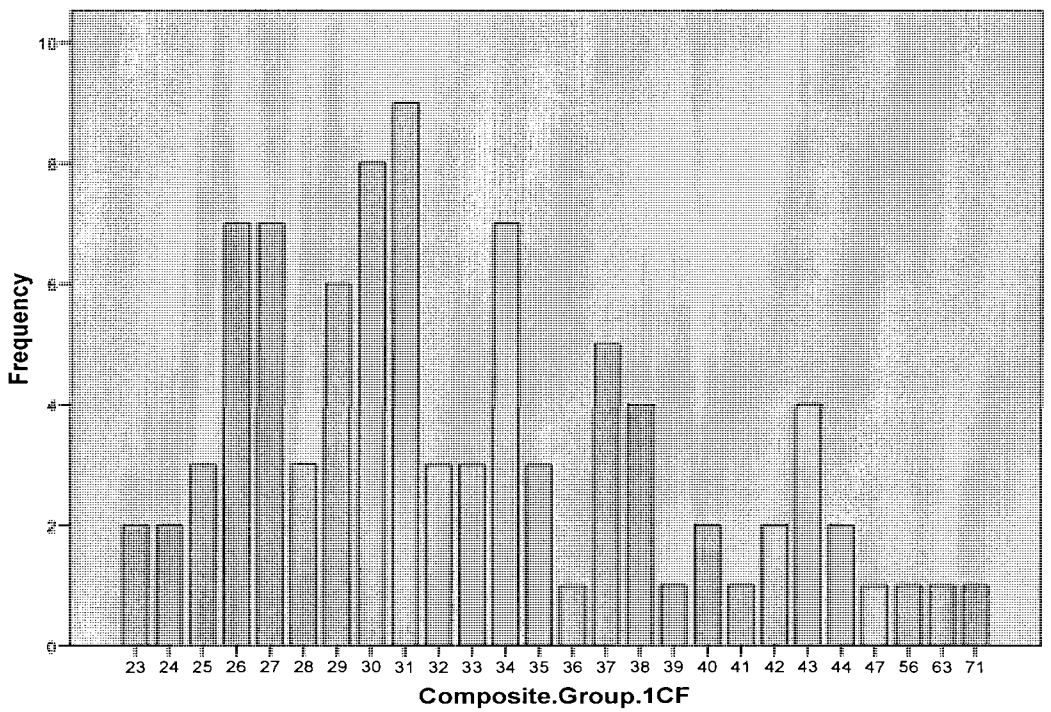
Fifty-five (61.8%) practitioners reported "more than once a week;" two (2.2%) reported "once a week;" seven (7.9%) reported "a few times a month;" four (4.5%) reported "a few times a year;" two (2.2%) reported "once a year or less;" and 19 (21.3%) reported never.

Scoring Responses for the Compassion Fatigue Survey

Practitioners were instructed to complete a 40-item survey, *Compassion Fatigue Self-Test for Psychotherapists*. Research question one of this study asked, "What level of risk for compassion fatigue and level or risk for burnout exist in master's level and above

practitioners in a southeastern region of the United States?" This section examines the risk for compassion fatigue. For the purpose of this research, scores were grouped into three levels, *Low/Extremely Low Risk, Moderate Risk,* and *High/Extremely High Risk.* The highest frequencies occurred between the ranges of 26 to 34 for the practitioners that responded to the compassion fatigue instrument, which is a score within the moderate risk range. Frequencies of practitioner's responses are presented below in Figure 6.

Figure 6
Compassion Fatigue in Practitioners



Practitioners completed a 40- item Likert scale for compassion fatigue. Practitioners were requested to respond to each of the 40 items identifying characteristics that best describe their current situation. Each response to the 40 item survey will be evaluated. The responses to items that identify the risk for compassion fatigue are listed in this section. The twenty-three items that assess compassion fatigue are 1 – 8, 10 – 13, 17 – 26, and item 29. Frequencies of practitioner's responses to item one are presented in

Table 12.

Table 12
I force myself to avoid certain thoughts or feelings that remind me of a frightening experience.

Response	Frequency	Percent
Rarely/Never	52	58.4
At times	30	33.7
Not Sure	3	3.4
Often	4	4.5
Total	89	100.0

Practitioners reported whether they forced themselves to avoid certain thoughts or feelings that remind them of a frightening experience. A total of 52 (58.4%) reported "rarely/never" and 30 (33.7%) responded, "at times."

In response to item two, practitioners reported whether they avoid certain activities or situations because they remind them of a frightening experience. Frequency of practitioner's responses to item two are presented below in Table 13.

Table 13
I find myself avoiding certain activities or situations because they remind me of a frightening experience.

Response	Frequency	Percent
Rarely/Never	56	62.9
At Times	29	32.6
Not Sure	1	1.1
Often	3	3.4
Total	89	100.0

Fifty-six practitioners reported "rarely/never" and 29 (32.6%) practitioners reported "at times."

Frequency of practitioner's responses to item three, "I have gaps in my memory about frightening events," are presented below in Table 14.

Table 14
I have gaps in my memory about frightening events.

Response	Frequency	Percent
Rarely/Never	76	85.4
At Times	10	11.2
Not Sure	3	3.4

Total	89	100.0

According to the data in Table 14, the majority, seventy-six out of 89 practitioners (85.4%), reported that they do not have gaps in their memory about frightening events. Of the 89 practitioners, only 10 responded "at times," and three that responded "not sure."

Practitioners reported how often they felt estranged from others. A total of 57 (64.0%) of the practitioners reported that they "rarely/never" and 30 (33.7%) responded, "at times." Frequency data are listed below in Table 15.

Table 15
I feel estranged from others.

Response	Frequency	Percent
Rarely/Never	57	64.0
At Times	30	33.7
Often	2	2.2
Total	89	100.0

Practitioners reported how often they have difficulty falling or staying asleep. A total of 39 (43.8%) of the practitioners reported that they "rarely/never," 36 (40.4%) responded, "at times," and nine practitioners responded that they "often" have difficulty falling or staying asleep. Five practitioners responded "very often" to this question. Frequency data for responses to item five are listed below in Table 16.

Table 16
I have difficulty falling or staying asleep.

Response	Frequency	Percent
Rarely/Never	39	43.8
At Times	36	40.4
Often	9	10.1
Very Often	5	5.6
Total	89	100.0

Practitioners reported how often they had outbursts of anger or irritability with little provocation. A total of 60 (67.4%) of the practitioners reported "rarely/never;" 24 (27%) responded, "at times," and five practitioners responded that they often have outbursts of anger or irritability with little provocation. Frequency data for the responses to item six are listed below in Table 17.

Table 17
I have outbursts of anger or irritability with little provocation.

Response	Frequency	Percent
Rarely/Never	60	67.4
At Times	24	27.0

Often	5	5.6
Total	89	100.0

Item seven asked how often practitioners startle easily. A total of 47 (52.8%) practitioners reported "rarely/never," 27 (30.3%) reported "at times," 13 (14.6%) practitioners reported "often," and the final 2 (2.2%) reported "very often." Frequency data for the responses are listed below in Table 18.

Table 18
I startle easily.

Response	Frequency	Percent
Rarely/Never	47	52.8
At Times	27	30.3
Often	13	14.6
Very Often	2	2.2
Total	89	100.0

Item eight requested a response to the following, "While working with a victim, I have thought about violence against the perpetrator." Frequency data for the responses are listed below in Table 19.

Table 19
While working with a victim, I have thought about violence against the perpetrator.

Response	Frequency	Percent
Rarely/Never	66	74.2
At Times	21	23.6
Often	2	2.2
Total	89	100.0

A total of 66 (74.2%) practitioners reported "rarely/never," 21 (23.6%) responded, "at times," and 2 practitioners responded that they often had thoughts about the perpetrator while working with the victim.

The practitioners were asked how often they had flashbacks connected to their clients. Frequency data for the responses are listed below in Table 20.

Table 20
I have had flashbacks connected to my clients.

Response	Frequency	Percent
Rarely/Never	69	77.5
At Times	17	19.1
Not Sure	1	1.1
Often	2	2.2

Total	89	100.0

A total of 69 (77.5%) of the practitioners reported "rarely/never," 17 (19.1%) responded, "at times;" one practitioner (1.1%) responded, "not sure," and 2 practitioners responded "often."

The practitioners in this study were asked to identify whether they have had first-hand experience with traumatic events in their adult life. Frequency data for the responses are listed in Table 21.

Table 21
I have had first-hand experience with traumatic events in my adult life.

Response	Frequency	Percent
Rarely/Never	44	49.4
At Times	40	44.9
Often	3	3.4
Very Often	2	2.2
Total	89	100.0

A total of 44 (49.44%) of the practitioners reported "rarely/never," 40 (44.9%) responded "at times," and three practitioners responded that they *often* have had first-hand experience with traumatic events in their adult life, and two practitioners responded "very often."

Practitioners reported how often they had first-hand experience with traumatic

events in their childhood. Frequency data for the responses are listed in Table 22.

Table 22
I have had first-hand experience with traumatic events in my childhood.

Response	Frequency	Percent
Rarely/Never	41	46.1
At Times	34	38.2
Not Sure	2	2.2
Often	10	11.2
Very Often	2	2.2
Total	89	100.0

A total of 41 (46.1%) of the practitioners reported "rarely/never," 34 (38.2%) responded, "at times," and two practitioners responded that they were "not sure," and 10 practitioners "often" have had first-hand experience with traumatic events in their childhood, and two practitioners responded "very often."

Practitioners reported how often they need to "work-through" a traumatic experience in their life. Frequency data for the responses are listed in Table 23.

Table 23
I have thought that I need to "work-through" a traumatic experience in my life.

Response	Frequency	Percent
Rarely/Never	49	55.1
At Times	27	30.3
Not Sure	2	2.2
Often	10	11.2
Very Often	1	1.1
Total	89	100.0

A total of 49 (55.1%) of the practitioners responded "rarely/never," 27 (30.3%) responded, "at times," and two practitioners responded "not sure," and 10 practitioners "often" have had first-hand experience with traumatic events in their childhood, and one practitioner responded "very often."

Item 17 requested a response to the following, "I am frightened of things a client has said or done to me." Frequency data for the responses are listed in Table 24.

Table 24
I am frightened of things a client has said or done to me.

Response	Frequency	Percent
Rarely/Never	73	82.0

At Times	16	18.0
Total	89	100.0

A total of 73 (82.0%) of the practitioners reported "rarely/never," 16 (18.0%) responded "at times."

Item 19 on requested a response to the following, "I experience troubling dreams similar to a client of mine." Frequency data for the responses are listed in Table 25.

Table 25
I experience troubling dreams similar to a client of mine.

Responses	Frequency	Percent
Rarely/Never	83	93.3
At Times	5	5.6
Often	1	1.1
Total	89	100.0

Practitioners reported how often experienced troubling dreams similar to those clients described. A total of 83 (93.3%) of the practitioners reported "rarely/never," five (5.6%) responded, "at times," and one responded "often."

Item 19 requested a response to the following, "I have experienced intrusive thoughts of sessions with especially difficult clients." Frequency data for the responses are listed in Table 26.

Table 26
I have experienced intrusive thoughts of sessions with especially difficult clients.

Response	Frequency	Percent
Rarely/Never	61	68.5
At Times	26	29.2
Often	2	2.2
Total	89	100.0

A total of 61 (68.5%) of the practitioners reported "rarely/never," 26 (29.2%) responded "at times," only two practitioners responded "often."

Item 20 requested a response to the following, "I have suddenly and involuntarily recalled a frightening experience while working with a client." Frequency data for the responses are listed in Table 27.

Table 27
I have suddenly and involuntarily recalled a frightening experience while working with a client.

Responses	Frequency	Percent
Rarely/Never	82	92.1
At Times	7	7.9
Total	89	100.0

A total of 82 (92.1%) of the practitioners reported "rarely/never," seven (7.9%) practitioners that responded, "at times." There were no other responses to this item.

Item 21 requested a response to the following, "I am preoccupied with more than one client." Frequency data for the responses are listed in Table 28.

Table 28
I am preoccupied with more than one client.

Response	Frequency	Percent
Rarely/Never	59	66.3
At Times	22	24.7
Often	5	5.6
Very Often	3	3.4
Total	89	100.0

The majority of the practitioners, 59 (66.3%), responded "rarely/never," 22 (24.7%) responded, "at times," five practitioners responded "often," and three responded "very often."

Item 22 on requested a response to the following, "I am losing sleep over a client's traumatic experience." Frequency data for the responses are listed in Table 29.

Table 29
I am losing sleep over a client's traumatic experiences.

Response	Frequency	Percent
Rarely/Never	77	86.5
At Times	11	12.4
Often	1	1.1
Total	89	100.0

A total of 77 (86.5%) reported "rarely/never," eleven practitioners responded "at times," and one participant responded "often."

Item 23 requested a response to the following, "I have thought that I might have been infected by the traumatic stress of my clients." Frequency data for the responses are listed in Table 30.

Table 30
I have thought that I might have been "infected" by the traumatic stress of my clients.

Response	Frequency	Percent
Rarely/Never	69	77.5
At Times	17	19.1
Often	3	3.4
Total	89	100.0

A total of 69 (77.5%) reported "rarely/never," 17 (19.1%) responded "at times." The remaining three practitioners responded "often."

Item 24 requested a response to the following, "I remind myself to be less connected about the well-being of my clients." Frequency data for the responses are listed in Table 31.

Table 31
I remind myself to be less connected about the well-being of my clients.

Response	Frequency	Percent
Rarely/Never	53	59.6
At Times	32	36.0
Not Sure	1	1.1
Often	3	3.4
Total	89	100.0

A total of 53 (59.6%) reported "rarely/never," 32 (36.0%) practitioners responded "at times;" and one participant responded "not sure." The remaining one participant responded "often."

Item 25 requested that practitioners identify whether they have felt trapped by their work as a therapist. Frequency data for the responses are listed in Table 32.

Table 32
I have felt trapped by my work as a therapist.

Response	Frequency	Percent
Rarely/Never	62	69.7
At Times	22	24.7
Not Sure	1	1.1
Often	3	3.4
Very Often	1	1.1
Total	89	100.0

A total of 62 (69.7%) reported "rarely/never," 22 (24.7%) responded "at times;" and one participant responded "not sure," three practitioners responded "often," and the remaining one participant responded "very often."

