

Compassion Satisfaction, Compassion Fatigue, and Burnout:
A Survey of CACREP Counseling Interns'
Perceptions of Wellness

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ABSTRACT

Counselor wellness is an important concept that can be taught in counselor education programs. However, it is difficult to teach concepts of wellness without addressing impairment issues such as compassion fatigue and burnout. Counseling interns tend to be at a higher risk of these impairment issues due to stressors related to being a novice counselor. The stress of engaging in therapeutic relationships with clients, lack of clinical experience, idealistic expectations of the profession, and personal issues can lead to possible impairment. CACREP accredited counselor education programs strive to educate counseling interns about wellness, foster compassion satisfaction, and overall well-being. Components of wellness include understanding the risks of the profession and learning self-care. Not educating counseling interns about impairment topics, such as compassion fatigue and burnout, can impede their professional growth and create barriers within the therapeutic context.

The purpose of this study was to a) determine the prevalence of compassion satisfaction, compassion fatigue, and burnout in CACREP counseling interns, b) determine CACREP counseling interns' perceptions of their program's wellness education, and c) examine the relationship between students' perceptions of their program's wellness education and levels of compassion satisfaction, compassion fatigue,

and burnout. The counseling interns were invited by their program liaisons to complete a Web-based survey, The Counseling Interns' Perceptions of Wellness Survey (CIPW) and the Professional Quality of Life (ProQOL). The participants included counseling interns from 20 CACREP accredited counselor education programs in the United States.

Descriptive statistics were conducted to determine compassion satisfaction, compassion fatigue, and burnout levels; to determine counseling interns' perceptions of their counselor education program's wellness education; and to determine counseling interns' knowledge of their counselor education program's assessment and retention policies.

Correlational statistics were conducted to determine the relationship between counseling interns' perceptions of their counselor education program's wellness education and curriculum and their levels of compassion satisfaction, compassion fatigue, and burnout.

The results suggest that, although counseling interns in this study were not at risk for compassion fatigue and burnout, a large percentage of them were at risk during a critical time during their training while providing therapeutic services to clients. Furthermore, counseling interns had overall high levels of compassion satisfaction, but there was a considerable amount of interns with low levels. On average, counseling interns had favorable perceptions of their programs' wellness education, but there were a large amount of students who believed their programs were not adequately educating them about counselor wellness. There were positive relationships between interns' perceptions of their programs' wellness education and compassion satisfaction; and between compassion fatigue and burnout. There were negative relationships between wellness education and burnout and compassion satisfaction and burnout. Noticeably, how interns regard their internship experiences and wellness training, program success,

and academic world can impact their compassion satisfaction, compassion fatigue, and burnout levels. Further results from the current study suggest that a number of interns were not knowledgeable about their programs' nonacademic and retention policies and most had concerns about the impairment of their peers. Although many counselor education programs have gatekeeping policies in place, it is evident from the current study that some of these policies need to be strengthened and highlighted more during counselor training.

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CHAPTER ONE: INTRODUCTION

The counseling profession has a long history of providing therapeutic services to clients through the adoption of a wellness model and by assisting with identifying problems, encouraging insight, and offering prescriptions for change. Countless researchers, educators, and theorists assisted in the development of counseling theories, interventions and methods. These innovations led to an abundant following of people interested in becoming helpers.

Counselors are responsible for assisting clients to identify problems, present interventions, model new behaviors, and encourage insight and awareness. The therapeutic relationship and knowledge and skills of the counselor can help the client progress towards wellness. However, counselors face additional challenges other than clinical competence. They are often confronted with problems related to being the helper in challenging cases. Long hours, difficult and resistant clients, crisis situations, abundance of paperwork, and therapeutic engagement can lead to counselor vulnerability (Figley, 1995, Figley, 2002b, Baird & Jenkins, 2003). These stressors may ultimately negatively affect the client (Hesse, 2002, Skovholt, 2001). Any seasoned counselor can face and deal with these pressures, but counseling students may struggle more so with the same challenges. The methods used to manage stress are also vital for counseling students. The question is raised as to how counselors learn about the risks of the profession and the importance of wellness education.

Significance of the Problem

The professional organizations that represent the counseling profession address the issues of wellness and personal development. The ethical guidelines for Counselor

Educators and Supervisors (Association for Counselor Education and Supervision [ACES], 1993) require counselor educators and supervisors to supervise and examine counseling students' professional and personal growth. The American Counseling Association's (ACA) Code of Ethics and Standards of Practice requires counselors to "refrain from offering...professional services when their physical, mental or emotional problems are likely to harm a client" (2005, Section C.2.g.). "In addition, counselors engage in self-care activities to maintain and promote their emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities" (2005, Section C, ACA Code). The Ethical Principles of Psychologists and Code of Conduct of the American Psychological Association (APA) states that psychologists "refrain from undertaking an activity when they know or should know that their personal problems are likely to lead to harm a patient, client, colleague, students, research participant, or other person to whom they may owe a professional or scientific obligation" (1992, Section 1.13). The Code of Ethics of the National Association of Social Workers states that (a) "Social workers who have direct knowledge of a social work colleague's impairment that is due to personal problems, psychosocial distress, substance abuse, or mental health difficulties and that interferes with practice effectiveness should consult with that colleague when feasible and assist the colleague in taking remedial action and (b) "Social workers who believe that a social work colleague's impairment interferes with practice effectiveness and that the colleague has not taken adequate steps to address the impairment should take action through appropriate channels established by employers, agencies, NASW, licensing and regulatory bodies, and other professional organizations" (2005, Section 2.09).

The ACA Code of Ethics and Standards of Practice states: “Counselors, through on-going evaluation and appraisal, are aware of the academic and personal limitations of students and supervisees that might impede performance” (1995, Section F. 3a., pp.15-16).

Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2001) standards specify necessary tasks for supporting the personal development of counseling students. Section II.K.5 states that counseling studies offer knowledge of counseling processes that include “counselor and consultant characteristics and behaviors that influence helping processes including age, gender, and ethnic differences, verbal and nonverbal behaviors and personal characteristics, orientations, and skills” (p. 62). “Studies will also facilitate student self-awareness so that the counselor-client relationship is therapeutic and the counselor maintains appropriate professional boundaries” (Section II.K.5.b, p. 62).

Yet, many counselor education programs have a uniform approach for evaluating the personal development and wellness of potential graduate students. For instance, some studies found that most programs use academic criteria such as the GRE and GPA, letters of recommendations, and interviews of potential students as admission procedures (Hosford, Johnson, & Atkinson, 1984; Market & Monke, 1990). However, counselor educators must consider students’ clinical skills and personality in addition to academic skills. Competence and appropriateness in the profession is not just about a student’s knowledge base, but also about their personality, values, personal stories, and coping skills (Miller & Koerin, 2001).

Gatekeeping models have been proposed and are essential to counselor development and review and retention policies. Specifically, the responsibility of counselor educators is to teach counseling students about “the costs of caring” and to determine counseling students’ readiness for the profession (Figley, 1995). Determining this readiness, or gatekeeping, is the responsibility of educators (Moore & Urwin, 1991). The premise behind gatekeeping is that educators protect the helping professions and clients from impaired students and professionals. The role of gatekeeper is traced in history and includes remediating and/or dismissing students who are impaired (Boxley, Drew, & Rangel, 1986; Bradey & Post, 1991; Gaubatz & Vera, 2002; Lumadue & Duffey, 1999).

The professions of psychology, counseling, and social work have presented research on gatekeeping practices. Surprisingly, some of these programs lacked in areas of formal gatekeeping policies, remedial interventions for impaired students, and marked levels of impairment in students (Boxley, Drew, & Rangel, 1986; Gaubatz & Vera, 2002). Due to programs’ difficulties with efficient gatekeeping practices, researchers proposed gatekeeping models (Baldo, Softas-Nall, & Shaw, 1997; Frame & Stevens-Smith, 1995; Knoff & Prout, 1985; Lumadue & Duffey, 1999; Oklin & Gaughlin, 1991). Five gatekeeping models will be presented in detail in chapter two.

Despite the development of these gatekeeping models, many counseling programs have been hesitant to implement those (Gaubatz & Vera, 2002). Counselor educators must consider the emotional strength and wellness of their counseling students who will become professional counselors, as well as their academic progress. “Otherwise,

counselor educators participate in creating a growing work force of impaired counselors” (Bradey & Post, 1991, p. 108).

Counselor impairment, which can result from anxiety, job stressors and burnout, is well-documented in the literature (Emerson & Markos, 1996; Olsheski & Leech, 1996; Sheffield, 1998). The counseling literature has been sparse regarding impairment until 2003 when the Governing Council of the American Counseling Association developed a Task Force for Impaired Counselors. The ACA Task Force has developed new guidelines regarding impairment in the counseling profession (Lawson & Venart, 2005). These guidelines are necessary as counseling students do not seem to understand how their personal issues can affect the therapeutic process and unavoidably their clients (Bemak, Epps, & Keys, 1999; Vacha-Haase, Davenport, & Kerewsky, 2004).

Many authors have researched the prevalence of impairment in psychology and counseling students (Bemak, Epps, & Keys, 1999; Fly, van Bark, Weinman, Kitchener, & Lang, 1997; Lamb, Presser, Pfof, Baum, Jackson, & Harvis, 1987). White and Franzoni (1990) and Vacha-Haase et al. (2004) found that students were prone to higher levels of psychological problems and more ethical violations.

Counselor impairment is not the primary focus of this study; however, it provides a strong rationale for promoting wellness in counseling students. Two specific forms of impairment and risks of the profession are compassion fatigue and burnout. The professional risk of taking on the stress of a client can be traced back through the years (Baird & Jenkins, 2003; English, 1976; Figley, 1995; Jung, 1966).

Burnout has been defined as “a state of fatigue or frustration brought about by devotion to a cause, way of life, or relationship that failed to produce the expected

reward” (Freudenberg, 1982, p. 13). Maslach (1982) referred to burnout as occupational stress condition taking place when mental health professionals become mentally and emotionally tired. Burnout is the psychological damage that comes from working with complicated populations. Working with victims may cause symptoms of burnout in mental health professionals (McCann & Pearlman, 1990).

Researchers stress that compassion fatigue not be confused with the concepts of burnout (Hesse, 2002). Compassion fatigue has been defined as “the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other – the stress resulting from helping or wanting to help the traumatized or suffering person” (Figley, 1993a, p. 7). Stamm (1995) defined it as a risk that is related to empathically engaging with a client’s traumatic background. Boscarino, Figley, and Adams (2004) defined it as “reduced capacity or interest in being empathic...” (p. 58). Figley (1995) defined compassion fatigue as “a state of tension and preoccupation with the traumatized patients by reexperiencing traumatic events, avoidance/numbing or reminders, and persistent arousal (e.g., anxiety) associated with the patient” (2002, p. 1435).

Several authors have called for graduate training programs to include coursework on the signs and symptoms of compassion fatigue and preventative measures such as components of wellness (Figley, 1995; Marlow & Urwin, 1991; Nelson-Gardell & Harris, 2000, Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995; Stamm, 1995). Furthermore, other authors support that compassion fatigue can be prevented by including it in graduate curriculum (Baird & Jenkins, 2003; Brady, Guy, Poelstra, & Brokaw, 1999; Hesse, 2002; Munroe, 1995; Nelson-Gardell & Harris, 2003;

Pearlman & Mac Ian, 1995; Vacha-Haase et al., 2004; Witmer & Young, 1996). Figley (1995) stated, “We as practicing professionals have a special obligation to our students and trainees to prepare them for these hazards. A place to start is to incorporate stress, burnout, and compassion fatigue into our curriculum, and especially our supervision in practica” (p. 17). Furthermore, the authors recommend including topics on the effects of distress on professional functioning, wellness, coping skills, and monitoring job stress. This would alert students to the demands of their profession. The authors reported more studies are needed on students’ perceptions and understanding of impairment. However, there are no available studies that address whether counseling programs are educating students about impairment issues, such as burnout and compassion fatigue.