Item 26 requested a response to whether practitioners had felt a sense of hopelessness associated with working with clients. Frequency data for the responses are listed in Table 33.

Table 33
I have felt a sense of hopelessness associated with working with clients.

Response	Frequency	Percent
Rarely/Never	38	42.7

At Times	47	52.8
Often	4	4.5
Total	89	100.0

A total of 38 (42.7%) reported "rarely/never," 47 (52.8%) responded "at times," and the remaining four practitioners responded "often."

Item 29 is the final item on the compassion fatigue instrument that identifies a practitioner's risk for developing compassion fatigue; practitioners were requested to identify whether they had been in danger working with therapy clients. Frequency data for the responses are listed in Table 34.

Table 34
I have been in danger working with therapy clients.

Response	Frequency	Percent
Rarely/Never	51	57.3
At Times	34	38.2
Not Sure	1	1.1
Often	3	3.4
Total	89	100.0

A total of 51 (57.3%) reported "rarely/never," 34 (38.2%) responded "at times," one practitioner responded "not sure," and the remaining four practitioners responded "often."

This researcher examined the dependent variable, *compassion fatigue* as it correlates with *burnout*. There is a statistical significance as identified in the Spearman

Correlation test in Table 35. The statistical value of significance for this project is $p <$ .05. The p-value identified below, $p = .000$. Since $p = .000$ is less than $p < .05$, the risk for compassion fatigue does exist in practitioners.

Table 35
Compassion Fatigue

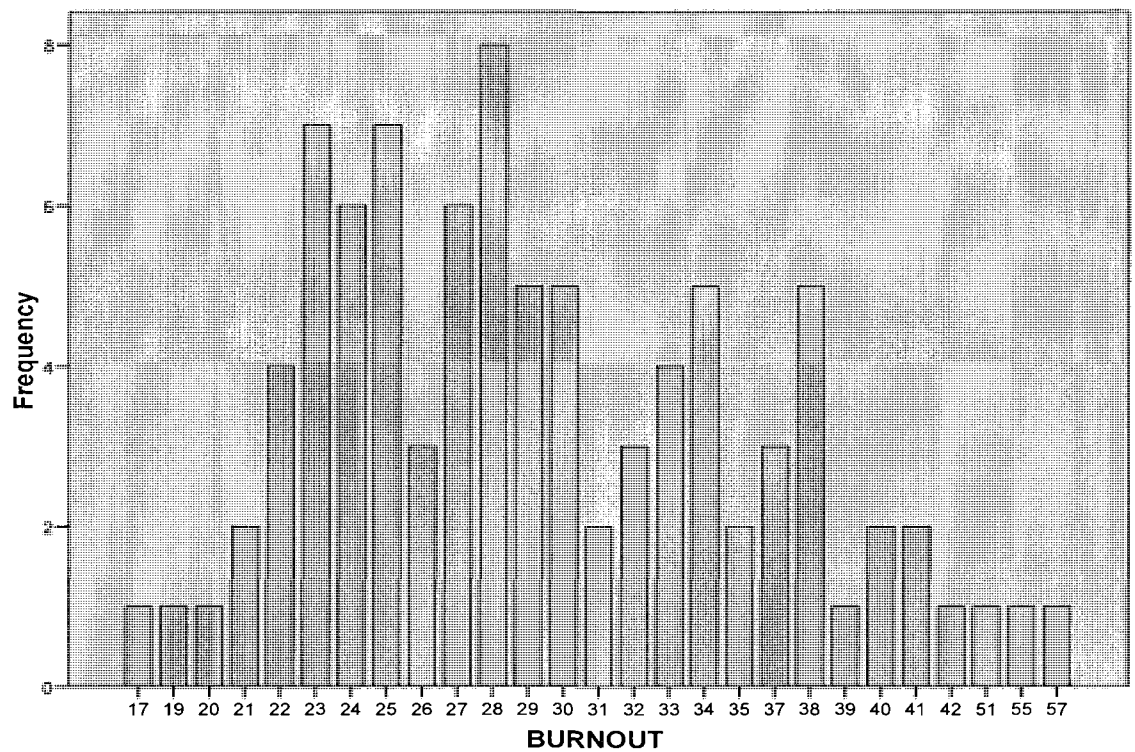
		Value	Asymp. Std. Error(a)	Approx. T(b)	Approx. Sig.
Ordinal by Ordinal	Spearman Correlation	.599	.074	6.976	.000(c)

Scoring Responses for Burnout

Practitioners were instructed to complete a 40- item instrument, *Compassion Fatigue Self-Test for Psychotherapists*.There were 17 items that identify the risks for *burnout*. Research question one of my study asked, "What level of risk for compassion fatigue and level or risk for burnout exist in master's level and above practitioners in a southeastern region of the United States?" This section examines the risk for *burnout*. For the purpose of this research *burnout* was grouped into 3 levels, *Low/Extremely Low Risk, Moderate Risk,* and *High/Extremely High Risk.* The results for each of the 17 remaining items will be listed below.

Frequency of practitioners cumulative responses are presented below in Figure 7.

Figure 7
Burnout



The highest frequencies occurred between the range of 30 and higher which is a score within the "high/extremely high" ranges.

Item nine requested a response to the following, "I am a sensitive person." This is the first item on the compassion fatigue instrument that targets *burnout*. Frequency data for the responses are listed in Table 36.

Table 36
I am a sensitive person.

Response	Frequency	Percent
Rarely/Never	5	5.6
At Times	37	41.6
Often	31	34.8
Very Often	16	18.0
Total	89	100.0

A total of five (5.6%) practitioners reported "rarely/never," 37 (41.6%) responded "at times," and 31 practitioners responded "often." The final 16 practitioners responded "very often."

Item 14 requested that practitioners identify whether they had ever thought that they needed more close friends. Frequency data for the responses are listed in Table 37.

Table 37
I have thought that I need more close friends.

Response	Frequency	Percent
Rarely/Never	45	50.6
At Times	35	39.3
Not Sure	1	1.1
Often	8	9.0
Total	89	100.0

A total of 45 (50.6%) reported "rarely/never," 35 (39.3%) responded "at times," and there was one participant that responded "not sure." The remaining eight practitioners responded "often."

Practitioners reported whether they had thought that there was no one to talk with about highly stressful experiences. Frequency data for the responses are listed in Table 38.

Table 38
I have thought that there is no one to talk with about highly stressful experiences.

Response	Frequency	Percent
Rarely/Never	56	62.9
At Times	27	30.3
Often	6	6.7
Total	89	100.0

A total of 56 (62.9%) reported "rarely/never," 27 (30.3%) practitioners that responded "at times," and the remaining six practitioners responded "often."

Practitioners reported whether they have concluded that they work too hard for their own good. Frequency data for the responses are listed in Table 39.

Table 39
I have concluded that I work too hard for my own good.

Response	Frequency	Percent
Rarely/Never	19	21.3
At Times	52	58.4
Not Sure	1	1.1
Often	10	11.2
Very Often	7	7.9
Total	89	100.0

A total of 19 (21.3%) reported "rarely/never," 52 (58.4%) responded "at times," 10 responded "often," and seven responded "very often." The final one participant responded, "not sure." Based upon the 58.4 percentage listed above, the majority of practitioners indicated that there are times that they feel as if they work too much for their own good.

Practitioners reported whether they had felt "on edge" about various things and whether they attributed those things to working with certain clients. Frequency data for the responses are listed in Table 40.

Table 40
I have felt "on edge" about various things and I attribute this to working with certain clients.

Response	Frequency	Percent
Rarely/Never	52	58.4
At Times	29	32.6
Not Sure	3	3.4
Often	5	5.6
Total	89	100.0

A total of 52 (58.4%) reported "rarely/never," 29 (32.6%) responded "at times," three (3.4%) responded "not sure," five (5.6%) responded "often."

Practitioners reported whether they had wished they could avoid working with some therapy clients. Frequency data for the responses are listed in 41.

Table 41
I have wished that I could avoid working with some therapy clients.

Response	Frequency	Percent
Rarely/Never	26	29.2
At Times	55	61.8
Often	6	6.7
Very Often	2	2.2
Total	89	100.0

A total of 26 (29.2%) reported "rarely/never" 55 (61.8%) responded "at times" (this accounts for the largest score on this particular item, indicating that the majority of practitioners wished that they could avoid working with some therapy clients). Six practitioners responded "often;" and the remaining two practitioners responded "very often."

Practitioners reported whether they had felt that their clients disliked them personally. Frequency data for the responses are listed in Table 42

Table 42
I have felt that my clients dislike me personally.

Responded	Frequency	Percent
Rarely/Never	64	71.9
At Times	20	22.5
Not Sure	3	3.4
Often	2	2.2
Total	89	100.0

A total of 64 (71.9%) reported "rarely/never," 20 (22.5%) responded "at times," three responded "not sure," and two responded "often."

Practitioners responded as to whether they had felt weak, tired, and rundown as a result of their work as a therapist. Frequency data for the responses are listed in Table 43.

Table 43
I have felt weak, tired, and rundown as a result of my work as a therapist.

Response	Frequency	Percent
Rarely/Never	25	28.1
At Times	53	59.6
Often	9	10.1
Very Often	2	2.2
Total	89	100.0

A total of 25 (28.1%) reported "rarely/never," 53 (59.6%) responded "at times," nine responded "often," and two responded "very often."

Practitioners reported whether they had felt depressed as a result of their work as a helper. Frequency data for the responses are listed in Table 44.

Table 44
I have felt depressed as a result of my work as a helper.

Response	Frequency	Percent
Rarely/Never	48	53.9
At Times	37	41.6
Not Sure	1	1.1
Often	2	2.2
Very Often	1	1.1
Total	89	100.0

A total of 48 (53.9%) reported "rarely/never" 37 (41.6%) responded "at times," one responded "not sure," and two responded "often." The remaining one participant responded "very often."

Practitioners reported whether they were unsuccessful at separating work from personal life. Frequency data for the responses are listed in Table 45.

Table 45
I am unsuccessful at separating work from personal life.

Response	Frequency	Percent
Rarely/Never	53	59.6
At Times	30	33.7
Often	1	1.1
Very Often	5	5.6
Total	89	100.0

A total of 53 (59.6%) reported "rarely/never," 30 (33.7%) responded rarely/never," one participant responded "often," and one participant responded "very often."

Practitioners reported whether they felt little compassion toward most of their coworkers." Frequency data for the responses are listed in Table 46.

Table 46
I feel little compassion toward most of my co-workers.

Response	Frequency	Percent
Rarely/Never	75	84.3
At Times	10	11.2
Not Sure	1	1.1
Often	1	1.1
Very Often	2	2.2
Total	89	100.0

A total of 75 (84.3%) reported "rarely/never," 10 (11.2%) responded "at times," one (1.1%) responded "not sure" and "often," and two (2.2%) responded "very often."

Practitioners reported whether they felt they were working more for the money than for personal fulfillment." Frequency data for the responses are listed in Table 47.

Table 47
I feel I am working more for the money than for personal fulfillment.

Response	Frequency	Percent
Rarely/Never	59	66.3
At Times	20	22.5
Not Sure	3	3.4
Often	4	4.5
Very Often	3	3.4
Total	89	100.0

A total of 59 (66.3%) reported "rarely/never" The fact that practitioners did not feel that they are working more for the money indicates that the majority of the 89 practitioners enjoy their jobs to some degree. Twenty (22.5) practitioners reported that they felt they were working more for the money than personal fulfillment. Three (3.4%) responded "not sure" and "very often," and four responded "often."

Practitioners reported whether they found it difficult separating their personal life from their work life. Frequency data for the responses are listed in Table 48.

Table 48
I find it difficult separating my personal life from my work life.

Response	Frequency	Percent
Rarely/Never	65	73.0
At Times	22	24.7
Often	2	2.2
Total	89	100.0

A total of 65 (73.0%) reported "rarely/never," 22 (24.7) responded "at times," and two responded "often."

Practitioners reported whether they have a sense of worthlessness, disillusionment, and or resentment associated with their work. Frequency data for the responses are listed in Table 49.

Table 49
I have a sense of worthlessness/disillusionment/resentment associated with my work.

Response	Frequency	Percent
Rarely/Never	67	75.3
At Times	19	21.3
Often	3	3.4
Total	89	100.0

A total of 67 (75.3%) reported "rarely/never," 19 (21.3) responded "at times," and three responded "often."

Practitioners identify whether they have thoughts that they are a "failure" as a therapist. Descriptive data for the responses are listed below in Table 50.

Table 50
I have thoughts that I am a "failure" as a therapist.

Response	Frequency	Percent
Rarely/Never	66	74.2
At Times	20	22.5
Not Sure	1	1.1
Often	2	2.2
Total	89	100.0

A total of 66 (74.2%) reported "rarely/never" 20 (22.5%) responded that "at times," one responded "not sure," and two responded "often."

Practitioners reported whether they had thoughts that they were not succeeding at achieving their life's goals. Frequency data for the responses are listed in Table 51.

Table 51
I have thoughts that I am not succeeding at achieving my life goals.

Response	Frequency	Percent
Rarely/Never	42	47.2
At Times	39	43.8
Not Sure	1	1.1
Often	5	5.6
Very Often	2	2.2
Total	89	100.0

A total of 42 (47.2%) responded "rarely/never" 39 (43.8%) responded "at times," five (5.6%) responded "often," two responded "very often," and one responded "not sure."

Practitioners identify whether they have to deal with bureaucratic, unimportant tasks in their work life. Descriptive data for the responses are listed below in Table 52.

Table 52
I have to deal with bureaucratic, unimportant tasks in my work life.

Response	Frequency	Percent
Rarely/Never	9	10.1
At Times	45	50.6
Not Sure	2	2.2
Often	18	20.2
Very Often	15	16.9
Total	89	100.0

A total of 9 (10.1%) reported "rarely/never," 45 (50.6%) reported "at times," two (2.2%) responded "not sure;" 18 (20.2%) responded "often," and 15 (16.9%) responded "very often."