Counselor Wellness and Compassion Satisfaction

Counselor wellness is not a new concept and authors over the years have supported the need for it (Iliffe & Steed, 2000; Rosenbloom, Pratt & Pearlman, 1995; White & Franzoni, 1990; Witmer & Young, 1996). Wellness is making the most of human capabilities through healthy life choices (Myers, 1991). Witmer and Young (1996) state that counselor wellness refers to the personal growth and professional expertise obtained from emotional, mental, physical, social, vocational, and spiritual well-being.

More importantly, counselor wellness is a key concept that can be taught in graduate school, prior to entering the profession (Bockrath, 1999; Chandler, Bodenhamer-Davis, Holden, Evenson, & Bratton, 2002; Coster & Shewebel, 1997; Hesse, 2000; Yassen 1995). Some studies support incorporating a wellness model into counselor education curriculums (Myers, Mobley, & Booth 2003; Witmer & Young,

1996). Furthermore, several models of wellness have been developed (Myers, Sweeney, & Witmer, 2000; Sweeney & Witmer, 1991; Witmer & Sweeney, 1992).

Counselor wellness may increase the likelihood of job satisfaction. Compassion satisfaction is the pleasure you receive from having the ability to do a therapeutic job well. Counselors often have a sense of compassion satisfaction by helping others through their work. They may gain satisfaction from knowing that their abilities as counselors help others grow and succeed in life (Stamm, 2005). “By achieving and maintaining a greater sense of wellness, counseling students may enhance their personal growth and development, experience more satisfaction, and as a result, remain better able to meet the demands of their training and future work environments by dealing more effectively with stress and anxiety thus reducing impairment and burnout” (Roach, 2005, p. 13).

Problem Statement

According to the 2005 Wellness Councils of America, 40% of individuals say that their job is “very” or “extremely” stressful. Forty-three percent of adults, or approximately 90 million people, suffer health problems due to stress. Finally, 75% to 90% of all visits to primary care physicians are stress related (Wellness Councils of America, 2005). Closer to home, actual counseling can be stressful for professionals, especially during the training period (Chandler, et al., 2001). “Practitioners often schedule their time to the minute, are exhausted by the stresses of their work and don’t always set themselves or their families as priorities” (Edwards, 1990, p. 40).

It is important for counselor education programs to address personal development through the use of wellness approaches during counselor training. Especially, because counseling is demanding and taxing (Skovholt, 2001) and a lack of counselor wellness

may have a negative impact on clients (Bemak, Epps, & Keys, 1999). For instance, counselors that ignore their own personal development may tend to focus only on the well-being of the client. Furthermore, many people are drawn to the field of counseling because of unresolved personal issues (Maeder, 1989).

Promoting wellness enhances counselor development by educating students about the risks of impairment, such as burnout and compassion fatigue, and by offering a foundation for their own wellness. Munroe (1995) reported that if therapists have a duty to warn clients if they are in danger, then educators have a “duty to train” students about the potential hazards of the profession, such as burnout and compassion fatigue (p. 14). Lack of wellness can lead to impairment, which may lead to difficulties between the counselor-client relationship. Components of wellness are to understand the risks of the profession and for counselors to learn ways to care for themselves. Wellness education offers these methods. Therefore, counselor educators or gatekeepers become the teachers of these concepts.

Several authors contend that counseling programs need to take more initiative in preparing their students for the pressures and risks associated with practice, as well as screen out the ones not committed to wellness (Marlow & Urwin, 2001; Nelson-Gardell, & Harris, 2003; Pearlman & Mac Ian, 1995, Schauben & Frazier, 1995, Witmer & Young, 1996). These authors also suggest that counselor educators develop a curriculum that stresses preventing impairment and includes skills training for coping with stress and burnout.

Wellness literature teaches counselors to protect themselves from the demanding challenges of this profession. Gatekeeping literature teaches counselor educators how to

protect the profession from impaired counselor trainees. Compassion fatigue and burnout literature teaches counselors to protect themselves from becoming impaired. However, there are gaps in the literature about this connection and about compassion fatigue as an impairment and gatekeeping issue.

Most of the literature addressing compassion fatigue and burnout tends to focus primarily on its existence and ways to treat the symptoms and to prevent counselor vulnerability. This important preventative literature precludes the need for educators to teach students about the signs, symptoms of burnout and compassion fatigue and potential interventions (Figley, 1995; Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995; Stamm, 1995). However, there is no known literature that particularly addresses whether graduate programs are implementing compassion fatigue and other wellness education into their counselor education curriculum. Therefore, it is appropriate and necessary to conduct research regarding this potential deficit. Furthermore, no studies have been conducted that examine the presence of compassion fatigue and burnout among counseling student interns.

The purpose of this study is to survey counseling interns at CACREP accredited masters programs regarding their perception of their program's wellness curriculum and to compare these perceptions to their actual levels of compassion satisfaction, compassion fatigue, and burnout.

Methodology

This study targets a population of counseling interns from 209 CACREP master's programs. This research will explore the wellness perceptions of CACREP master's counseling interns and levels of compassion satisfaction, compassion fatigue, and

burnout. The results of this study will add to the literature in the fields of counseling, social work, psychology, and traumatic stress.

The study is designed to: (a) assess counseling interns' perceptions of their program's wellness education; (b) assess counseling interns' level of compassion satisfaction, compassion fatigue, and burnout; and, (c) determine the relationship between counseling interns' perceptions of wellness with their actual levels of compassion satisfaction, compassion fatigue and burnout. To achieve these goals, the following research questions will be used:

- 1) What are counseling interns' compassion satisfaction levels as measured by the Professional Quality of Life (III-R)?
- 2) What are counseling interns' compassion fatigue levels as measured by the Professional Quality of Life (III-R)?
- 3) What are counseling interns' burnout levels as measured by the Professional Quality of Life (III-R)?
- 4) What are counseling interns' perceptions of their counselor education program's wellness education and curriculum?
- 5) Is there a positive relationship between counselor interns' perceptions of wellness and compassion satisfaction and a negative relationship between counselor interns' perceptions of wellness and compassion fatigue and burnout?
- 6) Are counseling interns aware of their counselor education programs' nonacademic retention and dismissal policies?

Definition of Terms

Counseling Intern

Any individual currently enrolled in a CACREP master's counseling program (48 to 60 hours) and in the process of taking his or her internship.

Counselor Educator

Any person with a Ph. D. teaching courses in a master's or doctoral counseling program.

Compassion Satisfaction

The pleasure you receive from doing a therapeutic job well (Stamm, 2005).

Compassion Fatigue

Figley (1995) explained that the term compassion fatigue is an alternative to secondary traumatic stress. It is defined as “a state of tension and preoccupation with the traumatized patients by reexperiencing traumatic events, avoidance/numbing or reminders, and persistent arousal (e.g., anxiety) associated with the patient” (2002, p.1435).

Burnout

It is “a state of physical, emotional, and mental exhaustion caused by long term involvement in emotionally demanding situations (Figley, 1995, p. 11). A process that begins little by little and becomes worse.

Gatekeeping

Gatekeeping is the professional responsibility of educators to determine if a student is ready to enter the profession (Moore & Urwin, 1991).

Impairment

The Task Force on Counselor Wellness and Impairment defines counselor impairment as “Therapeutic impairment occurs when there is a significant negative impact on a counselor’s professional functioning which comprises client care or poses the potential for harm to the client. Impairment may be due to: substance abuse or chemical dependency, mental illness, personal crisis (traumatic events or vicarious trauma, burnout, life crisis), and physical illness or debilitation (Lawson & Venart, 2005, p. 3).

Wellness

A counselor’s overall emotional and physical state. Wellness is related to counselors who adopt methods to prevent the negative effects on the body, mind and spirit triggered by working with clients. (Myers, Sweeney, & Witmer, 2000).

CACREP

Council for Accreditation of Counseling and Related Educational Programs. The vision of CACREP is to provide leadership and to promote excellence in professional preparation through the accreditation of counseling and related educational programs (CACREP, 2006).

These definitions will also be discussed in chapter two with additional explanations about their interconnectedness.

Summary

Chapter one outlines the purpose of the study. A study to determine levels of compassion satisfaction, compassion fatigue, and burnout among counseling student interns is important because these students are about to enter the profession and work with clients. Assessing counseling student interns’ perceptions of their program’s

wellness curriculum is vital to understand whether CACREP master's programs are educating their students on impairment and wellness. Comparing counseling student interns' perceptions with their actual levels of compassion satisfaction, compassion fatigue, and burnout will assist counselor educators with their gatekeeping responsibilities. It will also reveal whether or not counseling student interns are at risk of burnout and compassion fatigue during their fieldwork experiences.

A comprehensive review of the literature provided in Chapter 2 will highlight concepts of wellness in counselor education programs, compassion satisfaction, compassion fatigue, burnout, impairment and gatekeeping. This literature review will support the rationale to conduct research in these areas. Chapter three will introduce the methodology for this study including research questions, research design, research participants, sampling procedures, instrumentation, data collection, and data analysis. Chapter four will report data analysis and research questions testing. Chapter five will discuss the findings of the study, research implications, and limitations of the study, recommendations, and possible future research.

CHAPTER TWO: LITERATURE REVIEW

Chapter two will present a comprehensive literature review on wellness in counselor education programs, compassion satisfaction, compassion fatigue, burnout, impairment and gatekeeping.

Introduction

Counselors are trained to help their clients overcome the most trying problems. Clients' therapeutic issues may include abuse, anger, anxiety, death, grief, family-of-origin issues, marital issues, and stress. Clearly, counselors are exposed to more than just their clients' problems; they listen to their clients' stories often laced with horrific details of abuse, trauma, and exploitation. Furthermore, while counselors must remain objective, they must also open themselves up to the experiences of their clients through empathy. Over time, this vulnerability may possibly lead to counselors experiencing stress, fatigue, and feelings of hopelessness and uncertainty (Bosarino, Figley, & Adams, 2004). Therefore, it is essential for counselors to find a means to balance their professional and personal lives. The curriculum, coursework, practicum, internship, and supervision experiences of counselor education programs may contribute to improving and enhancing counseling students' knowledge and skills in the areas of client care and of self-care.

Counselor educators serve as gatekeepers for the counseling profession, protecting the welfare of clients by preventing impaired counseling students from entering the field. Counselor educators use their clinical skills to identify and monitor counseling students' problems that may interfere with their abilities to provide ethical and effective services to their clients. Impaired counseling students may lack empathy or display narcissism, personality problems, poor coping skills, poor interpersonal skills, or

substance abuse issues. Encouraging restorative awareness within counseling students not only teaches them reflection and self-monitoring, but also provides them with the opportunity to work through any unresolved issues by remedial interventions. Should the counseling student's personal problems, or impairment, continue to harmfully affect the student and even his/her clients, counselor educators may dismiss these counseling student from their graduate program and prohibit them from entering into the profession.

There seems to be an overlap in the literature between the basic concepts of counselor wellness and the literature on compassion fatigue, burnout, impairment, and gatekeeping. This review of literature will discuss the connections between the literature on counselor wellness and self-care, burnout, compassion fatigue, impairment, incorporating wellness components into counseling graduate programs, and counselor education as gatekeepers.

Counselor Wellness and Self-Care

In the article "Wounded Healers," Maeder (1989) summarized why some individuals enter into the field of counseling. The author suggested that some people who enter into this profession not only want to help others, but are also enticed by the position of power and authority and by the desire to help themselves through helping others. He reported, "The danger occurs when the wounded healer has not resolved, or cannot control, his own injury" (p. 40).