EXAMINING DIFFERENCES AMONG RESPONSES TO INSTRUMENTS

Scoring for Professional Characteristics

This section of this study examines the differences in compassion fatigue or burnout responses when practitioners are grouped based on their responses to the demographics survey (personal and professional characteristics), Objectivism Scale, and the adapted DUREL. As indicated in detail in the methods section of this research, practitioners were asked four questions concerning their professional characteristics in order to address Research Question Two: Are the following professional characteristics of practitioners associated with their levels of risk for compassion fatigue or with their levels of risk for burnout: (a) the number of years that they have possessed a master's

level degree; (b) their years of experience as a master's level or above practitioner; (c) the hours per week they currently counsel/assist trauma survivors; and (d) their years of experience in counseling/assisting trauma survivors?

This research study examined each independent variable using five composite variables. Compassion fatigue and burnout was examined in addition to three other composite variables. All of the dependent variables groupings were drawn from the *Compassion Fatigue Instrument*. The five composite variables used in this study are as follows: (1) compassion fatigue, (2) burnout, (3) self, (4) client and their families, and (5) work environment. These five composite scores (dependent variables) were used to examine each question throughout this research.

Inferential data for responses to the number of years that practitioners have held a master's level degree are listed below in Table 53.

Table 53
Years with Master's Level Degree and Compassion Fatigue or Burnout

	Composite.1 CF	Composite.2 BO	Composite.3 Self	Composite.4 Client	Composite.5 Work
0 - 5 years (N=31)	49.10	50.26	49.71	44.74	51.11
6 -10 years (N=20)	47.73	50.03	47.75	47.25	47.33
11- 20 years (N=20)	39.20	33.58	38.55	40.90	33.35
21 + years (N=18)	41.36	43.06	41.00	47.50	44.83
Asymp. Sig.	.498	.108	.399	.841	.111

[a]Mean Ranks

Practitioners reported how many years they have held a master's level degree. The years were recoded into the following: 1 = 0 to 5 years, 2 = 6 to10 years, 3 = 11 to 20 years, and 4 = 21 years and over. Kruskal Wallis was used to analyze this data. Since the *p*-values are all greater than the significance level of 0.05, $p < .05$, there is no statistically significant difference in compassion fatigue/burnout among groups with different years of master's level degree. There is no indication that the years a practitioner has held a master's level degree increase their risk for *compassion fatigue* or *burnout*. The respective *p*-values are .498, .108, .399, .841, and 0.111, $p > .05$.

Inferential data for the responses to the number of clinical years of experience that practitioners have worked at the master's level or above are listed below in Table 54.

Table 54
Years of Clinical Experience as a Master's Level or Above Practitioner

	Composite.1 CF	Composite.2 BO	Composite.3 Self	Composite.4 Client	Composite.5 Work
0 to 5 years (N=8)	46.25	52.81	41.00	51.50	59.38
6 to 10 years (N=27)	46.22	47.63	48.50	42.07	46.30
11 to 20 years (N=29)	42.81	41.98	41.19	46.66	42.19
21 + years (N=25)	45.82	43.16	46.92	44.16	42.26
Asymp. Sig.	.957	.673	.690	.799	.362

[a] Mean Ranks

Practitioners reported how many years they worked at the master's level or above in the clinical field. The years were recoded into the following levels: 1 = 0 to 5 years, 2 = 6 to10 years, 3 = 11 to 20 years, and 4 = 21 years and over. The statistical test used to examine whether the practitioners years of clinical experience at the master's level or above increase their risk for the five composite dependent variables, was the Kruskal Wallis test. Since the *p*-values are all greater than the significance level of 0.05, $p < .05$, there is no statistically significant difference between the years of clinical experience and

compassion fatigue/burnout. There is no difference in years a practitioner has worked as a master's level or above practitioner. There are no increased risks for *compassion fatigue* or *burnout*. The respective *p*-values are 0.957, 0.673, 0.690, 0.799 and 0.362, p > .05.

Inferential data for the responses to the hours the practitioners currently counsel/assist trauma survivors are listed below in Table 55.

Table 55
Hours per Week Practitioners Currently Counsel/Assist Trauma Survivors

	Composite.1 CF	Composite.2 BO	Composite.3 Self	Composite.4 Client	Composite.5 Work
Group 1 0 to 16 years (N=33)	41.83	43.27	43.71	42.77	43.17
Group 2 17 to 32 years (N=24)	42.65	36.94	38.83	44.13	38.23
Group 3 33+ years (N=32)	50.03	52.83	50.95	47.95	51.97
Asymp. Sig.	.384	.066	.205	.705	.124

[a] Mean Ranks

Practitioners reported how many hours per week they counsel/assist survivors of trauma. The hours were recoded into the following levels: 1 = 0 to 16 hours, 2 = 17 to 32 hours, and 3 = 33 hours and over. The statistical test used to examine this data was the Kruskal Wallis test. Since the p-values are all greater than the significance level of 0.05, $p < .05$, there is no statistically significant difference between the hours per week that

practitioners counsel/assist trauma survivors. There is no difference in the number of hours a practitioner worked each week with trauma survivors within 5 composite variables. There are no increased risks for *compassion fatigue* or *burnout*. The respective *p*-values are 0.384, 0.066, 0.205, 0.705 and 0.124, $p > .05$.

Inferential data for the responses to the number of years of experience practitioners have counseling/assisting trauma survivors are listed below in Table 56.

Table 56
Years of Trauma Experience

	Composite.1 CF	Composite.2 BO	Composite.3 Self	Composite.4 Client	Composite.5 Work
0 to 5 years (N=9)	42.83	40.28	44.06	38.11	45.22
6 to 10 years (N=24)	48.79	52.77	47.33	51.71	50.19
11 to 20 years (N=33)	42.20	44.45	43.41	42.71	46.00
21 + years (N=23)	45.91	39.52	45.22	43.98	38.07
Asymp. Sig.	.801	.317	.953	.461	.441

Practitioners reported the number of years of experience they have counseling trauma survivors. The years were recoded into the following levels: 1 = 0 to 5 years, 2 = 6 to10 years, 3 = 11 to 20 years, and 4 = 21 years and over. The statistical test that was

used is the Kruskal Wallis test. Since the *p*-values are all greater than the significance level of 0.05, $p < .05$, there is no statistically significant difference in practitioners' years of experience and their risk for compassion fatigue/burnout. There is no difference between the number of years a practitioner has worked with trauma survivors and *compassion fatigue* or *burnout*. The respective *p*-values are 0.801, 0.317, 0.953, 0.461 and 0.441, $p > .05$.

Scoring for the Personal Characteristics of Practitioners

Practitioners were asked to respond to eight personal characteristics that address Research Question Three: Are the following personal characteristics of practitioners associated with their levels of risk for compassion fatigue and/or with their levels of risk for burnout: (a) gender; (b) race; (c) whether they are trauma survivors themselves; (d) the type of community where they spent their childhood; (e) whether they regularly participate in leisure activities; (f) their level of objectivity in decision making; and (g) their religious activities and beliefs?

Inferential data for responses to gender are listed below in Table 57.

Table 57
Gender

	Composite.1 CF	Composite.2 BO	Composite.3 Self	Composite.4 Client	Composite.5 Work
Males (N=21)	43.71	41.33	41.26	49.12	41.83
Females (N=68)	45.40	46.13	46.15	43.73	45.98
Asymp. Sig	.794	.456	.447	.401	.519

Practitioners reported their gender, and mean ranks are listed in Table 57. The Mann-Whitney was used to examine this variable. There were no statistically significant findings between practitioners' gender and their level of risk for compassion fatigue or their level of risk for burnout. Practitioners from different genders did not differ statistically; there is no significance within each of the five composite variables, since the p-values are all greater than the significance level of 0.05, $p < .05$. The respective p-values are 0.794, 0.456, 0.447, 0.401, and 0.519, $p > .05$. There were 68 (76.4%) females and 21 (23.6%) males identified in this study.

Practitioners reported their race. Inferential data for responses are listed below in Table 58.

Table 58
Race

	Composite.1 CF	Composite.2 BO	Composite.3 Self	Composite.4 Client	Composite.5 Work
Asian (N=3)	35.83	37.17	46.17	27.83	38.67
Black (N=43)	43.79	47.59	43.48	48.02	47.13
Hispanic (N=1)	57.00	7.50	58.50	31.00	9.50
White (N=41)	46.90	44.76	46.51	44.28	44.79
Biracial (N=1)	34.50	4.50	31.50	10.00	16.50
Asymp. Sig.	.898	.258	.932	.391	.461

Practitioners from different racial or ethnic groups do not differ significantly in that there are no statistically significant differences between ethnicity within each of the five composite variables, since the *p*-values are all greater than the significance level of 0.05, $p < .05$. The respective *p*-values are .898, .258, .932, .391 and .461, $p > .05$.

Practitioners reported whether they are trauma survivors themselves. Inferential

data for responses are displayed below in Table 59.

Table 59
Practitioners who are Trauma Survivors

Trauma Groups (N)	CF1 (CF)	CF2 (BO)	CF3 (Self)	CF4 (Client)	CF5 (Work)
None (39)	47.92	49.15	47.91	46.44	47.83
Mild (29)	41.95	41.45	40.83	43.17	45.98
Serious (21)	43.79	42.19	45.36	44.86	38.38
Asymp. Sig. Value (*p* Value)	.621	.404	.532	.874	.386

Practitioners reported whether they are survivors of trauma. This category was grouped into three levels, *no trauma, mild trauma, and serious trauma.* Twenty-one (38.38%) reported "serious trauma," 29 (45.98%) reported "mild trauma," and 39 (47.83%) reported "no trauma." There is no statistically significant difference within each level of exposure to trauma and the five composite variables, since the *p*-values are all greater than the significance level of 0.05, $p < .05$. The respective *p*-values are 0.621, 0.404, 0.532, 0.874 and 0.386, $p > .05$.

Practitioners were requested to identify the type of community where they lived the majority of their childhood from ages 3-19." Practitioners reported 11 (12.4%) lived in rural communities; 12 (13.5%) lived in small towns; 40 (44.9%) lived in urban communities; 20 (22.5%) practitioners lived in suburban communities, and 6 (6.7%) lived

in a mixture of communities. Inferential data is listed below in Table 60.

Table 60
The Communities Where Practitioners Lived from Ages 3 to 19

Community Groups (N)	CF1 (CF)	CF2 (BO)	CF3 (Self)	CF4 (Clients)	CF5 (Work)
Rural (11)	48.32	41.09	47.45	47.27	41.41
Small Town (12)	56.08	45.63	52.04	44.83	49.42
Urban (40)	42.14	45.63	43.31	46.64	44.71
Suburban (20)	40.85	43.60	39.30	43.93	43.93
Mixed (6)	49.67	51.42	56.67	33.83	48.25
Asymp. Sig. Value (*p* Value)	.462	.950	.497	.841	.951

The various types of communities where practitioners lived and the five composite variables are not statistically significant, since the *p*-values are all greater than the significance level of 0.05, $p < .05$. There is no difference between the communities where practitioners grew up and the risk for compassion fatigue or burnout. The respective *p*-values are 0.462, 0.950, 0.497, 0.841, and 0.951, $p > .05$.

Practitioners reported whether they participate in leisure activities at least three hours a week or more. Inferential data for the responses are listed below in table 61.

Table 61
Leisure Activity

Leisure Activity (N)	CF1 (CF)	CF2 (BO)	CF3 (Self)	CF4 (Client)	CF5 (Work)
Yes (70)	44.20	45.09	44.21	44.53	45.00
No (19)	47.95	44.66	47.89	46.74	45.00
Asymp. Sig. Value (*p* Value)	.574	.948	.581	.740	1.000

Reported leisure activities are not statistically significant with any of the variables, since the *p*-values are all greater than the significance level of 0.05, $p < .05$. The respective *p*-values are 0.574, 0.948, 0.581, 0.740, and 1.000, $p > .05$. Practitioners who participated in leisure activities weekly did not differ significantly with those who did not participate in leisure activities weekly. There is no difference between the composite groups and leisure activities, as the Spearman correlation test statistic = 0.024 with *p*-value = .824. However it can be determined that those in the sample study who have leisure activities would be at low risk (Count = 31, relative frequency = 34.8%).

Inferential Responses for the Objectivism

Objectivism was examined using the Kruskal Wallis test to examine the differences between groups to determine whether the way practitioners make decisions increase their risk for compassion fatigue/burnout. The five composite dependent

variables were used, *compassion fatigue*, *burnout*, *self*, *client and families*, and *work environment*. Inferential data for practitioners' responses are listed below in Table 62.

Table 62
Objectivism Scores (3 Levels)

Objectivism 3 Groups (N)	CF1 (CF)	CF2 (BO)	CF3 (Self)	CF4 (Client)	CF5 (Work)
Low (25)	47.84	38.62	42.78	46.94	38.34
Moderate (32)	40.55	48.89	41.86	43.98	50.92
High (32)	47.23	46.09	49.88	44.50	44.28
Asymp. Sig. Value (*p* Value)	.473	.314	.405	.903	.183

[a]Mean Ranks

The mean ranks indicate that the highest frequencies occurred in the low and high groups in CF1, CF3, and CF4. With CF2 and CF5, the highest frequencies occurred in the moderate and high groups. Practitioners' responses indicate that the three levels of objectivism were not statistically significant within each composite level of *compassion fatigue, burnout, self, client and families, and work environment,* since the *p*-values are all greater than the significance level of 0.05. The respective *p*-values are 0.473, 0.314, 0.405, 0.903, and 0.183.

This researcher also grouped objectivism into two groupings (low objectivism and high objectivism) levels to examine whether there was any statistically significant difference within the five composite variables. Inferential data for the responses from the

Mann-Whitney test are listed below in Table 63.

Table 63
Objectivism (2 Levels) and Composite Groups

Objectivism 2 Groups (N)	CF1 (CF)	CF2 (BO)	CF3 (Self)	CF4 (Client)	CF5 (Work)
Low (46)	46.82	44.33	43.60	48.16	45.46
High (43)	43.06	45.72	46.50	41.62	44.51
Asymp. Sig. Value (*p* Value)	.492	.799	.595	.230	.863

There was no statistically significance within each composite level of *compassion fatigue, burnout, self, client and families, and work environment,* because the *p*-values are all greater than the significance level of 0.05. The respective *p*-values are 0.492, 0.799, 0.595, 0.230 and 0.863.