Schoener (1999) stated that the wellness of mental health professionals has become an issue and issues related to benevolence to the client. Guy (1987) added that those who enter the helping professions go into the field to help others overcome emotional issues, trauma, and other issues. However, some individuals enter into this

field to work out their own issues through their therapeutic work with clients (Williams & Sommer, 1995).

Fortunately, many counselors take their professional responsibilities seriously and maintain a lifestyle of health. Furthermore, counseling is stressful work, but there are ways to prevent stress and improve counselor wellness. “Well counselors are more likely to produce well clients” (Witmer & Young, 1996, p. 151). Counselors’ mental health is an essential component of the therapeutic process (White & Franzoni, 1990). Iliffe and Steed (2000) assert that regardless of clients’ problems, counselors have the responsibility to preserve wellness. However, counselors sometimes focus more on their clients’ wellness than their own and ignore the need for personal self-care. The authors urge counselors to consider, “Following the advice Hippocrates might have made, ‘Counselor heal thyself,’ we recommend that counselors prescribe self-care for themselves” (p. 354).

Fortunately, in the early 1990’s there was a shift towards a wellness model for the counseling profession. Counselor wellness is the maximizing of the counselors’ therapeutic potential through healthy lifestyle choices (Myers, 1991, p. 183). The author believes the counseling profession needs to establish a commitment to a wellness philosophy and counselors need to become key supporters of wellness. This can be done by encouraging counselor preparation programs to incorporate a wellness philosophy by having all aspects of counselor training to include a wellness component.

More recently, a new wellness model emerged that is an alternative to illness-based models for treating mental and physical conditions. The Wheel of Wellness was first described by Sweeney and Witmer (1991) and Witmer and Sweeney (1992). The

authors later proposed a revised model: “We define wellness as a way of life oriented toward optimal health and well-being in which body, mind, and spirit are integrated by the individual to live more fully within the human and natural community” (Myers, Sweeney & Witmer, 2000, p. 252). The original model had 5 life tasks: spirituality, self-regulation, work and leisure, friendship, and love. Self-regulation originally included seven areas. After much research, self-regulation was renamed self-direction and included 12 components. They are as follows: (a) sense of worth, (b) sense of control, (c) realistic beliefs, (d) emotional awareness and coping, (e) problem solving and creativity, (f) sense of humor, (g) nutrition, (h) exercise, (i) self-care, (j) stress management, (k) gender identity, and (l) cultural identity.

Life task 2, self-direction, incorporated many components that are of interest for this study. The self-care component of the Wellness Wheel states that individuals should take responsibility for their well-being to prevent problems. Stress management, another component of Life task 2, helps individuals identify stressors and reduce stress through specific techniques. Life task 3, work and leisure, encompasses balancing personal and professional tasks. The authors have used The Wheel of Wellness in workshops with students and educators and have suggested ways to use the wheel in counseling (Myers, et. al., 2000). This philosophy of wellness could be adopted by counselor education programs for graduate students. An awareness of these components of wellness and the skills to maintain optimal well-being can and should be taught to counseling interns during their graduate studies.

One study (Herman & Hazler, 1999) investigated whether wellness can lead to overall well-being. The authors considered whether 155 undergraduate students, at a

large Midwestern university, who followed a wellness regimen reported a greater sense of psychological well-being than those students who did not follow a wellness regimen. The five-factor wellness model utilized in this study included spirituality; work and leisure; self-regulation; friendship; and love adapted from Witmer, Sweeney, and Myers (1993). The Wellness Evaluation of Lifestyle (WEL), consisting of 114 statements, was used to assess the five life areas. Additionally, the Memorial University of Newfoundland Scale of Happiness (MUNSH), a 24-item instrument measuring both state and trait features of psychological well-being, was used. Both the WEL and MUNSH were distributed to the 155 students enrolled in communications and organizational behavior courses. The results revealed a significant relationship between reported observance to a wellness model and state and trait characteristics of psychological well-being. The variables of self-regulation and work, recreation and leisure of the model appeared to be the best predictors of students' psychological well-being. Therefore, students who were successful at tasks such as: dealing with stress, sense of self-worth, nutrition and exercise, emotional openness (self-regulation variables), were also students that felt good about their lives. These findings offer implications for counselor education programs as well as counseling in higher education. The authors suggest that institutions of higher education employ activities that help students develop self-regulating behaviors. Specifically, activities that would help students gain control over stress, nutritional problems, self-worth, cultural and gender issues. These wellness activities can result in higher levels of students' psychological well-being.

Well-functioning “refers to the enduring quality in one’s professional functioning over time and in the face of professional and personal stressors” and is the opposite of

impairment (Coster & Schwebel, 1997, p. 7). The authors' sought to obtain information from psychologists regarding their well-functioning in two studies. In the first study, six selected psychologists were interviewed about what contributed to their well-functioning. The analysis revealed 10 themes the psychologists thought led to well-functioning: peer support, stable personal relationships, supervision, a balanced life, affiliation with graduate department or university, personal therapy, continuing education, family of origin, the consequences of being impaired, and coping mechanisms. In the end, the psychologists recommended resources to help them cope with personal and professional stressors. In the second study, questionnaire packets were sent to 950 licensed members of the New Jersey Psychological Association. However, 339 met criteria to participate in the study. The Impairment and Well-Functioning Questionnaires were sent to assess the factors psychologists consider contribute to well-functioning. Overall, participants believed that their graduate school learning and experiences were important to their well-functioning state as a professional. Other important contributors were self-awareness, balance between personal and professional lives, relationships with others, and therapy. The authors suggested that impairment is not only a deficiency in professional skills, but also in coping skills to handle stressful situations. Therefore, the authors proposed that coping and self-care skills can be improved through learning opportunities during graduate school and over the course of their career (Coster & Schwebel, 1997).

“Wellness is a positive state of health that can be promoted in all counselors, impaired or not” (Witmer & Young, 1996, p. 141). These authors encouraged counseling programs to adopt a wellness philosophy. They proposed that counselor education curriculums “...Should integrate the wellness philosophy of the program and the

responsibilities that counselors have for maintaining a practice free of impairment” (p. 143). This wellness philosophy encompasses many areas for growth. Students would be expected to make a statement and commitment to personal and professional growth through experiences that promote wellness which include: personal growth opportunities throughout the program, available counseling for students, teaching students stress management skills, and assessment of students’ risks for impairment. The authors support the notion that counselor educators need to be models of personal wellness and build a wellness community through compassion, commitment, leadership, personal involvement, innovative problem-solving methods, open communication, and autonomy. They suggested that these beliefs be integrated into academic courses and clinical experiences. Their model for counselor education programs includes spiritual, intellectual, physical, and social components. Specifically, the intellectual and physical components encourage stress management and taking responsibility for one’s wellness. Overall, the authors recommend, “Counselor education should implement a wellness model as the basis of a curriculum that emphasizes a positive view of human nature and makes students aware of prevention rather than simply educating them in the treatment of disorders” (p. 152). They further suggest a separate course on wellness or at least making wellness a major component of student training.

Moreover, Myers, Mobley, and Booth (2003) agreed that counseling programs should focus on different facets of wellness. Their study examined the wellness of counseling students during their first year of training in counseling programs in Florida, Louisiana, Nevada, North Carolina, and Ohio at entry and advanced levels (master’s and doctoral levels). The instrumentation was an existing database using individuals’

responses to the Wellness Evaluation of Lifestyle (WEL) instrument used to measure certain characteristics of wellness such as: friendship, love, self-direction, spirituality, and work and leisure. Two hundred sixty-three counseling students were among the 3,043 individuals in the WEL database. The authors were surprised to discover that counseling students expressed greater wellness over the general population group and doctoral students experienced higher levels of wellness than entry level students in the areas of spirituality, work, and total wellness. However, the authors couldn't determine how much of the counseling students' wellness was related to the effects of the counseling program and how much was present at the time of admission. Consequently, the authors suggested that further research be conducted to determine counseling students' wellness at different times of their programs. The authors stated, "Assessing wellness is one approach that counselor educators can use to increase awareness of personal wellness and to stimulate dialogue while they are in training and throughout their careers" (p. 273). The present study will not only assess counseling students' at the time of internship, but it will evaluate their perceptions of the wellness curriculum of the counselor education program.

Roach (2005) examined the wellness levels of master's level students at three points in their counselor training. The participants were enrolled in master's level counseling programs at three universities in the United States. The total sample size was 204; 86 in the beginning group, 52 in the middle, and 66 in the ending group. The Five Factor Wellness Inventory was used. The instrument includes 91 items on scales for Total Wellness, five second order factors of the Self, and seventeen third order factors. In addition, a demographic questionnaire was administered to participants. Students scored lower on the second order factor, the Coping Self, which refers to the ability to moderate

negative effects of life events. The Coping Self also includes the third order factors of leisure, stress management, self-worth, and realistic beliefs. “Helping students learn to balance the various aspects of work, graduate training, and leisure might provide benefits with regards to preventing burnout” (Roach, 2005, p. 71). The author was also surprised to discover that students did not mention stress management as a skill they had learned and stated that it would be vital for counselor educators to provide stress management techniques. The study also found that those students who reported that their counselor education program offered a wellness course, reported higher levels of wellness.

Bockrath (1999) discovered that the concept of self-care had been poorly addressed in counselor education programs, if at all. Several of the participants in her qualitative study denied even hearing about self-care as part of their graduate training. “Strategies for self-care could be integrated into existing course work”, she reports (p. 158). What's more, the author believed counselor educators should teach self-care as a process, rather than just warning students to take better care of themselves.

Wellness models and self-care are ways counselors can counteract the risks of the counseling profession, such as difficult clients, transference, resistance, work overload, stress emotions, professional loss, and empathic engagement (Skovholt, 2001). If these hazards are not dealt with effectively, the result could lead to compassion fatigue and/or burnout. The following section will review the literature on the outcome of these risks: burnout and compassion fatigue.

Burnout

“Burnout is the biggest occupational hazard of the twenty-first century” (Leiter & Maslach, 2005, p. 3). Stress brought on by jobs is expected to cost the United States economy approximately \$300 billion in long-term disability, in sick leave, and job turnover. Furthermore, long-term disability claims rooted in burnout, stress, and depression are the fastest growing claims in the United States and Europe (Leiter & Maslach, 2005).

Use of the term burnout started in the 1970s in the United States among the helping professions. The result of the research is the concept of job burnout as a “psychological syndrome in response to chronic interpersonal stressors on the job” (p. 399). In addition, research focused on the symptoms of burnout and implications for the mental health field. In the 1980s, the research on burnout was more quantitative than qualitative. Researchers increased assessment studies of burnout and ways to measure the variable were developed. The most widely used scale by researchers is the Maslach Burnout Inventory (MBI) developed by Maslach and Jackson (1981). The MBI is the only measure that assesses all three of the central areas of burnout; 1) exhaustion, 2) depersonalization, and 3) lack of achievement (Maslach, Schaufeli, & Leiter, 2001). Exhaustion refers to the feeling of being overwhelmed and physical and emotional fading. “When people describe themselves or others as experiencing burnout, they are most often referring to the experience of exhaustion” (Maslach et al., 2001, p. 402). People cope with overwork by distancing themselves emotionally from their work. Depersonalization refers to a negative and detached outlook about the job. It is a way for the person to distance oneself from the people they serve, such as clients. The research

reveals a link between exhaustion and depersonalization. Lack of achievement refers to feelings of being incompetent and unproductive at the job.

Later in the 1990s, the concept of burnout was researched in other professions such as the military, clerical, and management, to name a few. Burnout research was improved through more refined tools and methods. The research also began discussing structural models to prevent burnout. It seems burnout is a response to work overload. Furthermore, younger employees have higher burnout than those over 30 or 40 years old. “Age is confounded with work experience, so burnout appears to be more of a risk earlier in one’s career” (Maslach et. al., 2001, p. 409). People that learn through how others treat them and other external factors, rather than their own awareness and intuitions, may experience more burnout. Counseling interns may rely on their external locus of control rather than an internal locus of control and; therefore may be at higher risk for experiencing burnout.

Watkins (1983) states that counselors may experience burnout related to the hazards of the profession. He describes symptoms of burnout as a result of job stress. The author cites that the job itself, listening to clients’ personal and emotional problems, can increase the likelihood of burnout symptoms. Guilt can also be a symptom of burnout. For example, the counselor may feel guilty because he/she wants to avoid the client, yet also has a feeling that he/she wants to help the client. Counselors may also have feelings of emptiness in their personal and professional lives. The author believes that it is not surprising that many counselors leave their roles and seek other professions. Marital discord may arise as a symptom of burnout because the counselor may believe that he/she has to be a source of strength to their spouse, whether the spouse asked for the assistance

or not. Friendships may also be at risk due to burnout. A major problem is when the counselor's personal and professional lives come together and the counselor is engrossed in his/her work with little escape from his/her problems. Another problematic area is when the counseling session becomes a chore and the counselor has difficulty even attending and listening to the client. This psychological distance could lead to a resentful and damaged client.

Over the past two decades, counseling literature has studied issues related to counselor job stress. Initially, the literature focused on burnout as a result of this stress. More recently, the focus of literature has moved to the study of compassion fatigue, also known as secondary traumatic stress.

Compassion Fatigue

The research on compassion fatigue has focused on professionals in health care, emergency settings, domestic violence, clinical, and protective services. There is much empirical support on the concept of compassion fatigue and the importance of understanding how to prevent it and cope with its effects. Understanding the effects of compassion fatigue on the counselors' mental health and satisfaction is vital (Boscarino, Figley, & Adams, 2004).

English (1976) says that when a psychotherapist "encounters a client the stress can be painful... The therapist must be fully conscious of the needs of his or her patient, and fully aware of the tactics he uses in an attempt to repair himself... If he is not, the therapist may find he has taken over the pathology of his patient within himself to such an extent that the therapist himself feels sick" (p. 200). Even years earlier, Jung (1966) spoke of the "unconscious infection" that may result from working with clients. More

recently, Figley (1995) stated that working with traumatized clients includes “absorbing information that is about suffering” and that often, this “includes absorbing the suffering as well” (p. 2). Baird and Jenkins (2003), cite that working with victims of violence can be an “emotionally hazardous” occupation for therapists (p 71).

Symptoms of burnout appear little by little, while compassion fatigue may appear abruptly with little or no warning (Figley, 1995). Someone who experiences burnout will be more likely to identify the cause of the symptoms more readily than with the symptoms of compassion fatigue (Figley, 1995). Burnout may require a change in employment (Figley, 2002), but compassion fatigue is treatable once the clinician becomes aware of the problem. Figley (1993a) developed a self-test in order for therapists to identify the difference between burnout and compassion fatigue.

Kassam-Adams (1995) studied compassion fatigue in psychotherapists treating traumatized clients. The study looked at the relationship between psychotherapist’s exposure to sexually abused clients and the clinicians’ own symptoms of work related stress and PTSD. One hundred psychotherapists in outpatient mental health agencies located in Maryland and Virginia completed self-report questionnaires. The packets included The Therapist Questionnaire, Impact of Events Scale, the Barrett-Lennard Relationship Inventory, the Personal Strain Questionnaire of the Occupational Stress Inventory, and two questions about the clinician’s experiences of work stress. Psychotherapists’ level of PTSD symptoms related to their contact with clients was found to be significantly related to their level of contact with sexually abused clients. Another predictor of trauma symptoms was related to females with a history of childhood trauma.

One hundred sixty-six child welfare workers participated in Nelson-Gardell and Harris' study. Participants completed The Compassion Fatigue Self Test for Psychotherapists and The Childhood Trauma Questionnaire. According to the study, a history of child abuse or neglect increased the child welfare worker's risk of compassion fatigue. More specifically, a history of emotional abuse or neglect seemed to put the child welfare workers at the most risk. The authors recommended that the "occupational hazard" of compassion fatigue be addressed and that staff participate in training about the phenomenon. Furthermore, the authors recommended that educators of child welfare workers inform these students, prior to entrance into the field, about their risks and how to prevent and treat compassion fatigue (2003, p. 22).

A study of 236 clinically active social workers residing in New York City was what Boscarino, Figley, & Adams (2004) called "the first to fully test the compassion fatigue/vicarious trauma concept" (p. 62). Their survey included 13 items relating to the various ways of helping the people that were affected by the September 11 terrorist attacks. Sixty-seven percent (67%) of the participants were moderately or significantly involved in counseling those people exposed to the World Trade Center attacks. This research supported the concept that a group of mental health professionals working with traumatized clients were at a higher risk for compassion fatigue. The authors believe that predictors of compassion fatigue include level of exposure, personal history, support, and environmental factors.

Marlow and Urwin (2001) explored the extent of compassion fatigue among social work educators. The authors wanted to examine if these faculty experienced compassion fatigue from their work with trainees. One hundred ninety-five programs

were sent questionnaires and the Compassion Fatigue Self Test, with a response from 89 different programs. The results indicated that social work undergraduate educators had a low risk of compassion fatigue. However, field faculty had higher levels of compassion fatigue. Another important outcome of the study is that the authors encouraged educators to prepare their students for the demands of the profession by presenting them with education and training on compassion fatigue in order to protect themselves from the risks. The authors asserted that this education can take place in graduate social work courses.

Empirical research sustains the notion that compassion fatigue is a result of working with victims of trauma and symptoms often occur in therapists, social workers, and counselors. However, the literature is lacking in its definitions of trauma and in evidence that compassion fatigue may be a risk to all counselors. The following section illustrates information supporting this theory.

In 1980, Posttraumatic Stress Disorder (PTSD) was included in the Diagnostic and Statistical Manual of Mental Disorders 4th Edition (DSM-IV, Figley, 2002). PTSD had been commonly diagnosed and used in mental health research. The research mostly focuses on the direct victims of trauma. The description of PTSD in the DSM-IV clearly defines the above:

“The essential feature of posttraumatic stress disorder is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves death, actual or threatened serious injury, or other threat to one’s physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or *learning about*

unexperienced or violent death, serious harm, or threat of death or injury experienced by a family member or other close associates (Criterion A1; DSM-IV, p. 424). The italicized statement stresses that people can be traumatized by learning about a traumatic event without being physically hurt or threatened with harm (Figley, 1995).

Schauben and Frazier (1995) assessed the effects on psychologists working with sexual violence survivors. Five hundred twenty-five questionnaires were sent out, and 220 were returned. Questionnaires were sent to female psychologists who worked as sexual assault counselors in centers in the Midwest. To assess the effects of working with sexual violence survivors on psychologists, the TSI Belief Scales, Brief Symptom Inventory (BSI), and The Maslach Burnout Inventory (MBI) were distributed to participants. Their data suggest that female psychologists who work with more survivors reported more disturbed beliefs about people, more PTSD associated symptoms, and more vicarious trauma than psychologists who saw less survivor clients. The findings also revealed that psychologists with a personal history of abuse were not more troubled by seeing survivors of abuse than psychologists without a personal history of abuse. The authors recommended training psychologists, especially in the area of sexual abuse and violence. The participants of the study revealed that their self-care skills such as exercising, leisure time, support networks, and meditation helped them deal with the stressors of this line of work.

Pearlman and Mac Ian (1995) performed a study of the effects of trauma therapy on trauma therapists. The 188 participants, identified as trauma therapists, completed surveys concerning their work with trauma survivors and their own trauma history. The TSI (Traumatic Stress Institute) Belief Scale measured disrupted cognitive schemas. The

Impact of Events Scale (IES) was distributed to assess signs and symptoms of PTSD in trauma therapists. The Symptom Checklist-90-Revised and Marlowe-Crowne Social Desirability Scale were also used to distinguish between general stress and trauma-specific distress, as well as to assess the participants' need for approval. The authors found that therapists with the least amount of work experience encountered more mental and emotional difficulties, and the therapists with a history of trauma demonstrated more negative consequences from their work. Important clinical implications include further training in trauma therapy, more supervision for trauma therapists, and self-care training for trauma therapists.

Figley discussed a phenomenon called “secondary victimization” (1989, p. 9). He noted that caring for the victim can traumatize family members and other supportive friends. He classifies different types of trauma as: 1) simultaneous trauma is when all members of the system are affected at the same time, such as a national disaster, 2) vicarious trauma is when one member is affected alone, such as one member of the family being in a hostage situation, (3) intrafamilial trauma takes place when a member inflicts emotional harm on another person, and (4) secondary trauma takes place when the traumatic stress affects the entire system after appearing first in only one person. This phenomenon is what Figley (1985) calls secondary traumatic stress (STS) and secondary traumatic stress disorder (STSD).

Figley (1993a) defines secondary traumatic stress (STS) as “the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other – the stress resulting from helping or wanting to help the traumatized or suffering person” (p. 7). Stamm (1995) defined STS as a risk that is

related to empathically engaging with a client's traumatic background. Boscarino, Figley, and Adams (2004) define secondary traumatic stress as "reduced capacity or interest in being empathic" (p. 58).

Figley (1995) explained that the term compassion fatigue is an alternative to secondary traumatic stress (STS). He defined compassion fatigue as "a state of tension and preoccupation with the traumatized patients by reexperiencing traumatic events, avoidance/numbing or reminders, and persistent arousal (e.g., anxiety) associated with the patient" (2002, p. 1435). "In other words, the therapist witnesses the traumatic event through the disclosure of the client" (Good, 1996, pp. 23-24). When the symptoms of compassion fatigue last less than one month, they are considered normal reactions to a crisis. However, these symptoms become classified as a disorder after they have been experienced more than 30 days after the traumatic event.

Symptoms of STS or compassion fatigue include: reexperiencing the traumatic events through intrusive thoughts or dreams, avoidance of reminders of the event, problems sleeping and concentrating, and changes in their relationships. Counselors that listen to their clients' stories of trauma, loss, and malice may become overwhelmed and begin to experience feelings of pain, suffering, and anxiety similar to that of their clients (Gentry, Baggerly, & Baranowsky, 2004). Behavioral signs of compassion fatigue are clock watching, avoiding returning phone calls, marital discord, absenteeism, increased use of alcohol and drugs to sleep and elevate mood. Psychological signs include: sense of failure, worrying, depression, guilt feelings, suppressing emotions, difficulty saying no, and sacrificing personal life for work. Finally, physical signs of compassion fatigue

include: tired during the work day, frequent illnesses, headaches, stomach problems, fatigue, and sleep problems (Millner, 2005).

Compassion Fatigue: Risk to All Counselors.

Figley (1995) offers a model of compassion stress and compassion fatigue. This model begins when a helping professional responds empathically to a client's situation. More recently, Figley (2002) expanded his ideas and proposed variables that, together, form a model that predicts compassion fatigue.

These variables begin with the concept of empathic ability. This concept is defined as the counselor's ability to distinguish experiences in others. Additionally, empathic concern is the drive to help others in need, and assists counselors to provide the best services to clients (Figley, 2002). Without empathy, there would be little compassion stress, and no compassion fatigue, but there would also be no therapeutic benefit to counseling. So, the capacity to empathize with others is an important part of helping others and can lead to increased risk to the counselor.

The next variable, empathic response is the counselor's response to the client's suffering. Understanding client's feelings and thoughts is accomplished when a counselor is aware of the perspective of the client. Naturally, compassion stress is the long-term effects of the empathic response. Together with other factors (exposure to client, traumatic recollection, and life disruption), it can contribute to compassion fatigue unless the counselor learns ways to control the stress (Figley, 2002).