Inferential Responses for the Researcher Adaption of the DUREL

Practitioners were instructed to complete a 5-item Likert instrument based on questions taken from the *Duke University Religion Index (DUREL).* Only frequency information will be obtained from the researcher adaption of the DUREL Index.

Composite variables were created for responses on the researcher adaption of the DUREL. Item 1 on the scale is called Subscale 1; item 2 is called Subscale 2, and items 3, 4, and 5 are called Subscale 3. Only frequency data will be was examined with the researcher adaption of the DUREL index. The responses range from low to high, and low

indicated low religious activities and beliefs and high indicated high religious activities and beliefs.

The researcher reconfigured the DUREL for the purpose of this research, Subscale 2 was examined to identify the private religious activities that practitioners practice, and Subscale 3 was used to identify whether there is any statistically significant difference between religious beliefs and the risks for compassion fatigue/burnout. Both the religious activities responses and the religious beliefs responses are grouped into three categories: *low religious activities*, *moderate religious activities*, and *high religious activities*.

The statistical test that was use to examine religious activities was the Kruskal Wallis test. Inferential data for the responses from the DUREL's Subscale 2 are listed below in Table 64

Table 64
DUREL – Subscale 2

Religious Activities (N)	CF1 (CF)	CF2 (BO)	CF3 (Self)	CF4 (Client)	CF5 (Work)
Low (18)	53.89	58.14	52.42	54.00	59.58
Moderate (15)	54.00	53.37	53.33	50.73	54.77
High (56)	39.73	38.54	40.38	40.57	37.70
Asymp. Sig. Value (*p* Value)	.043	.008	.088	.100	.002

There were 18 practitioners that scored in the low religious activities range; 15 practitioners scored in the medium religious activities range, and 56 practitioners scored in the high religious activities range. In identifying the differences between religious activities and compassion fatigue/burnout, the inferential data indicate statistically significance within three of the composite variables, *compassion fatigue, burnout, and work environment.* The *p*-values of the aforementioned three composite variables are less than the value used to indicate statistical significance, $p < .05$. The respective *p*-values are as follows: compassion fatigue, $p = .043$; burnout, $p = .008$; and work and environment, $p = .002$. In examining how practitioners responded to variables that concerned, *self* ($p = 0.088$) and client and families ($p = 0.100$, there is no statistical

significance, as $p > .05$.

Because there is statistical significance within three groups of religious activities, a Mann Whitney was used to examine where the differences exist. Inferential data for the results are listed in Table 65.

Table 65
Examining Groups with Statistical Significance (Religious Activities)

Religious Activities/ Group Differences	CF1	CF2	CF3	CF4	CF5
Low-Moderate *p*-value	.986	.605	.929	.630	.509
Moderate - High *p*-value	.056	.047	.083	.158	.019
Low-High *p*-value	.044	.005	.086	.060	.002

Because the Kruskal Wallis *p*-value indicated statistically significant differences with religious activities and three composite variables (compassion fatigue, burnout and work environment), a Mann Whitney was run to determine where the differences are between the groups. There are statistically significant differences between the *moderate* to *high* group (burnout and work environment) and the *low* to *high* groups (compassion fatigue, burnout and work environment). No significant differences exist between the *low* to *moderate* groups.

In examining religious beliefs in practitioners, this researcher grouped the responses into three levels, (1) low religious beliefs, (2) moderate religious beliefs, and

(3) high religious beliefs five composite variables were examined. Inferential data for the results are listed in Table 66.

Table 66
Researcher Adaption of DUREL – Subscale 3

Religious Beliefs (N)	CF1	CF2	CF3	CF4	CF5
Low Beliefs (66)	40.73	41.26	41.69	40.07	41.21
Moderate Beliefs (12)	60.88	51.50	56.13	59.63	52.04
High Beliefs (11)	53.32	60.36	52.73	53.82	60.05
Asymp. Sig. Value (*p* Value)	.023	.048	.115	.032	.048

Practitioners' responses indicate that there are statistically significant differences between those with different levels of religious beliefs on four of the composite variables. Composite 1 (compassion fatigue) has a *p*-value of .023; composite 2 (burnout) has a *p*-value of .048; composite value 4 (client) has a *p*-value of .032, composite variable 5 (work) has a *p*-value of .048. However, composite variable 3 (self) has a *p*-value of .115.

Because there is statistical significance within three groups of religious beliefs, a Mann Whitney was used to examine the groups in pairs to see where the differences exist. Inferential data for the results are listed in Table 67.

Table 67
Examining Groups with Statistical Significance (Religious Beliefs)

Religious Beliefs/ Group Differences	CF1	CF2	CF3	CF4	CF5
Low-Moderate *p*-value	.013	.225	.086	.018	.182
Moderate - High *p*-value	.487	.566	.566	.740	.487
Low-High *p*-value	.131	.020	.165	.134	.024

Because the Kruskal Wallis *p*-value indicate statistical differences with religious beliefs and four composite variables (compassion fatigue, burnout, client and families, and work environment), a Mann Whitney was run to determine where the statistically significant differences are between the groups. The differences are with the *low* to *moderate* groups (compassion fatigue and client/families) and the *low* to *high* groups (burnout and work environment). No significant differences exist between the *moderate* to *high* groups. The discussion for all of the collected data for the research is discussed in Chapter 5 of this research study.

Chapter Five

DISCUSSION

In the following section, a detailed discussion of the results of this study on compassion fatigue, burnout, objectivism, religious activities and beliefs in practitioners are presented. Discussions of the results are being presented in a format where the researcher will present each research question and identify the findings of each research question. In addition to the summary of findings, limitations of the study are also presented. The chapter concludes with implications for practitioners, future research recommendations, and a summary.

Analysis of Survey Instruments

This section analyzes each instrument that was used to collect data and the responses of the practitioners that participated in the study. While only the researcher adaption of the Duke University Religious Index (DUREL) revealed any statistical significant findings, $p < .05$, the other instruments did reveal some interesting results.

Personal and Professional Information Instrument

The *Personal and Professional Instrument*, a survey, a researcher created instrument that was designed to obtain information about the practitioners. Out of the 89 practitioners that completed the survey, the years they have held a master's level degree ranged from 0 to 45 years. The practitioners consisted of 43 black practitioners (African Americans), 41 white practitioners (Caucasians), three Asian practitioners, one Hispanic practitioner, and one Biracial practitioner. Consistent with this researcher's experience as a graduate student and educator in the college setting, this study produced findings that indicated that females outnumber males in both counselor training programs and

professional counseling settings. There were only 21 (23.6%) males out of the 89 practitioners 68 (76.4) females.

While working on a qualitative study for one of my classes in the PhD program at Old Dominion University, two clinical social workers (license eligible) were interviewed for a project. While one social worker grew up in an urban community, the other social worker was reared in a rural community. They had both experienced trauma, but the one that grew up in the rural community expressed a close knit community that helped resolve issues as a unit and she did not feel traumatized by her clients at all. On the other hand, the urban interviewee expressed feeling isolated in working through personal issues as he/she grew up (he/she felt that there were times that he/she felt traumatized by his clients). Social support is very important in assisting communities through traumatic events. From a community perspective, no element of trauma intervention is more far-reaching than the goal of augmenting naturally occurring social support (Norris & Stevens, 2007). "While social networks, are undeniably a source of stress as well as comfort in the aftermath of disasters, the weight of the evidence shows that social supports is the single powerful protective factor for trauma survivors" (Norris & Stevens, 2007, p. 325).

One of the questions on The Personal and Professional Instrument requested that practitioners identify the type of community that they grew up in from ages three through 19 years of age. The choices were as follows: rural community (county) – 11 practitioners (12.4%); small town (town smaller than 25,000 population) -12 (13.5%); urban community (in a large city more than 25,000 population) – 40 (44.9%); suburban community (near a city of more than 25,000) – 20 (22.5%), and mixture of community

(lived in more than one area equally) – six (6.7%).

This study was a convenience sample, and the practitioners were recruited based upon the networking (an exchange of information) principle. The practitioners were recruited from a variety of agencies and private practices (human service agencies, mental health agencies, counseling agencies, hospital trauma centers, doctoral level students, and private practices). This researcher contacted administrators and senior level workers by e-mail to solicit their help in identifying practitioners with the appropriate qualifications. Once the need for practitioners was identified, the researcher started to receive e-mails from qualified practitioners. Many of the participating practitioners referred other possible participants. Within approximately two weeks of the initial request, 113 individuals were identified as qualified participants. While it was clearly stated that only master's level and above practitioners with trauma experience were to complete the survey package, there were two (2.2%) practitioners that did not have any trauma experience. The remaining 87 (98.8%) of the practitioners identified themselves as having trauma experience.

The hours that the practitioners worked ranged from zero to 63 hours per week. The number of years that the practitioners have worked with trauma clients ranged from one to 37 years. Practitioners were asked to identify whether or not they had been victims of trauma, and 21 (23.6%) of practitioners were survivors of serious trauma; 29 (32.6%) were survivors of mild trauma; and 39 (43.8%) had not experienced trauma on any level. The final question on the survey requested that practitioners identify whether they participate in a leisure activity at least three hours a week. The majority of the practitioners, 70 (78.7%), do participate in leisure activities, while 19 (21.3%) responded

that they do not participate in leisure activities at least three hours a week.

Response to Questions to Objectivism Scale

The Objectivism Scale was used to identify whether the decision making process of practitioners influenced their risk for compassion fatigue or their risk for burnout. The scores were divided two different ways to identify whether any statistical significance would be identified. The scale was divided into low objectivism (11 – 19), moderate objectivism (20 – 25), and high objectivism (26 – 34). The scale was also divided into low objectivism and high objectivism. According to the responses from the three level groupings of objectivism, there were 25 practitioners identified in the low objectivism range, while 32 practitioners scored within the moderate and high ranges of objectivism. In examining responses in the two level groupings of objectivism, there were 46 practitioners that scored in the low objectivism range (11 – 22) and 43 percent that scored within the high objectivism range (23 – 34).

Response to the Researcher Adapted Duke University Religious Index

The researcher adaption of the Duke University Religious Index was used to identify whether religious activities and beliefs increase or decrease a practitioner's risk for compassion fatigue or the risk for burnout. The DUREL consists of five questions (three Subscales). Item one on the index is considered as Subscale 2, and it identifies religious attendance. Item two on the index is considered as Subscale 2, and it identifies private religious activities. Items three through five are considered as Subscale 3, which identified overall religiosity. This researcher adapted the original DUREL by using only questions from Subscale 2. Practitioners were requested to respond to the following question: "I think the answers to most questions in life can be found through careful,

objective analysis of the situation." The Likert scale that was used identified the following responses: More than once a week = 1; Once a week = 2; A few times a month = 3; A few times a year = 4; Once a year or less = 5, and Never = 6. The responses were grouped and reverse scored to 1 = low religious activities, 2 = moderate religious activities, and 3 = high religious activities. The responses identified that 18 practitioners scored within the range of low religious activities, 15 of the practitioners scored in the range of moderate religious activities, and 56 practitioners scored in the range of high religious activities. Religious belief revealed the following results: 66 scored in the low range, 12 scored in the moderate range and 11 scored in the high range.

Responses for the Compassion Fatigue Self-Test for Psychotherapists

The Compassion Fatigue Self-Test for Psychotherapist is a 40-item Likert scale test that was divided into three sections: items one – 16 (*Items about Self),* items 17 -30 *(Items about Client and Families)*, and items 31 – 40 *(Items about being a helper and work environment).* The scoring instructions clearly identified the ranges for compassion fatigue as follows: extremely low risk = 23 to 26; low risk = 27 to 30; moderate risk = 31 to 35; high risk = 36 to 40; and extremely high risk = 41 or more. For the purpose of this research, composite scores were created and the dependent variable compassion fatigue was grouped into 3 levels, *Low/Extremely Low Risk, Moderate Risk,* and *High/Extremely High Risk.* The highest frequencies occurred between the ranges of 26 to 34 for the practitioners that responded to the compassion fatigue instrument, which is a score within the moderate risk range; thus is the risk for compassion fatigue in the sample group that was drawn.

Burnout is another component of the Compassion Fatigue Self-Test for

Psychotherapists. The identified ranges for *burnout* are as follows: extremely low risk = 19 or less; low risk = 20 to 24; moderate risk = 25 to 29; high risk = 30 to 42; and extremely high risk = 43 or more. For the purpose of this research, composite scores were created and the dependent variable *burnout* was grouped into three levels. Composite scores were created to account for the size of the population in this study. In recording the scores, the following composite levels were created: *Low/Extremely Low Risk, Moderate Risk,* and *High/Extremely High Risk.* In essence, the levels of *low* and *extremely low* were grouped together, the *moderate* level did not change, and the *high* and *extremely high* levels were grouped together, thereby forming composite scores. The highest frequencies occurred between the range of 30 and higher for the practitioners that responded to the compassion fatigue instrument, which is a score within the "extremely high/high" ranges. The practitioners' responses indicate that there is a risk for burnout.

SUMMARY OF FINDINGS

Research Question One

The dependent variables of this research were the risk for compassion fatigue and the risk for burnout. The first question of this research was as follows: "What level of risk for compassion fatigue and level of risk for burnout exist in master's level and above practitioners (counselors, social workers, and mental health clinicians) in the southeastern region of the United States?" This question was answered based upon a convenience sample collected from regional practitioners. The results revealed that the practitioners were at risk for compassion fatigue. The Spearman Correlation revealed a p-value of, $p < .000$, which is definitely a statistically significant. The scores for the practitioners were as follows: thirty-eight were at low risk for compassion fatigue: twenty-five were at

moderate risk for compassion fatigue, and twenty-six were at high risk for compassion fatigue.

The practitioners' responses in this study were also examined for burnout. The Spearman Correlation revealed a *p*-value of, $p < .000$, which is statistically significant. The practitioners scored within the following levels: twenty-two scored in the low range, twenty-nine scored in the moderate range and thirty-eight scored in the high range. The practitioners examined were at risk for burnout.