Preventing compassion stress includes two sets of coping skills that counselors need to possess: sense of achievement and disengagement. A counselor with a sense of achievement recognizes successful counseling outcomes, large and small. Disengagement

occurs when the counselor can balance professional issues and personal issues between counseling sessions, thus facilitating the counselor's understanding of the importance of wellness and self-care. If compassion stress still increases, despite the above two factors, a counselor is at even greater risk of compassion fatigue (Figley, 2002).

Based upon the information presented in this model, there are no stringent reasons that compassion fatigue could not occur in all counselors. Empathic response, compassion, concern, stress, and exposure to the client are situations that counselors face. Clients experience major and minor traumas throughout their lives, as can counselors. People react to different situations in very diverse ways and it is the client's reactions to these traumas that may be vicariously passed on to the counselor.

Furthermore, the two coping skills outlined in Figley's (2002) compassion stress and compassion fatigue model, represent the premise behind this study. Disengagement is clearly the balance between professional and personal issues. If disengagement is a factor that may prevent compassion stress, then it is crucial that counseling interns learn about this preventative measure in graduate training. Subsequently, counseling interns are in their initial stages of counseling field experience and do not necessarily have a true sense of successful counseling outcomes. So counseling intern's sense of achievement is skewed because at this level many are unsure about their abilities and lack clinical experience. "The novice enters practice as a new canoeist enters white water – with anxiety, some instruction, a crude map, and some previous life experience" (Skovholt, 2001, p. 56).

Impairment

As of 1988, the counseling literature had not addressed the issue of impairment, nor had the American Association for Counseling and Development (AACD) convened to address the topic (Stadler, Willing, Eberhage, & Ward, 1988). Furthermore, much of the literature on impairment originated from the fields of medicine and psychology. Stadler et. al. (1988) and Witmer and Young (1996) challenged the counseling profession to focus on the issue of impairment. Decisively, The Governing Council of the American Counseling Association set up a Task Force on Impaired Counselors in 2003. The purpose of the task force was to address issues related to impaired counselors (Lawson & Venart, 2005).

The Task Force on Counselor Impairment defines counselor impairment as:

Therapeutic impairment occurs when there is a significant negative impact on a counselor's professional functioning which compromises client care or poses the potential for harm to the client. Impairment may be due to:

- Substance abuse or chemical dependency
- Mental illness
- Personal crisis (traumatic events or vicarious trauma, burnout, life crisis)
- Physical illness or debilitation

Therapeutic impairment occurs when there is a significant negative impact on a counselor's profession functioning which compromises client care or poses the potential for harm to the client. Impairment may be due to: substance abuse or chemical dependency, mental illness, personal crisis (traumatic events or vicarious trauma, burnout, life crisis), and physical illness or debilitation. Impairment in and of itself does not imply unethical behavior. Such behavior may occur as a symptom of impairment, or may occur in counselors who are not impaired. Impairment may be due to: substance abuse or chemical impaired are distinguished from stressed or

distressed counselors who are experiencing significant stressors, but those whose work is not significantly impacted. Similarly, it is assumed that an impaired counselor has at some point had a sufficient level of clinical competence, which has become diminished as described above” (Lawson & Venart, 2005, p. 3).

Behavioral signs of impairment include mood swings, arrogant remarks, lack of empathy, difficulty concentrating, disorganization, poor hygiene, and problems with colleagues (Freudenberger, 1986). Boxley, Drew, and Rangel (1986) found that personality disorders, depressed mood, emotional instability, marital discord, illness, and fatigue were all associated with psychology student impairment. Emerson and Markos (1996) reported that symptoms of impairment in counseling students included anger, depression, substance abuse, stress, paranoia, denial, and pessimism.

More recently, Vacha-Haase, Davenport, and Kerewsky (2004) revealed surprising results related to impairment. Training directors at 281 APA-accredited psychology programs were surveyed about problematic students and their programs’ remedial policies. Surveys were received from 106 programs representing a 37% response rate. Fifty-two percent of the programs reported that they dismissed at least one student over the course of three years. Poor clinical skills were reported most frequently for dismissal of the student. Personal counseling was the most likely recommendation for impaired students who were not dismissed in this study. Furthermore, half (53%) of the programs reported that they did not have formal gatekeeping policies in place regarding impaired students. The authors also believed that impaired students were unaware of the potential harm to the therapeutic process. Furthermore, the study illustrated the prevalence of impairment in graduate programs. The study found that 66% of these

internship programs had impaired students over a five-year span. This number averages out to approximately 18 impaired students a year among the programs that responded.

The American Psychology Association (APA) Advisory Committee on the Impaired Psychologist stressed the importance of discovering impairment of students in training and addressing problems early on (Schoener, 1999). Wakefield (1995) reported that a critical component of preventing impairment is to educate helping professionals about their susceptibility and their responsibility to avoid impairment. He urged the profession to resolve issues of impairment and to “be our brother’s keeper” (p. 89).

Furthermore, Stadler (1986) informed the professional community that when counselors become impaired and jeopardize the welfare of others, setting up boundaries of professional independence and handling those who have violated these boundaries are crucial. To prevent impairment, ongoing screening and evaluation policies are essential (Witmer & Young, 1996). Laliotis and Grayson (1985) believe an approach that had been underutilized to prevent impairment is education. Counselor educators not only have this responsibility, but they also play an important role of gatekeeper.

White and Franzoni (1990) examined the mental health of counseling students. One hundred-eighty counseling students were administered the Minnesota Multiphasic Personality Inventory (MMPI), the Adult Nowicki-Strickland Internal-External Control Scale (ANSIE), the Life Style Personality Inventory (LSPI), and the Coping Resources Inventory for Stress (CRIS). As a group, the counseling students had lower levels of mental health than the general population. Also, counseling students were found to have higher levels of psychological problems. The implications of this study suggested the need to identify impaired counseling students. Indeed, one can infer that counseling

students may be at greater risk for impairment issues such as compassion fatigue and burnout.

Not only do counseling students have higher levels of psychological problems, but there are also specific hazards of the counseling practice that put counseling students at a higher risk for compassion fatigue and burnout. For instance, clients often have very large problems that need to be solved right away. Additionally, the work of the counselor involves being empathic which may lead to counseling students becoming emotionally connected to the client. This connection may also include the negative client emotions, including stress emotions. So, counseling students must learn how to be both empathic to the positive and negative client emotions and disengaged from the clients emotions. This effort can wear on the student counselors. Counseling students should avoid underinvolvement with the client, but overinvolvement can be risky to the client and the counseling student's own well-being. Another hazard is the ability to build rapport with a client, maintain a therapeutic relationship, and then separate from the client over and over again. This must be done in a way that will strengthen and inspire or it will drain the counselor (Skovholt, 2001).

“Students are usually accepted into graduate training in the helping professions because they are so good at using compulsive strategies to gain control” (Skovholt, 2001, p. 56). The inexperience of the novice counselor leads to increased stressors related to several factors. Novice counselors tend to rely on external experience, while seasoned counselors rely on internal expertise. Furthermore, novice counselors have more performance anxiety and question their competence more than experienced counselors do. It seems that during a novice counselor's training there comes a time when the

student criticizes everyone for their feelings of incompetence; i.e., the university, the department, and professors. The student also blames himself/herself and thinks they are not qualified to be a counselor. Thus, pointing the blame at the inadequacy of their education and of self is often characteristic of a novice counselor (Skovholt, 2001).

Counseling students also have glamorized expectations of the counseling profession. Often, counseling students daydream about what it will be like to make a difference in a client's life. However, "the models we tend to use for inspiration to enter a career field seem to excel at miracles" (Skovholt, 2001, p. 66). Counseling students are often overly optimistic about their impact on clients' lives. They believe that if they are good enough that their clients will improve and this affirms their career choice. On the other hand, counseling students believe if their clients do not improve then they must not be effective and therefore have made a poor career choice. Thus, the counseling students' stress increases when they realize that their original expectations of becoming an effective counselor are crushed. "When the novice thinks, I want to have an impact in every session, every class, every health consultation, then there is pressure and stress" (p. 68). This stress is reduced only when they realize that client change is a gradual process in which counselors only play a small part.

Another stressor for novice counselors is the issue of boundaries. Novice counselors learn about the importance of appropriate physical boundaries, however, less attention is given to emotional boundaries – the inner feelings and thoughts of the helper. The capacity to detach and reattach is a complicated and advanced skill. The development of different boundaries takes time and experience. "One looks for a positive interplay between empathic attachment to the other and one's own very important self-

care needs. It takes time and experience, something the novice does not have (Skovholt, 2001, p. 72-73).

Furthermore, Lamb, et al. (1987) discussed stressors related to the internship. The authors believe that developmentally, the transition from graduate training to the internship is stressful and if these issues are not dealt with efficiently they can escalate into impairment. Situational stress related to changes in their support systems, living arrangements, and school responsibilities could also lead to impairment. The interns are, for the first time, exposed to actual clinical work, which may elicit stress. The authors (Lamb, et al., 1987) assert that problems are more likely identified in the internship phase than at any other time during a career. Additionally, the authors report that the internship phase is the last place for educators and/or clinicians to identify impairment in their students and determine their readiness for the profession. Overall, the authors urge educators to monitor internship students, establish methods for evaluating impaired students, and educate students about impairment.

Counseling interns are just beginning to apply the knowledge and skills learned during counseling courses in their work with clients. Their stress levels are on the rise and they are faced with hazards of the counseling practice. Therefore, teaching counseling interns about the risk of working with clients and how to take care of themselves is a critical part of their graduate education. Counselor educators, the gatekeepers, must view this education as a priority.

It is obvious from the literature that wellness education should be an important part of counselor education programs, however; it is not always included in the counseling curriculum. Counselor wellness education will promote mental health in

counseling students, teach stress management skills, and make them aware of their career responsibility.

Incorporating Wellness Components into Counseling Graduate Programs

Counselor wellness is an important concept that counselor educators should teach to counseling students. Several authors agreed with this statement. As early as the 1980s, suggestions were being made for counseling training regarding wellness. Savicki and Cooley (1982) made specific recommendations for the counseling field. “Counselors need to have skills in stress reduction techniques if they are to avoid the long-term effects of stress. The most efficient place to begin developing stress reduction skills is during graduate training” (p. 417). The authors believe that educators can use different occasions, such as practicum, internship, and exams, to coach counseling students about their reactions to the stress and offer numerous methods to counteract its effects.

Moreover, the authors stated that educators should encourage and teach counseling students an attitude of detached concern (Savicki & Cooley, 1982). This task may be difficult for counselor educators, as they are helping students develop empathy and compassion for their clients. Nevertheless, the authors believe that clearer training in this area is useful for beginning counseling students. In addition, it is suggested that counseling students be taught about the realistic impact they can expect to have on clients. The authors believe that a realistic approach for students is a critical educational tool learned in counselor training. They also believe that these methods, once taught, prevent burnout and promote professional longevity.

Additionally, Rosenbloom, Pratt, and Pearlman (1995) discussed the importance of the “emotional well-being” of counselors and its impact on the work counselors do and

the clients they serve (p. 66). They emphasized that a beginning step to self-care is to have a basis for understanding the effects of doing counseling. This education is an important concept that can be taught in graduate counselor education programs.

Yassen (1995) also points out the importance of self-care and wellness. The author believes that this awareness and knowledge can be taught in counselor education, social work, and psychology training programs. Additionally, Munroe (1995) proposed that counselor educators must not only be concerned with teaching counseling students about the possible hazards of being a counselor, but also that they should train counseling students on how to cope better with the stresses of the job.

Hesse (2000) supported the ideas of her colleagues by stating that preventative education is imperative and should preferably begin in undergraduate and graduate programs. Danieli (1990) agreed and stated that it is important to train counselors how to care for themselves in order to “provide the best standards of care for those suffering individual, communities, and nations” (p. 244). Furthermore, Salston and Figley (2003) believed that educators should also discuss the rewards of being a helping professional, which begins with balancing care for ourselves and care for our clients.

Maintaining wellness and learning how to manage the risks of the counseling profession comes together in counselor education programs. As shown, wellness education is a critical component to counselor education programs. Some counseling programs are going beyond just incorporating wellness classes into their curriculum; they are offering a wellness experience to their students.

“The teaching well” was the foundation for two classes planned to help graduate counseling students develop their understanding of wellness. The authors (Rybak &

Russell-Chapin, 1998) designed one class based on Western philosophies and the other class primarily centered on Eastern philosophies. "...Teaching students both philosophical perspectives offers wellness strategies which seem to be complementary, allow for personal choices, and build on students existing knowledge" (p. 135). Students were initially taught meditation and mindfulness exercises to promote wellness. Each class session involved an experiential activity, reflection, and followed with discussion. The exercises used in the wellness training included guided imagery, mindful eating, mandala drawing, poetry, body scan meditation, other meditation activities, and a wellness survey. The process allowed students to retrieve their inner resources and gain a comprehensive view of the techniques.

Obviously, counseling can be particularly stressful during a counselor student's training. The stress response can generate anxiety in counselor trainees and can affect clinical success with clients. The purpose of one study (Chandler, Bodenhamer-Davis, Holden, Evenson, & Bratton, 2001) was to establish if biofeedback-assisted relaxation training could decrease stress levels in counselor trainees and enhance personal wellness. Participants were beginning counselor trainees enrolled in a master's basic counseling skills course in a counselor education program in south-central United States. Nineteen students (11 in the control group and 8 in the treatment group) participated. Students were asked to not participate in any other relaxation activities during the course of the study. The Symptom Checklist-90-Revised (SCL-90-R) was used to identify the number of stress symptoms at hand for each student. The SCL-90-R has nine symptom categories and three global symptom scores: Somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and

psychoticism. The treatment intervention was ten weekly, 45-minute sessions of biofeedback activities. It seems that the biofeedback-assisted relaxation therapy was helpful in reducing harmful symptoms in graduate students in counselor education programs. The symptom that improved the most was somatization (headaches, body aches, and physical pain). The area with the second greatest improvement was psychoticism, signifying that counselor trainees felt less withdrawn and distant. The area for improvement was a decrease in interpersonal sensitivity, suggesting that the counselor trainees felt more confident after the interventions. Surprisingly, there was no significant reduction in anxiety. The authors believe, “These skills could allow the counselor to better manage the stress of life and of the job and perhaps enhance job satisfaction” (p. 6). The authors affirm that this type of relaxation therapy is a valuable part of the counselor training process.

It has also been proposed that spirituality be incorporated as a component of wellness into counselor education programs (Myers & Williard, 2003). The authors recommended that a “developmentally based wellness orientation that promotes human spirituality as the core element of the individual” may be useful in counselor preparation (p. 150). The authors suggested that counselor trainees be given opportunities during their training to understand their own personal spirituality and how this will affect their abilities as counselors. They further advised that counselor trainees be exposed to different spiritual beliefs and values by integrating a wellness philosophy in core counseling courses. Furthermore, counselor trainees should become familiar with assessment instruments and intervention techniques that are attuned with a wellness philosophy.

Christopher, Christopher, and Dunnagan (2006) developed a semester long course that was developed to provide counseling students with personal growth opportunities through self-care activities and through stress reduction and mindfulness activities that can help prevent burnout. “Although mainstream, accredited counseling training programs often emphasize the need for self-care strategies to prevent burnout, the demands of the curricula and clinical training often leave little room for directly teaching these strategies” (p. 496). Students were taught and practiced yoga, meditation, body scanning, and Qi gong for the first part of the class. Students were given an opportunity to process this practice activity weekly throughout the semester. The academic part of the course included literature about eastern philosophy, mindfulness practice, research, etc. The students also kept a journal in order to process their reactions to their reading and practice areas.

Participants were first and second year master’s level graduate students in mental health counseling, school counseling, and marriage and family counseling that enrolled in this elective graduate course. Focus group data, a qualitative method, was collected from 11 students. Inductive content analysis was used to find themes in the data. Students reported that this course was very relevant to their education and made a significant impression on their professional and personal lives. Many students reported having a greater awareness of themselves and were able to stay more centered and focused. Others reported they felt more prepared to deal with the stressors in their lives. The authors stated, “The findings most strongly support the values of these types of courses on student training to be caregivers (i.e., therapists and other health professionals)” (Christopher, et. al., 2006, p. 506). The authors further declared that similarly structured

classes should be incorporated into counseling curricula. "...Counselor educators can use holistic wellness paradigms as a foundation for preparing counselor's to meet the unique needs of their clients more effectively (Myers & Williard, 2003, p. 153).

Figley (1995) stated, "There is a cost to caring" (p. 1). This statement unmistakably refers to the effects of the demands of the profession. The author asserted that professional counselors have a responsibility to counseling students to prepare them for these risks and their vulnerability to them. He believes that it is crucial to include the topics of stress, burnout, compassion fatigue, and wellness into the program curriculum as well as into supervision and practicum.

It seems that to not address student wellness during counselor training may increase the risk for student impairment. Likewise, counselor educators have a responsibility to monitor counseling students and determine their readiness for the counseling profession.

Gatekeeping

Gatekeeping is not a new concept. The concept of gatekeeping derived from the medical, psychology, and social work literature. In 1971 at The Allenberry Colloquium, social work educators spoke of the responsibility to guard the profession and to only allow competent students to enter the profession (Moore & Urwin, 1991).

Gatekeeping is the professional responsibility of educators (counseling, social work, psychology) to determine if a student should enter the profession (Moore & Urwin, 1991). Likewise, gatekeeping is preparing counseling students to become skilled, proficient, and physically and mentally healthy professional counselors through education, training, supervision, and evaluation. Additionally, gatekeeping is protecting

the counseling profession by identifying and intervening with impaired counseling students.

Counselor educators have a responsibility to function as gatekeepers for the profession, based on the possible harm done to clients if counselors do not possess favorable personality traits and effective clinical skills (Lumadue & Duffey, 1999). Moore and Urwin (1991) best described the nature of gatekeeping as, “It begins with guarding the entrance, includes providing responsible education, and concludes with guarding the exit” (p. 9). Schoener (1999) added, “Not only are trainer and trainee often closely involved, but the field we are in requires that the practitioner not only use tools but also be the tool” (p. 693).

In Boxley, Drew, and Rangel’s (1986) study, 246 APA accredited psychology internship programs were surveyed regarding gatekeeping procedures. Specifically, a 62-item questionnaire was developed to gather information on admission procedures, demographics of impaired psychology students, types of impairment, and remedial intervention used to manage the program’s impaired psychology students. Approximately 66% of the internship sites reported having impaired students over the past five years. Yet, roughly 44% of the internship programs had no formal gatekeeping policies in place to deal with impaired students. Additionally, 10% of these programs reported that there was no reason to develop these policies. Therefore, only 24% of the APA programs reported that they did have formal gatekeeping policies in place. The psychology programs’ available policies included specific guidelines given to incoming students, supervision, personal growth opportunities, and annual evaluations. The authors

recommended that psychology internship programs receive more education about gatekeeping procedures and impairment prevention.

Additionally, Gaubatz and Vera (2002) researched two important questions about the characteristics and success rates of the gatekeeping procedures of 29 CACREP and 38 non-CACREP programs in the United States. Specifically, the authors investigated whether formal gatekeeping procedures would prevent students from “slipping through program gates (i.e., graduate without remedial attention)”, (p. 296). Questionnaire packets with a survey were sent out to counselor educators in the counseling programs. Of the 253 counselor educators who received packets, 118 responded to the survey. Counselor educators reported that about 10.4% of their master’s level students were poorly matched for the counseling field. Counselor educators in seven programs reported deficiency rates of 30% or more, and in four programs deficiency rates were above 50%. There were more “gateslipping students” in programs that employed a higher number of adjunct counselor educators because this part-time faculty generally had much less contact with students (p. 299). There were also a higher number of unremediated students among counseling programs whose counselor educators reported that their colleagues faced pressures not to screen impaired students. However, program size did not affect these rates. CACREP programs reported that 35% of their deficient students were neither remediated nor dismissed from their programs. As well, non-CACREP faculty reported that approximately 45% of their deficient students were overlooked. Accredited programs used more formalized gatekeeping procedures and faculty in programs that used more formalized procedures reported significantly lower gateslipping rates. Therefore, CACREP programs were associated with lower rates of student impairment and

gateslipping. However, although CACREP programs did better than non-CACREP programs, both seem to have problems with student gateslipping. Therefore, this study suggests that many students whom counselor educators viewed as impaired might have completed their programs without receiving any remediation for their impairment issues. “This apparent inattention raises questions about the welfare of the clients such student may see in the future and underscores the obstacles of counselor educators encounters when they decide to intervene with questionably fit students” (p. 30). The authors recommended more formalized gatekeeping procedures to assist counselor educators in training qualified counselors.

There are five models of gatekeeping in current counseling literature. Frame and Stevens-Smith (1995) used their model in the Counselor Education program at the University of Colorado at Denver. The authors presented a three step process for monitoring and dismissing students. Fifty percent of the faculty reported that the process gave them a concrete way for dealing with student impairment.

The second model of gatekeeping was developed by Baldo, Softas-Nall, and Shaw (1997). The policy was developed due to issues that arose at the University of North Colorado (UNC) after a student was terminated from their counseling program. After this suit, it became apparent that one individual should not be responsible for a student’s dismissal from a program. Therefore, these authors believed that the Frame and Stevens-Smith’s model could place a faculty member in a sensitive position due to having to report students’ impairment. These authors presented a “review and retention policy” instead of a model for dismissal (p. 249).

Lumadue and Duffy (1999) incorporated the gatekeeping model of Frame and Stevens-Smith (1995) and Baldo, et al. (1997) into one model but added a behavioral student evaluation tool. Their gatekeeping model was developed by the counseling faculty at Southwest Texas State University and was used to accomplish six important goals: 1) To point out expected student behaviors; 2) To achieve agreement amongst the faculty about student expectations; 3) To create a behavior list; 4) To standardize evaluation policies in the department; 5) To share these expectations to all students in their program; 6) To add these expectations to their admissions packets. The instrument was named the Professional Performance Fitness Evaluation (PPFE), which assessed counseling skills, professional responsibility, competence, honesty, and maturity. The competencies summarized in the ACA (1995) Code of Ethics and Standards of Practice were the source for the PPFE.

Oklin and Gaughen (1991) proposed a three-step gatekeeping model. A questionnaire designed for this study was sent to the chairs of 100 master's programs in mental health. Of the 100, 54 master's programs in mental health (counseling, counselor education, psychology, clinical psychology, counseling psychology, and marriage, family, and child counseling) were surveyed. Their study determined that a median rate of 3.3% impaired students are acknowledged per year. The authors stated, "While 3.3% is not an alarmingly high number, it is a steady trickle that requires attention" (p. 285). In summary, the authors recommended programs have a written policy and procedures including information on evaluation and remediation; scheduled student evaluations (in writing) of academic and nonacademic areas; more creativity regarding remediation; and,

“operational definitions” of expected behaviors of students in counselor education programs (p. 287).