Research Question Two

In examining question two of this research study, "Are the following professional characteristics of practitioners associated with their level or risk for compassion fatigue or their level of risk for burnout: (a) the number of years that they have possessed a master's level degree; (b) their years of experience as a master's level or above practitioner; (c) the hours they currently counsel/assist trauma survivors, and (d) their experience in counseling/assisting trauma survivors?"

The number or years that a practitioners have held a master's degree had no statistical significance in identifying their level or risk for compassion fatigue and their level of risk for burnout. Using levels to create groups, 1 = 0 to 5 years; 2 = 6-10 years; 3 = 11 – 20 years, and 4 = 21 years and over, compassion fatigue was examined. The *p*-values were greater than $p < .05$.

The number of years of clinical experience that practitioners had did not reveal any statistical significance in identifying their level of risk for compassion fatigue or their level or risk for burnout. Using levels to create groups, 1 = 0 to 5 years; 2 = 6-10 years; 3 = 11 – 20 years, and 4 = 21 years and over, there was no statistical significance

identified. The *p*-values were greater than the significance level of 0.05.

In researching compassion fatigue, the Spearman correlation revealed test statistics = -.161 with *p*-value = .132. Statistics also revealed that those who have had experience with trauma are at risk, especially high risk of burnout (count = 38, relative frequency = 42.7%). However, there is no statistically significant relationship between the levels of burnout groups and trauma experience (Spearman Correlation test statistic = -.051 and *p*-value = -. 638).

The hours that practitioners work with trauma clients had no statistical significance in the relationship between compassion fatigue and burnout. The hours were grouped into the following levels: 1 = 0 – 8; 2 = 9 – 16; 3 = 17-32, and 4 = 33 and over. During the data entry process, it was identified that one practitioner identified years of experience when hours of experience were being requested. It cannot be proven whether this one inconsistency could have altered the results.

Research Question Three

In evaluating whether certain independent variables are factors that may reduce the risk for compassion fatigue or burnout, the question was asked, "Are the following personal characteristics of practitioners associated with their levels of risk for compassion fatigue and/with their levels or risk of burnout: (a) gender; (b) race; (c) whether they are trauma survivors themselves; (d) the type of community where they spent their childhood; (e) whether they regularly participate in leisure activities; (f) their level of objectivity in decision making, and (g) their religious activities and beliefs?"

The results for identifying whether gender influences the risk for compassion fatigue or the risk for burnout were examined, and there were more frequencies in

females than males, especially at low risk (Count = 28, relative frequency = 31.5%). However, there is no significant relationship between the two since the correlation test statistic is -0.017 and *p*-value =.878. The results suggest that gender does not increase the risk for compassion fatigue or the risk for burnout.

The results for whether race is a factor that influences the risk for compassion fatigue or the risk for burnout suggest that the maximum low risk frequency is black (African American). It can also be suggested that most of the other races were either at low risk or moderate risk. However, there is no statistically significant relationship between compassion fatigue and race, as the Spearman Correlation test statistic = 0.995 with, $p = .377$. In examining burnout, the higher frequencies were among the black and white races that were at high risk for burnout. This is probably because there were only 5 practitioners from other races in this study. There is no significant relationship between the levels of burnout groups and race (Spearman correlation test statistic = -.034 and *p*-value = .752).

The results for identifying whether practitioners who were trauma survivors were at an increased risk for compassion fatigue or burnout indicated that there were no statistical significant relationship between practitioners who were previous trauma survivors and those who were not previous trauma survivors. However, based on the crosstabs data, one could infer that higher frequencies in low risk or high risk indicate the potential for the risk of compassion fatigue and the risk for burnout. Statistically, there was no significant relationship between the levels of compassion fatigue and previous survivors of trauma as test statistic = 0.069 with *p*-value = .518. In reference to burnout, there was a greater frequency of those with no trauma in their history who were at high

risk; the count = 19 and relative frequency = 48.7%. However, there was no significant relationship between the levels of burnout groups and trauma victims, as the Spearman Correlation test statistic = .0.126 and *p*-value = 0. 238.

In examining whether the community where practitioners spent their childhood indicated a risk for compassion fatigue/burnout, the results identified that there was not a statistically significant relationship between the independent variable and the dependent variable. The highest frequency was in the urban communities with relative frequencies being 22.5%, 12.4% and 10.1% identifying that those communities were more at risk as opposed to the other types of communities. There is no statistically significant relationship between the levels of compassion fatigue and different types of community, since the Spearman correlation test statistic = -.143 with *p*-value = .182. In examining burnout, there are higher frequencies in the urban communities which are at risk. However, there is no significant relationship between the levels of burnout groups and different communities (Spearman Correlation test statistic = .024 and *p*-value = .826).

The results for whether incorporating leisure as a part of the practitioner's weekly routine would potentially reduce the risk for compassion fatigue or the risk for burnout provided scores that indicated that no statistically significant relationship between the two variables exist. The maximum frequency is in those who had leisure activities as a part of their weekly routine were identified as being at low risk for compassion fatigue and burnout as the count = 31, relative frequency = 34.8%. There is no significant relationship between the levels of fatigue groups and leisure activities (Spearman correlation test statistic = 0.024 with *p*-value = .824). In reference to burnout, there were more counts in those with leisure activities as a part of their lives were at high risk as the

count = 30, relative frequency = 33.7%. However, there is no significant relationship between the levels of burnout groups and leisure activities (Spearman Correlation test statistic = 0.045 and *p*-value = 0.674).

Objectivism was grouped into two different levels, two groups (low objectivism and high objectivism) and three groups (low objectivism, moderate objectivism, and high objectivism). First, the three level grouping will be examined. The maximum frequency count was in high objectivism and low risk of the levels of Compassion Fatigue (count = 14, relative frequency = 15.7%) based on a sample of 89 subjects. Spearman Correlation tests showed there was no significant difference between the levels of Compassion Fatigue and objectivism (three levels) with a test statistic value of -.021 and *p*-value = .844. The maximum frequency is in the high risk of burnout groups and moderate and high objectivism. It can also be seen that there is an increasing trend based on the sample. However, there is no significant relationship between the levels of burnout groups and objectivism groups (3). The Spearman Correlation test statistic has a value of 0.089 and *p*-value of 0.405. Hence, no conclusion can be made about the population. It does not appear to be a factor as to how the practitioners make decisions.

In examining the two levels of objectivism, the tests suggest that high objectivism and low risk has the highest count. (Count = 21 and relative frequency = 23.6%) based on the sample. The three levels of compassion fatigue and the two levels of objectivism are not significantly correlated. (Spearman's Correlation test statistic = -.115 with *p*-value = .283). In examining burnout, the highest frequency is in the high risk of burnout groups and low objectivism (count = 20, relative frequency = 22.5%). There is no significant relationship between the three burnout groups and two levels of objectivism (Spearman

Correlation test statistic= 0.028 with *p*-value = .797).

The researcher adaption of the DUREL was used to identify whether religious activities and beliefs were factors that implicated the risk for compassion fatigue or the risk for burnout. When reading the literature on studies that have encompassed the examination of religious activities (practices) and beliefs, they are both components of religiosity. Koenig (2001) conceptualizes religion as an organized system of beliefs and practices designed to help the individual with sacred and/or transcendent aspects.

The maximum frequency is in high religious activities of the low fatigue group. (Count = 31 and relative frequency = 34.8%). There is a significant relationship between the levels of compassion fatigue and the DUREL groups. (Spearman Correlation's test statistic = -.260, *p*-value = 0.014). The maximum count is in the moderate risk and high religious activity (Count = 22 with relative frequency = 24.7%). There is also a significant relationship between the burnout groups and adapted DUREL groupings (Spearman Correlation test statistic = -.307 with *p*-value = .003). When looking at the five composite groups, the 3 levels of religious activities (adapted DUREL) are statistically significant within each type of composite levels of compassion fatigue, burnout, and work environment at the significance level of, $p < 0.05$, since their respective *p*-values are 0.043, 0.008, and 0.002. However, the three levels of the adapted DUREL are statistically significant with the composite levels to include "self" and "client and family" at significance level of 0.10 since their respective *p*-values are 0.088 and 0.100. While the composite scores for "self" and "client and family" were not statistically significant, the scores were close enough to mention. The low scores are an indication that there is some level of relationship between the variables. This implies that the

involvement of religious activities decreased practitioner's risk for compassion fatigue and/or burnout.

The maximum frequency is in low religious beliefs. There is a significant relationship between the composite levels of compassion fatigue and the adapted DUREL groups, $p < .05$. There is a statistically significant difference in *compassion fatigue*, *burnout*, *client/families*, and *work environment* since their respective *p*-values are 0.023, 0.048, 0.032, and 0.048. There is no statistically significant difference in *self*, $p > .05$, and the adapted DUREL groupings; the respective *p*-value is .115. This implies that the involvement of religious beliefs have a negative correlation with religious activities. A Mann-Whitney was used to determine where the statistical difference occurred. In the *low* to *moderate* range, the difference was in the *compassion fatigue* and *client/families* groups, $p < .05$. The respective *p*-values were .013 and .018. There were no differences in the *moderate* to *high* groups. The *low* to *high* groups had a difference in *burnout* and *work environment*.

Limitations of the Study

There are several important limitations that should be considered when interpreting the results of this study, which are:

(1) The population sample was low; thus the results are less generalizable to the population of practitioners.

(2) The experiences of the practitioners varied, which could affect the amount of time that each of the practitioners worked with trauma survivors. In other words, the various practitioners assisted clients in various capacities such as, counseling and social work, and mental health. While all of the practitioners may counsel/assist trauma survivors, the

level or interaction that they have with their clients may vary to the degree that they are not all working with clients in the same context.

(3) The populations were primarily Black (African American) and White (Caucasian); thus the results were less generalizable to other ethnic groups; the diversity of the practitioners could have been an issue with identifying compassion fatigue or burnout.

(4) The population was not representative of a national study; thus the results are less generalizable to the entire population of practitioners.

(5) Leaving the e-mail invitation open longer may have allowed more practitioners to participate; thus a larger sample size may have been possible.

(7) There was no random order to the population; it was a convenience sample.

(8) Data was gathered through self-report and the results may have been skewed because of social desirability issues.

(9) Practitioners may have wished to avoid being identified as "at risk" for compassion fatigue or burnout, for fear of being considered unprofessional; therefore, they may have responded in a way that they were not identified as "at risk." This could also be a limitation of a national study.

(10) Practitioners were requested to recall experiences or to reflect on current experiences that may have been painful; therefore they may have avoided exploring their feelings.

Implications for Practitioners

Practitioners are out on the "front line" helping clients through disasters, grief and loss issues, and other traumatic events. In other words, practitioners are major stakeholders in assisting survivors of trauma. Studies indicate that trauma survivors who experience acute stress reactions are vulnerable to enduring debilitation, and "if left

untreated, approximately 78% will exhibit PTSD six months later" (Phipps % Byrne, 2003, p. 140). The intervention of a practitioner is a major step to recovery for trauma survivors of traumatic events. With this type of intervention, practitioners are at risk for compassion fatigue/burnout.

While many of the independent variables did not produce statistically significant results, there were many suggested findings that could assist practitioners with remaining healthy. For example, leisure is an activity that can be used to help reduce stress. Super has emphasized leisure as "an important component of life-career development, noting that persons fulfill the role of the leisurite for a greater portion of the life span that any other major life role." (as cited in Tinsley & Eldredge, 1995, p. 123). Tinsley and Eldredge (1995) did a study that examined the importance of leisure in employment. The findings supported the theory that leisure experiences affect the physical and mental health of the individual.

In examining the findings of the relationship between compassion fatigue and burnout as it relates to religious beliefs and activities, a relationship does exist between practitioners and their participation in religion activities. This finding was consistent with Koenig et al., who strongly suggested that even simplistic religion and spirituality measures such as denominational affiliation or church attendance, are significant predictors of health outcome variables" (as cited in Hill & Pargament, 2003, p. 64). In a different study done by Koenig et al., the study implied that almost 4,000 older adults who engaged in frequent church attendance had a lower mortality rate than less frequent attendees (Koenig & Vaillant, 2009, p. 117).

Practitioners need to be aware of behavioral warning signs that exist in identifying

Post Traumatic Stress Disorder. The same symptoms that exist with PTSD may be present in practitioners who encounter compassion fatigue or secondary traumatic stress disorder. The symptoms that identify traumatic stress are as follows: (1) Stressors (Unusual experience from an event that causes serious threat, destruction or trauma); (2) Reexperiencing trauma events (recollection of an event, dreams of event, and/or reminders of a stressing event); (3) Avoidance of reminders of events (efforts to avoid thoughts/feelings/activities/situations, psychogenic amnesia, diminished interest in activities, detachment from others); and (4) Persistent arousal (difficulty falling asleep, irritability or outbursts of anger, difficulty concentrating, hypervigilance for therapist, exaggerated startle response, and physiologic reactivity to cures)" (Figley, 1995, p. 8). The inference here is for practitioners to seek and attend counseling, if needed. When dealing with difficult cases, consultations with a supervisor or expert might be an alternative.

Implications for Future Research

There are implications for a national study. The religious component of the study suggested that practitioners that participate in religious activities were at lower risk for compassion fatigue and burnout. With the statistically significant findings on religion, there are implications for creating a wellness model (or using one that is already in place). Adams identified "wellness as a construct reflecting the process on enhancing life quality by integrating and balancing one's physical, mental and spiritual well-being (as cited in Harari, Wachler &Rogers, 2005, p. 93). Wellness as a model incorporates the freedom to do activities that encompass wholeness or completeness in all aspects of health.

Conclusion

The study was a descriptive study of the experiences and feelings of practitioners in relation to working with victims of trauma. The purpose of the study was to explore the risk for master's level and above practitioners to be susceptible to compassion fatigue or burnout. Practitioners in the southeastern region of the United States were assessed based upon their responses to four instruments, the Personal and Professional Survey, the Compassion Fatigue Self-Test for Psychotherapists, the Objectivism Scale, and the researcher adaption of the Duke Religious Index. The results of this study can encourage practitioners to seek complete wholeness by incorporating wellness as a model, encompassing the activities of practitioners. According to Adams (as cited in Harari, Wachler, & Rogers, 2005, p. 93), wellness refers to a highly personalized process on integrating different personal strengths and interests in the ways that maximize practitioners' potential within their social environments. Finally, the results of this study can be used to educated practitioners and to inform students in master's level and above programs about how to incorporate wellness into their careers. There are courses that are being taught at colleges and/or universities where the wellness model can be included into the curriculum, such as diversity courses, multicultural counseling courses, or skills courses. Training students on the benefits of incorporating their religious/spiritual practices into their careers could potentially reduce the risk for compassion fatigue or burnout throughout the counseling/helping field, which could impact the practitioner's ability to remain healthy. This holistic component may be an essential tool that college professors can use to train future practitioners.

Chapter 6

PUBLICATION MANUSCRIPT

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Running head: THE INESCAPABLE COMPASSION FATIGUE

The Inescapable Compassion Fatigue:

A Lifeline to Practitioners

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Abstract

As major stakeholders in the helping profession, counselors and other mental health professionals are prepared to assist clients in coping with intensely painful and traumatic experiences. While assisting their clients in processing traumatic events (e.g., natural disasters, violent crimes, grief, accidents, terrorist attacks), however, some professional helpers may become overwhelmed themselves and thereby experience compassion fatigue and/or burnout. This study evaluated whether certain personal and professional factors in counselors – including objectivism in decision-making and religious beliefs and activities – are related to their ability to avoid compassion fatigue and/or burnout.

The Inescapable Compassion Fatigue: A Lifeline to Practitioners

Compassion fatigue has the potential to inflict great harm on the vast number of practitioners who are susceptible to this phenomenon. The concept of the helper being traumatized as a result of helping has a framework and is a vein in a field of study known as *traumatology*. Traumatology is the study of the impact of trauma on humans, and the concept of traumatology can be traced back to the medical writings of Kunus Pyprus in Egypt circa 1900 B.C. (Figley, 1995).

The concept of compassion fatigue is receiving increasing attention and more researchers are slowly beginning to study this powerful and potentially damaging phenomenon. In recent years, with the occurrences of natural disasters, increased crime rates, killings in schools, and other traumatic experiences, the need for mental health services has increased dramatically and more victims of these traumatic experiences are seeking assistance. Practitioners are expected to utilize empathy to a degree such that the emotional well-being of the practitioner could be negatively affected. According to Dunkley and Whelan (2006), as clients describe the details of their trauma, practitioners can experience parallel states of fear, grief, and helplessness. Another name for the phenomenon of vicarious traumatization *is compassion fatigue*. In this study, the term *compassion fatigue* will be used to indicate vicarious traumatization, secondary traumatic stress, and Secondary Traumatic Stress Disorder.

Literature Review

It has been suggested that a unique feature of some mental health practitioners' work is exposure through their role as practitioners to clients' descriptions of traumatic

events and reactions to a trauma, and that these experiences may actually indirectly cause distress and traumatization to the therapist (Farell & Turpin, 2003). It is not an easy task for some counselors to listen the problems, and the traumatic events of clients on a regular basis without experiencing some form of anguish.

There have been several attempts to identify the deleterious effects that helpers in the trauma field may experience (Sexton, 1999). Practitioners may not realize what is happening when they are being negatively impacted by exposure to trauma through the experiences of their clients. Bell (2003) found that when counselors of trauma victims were asked whether they were affected by the trauma experienced by their clients, "Forty percent of counselors felt that their work with trauma survivors had had a positive effect on them, feeling that they had become more compassionate, more grateful and less judgmental as a result. Only 10% of counselors felt that their work had a negative effect on them, making them feel more negative toward others. Forty-three percent of the counselors could name both positive and negative effects of their work or were unsure of its effect" (p. 516).

Practitioner Susceptibility to Compassion Fatigue

Some of the gaps in the current research pivot on the definition of compassion fatigue as well as the type of practitioner that is more susceptible to secondary trauma. Some researchers view compassion fatigue and secondary trauma as parallel to vicarious traumatization, while others view vicarious traumatization and secondary trauma as being synonymous, with compassion fatigue being a separate entity. Figley (1995) has said that "secondary traumatic stress has been called different names over the years" (p. 9). It is furthered suggested by Figley that "compassion stress and compassion fatigue are

appropriate substitutes" (p. 9). Bell (2003) said that practitioners who work with trauma survivors are susceptible to secondary trauma, a form of work-induced posttraumatic stress disorder. During the past 10 years, researchers have examined this experience using several similar terms: compassion fatigue, secondary traumatic stress, and vicarious trauma (Figley, 1993; Herman, 1992; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Wilson & Lindy, 1994; Stamm, 1995/1999). Regardless of their theoretical frameworks, all of the terms used by various experts refer to negative reactions of helping professionals specific to their work with trauma survivors (Bell).

Previous personal history of practitioners may be a major contributing factor to the development of compassion fatigue in mental health professionals. Pearlman and Ian (1995) said "Literature tells us that doing trauma therapy can affect therapists negatively and that its effects are different from those related to doing general psychotherapy. The research suggests that aspects of the therapist, such as personal history, gender, and personal stress, may interact with exposure to trauma material to contribute to trauma-related symptoms in therapists" (p. 559). The impact of a counselor's personal history of trauma or his or her vulnerability to secondary trauma/compassion fatigue has been a major focus of research interest, but the findings are inconclusive (Bell, 2003).

It has been proposed that practitioners may be unaware that they have compassion fatigue because of their tendency to avoid self-evaluation. Norcross and Guy (2007) said, "Mental health professionals, by definition, study and modify human behavior. That is, we study and modify other humans. Psychological principles, methods, and research are rarely brought to bear on psychotherapists ourselves, with the probable exception of our unsolicited attempts to diagnose one another" (p, 1). However, there are symptoms that

can identify compassion fatigue, making a counselor aware that he or she has been affected by a traumatic counseling session. These symptoms, analogous to post-trauma symptoms, can include sleep disturbance, intrusive images, and disruption to core schema about safety in the world, trust, intimacy and control (McLean, Wade, & Encel, 2003). Cunningham (2003) found that acknowledging and addressing compassion fatigue can alleviate the negative effects of trauma work for practitioners and help ensure quality services for the clients they treat. Practitioners must be cautious and approach each client's trauma with care, recognizing that the client's trauma could be contagious.

Burnout

Practitioners' reactions to trauma have historically been characterized as forms of either *burnout* or *countertransference* (Figley, 1995). The professional literature has more recently begun to use different terms, such as *vicarious trauma*, *compassion fatigue*, *secondary trauma* and *secondary traumatic stress*. Burnout and compassion fatigue are different in that burnout is described more as a result of the general psychological stress of working with difficult clients (Figley). Burnout occurs over the course of time while providing services. Compassion fatigue or vicarious traumatization is seen as a traumatic reaction to specific client-presented information (Tripanny, Kress, & Wilcoxon, 2004).

Initially, there were various opinions and debates over the constructs and how they differ. For example, Pearlman and Saakvitne (1995) contended that vicarious traumatization has its foundation in a constructivist personality theory and focuses on meaning and adaptation, whereas secondary traumatic stress disorder focuses on symptoms. "Researchers have attempted to distinguish secondary trauma from earlier conceptualizations of counselor stress, such as burnout" (Bell, 2003). Figley (1995)

hypothesized that there may be similarities between burnout and compassion fatigue. Burnout, however, emerges gradually and is a result of emotional exhaustion, whereas compassion fatigue can emerge suddenly with little or no warning.

Burnout is different from compassion fatigue. Sexton (1999) concluded that burnout, "...is a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who do people work of some kind" (p. 395). Although some researchers have equated burnout and secondary trauma, in this research project, these two constructs will be treated as separate and different constructs.

There have been several employment positions that I have held in which I experienced burnout. In thinking back on some of those positions, it was more the nature of the work than the population that was served. In my opinion, compassion fatigue is more clearly defined than burnout. While the two may cross in definitions, behaviors, or emotions, burnout occurs over time; however, compassion fatigue and vicarious traumatization could occur the first time that a counselor meets a client. Burnout may take a while; it is a process that an individual goes through over time in a position or role. There could be a variety of stressors that could produce burnout, which may include counseling victims of traumatic events. Traumatic events could include actual or threatened deaths or injuries to oneself or others, around which feelings of fear, helplessness, or horror were present. No person is immune to experiencing traumatic events; they can affect anyone regardless of age, race, sex, ethnicity, sexual orientation, religious affiliation, or educational level (Hesse, 2002). Theoretically, individuals working in the caring professions often attempt to alter the behaviors and emotions of their clients by providing emotional support (e.g., empathy), strategies for coping with

emotions, or better cognitive management skills (Adams, Boscarino, & Figley, 2006)). However, as the practitioner attempts to rescue the client, the practitioner is placed in the tangible position of needing to be rescued from the very event that placed the client in a vulnerable position.

Burnout for mental health professional has been extensively studied over a long period of time (Maslach, 1976). Burnout occurs when professionals lose interest in their jobs because they work too hard over a period of time. They become tired or *worn out.* Burnout is included in this study to distinguish the construct from compassion fatigue. Norris and Guy (2007) indicated that avoiding burnout would be equivalent to discussing how to avoid catching a cold, how to avoid a bad marriage, or how to avoid an automobile accident. Research indicates that approximately 2-6% of psychotherapists are experiencing burnout at any one time (Norris and Guy).

Is Compassion Fatigue Inescapable?

It is not an easy task for some practitioners to listen to the problems, stories, or issues of their clients each day without bearing some form of anguish. Sometimes, as practitioners assist clients, they pay the ultimate price of having the very problems that their clients are struggling with trickle over into their lives. When practitioners have difficulty separating their personal lives from their professional lives, they may fail to utilize empathy. If the information that the clients have relayed to them is of such a great magnitude, the practitioners may become vicariously traumatized by their clients' pain, thereby developing compassion fatigue.

As noted by Fox and Cooper (1989), practitioners are not immune to painful images, thoughts, and feelings that are presented by clients. This study will explore the

phenomenon of compassion fatigue, including factors – such as objectivism or religion – that may prevent its development in practitioners.

Method

The study examined information from master's level and above practitioners in the southeastern region of the United States. Master's level and above practitioners are more apt to actively work in the areas of trauma, crisis situations, or grief and loss counseling more often than undergraduates. The opportunity to participate in this study was extended to practitioners who had an earned master's degree (social work, counseling, education, and psychology), licensed social workers (LCSW), licensed counselors (LPC) and PhD level practitioners.

Instrumentation

The Compassion Fatigue Self-Test for Psychotherapist. The inventory consisted of 40 items. The *CF Self Test* required that the test taker responded to items according to a Likert scale, with 1 = Rarely/Never; 2 = At Times; 3 = Not Sure; 4 = Often, and 5 = Very Often. "Compassion fatigue scores were as follows: 26 or less = Extremely low risk; 27 to 30 = Low risk; 31- 35 = Moderate risk; 36 to 40 = High risk; 41 or more = Extremely high risk. The scores for 'burn out' were as follows: 17 – 36 or less = Extremely low risk; 37 – 50 = Moderate risk; 51 – 75 = High risk, and 76 – 85 = Extremely high risk" (Figley, 1995, p. 14). This instrument consisted of two subscales, where one subscale identified compassion fatigue, and the other subscale identified burnout. The following items identified compassion fatigue scores: items 1-8; 10-13; 17-26; and 29. The remaining items of the 40-item instrument identify whether burnout was present in counselors: items 9; 14-16; 27-28; and 30-40. The scores for this instrument

were obtained by adding together identified items for each subscale. The scores were grouped into three levels, *low/extremely low risk, moderate risk* and *high/extremely high risk.* The scores for low and extremely low were combined. The scores for high and extremely high were combined.

The *Objectivism Scale's* 11 items are as follows: (1) I seek as much information as possible before making decisions; (2) I think the answers to most questions in life can be found through careful, objective analysis of the situation; (3) I do not like to be too objective in the way I look at things; (4) Trying to be highly objective and rational does not improve my ability to make good decisions; (5) I see myself as a rational and objective person; (6) After I make a decision, it is often difficult for me to give logical reasons for it; (7) I gather as much information as possible before making decisions; (8) The solution to many problems in life cannot be found through an intellectual examination of the facts; (9) I try to employ a cool-headed, objective approach when making decisions about my life; (10) I am only confident of decisions that are made after careful analysis of all available information; and (11) I tend not to be particularly objective or logical in my approach to life (Leary et al., 1986). Items 3, 4, 6, 8, and 11 are reversed scored. Scores ranged from 11 to 55 with higher scores indicating more objectivism.

The *DUREL* is a brief self-administered measure that was designed to assess the religious involvement of its users. This instrument has been used in a variety of research studies and it has proven construct validity. The *DUREL* is a five-item survey consisting of the following: (1) How often do you attend church or other religious meetings; (2) How often do you spend time in private religious activities, such as prayer, mediation or

Bible study; (3) In my life, I experience the presence of the Divine (i.e. God); (4) My religious beliefs are what really lie behind my whole approach to life; (5) I try hard to carry my religion over into all other dealings in my life (Koenig, 1996). This index was adapted and used to determine whether participants have religious beliefs and engage in religious activities.