Knoff and Prout (1985) proposed a simple and logical gatekeeping model used with psychology students and faculty. First, the authors suggested the development of official policy regarding professional and personal development in the program. This proposal needed to clearly state expected student behaviors within the program and be given to students once they enter the program. Secondly, students’ progress must be evaluated and reviewed by a “student progress committee” comprised of faculty (p. 795). Should there be a problem, the faculty will discuss them with the student, help develop a remediation plan and choose a date for reevaluation. Finally, at reevaluation there are options including the student’s continuing in the program, continued remediation, counseling the student out of the program, or formal dismissal. If the committee determines that formal dismissal is the only option, they must present the student with written notification including their reasons for dismissal. In addition, the student must be given time to respond to the notification and the chance to ask the faculty to review the case again.

Despite the development of these gatekeeping models, many counseling programs have been hesitant to implement these models (Gaubatz & Vera, 2002). Counselor educators must consider the emotional strength and wellness of their counseling students who will become professional counselors, as well as their academic progress. “Otherwise, counselor educators participate in creating a growing work force of impaired counselors” (Bradey & Post 1991, p. 108).

Counselor educators have the responsibility to make recommendations when a student is impaired. Clearly, the Task Force on Counselor Impairment reports that impairment may be due to “personal crisis” including traumatic incidents, vicarious trauma, burnout, or a life crisis (Lawson & Venart, 2005, p. 3). Therefore, in order to be successful gatekeepers, counselor educators must instruct counseling students about personal wellness and, specifically, to teach counseling students how to offset the risks of the profession such as compassion fatigue and burnout.

Summary

This chapter provides a thorough review of the literature on counselor wellness and self-care, burnout, compassion fatigue, impairment, incorporating wellness components into counseling graduate programs, and counselor education as gatekeepers. This chapter also provides extensive support for conducting this study. The next chapter will delineate the methodology and data analysis for this study.

CHAPTER THREE: METHODOLOGY

Chapter three will introduce the methodology for this study including research questions, research design, research participants, sampling procedures, instrumentation, data collection, and data analysis.

Purpose/Overview of the Study

Specifically, this study will (a) assess counseling interns' perceptions of their programs; wellness education; (b) assess counseling interns' level of compassion fatigue, compassion satisfaction and burnout; and (c) determine the relationship between compassion fatigue, compassion satisfaction, burnout and counseling interns' perceptions of their programs' wellness education. The information gathered from this study will add to the literature on wellness, compassion fatigue, gatekeeping, and counselor training.

Research Questions

This study is designed to (a) assess counseling interns' perceptions of their programs' wellness education; (b) assess counseling interns' level of compassion fatigue, compassion satisfaction and burnout; and (c) determine the relationship between compassion fatigue, compassion satisfaction, burnout and counseling interns' perceptions of their programs' wellness education. To ascertain this information, the following research questions will be used:

- 1) What are counseling interns' compassion fatigue levels as measured by the Professional Quality of Life (III-R)?
- 2) What are counseling interns' compassion satisfaction levels as measured by the Professional Quality of Life (III-R)?

- 3) What are counseling interns' burnout levels as measured by the Professional Quality of Life (III-R)?
- 4) What are counseling interns' perceptions of their counselor education programs' wellness education and curriculum?
- 5) Is there a positive relationship between counselor interns' perceptions of wellness and compassion satisfaction and compassion fatigue and burnout?
- 6) Are counseling interns knowledgeable of their counselor education programs' nonacademic retention and dismissal policies?

Web Surveys

Internet research is becoming popular. Schleyer and Forrest (2000) reported that researchers from various disciplines are beginning to understand the benefits of collecting data using the Internet and more journals are publishing studies that have collected data online (Granello & Wheaton, 2004).

The benefits to online data collection are available in the literature. Authors cite advantages in using web surveys over regular mail surveys: (1) Web surveys may reach larger numbers of possible participants (Lazar & Preece, 1999; Topp & Pawloski, 2002); (2) accuracy and speed of data entry (Lazar & Preece, 1999; Topp & Pawloski, 2002; Granello & Wheaton, 2004; Duffy, 2002); (3) lowered costs (Lazar & Preece, 1999; Duffy, 2002; Granello & Wheaton, 2004); (4) flexibility over format (Topp & Pawloski, 2002; Granello & Wheaton, 2004); and, (5) decrease in the chance of human error during the data-entry process because many of the survey programs collect the data automatically (Lazar & Preece, 1999; Duffy, 2002).

However, with these advantages there are also limitations of Web research: (1) technical problems may occur should a participant not be computer savvy (Topp & Pawloski, 2004; Granello & Wheaton, 2004); (2) problems obtaining a representative sample can occur as most users of the Web are educated, white males, who have access to the Internet on a daily basis (Duffy, 2002; Granello & Wheaton, 2004); (3) Web-based surveys have a lower response rate than mail surveys (Duffy, 2002; Granello & Wheaton, 2004). To reduce this problem, research has supported the notion of multiple reminders to participants (Granello & Wheaton, 2004). The survey includes a demographic section. The demographics of the participants can be compared to the demographics of the population to address non-response bias; (4) Confidentiality and informed consent are an issue because information on the Internet can be accessed by other sources and because written informed consent is usually not obtained (Duffy, 2002).

Methodology

Research Design/Procedures

This study will use a Web-based survey research design. The survey will be sent to the program liaisons of 209 CACREP counselor education programs and distributed by those program liaisons to all full-time counseling students engaged in the clinical internship phase of their counseling programs. The purpose of this study is to determine the prevalence of compassion satisfaction, compassion fatigue, and burnout in CACREP counseling interns, to determine CACREP counseling interns' perceptions of their programs' wellness education, and to examine the relationship between students' perceptions of their programs' wellness education and levels of compassion satisfaction, compassion fatigue, and burnout. In order to accomplish these goals a non-experimental, descriptive, correlation design was chosen.

Participants

The research participants will be full-time students enrolled in master's level counseling programs at 209 universities located in 48 states in the United States. These students will be engaged in the clinical internship phase of their counseling programs. The counseling students will be invited by their respective program liaisons to complete a Web-based survey, Counseling Interns Perceptions of Wellness, and The Professional Quality of Life (ProQOL), either at on-campus labs or internship sites. The data will be collected during the spring semester. All universities to be selected for participation are accredited by the Council for the Accreditation of Counseling and Related Educational Programs (CACREP). CACREP offers accreditation to counselor education programs in the United States, guaranteeing that these programs are committed to academic excellence and have met professional standards. The students are enrolled in mental health, school, marriage and family, or community counseling program tracks.

Sampling Procedures and Sample Size

A sample of those counseling students currently engaged in the clinical internship phase of their master's level counseling program will be selected by contacting program liaisons at 209 universities. Identifying and selecting accredited counselor education programs in the United States, including the names and email addresses of program liaisons will be obtained through the CACREP website. Research participants will be recruited by the program liaisons by a personal email invitation. The email message (see Appendix A) will include the email address of the researcher, information about the study, and instructions on distributing the upcoming Web-survey and instrument to the program's full-time counseling interns.

To increase the response rate, full-time counseling interns were selected to complete this study. These students may have access to computer labs on campus, as well as at internship sites. According to Granello and Wheaton (2004), an example of a population that would have equal access to the Internet would be students or faculty at a university. Therefore, full-time counseling interns of CACREP programs have access to computers and Internet to complete the survey and may fully participate in this study.

To address potential non-response bias, the program liaisons were asked to complete a demographic questionnaire about the program as a whole. The demographics of the program will be compared to those of the sample, counseling interns. The comparison will ensure that the sample is representative on the demographic variables.

Informed Consent and Permission Procedures

The entry page of the Web-survey includes a section on the possible risks of confidentiality, such as information being obtained by a third party. Another section explains confidentiality in great detail and includes discussion regarding IRB approval, participant's responsibility, informed consent, and participants' right to withdraw from the study. Participants are required to accept all conditions of the study before completing the two instruments.

Limitations and Delimitations

There are certain limitations of this study, which need to be addressed. This study measures compassion fatigue, compassion satisfaction, and burnout at one point in time during counseling students' clinical internships. Similarly, counseling students' perceptions of wellness of their counseling programs' education will also be observed only during the students' internship phase of their counseling programs. Additionally,

data collection for the study is limited to two weeks and collected only from counseling students who respond within the proposed time limit. This study is also limited to counseling students who are capable of using the Internet and volunteer to participate. A delimitation of this study is that the study is confined to surveying counseling students enrolled in CACREP master's counseling programs.

Instrumentation

Professional Quality of Life: Compassion Satisfaction and Fatigue Subscales-III

The Professional Quality of Life Scale (ProQOL) is the third version of the previous Compassion Fatigue Self Test (Figley, 1995). This instrument is being used in this study because it is the current (and only) measurement for compassion fatigue. The test's name and version was changed for a couple of reasons. First, the original instrument had psychometric problems due to asking only negatively phrased questions (Stamm, 2002). Second, the author (Stamm, 2005) wanted to support a more positive notion of the effects of providing care.

The ProQOL is comprised of three separate scales. Each scale is exclusive and cannot be combined with the scores from the other scales of the instrument. The third version of the ProQOL focuses on problems separating burnout and secondary/vicarious trauma. The instrument was shortened from 66 to 30 items. The instrument uses a 6-point Likert scale (Gentry, Baggerly, & Baranowskly, 2004). Each new subscale has 10 items; 7 from the CSF and 3 new items used to strengthen the overall theory of the subscale. This version of the instrument was developed by keeping the strongest and most significant items that met both high item-to-scale criteria and were good representatives of the subscale construct (Stamm, 2005).

The ProQOL measures compassion satisfaction, burnout, and compassion fatigue/secondary trauma (Stamm, 2005). The psychometric properties of this instrument are reported as having an alpha reliability range: Compassion Satisfaction alpha = .87; Burnout alpha = .72, and Compassion Fatigue alpha = .80. These scores are more reliable than the longer version of the instrument. The measure has significant improvement on the item-to-scale statistics. The standard errors of the measure are small so the instrument has less error interference improving the possible measurable effect size. Returns on test-retest data imply good reliability across time with a small standard of error of the estimate.

The construct validity upon which the test is based is entrenched having been documented in the literature in over 200 articles. The scales on the ProQOL do measure different constructs, using the multi-trait multi-method mode for convergent and discriminant validity. Furthermore, the ProQOL revision of the CFST reduced the known colinearity between Compassion Fatigue and Burnout. The interscale correlations are small. Compassion Satisfaction has 5% shared variance with Burnout and 2% shared variance with Compassion Fatigue. The shared variance between Compassion Fatigue and Burnout is a little higher, 21%, possibly signifying the distress that is normal to both conditions.). A conservative quartile method is used regarding scoring with high (top 25%), middle (50%), and the low (bottom 25%)(Stamm, 2005).

Substantial work has been conducted in order to create a composite indicator score, but this task has not been completed as of yet. One of the main reasons for this concerns the involved relationship between the scales. It is possible for people to report high scores on Compassion Satisfaction combined with high scores on Compassion

Fatigue (i.e. person working in war or refugee camp). Usually, there are not high scores on burnout with high scores on compassion satisfaction (Stamm, 2005).

Compassion satisfaction is the pleasure you receive from doing your job well. The average score on this scale is 37 (SD 7; alpha scale reliability .87). If a person scores in the higher range, they gain professional satisfaction from their job position and their ability as an effective helper. If a person's score is lower than 33, then he or she will find difficulties with their job (Stamm, 2005).

Burnout is associated with feelings of hopelessness and problems in dealing with work or in doing your job efficiently. These negative feelings have a gradual onset; high scores on this scale mean higher risk for burnout. The average score on the burnout scale is 23 (SD 6.0; alpha scale reliability .72). If a person's score is lower than 18, this reflects positive feelings about his or her job skills and doing efficient work. If a person's score is above 22, this reflects feelings of ineffectiveness and incompetence. If this high score continues, there may be reason for concern (Stamm, 2005).