Procedure

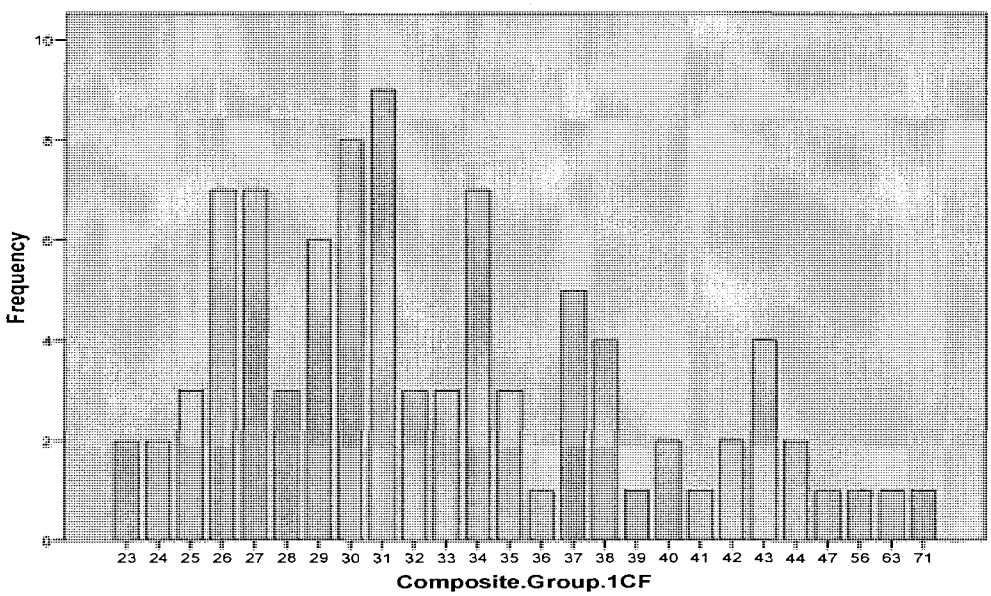
An e-mail list was obtained from Virginia Beach Social Services, Virginia Beach Community Services Board, regional private counseling practices, Norfolk General Social Work Trauma Burn Unit, Chesapeake Community Services Board, Chesapeake Social Services, Portsmouth Behavioral Center, and other clinical agencies./universities This process incorporated a convenience data collection process. Once administration and/or acquaintances were contacted, potential participants were contacted via e-mail with a request that they participate and participation instructions explaining the details of the research project. Practitioners who agreed to participate were instructed to click on the survey link that opened the instruments, and participants were instructed to answer each question. A demographic survey, the Personal and Professional Information instrument, was designed by the researcher and was included for the purpose of obtaining personal and professional information concerning characteristics of the participating practitioners. The *Compassion Fatigue Self-Test for Psychotherapists*, the *Objectivism Scale*, and the *Duke Religion Index* were also included in the survey package. These instruments were used to determine whether compassion fatigue or burnout were identifiable in the practitioners who chose to participate in the research; whether the manner in which practitioners' process information (primarily using feelings or empirical

data), and whether the religious activities and beliefs of the practitioners can be contributors of compassion fatigue or burnout.

Results

The dependent variable of this research was the risk for compassion fatigue and the risk for burnout. The first question of this research was as follows: "What level of risk for compassion fatigue and level of risk for burnout exist in master's level and above practitioners (counselors, social workers, and mental health clinicians) in the southeastern region of the United States?" The data was collected using a convenience sample. The results revealed that the practitioners were at risk for compassion fatigue. The Spearman Correlation revealed a p-value of, $p < .000$. There is definitely a statistical significance since $p < .05$. The practitioners scores were as follows: thirty-eight were at low risk for compassion fatigue: twenty-five were at moderate risk for compassion fatigue, and twenty-six were at high risk for compassion fatigue.

Figure 1
Compassion Fatigue



Objectivism Results

Objectivism was grouped into two different levels, two groups (low objectivism and high objectivism) and three groups (low objectivism, moderate objectivism, and high objectivism). First, the three level groupings were examined. The maximum frequency count was in high objectivism and low risk of the levels of Compassion Fatigue (count = 14, relative frequency = 15.7%) based on a sample of 89 clients. Spearman Correlation tests showed there is no significant difference between the levels of Compassion Fatigue and objectivism (3 levels) with a test statistic value of -.021 and *p*-value = .844. The maximum frequency is in the high risk of burnout groups and moderate and high objectivism. It can also be seen that there is an increasing trend based on the sample. However, there is no significant relationship between the levels of burnout groups and objectivism groups (3). The Spearman Correlation test statistic has a value of 0.089 and *p*-value of 0.405. Hence, no conclusion can be made about the population. It does not appear to be a factor as to how the practitioners make decisions.

In examining the 2 levels of objectivism, the tests suggest that high objectivism and low risk has the highest count. (Count = 21 and Relative Frequency = 23.6%) based on the sample. The 3 levels of compassion fatigue and the 2 levels of objectivism are not significantly correlated. (Spearman's Correlation test statistic = -.115 with *p*-value = .283). In examining burnout, the highest frequency is in the high risk of burnout groups and low objectivism (count = 20, relative frequency = 22.5%). There is no significant relationship between the 3 burnout groups and 2 levels of objectivism (Spearman Correlation test statistic= 0.028 with *p*-value = .797).

Adapted DRUEL Results

The DUREL was adapted used to identify whether religious activities was a factor that implicated the risk for compassion fatigue or burnout. When reading the literature on studies that have encompassed the examination of religious activities (practices) and beliefs, they are both components of religiosity. Koenig (2001) conceptualizes religion as an organized system of beliefs and practices designed to help the individual with sacred and/or transcendent aspects.

The maximum frequency is in high religious activities of the low fatigue group. (Count = 31 and relative frequency = 34.8%). Here, there is a significant relationship between the levels of compassion fatigue and the DUREL groups. (Spearman Correlation's test statistic = -.260, *p*-value = 0.014). The maximum count is in the moderate risk and high religious activity (Count = 22 with relative frequency = 24.7%). There is also a significant relationship between the burnout groups and DUREL groupings (Spearman Correlation test statistic = -.307 with *p*-value = .003). When

looking at the five composite groups, the 3 levels of religious activities (DUREL) are statistically significant within each type of composite levels of compassion fatigue, burnout, and work environment at the significance level of, $p < 0.05$, since their respective p-values are 0.043, 0.008, and 0.002. However, the three levels of the DUREL are statistically significant with the type of composite levels to include "self" and "client and family" at significance level of 0.10 since their respective p-values are 0.088 and 0.100.

Discussion

The study was a descriptive study of the experiences and feelings of practitioners in relation to working with victims of trauma. The purpose of the study was to explore the risk for master's level and above practitioners to be susceptible to compassion fatigue or burnout. Practitioners in the southeastern region of the United States were assessed based upon their responses to four instruments, the Personal and Professional Survey, the Compassion Fatigue Self-Test for Psychotherapists, the Objectivism Scale, and the adapted Duke Religious Index. The results of this study can help practitioners seek emotional healthiness, by identifying factors that could potentially increase the risk of the practitioner to encounter compassion fatigue or burnout. It informs practitioners that regardless of their decision making style, there is no reflection on a counselor's ability to compartmentalize. Finally, these results can educate practitioners on the topic of compassion fatigue and burnout and increase their awareness of the possibility of being at risk if practitioners are not able to compartmentalize.

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APPENDICES

Appendix A: Personal and Professional Information

Please provide the personal information requested below.

1. Number of years since you earned your master's degree _____?

2. Number of years you have been a clinician, social worker, counselor _____?

3. Race/Ethnicity (check one):
(U.S. Census Bureau, 2006)
___ American Indian or Alaska Native
___ Asian
___ Black
___ Hispanic Origin
___ Native Hawaiian or Other Pacific Islander
___ White (not Hispanic)
___ Biracial
___ Other

4. Gender (check one):
___ Male
___ Female

5. What type of community did you live in during the majority of your childhood (ages 3-19) (check one):
___ Rural community – County

___ Small town – Town smaller than 25,000 population
___Urban community – In a large city with more than 25,000 population
___ Suburban community – Near a city of more than 25,000
___ Mixture of communities – I lived in more than one area equally

The following items are made up of statements using several terms which are defined below for you. Please refer to them throughout the rest of the questionnaire. Please read the definition of trauma before you answer the following questions:

Trauma: A physical, emotional, or mental condition that negatively impacts an individual and causes pain and suffering.

6. Do you currently counsel clients who have experienced trauma or have you counseled such clients in the past? (check one):
___ Yes
___ No

7. How many hours a week do you counsel (or work with in a professional setting) clients who have experienced trauma (on an average) or have you counseled (or worked with in a professional setting) such clients in the past? _____

8. Number of years you have counseled (or worked with a professional setting) clients who have experienced trauma: _____

9. Have you ever been a direct victim of trauma yourself?
_____ Yes, I have been a victim of what I consider to be serious trauma
_____ Yes, I have been a victim of what I consider to be mild trauma
_____ No, I have not been a victim of trauma

10. Leisure Activity (check one):
___ I **do** participate in a leisure activity at least three hours or more a week
___ I **do not** participate in a leisure activity at least three hours a week

Please now respond to the 3 instruments on the following pages:
1 – Objectivism Scale
2 – Duke Religion Index
3 – Compassion Fatigue Self-Test for Psychotherapists

Appendix B:
The Objectivism Scale

(Reprinted with Permission from Mark Leary)

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

1= Extremely characteristic of me
2= Very
3= Moderately
4= Slightly
5= Not at all

1. _____ I seek as much information as possible before making decisions

2. _____ I think the answers to most questions in life can be found through careful, objective analysis of the situation

3. _____ I do not like to be too objective in the way I look at things.

4. _____ Trying to be highly objective and rational does not improve my ability to make good decisions

5. _____ I see myself as a rational and objective person

6. _____ After I make a decision, it is often difficult for me to give logical reasons

for it

7. _____ I gather as much information as possible before making decisions

8. _____ The solution to many problems in life cannot be found through an intellectual examination of the facts

9. _____ I try to employ a cool-headed, objective approach when making decisions about my life

10. _____ I am only confident of decisions that are made after careful analysis of all available information

11. _____ I tend not to be particularly objective or logical in my approach to life

Appendix C:
DUREL: Duke University Religion Index

Directions: Please answer the following questions about your religious beliefs and/or involvement. Please indicate your answer with a checkmark.

(1) How often do you attend church or other religious meetings?

1. More than once/wk
2. Once a week
3. A few times a month
4. A few times a year
5. Once a year or less
6. Never

(2) How often do you spend time in private religious activities, such as prayer, meditation or Bible study?

1. More than once a day
2. Daily
3. Two or more times/week
4. Once a week
5. A few times a month
6. Rarely or never

The following section contains 3 statements about religious belief or experience. Please mark the extent to which each statement is true or not true for you.

(3) In my life, I experience the presence of the Divine (i.e., God).

1. Definitely true of me
2. Tends to be true

3. Unsure
4. Tends *not* to be true
5. Definitely *not* true

(4) My religious beliefs are what really lie behind my whole approach to life.

1. Definitely true of me
2. Tends to be true
3. Unsure
4. Tends *not* to be true
5. Definitely *not* true

(5) I try hard to carry my religion over into all other dealings in life.

1. Definitely true of me
2. Tends to be true
3. Unsure
4. Tends *not* to be true
5. Definitely *not* true

Koenig HG, Meador K, Parkerson G. Religion Index for Psychiatric Research: A 5-item Measure for Use in Health Outcome Studies. American Journal of Psychiatry 1997; 154:885-886

Permission is granted for research and clinical use of the scale. Further permission must be obtained before any modification or revision of the scale can be made.

Appendix D: CF Self-Test for Psychotherapist

This self-test is not intended to provide medical advice or diagnosis. Consult a physician or mental health professional if you think you might be suffering from Compassion Fatigue.

Consider each of the following characteristics about you and your current 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 or 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 thought about violence against the perpetrator.

9. ☐ I am a sensitive person.

10. ☐ I have had flashbacks connected to my clients.

11. ☐ I have had first-hand experience with traumatic events in my adult life.

12. ☐ I have had first-hand experience with traumatic events in my childhood.

13. ☐ I have thought that I need to "work-through" a traumatic experience in my life.

14. ☐ I have thought that I need more close friends.

15. ☐ I have thought that there is no one to talk with about highly stressful experiences.

16. ☐ I have concluded that I work too hard for my own good.

Items about your clients and their families:

17. ☐ I am frightened of things a client has said or done to me.

18. ☐ I experience troubling dreams similar to a client of mine.

19. ☐ I have experienced intrusive thoughts of sessions with especially difficult clients.

20. ☐ I have suddenly and involuntarily recalled a frightening experience while working with a client.

21. ☐ I am preoccupied with more than one client.

22. ☐ I am losing sleep over a client's traumatic experiences.

23. ☐ I have thought that I might have been "infected" by the traumatic stress of my clients.

24. ☐ I remind myself to be less concerned about the well-being of my clients.

25. ☐ I have felt trapped by my work as a therapist.

26. ☐ I have felt a sense of hopelessness associated with working with clients.

27. ☐ I have felt "on edge" about various things and I attribute this to working with certain clients.

28. ☐ I have wished that I could avoid working with some therapy clients.

29. ☐ I have been in danger working with therapy clients.

30. ☐ I have felt that my clients dislike me personally.

Items about being a helper and your work environment:

31. ☐ I have felt weak, tired, rundown as a result of my work as a therapist.

32. ☐ I have felt depressed as a result of my work as a helper.

33. ☐ I am unsuccessful at separating work from personal life.

34. ☐ I feel little compassion toward most of my co-workers.

35. ☐ I feel I am working more for the money than for personal fulfillment.

36. ☐ I find it difficult separating my personal life from my work life.

37. ☐ I have a sense of worthlessness/disillusionment/resentment associated with my work.

38. ☐ I have thoughts that I am a "failure" as a therapist.

39. ☐ I have thoughts that I am not succeeding at achieving my life goals.

40. ☐ I have to deal with bureaucratic, unimportant tasks in my work life.

Make sure you have responded to ALL questions.
**You do not have to score this test. I will score the test. If you have questions, please contact Brenda J. Smith at 757-839-1739.

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APPENDIX E: IRB APPLICATION AND ADDENDUM

Description of Proposed Study & Research Protocol

Study Title: COMPASSION FATIGUE, BURNOUT, OBJECTIVISM, AND RELIGIOUS BELIEFS IN COUNSELORS

Primary Purpose:
This purpose of this study is to explore whether counselors' objectivism (decision making skills), as well as their religious activities and, beliefs, are factors that are associated with their ability to avoid developing compassion fatigue when counseling victims of traumatic events. Not only counselors, but other helping professionals as well, could possibly benefit from the results of this study. This study will also examine whether the following traits of counselors are associated with their development of compassion fatigue or burnout: (a) gender, (b) race, (c) age, (d) years of experience, (e) whether they are objective or subjective decision makers, (f) whether they engage in leisure activities, (g) history of trauma (childhood/adult), (h) region (urban/rural), and (i) religious activities and beliefs.

Units of Analysis:
Participants' responses to 4 instruments: This researcher will use four instruments to collect data. The four instruments that will be used are as follows: the Compassion Fatigue Self Test for Psychotherapists (CF Self Test), the Objectivism Scale, the Duke University Religion Index (DUREL), and the Personal and Professional Demographic Instrument will be used in this study.

Sampling Strategy:
Convenience sampling will be used to identify counselors. An e-mail list will be obtained from the National Board for Certified Counselors (NBCC) for all

CCMHCs. All listed counselors will be e-mailed a cover letter explaining the details of the research project and a request that they participate. Counselors who agree to participate will click on a URL that will lead them to the instruments they will be asked to complete. A demographic survey, the Personal and Professional Information instrument, was designed by the researcher and will be included for the purpose of obtaining personal information concerning characteristics of the participating counselors. The *Compassion Fatigue Self-Test for Psychotherapists*, the *Objectivism Scale*, and the *Duke Religion Index* will also be included in the survey. These instruments will be used to determine whether compassion fatigue or burnout can be identified in the counselors who choose to participate in the research; whether manner in which counselors' process information (primarily using feelings or empirical data), and whether the religious activities and beliefs of the counselors can be contributors to compassion fatigue or burnout. No identifying information will be available to the researcher.

Data Collection and Analysis:

This study will be conducted utilizing the *Statistical Package for the Social Sciences (SPSS), Grad Pack 16.0 for Windows*. The independent variables of this study will be drawn from the Duke Religious Index (to measure religious values), and Objectivism Scale (to determine the characteristics of the counselors personalities). The dependent variables will be drawn from the Compassion Fatigue Self Test for Psychotherapists (CF Self Test). The CF Self Test will identify if compassion fatigue or burnout are present in the participants.

Descriptive data will be reported using frequency distribution statistics. All collected data will be measured using interval data. The researcher will examine the relationship between the independent variables from items in the DURELL and the Objectivism Scale and the dependent variables from items in the CF Self Test, using appropriate correlations coefficients. An overall score using composite variables will be created for each scale for each participant. Depending upon where relationships exist between independent and dependent variables, Mann Whitney, Wilcoxin and other appropriate statistical tests will be run to determine whether compassion fatigue and burnout can be identified from the independent variables.

Validity and Confidence in Findings:

There are two types of validity threats being identified in this paper and they are external validity threats and internal validity threats. "External validity refers to the ability to generalize the results of an experiment to individuals in a population outside of the experimental setting. A threat to external validity is a circumstance that limits the ability to generalize" (Orcher, 2005). "Internal validity is about credibility. It is defined as the extent to which all extraneous influences, other than the variable (s) under study, have been accounted for (controlled) and the observed effect can be attributed to this variable (s) (also called the independent or experimental variable)" (Drew, Hardman & Hosp, 2008). The participants in this study will be recruited from 1,127, Certified Clinical Mental Health Counselors (CCMHCs), in the United States. Only e-mail addresses are being requested. No identifying information will be accepted. A threat to this study is

subject effects. Subject effects could occur in this research, meaning counselors may respond in a way that they do not identify themselves as fatigued.

Confidentiality:
There are no foreseeable risks associated with this project. All information obtained about participants in this study is strictly confidential unless disclosure is required by law. The results of this study may be used in reports, presentations, and publications, but the researcher will not identify individual participants, as no identifiable information is being requested. Participation in this study is voluntary.

SECTION 2: Informed Consent Document

Old Dominion University

Project Title: A Study of Objectivism and Religious Beliefs and Practices

The purpose of this form is to give you information that affects your decision - whether to say YES or NO to participation in this research; it will also be used to record the consent of those who say YES. If you are interested in participating in the research project, your completion of the attached demographic sheet will serve as record of your consent. You may keep this form for your records.

The primary investigator of this study is Brenda J. Smith, MSW, M.A. Ed., a doctoral student in the Counselor Education and Supervision Program (mental health/school counseling) in the Department of Educational Leadership and Counseling in the College of Education at Old Dominion University.

The purpose of this study is to explore counselors' initial perceptions of clients as they relate to several independent variables. General cultural comfort will also be assessed in order to explore the role of culture in working with clients.

Data collection and data analysis will occur between January 2008 and March 2008. If you decide to participate, you will be asked to: (a) complete a Personal and Professional questionnaire, (b) complete three instruments. Completion of the full survey packet should take approximately 25-30 minutes. The primary investigator will have no knowledge of your identity.

Participation in this study is voluntary. You may opt out of this online study by simply not returning this packet to the primary researcher or leaving the responses blank and returning the packet via e-mail to the researcher.

There are no foreseeable risks associated with this project. All information obtained about you in this study is strictly confidential unless disclosure is required by law. The results of this study may be used in reports, presentations, and publications, but the researcher will not identify you.

The primary investigator wants your decision about participating in this study to be absolutely voluntary. It is OK for you to say NO. Even if you say YES now, you are free to say NO later, and walk away or withdraw from this study at any time. If you say YES, your consent in this document does not waive any of your legal rights. However, in the event of harm arising from this study, neither Old Dominion University nor the researcher are able to give you any money, insurance coverage, free medical care, or any compensation for such injury. In the event you suffer injury as a result of participation in this research project, you

may contact Brenda J. Smith at 757-839-1739 who will be glad to review the matter with you.

By completing the attached participant demographic sheet, you are saying several things. You are saying that you have read this form or have had it read to you, that you are satisfied that you understand this form, the research study, and its risks and benefits. The researcher should have answered any questions you may have had about the research. If you have any questions later on, please contact the primary investigator, Brenda J. Smith, at bjsmith@odu.edu.

SECTION 3:
OLD DOMINION UNIVERSITY
APPLICATION FOR EXEMPT RESEARCH

Note: For research projects regulated by or supported by the Federal Government, submit 10 copies of this application to the Institutional Review Board. Otherwise, submit to your college human subjects committee.

Responsible Project Investigator (RPI)

The RPI must be a member of ODU faculty or staff who will serve as the project supervisor and be held accountable for all aspects of the project. Students cannot be listed as RPIs.

First Name: Radha	**Middle Initial: J**	**Last Name: Horton-Parker**
Telephone: 683-6695	**Fax Number: 683-5756**	**E-mail:rparker@odu.edu**
Office Address: Darden College of Education, ED 110		
City: Norfolk	**State: VA**	**Zip: 23529**
Department: Educational Leadership and Counseling	**College: Darden College of Education**	
Complete Title of Research Project: Compassion Fatigue, Burnout, Objectivism, and Religious Beliefs in Counselors		**Code Name (One word): Fatigue**

Investigators

Individuals who are directly responsible for any of the following: the project's design, implementation, consent process, data collection, and data analysis. If more investigators exist than lines provided, please attach a separate list.

First Name: Brenda	**Middle Initial: J**	**Last Name: Smith**
Telephone: 757-839-1739	**Fax Number:**	**Email: bjsmith@odu.edu**
Office Address: 250-2 Education Building, Old Dominion University		
City: Norfolk	**State: VA**	**Zip: 23529**

Affiliation: __Faculty _X_Graduate Student __ Undergraduate Student
__Staff _x_Other__**Adjunct Faculty**_____

List additional investigators on attachment and check here: __

Type of Research

1. This study is being conducted as part of (check all that apply):

_	Faculty Research		Non-Thesis Graduate Student Research
X	Doctoral Dissertation	_	Honors or Individual Problems Project
_	Masters Thesis	_	Other_____

Funding

2. Is this research project externally funded or contracted for by an agency or institution which is independent of the university? Remember, if the project receives ANY federal support, then the project CANNOT be reviewed by a College Committee and MUST be reviewed by the University's Institutional Review Board (IRB).

___Yes **(If yes, indicate the granting or contracting agency and provide identifying information.)**
__X_No

Agency Name:
Mailing Address:
Point of Contact:
Telephone:

Research Dates

3a. Date you wish to start research (MM/DD/YY) ___01/02/2009__
3b. Date you wish to end research (MM/DD/YY) _04/15/2009_ (ending some point before this date)

Human Subjects Review

4. Has this project been reviewed by any other committee (university, governmental, private sector) for the protection of human research participants?

___Yes
__X_No

4a. If yes, is ODU conducting the primary review?

__Yes
__No (If no go to 4b)

4b. Who is conducting the primary review?

5. Attach a description of the following items:

X Description of the Proposed Study
X Research Protocol
X References
X Any Letters, Flyers, Questionnaires, etc. which will be distributed to the study subjects or other study participants
N/A If the research is part of a research proposal submitted for federal, state or external funding, submit a copy of the

FULL proposal

Note: The description should be in sufficient detail to allow the Human Subjects Review Committee to determine if the study can be classified as EXEMPT under Federal Regulations 45CFR46.101(b).

Exemption categories

6. Identify which of the 6 federal exemption categories below applies to your research proposal and explain why the proposed research meets the category. Federal law 45 CFR 46.101(b) identifies the following EXEMPT categories. Check all that apply and provide comments.

SPECIAL NOTE: The exemptions at 45 CFR 46.101(b) does not apply to research involving prisoners, fetuses, pregnant women, or human in vitro fertilization. The exemption at 45 CFR 46.101(b)(2), for research involving survey or interview procedures or observation of public behavior, does not apply to research with children, except for research involving observations of public behavior when the investigator(s) do not participate in the activities being observed.

____(6.1) Research conducted in established or commonly accepted educational settings, involving normal educational practices, such as (i) research on regular and special education instructional strategies, or (ii) research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.

Comments:

__X__(6.2) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless: (i) Information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; AND (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

Comments:

The study will include participant responses to a Personal and Professional Questionnaire, which includes demographic information only (counselor type, race/ethnicity, gender, etc.), Appendix A. It will also include participant responses to three survey instruments: Compassion Fatigue Self-Test for Psychotherapists, Objectivism Scale, and Duke Religion Index (See Appendices B**, C, and D**). Participants will not be identified by name and all responses will be analyzed in aggregate.

____(6.3) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior that is not exempt under paragraph (b)(2) of this section, if:

(i) The human subjects are elected or appointed public officials or candidates for public office; or (ii) federal statute(s) require(s) without exception that the confidentiality of the personally identifiable information will be maintained throughout the research and thereafter.

Comments:

____(6.4) Research, involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects.
Comments:

___ (6.5) Does not apply to the university setting; do not use it

____(6.6) Taste and food quality evaluation and consumer acceptance studies, (i) if wholesome foods without additives are consumed or (ii) if a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural chemical or environmental contaminant at or below the level found to be safe, by the Food and Drug Administration or approved by the Environmental Protection Agency or the Food Safety and Inspection Service of the U.S. Department of Agriculture.
Comments:

PLEASE NOTE:

1 You may begin research when the College Committee or Institutional Review Board gives notice of its approval.
2 You MUST inform the College Committee or Institutional Review Board of ANY changes in method or procedure that may conceivably alter the exempt status of the project.

Responsible Project Investigator (Must be original signature) **Date**

Addendum to the IRB Application for Brenda J. Smith

To: Dr. Ed Gomez and the IRB Committee
From: Brenda J. Smith, M.S.W., M.A. Ed
Subject: Addendum to IRB

Dissertation Title: Compassion Fatigue, Burnout, Objectivism, and Beliefs in
Practitioners

Dear Dr. Gomez,

Please accept this letter as an addendum to my IRB application. Initially, my IRB application indicated that I would collect data from the National Board of Certified Counselors (NBCC). However, due to a delay in obtaining the e-mail list for the aforementioned population, my population was changed to master's level and above practitioners in the southeastern region of the United States. The change in populations altered my selection process; therefore, my research study is now a convenience sample. The only identifying information is the e-mail addresses of the participants. No other identifying information is required or collected. Once this dissertation is defended, all e-mail addresses will be erased from the data base of Survey Monkey. The subjects *are not in any way* able to view the responses of other participants.

The title of my dissertation changed slightly to include the new term, *practitioner* into the title. Please see the old and new titles below:

Old Title: Compassion Fatigue, Burnout, Objectivism, and Beliefs in

Counselors
New Title: Compassion Fatigue, Burnout, Objectivism, and Beliefs in Practitioners

Finally, I have made some changes in my committee. My new committee is composed as follows: Dr. Vivian McCollum, Chair; Dr. Danica Hays, Committee Member; and Dr. Kate Ferguson, Methodologist. Dr. Vivian McCollum is my new Research Primary Investigator (RPI). Dr. Radha Parker (prior Research Primary Investigator) is no longer a part of my committee.

Please feel free to contact me should you have any questions. I can be contacted via e-mail or telephone. My e-mail address is bjsmith@odu.edu and my cell phone number is 757-839-1739.

Sincerely,

Brenda J. Smith

APPENDIX F: E-MAIL THAT WAS USED TO OBTAIN PARTICIPANTS

Compassion
Fatigue
Survey for
Brenda J
Smith

Body: My name is Brenda J. Smith; I am completing my PhD at Old Dominion University. I really need your help! I really need participants for my dissertation project. Should you choose to participate, it would be greatly appreciated. I am conducting this research in an effort to better understand the phenomenon of compassion fatigue. By sharing your thoughts, the profession can gain valuable insight that will help me to examine various variables that may be factors to identify why some counselors are more susceptible than others to becoming vicariously traumatized by clients (secondary trauma/compassion fatigue). Please know that your participation will be completely confidential. I have no interest in obtaining any identifiable information.
The survey should take you about 8-10 minutes to complete and your responses will be used for research purposes only. Survey Monkey upholds the strictest privacy policy. If you have any questions while taking this survey, please contact me at bjsmith@odu.edu

If you know other master's level counselors, clinicians, or social workers who would be willing to participate in this survey, please e-mail me with their e-mail address.
Thanks,
Brenda

Click the survey link to start the survey.

http://www.surveymonkey.com/s.aspx

If you do not want to participate, please click the link below.
http://www.surveymonkey.com/optout.aspx

VITAE

Brenda J. Smith holds a master of arts in social work from Norfolk State University, and a master of arts in school counseling from Norfolk State University. Professional experience includes over 25 years in the area human services and counseling, as well as recruitment, training, and job development with various agencies and departments. She has worked as a counselor, senior social worker, coordinator, special education teacher, facilitator, and an adjunct instructor. She is skilled with teaching using technology, distance learning, TELETECHNET, and video streaming.