“Compassion fatigue (CF), also called secondary trauma stress (STS) and related to Vicarious Trauma (VT), is about one's work-related, secondary exposure to extremely stressful events” (Stamm, 2005, p. 5). The symptoms of compassion fatigue are usually quite swift and brought on by a particular event. Some of the symptoms of compassion fatigue are problems sleeping, nightmares, intrusive thoughts, avoiding people and situations, and being scared (Figley, 2002). The average score on this scale is 13 (SD 6; alpha scale reliability .80). If a person's score is above 17, he or she may want to spend some time thinking about what it is that may be upsetting him or her at work. Higher scores do not necessarily indicate a problem, but may draw attention to issues with work

load, work environment, and should be discussed with a supervisor, colleague, and/or counselor.

Counseling Interns' Perceptions of Wellness Survey

In addition to the ProQOL, an original survey instrument was developed by the author of this study based on the literature review and consultation with experts in the field of gatekeeping, wellness, and compassion fatigue. The survey will obtain information from counseling interns about their perceptions of their counselor program's wellness education, gatekeeping, and internship experience. In addition, the survey includes demographic questions.

There are two common methods for collecting online data, e-mail surveys and Web-based surveys (Granello & Wheaton, 2004). This study will use a Web-based survey. Principles of online data collection and survey development have been published (Dillman, 2000; Granello & Wheaton, 2004; Dillman, Tortora, & Bowker, 1999; and Gaddis, 1998). The authors offer understandable guidelines for designing Web-based surveys. Principles of Web-survey design by Dillman (2000), Dillman et. al. (1998), and Lazar & Preece (1999) were used. According to Dillman (1998) the process of designing Web-based surveys is often complex and may be broken into different principles. These principles range from how questions should be presented to specific computer actions. The authors recommend respondent-friendly design in order to increase the likelihood that participants will respond accurately to the survey. Dillman (1998, 2000) recommends presenting questions in an easy, conventional format. The first question should grab the attention of the respondent and make them want to continue. In addition, Dillman (1998)

suggests limiting the line length and providing instructions for needed computer functions.

According to Lazar and Preece (1999) four steps must be completed in order to successfully execute a Web-based survey: 1) design the survey first on paper; 2) choose a methodology; 3) change the written survey into a web-based survey, and; 4) let the population of interest know that the survey exists. The researcher used the Virginia Tech's Survey Maker program to construct the Web-based survey for this study. This program has the capability to work with all Web browser programs.

Data Collection

This study will investigate the counseling interns' perceptions of their counselor education program's wellness education and the relationship between their perceptions and their actual levels of compassion satisfaction, compassion fatigue, and burnout. Each research participant completed a consent form at the beginning of the survey, a Web-based Counseling Interns Perceptions of Wellness Survey (CIPW)(Appendix C), and ProQOL instrument (Appendix B). With the permission from liaisons of each counseling program at the 209 universities, full-time counseling students currently in the internship phase of their programs will be surveyed. Participants' email addresses will be added to a confidential list. As the participants are added to the list by the researcher, they will receive an emailed welcome message (Appendix B). The informed consent and survey will take approximately 20 minutes to complete. The ProQOL will take approximately 20 minutes to complete. Data collected from the survey questions will include age; gender; race; employment status; emphasis in counseling (mental health, school, marriage and

family, community); questions regarding their program's wellness courses; questions about their program's gatekeeping policies; and questions regarding clinical experiences.

Initially, an email message will be sent out to CACREP counseling graduate program liaisons inviting them to participate in the study. The email will introduce the study, provide the purpose of the study as well as contact information and names, indicate ethical approval for study, and provide instructions on how to submit surveys and ProQOL to their programs' counseling students in the internship phase of their programs. The email will include a Uniform Resource Locator (URL) which, when clicked, would take the study's participants directly to the survey site (Duffy, 2000) with both the CIPW and ProQOL. Participants will use their web browser to access the survey page and complete the survey. Once respondents have completely entered their information, they will then click on the submit button. The Virginia Tech SurveyMaker program will collect all participants' data. Data will be downloaded from the SurveyMaker into a Microsoft Excel spreadsheet. The data will then be transferred to a data file in Statistical Package for the Social Sciences (SPSS).

The time length for data collection is limited to two weeks. Dillman (2000) recommended that participants receive four contacts about the study. The first contact will be the initial email reminding participants that the survey and ProQOL will be sent out on a later date. The second contact is the survey notice telling participants that they can complete the survey and ProQOL. At that point data collection begins. The third contact will be sent out two weeks after data collection began thanking those participants who completed the survey and ProQOL and reminding others who had not yet completed

the survey. The fourth contact will be a message announcing the closing of the survey and ProQOL instrument.

Data Analysis

In order to answer research question one, a descriptive analysis of all independent and dependent variables will be conducted. Descriptive statistics were calculated as the first phase of the analysis by counseling program and by sample. These descriptive statistics provide information that facilitates answering research questions one, two, three, four and six. Descriptive statistics will be reported in detail in chapter four. Correlational statistics (Pearson product moment correlation coefficient) will be calculated as the second phase of the analysis by counseling program and by sample. These statistics provide information that facilitates answering research question five. In addition, a MANOVA was conducted to assess inter-group differences between compassion fatigue, compassion satisfaction, and burnout, with age, years of experience and direct client hours.

Summary

This chapter provides an overview of the methodology, research design, data collection, and data analysis for this study. The purpose of this study is to determine the levels of compassion satisfaction, compassion fatigue, and burnout in CACREP counseling interns, to assess counseling interns' perceptions of their program's wellness education, and to determine the relationship between their perceptions and their actual levels of compassion fatigue, compassion satisfaction and burnout. To accomplish these goals a non-experimental, descriptive design was chosen. Results of the data analysis will be reported in the next chapter.

CHAPTER FOUR: RESULTS

Chapter Four contains the results of the data collection and analysis for the research study. The demographic profile of the participants is presented, and each of the research questions is addressed. Non-significant and significant results are identified.

Survey Responses

Data were collected through a process that included four email greetings sent to prospective counselor education program liaisons throughout the United States in order to recruit their programs' counseling interns. Twenty counselor education programs responded for a total of 68 respondents. The email greeting and subsequent reminders included links to both the Professional Quality of Life (ProQOL) and Counselor Interns' Perceptions of Wellness (CIPW) Survey. The final response rate was 10% of counselor education programs surveyed.

Demographic Profile of the Participants

There were 68 participants in the study. Eight (11.8%) of the participants were male, 59 (86.8%) were female, and 1 participant did not respond (Table 1). Three (4.4%) of the participants reported an ethnicity of Other, 3 (4.4%) of the participants were Hispanic, 56 (82.4%) of the participants were Caucasian, 4 (5.9%) of the participants were African-American, 1 (1%) did not answer. Twenty nine percent of participants were in the School Counseling track, 21% in Community Counseling, 22% in Mental Health Counseling, 6% in Student Affairs Counseling, 7% in Marriage and Family, and 15% reported Other. Ages of participants ranged from a minimum age of 23 and a maximum age of 60 ($M = 33.62$, $SD = 9.56$). Participants reported spending a minimum of zero hours per week in direct contact with clients and a maximum of 60 hours per week in

direct contact with clients ($M = 15.67, SD = 10.30$). In addition, participants indicated the ideal number of hours per week to spend in direct contact with clients as a minimum of three and a maximum of 60 ($M = 16.27, SD = 9.19$). Results of the descriptive statistics can be found in Tables 1 and 2.

Table 1
Frequencies and Percentages for Gender, Race/Ethnicity and Type of Track

Group	Frequency	Percent
<i>Gender:</i>		
Male	8	12
Female	59	87
<i>Race/Ethnicity:</i>		
African American	4	6
Asian/Pacific	0	0
Caucasian	56	82
Hispanic	3	4
Native American	0	0
Other	3	4
<i>Type of Track:</i>		
School Counseling	20	29
Community Counseling	14	21
Mental Health Counseling	15	22
Student Affairs Counseling	4	6
Marriage and Family	5	7
Other	10	15

Table 2
Means, Standard Deviations, Minimums, and Maximums for Age, Average Hours/Week, and Ideal Hours/Week

Group	M	SD	Min.	Max
Age	33.62	9.56	23	60
Average Hrs/Wk	15.67	10.30	0	60
Ideal Hrs/Wk	16.27	9.19	3	60

Compassion Satisfaction, Compassion Fatigue, and Burnout Among Counseling Interns

The Professional Quality of Life (III-R) Scale was used to measure compassion fatigue, compassion satisfaction, and burnout levels among the sample of counseling interns and used to answer research questions 1, 2, and 3. The scores for these scales are discussed below.

Research Question 1: What are counseling interns’ compassion fatigue levels as measured by the Professional Quality of Life (III-R) Scale?

This research question was answered by totaling responses to the questions 2, 5, 7, 9, 11, 13, 14, 23, 25, and 28 according to the scoring manual (Stamm, 2005). Examples of questions are: “I find it difficult to separate my personal life from my life as a [helper]” and “I feel depressed as a result of my work as a helper.” Responses to the 5-point Likert scale ranged from Very Often (5) to Rarely (0). The average score on this scale among participants is 9.53 (SD = 5.61)) with scores ranging from 2 to 25, where a score above 17 indicates a higher risk for compassion fatigue. On average, counseling interns in the current study had fairly optimistic findings compared to the normed sample

of 13 ($SD = 6$) on the compassion fatigue subscale. However, 14% of respondents scored a 17 or above on the compassion fatigue (Stamm, 2005).

A number of specific survey items on the compassion fatigue scale demonstrate relevant responses that highlight possible distress. Forty-six percent of participants answered 'a few times' to question 2, "I am preoccupied with more than one person I help." Additionally, 16% answered 'somewhat often' or higher to the same question. Fourteen percent answered 'often' or higher and 26% answered 'a few times' to question 5, "I jump or am startled by unexpected sounds." Furthermore, 15% of participants answered 'a few times' to question 9, "I think that I might have been infected by the traumatic stress of those I help." Question 11, "Because of my helping, I feel on edge about various things," generated noteworthy responses. Twenty-four percent answered 'a few times' or more frequently to the question. Sixteen percent of participants answered 'a few times' to feeling depressed as a result of their work as a helper (question 13).

Sixteen percent of participants answered 'a few times' to question 14, "I feel as though I am experiencing the trauma of someone I have helped." Two participants reported that 'often' or 'very often' they couldn't remember important parts of their work with trauma victims (question 28). Interestingly, 51% of participants reported they were counseling clients with a history of sexual abuse and 60% of participants reported counseling child abuse victims. Furthermore, 50% of participants agreed they experienced a traumatic incident. Means, standard deviations, frequencies, and percents are presented in Table 3.

Table 3
Mean, Standard Deviation, Percentages on Compassion Fatigue

Group	M	SD	Min.	Max.
Compassion Fatigue	9.53	5.61	2	25

Score	Frequency	Percent
2.00	3	4.4
3.00	6	8.8
4.00	6	8.8
5.00	5	7.4
6.00	2	2.9
7.00	5	7.4
8.00	2	2.0
9.00	7	10.3
10.00	5	7.4
11.00	3	4.4
12.00	5	7.4
13.00	1	1.5
15.00	2	2.0
16.00	2	2.9
17.00	2	2.9
18.00	3	4.4
19.00	2	2.9
20.00	1	1.5
22.00	1	1.5
25.00	1	1.5

Research Question 2: What are counseling interns' compassion satisfaction levels as measured by the Professional Quality of Life (III-R)?

The second research question was answered by calculating responses to questions 3, 6, 12, 16, 18, 20, 22, 24, 27, and 30 according to the scoring manual (Stamm, 2005). The average score among participants on this compassion satisfaction scale was 39.29 ($SD=6.71$) with scores ranging from 17 to 50. A score of 32 or higher indicates higher levels of compassion satisfaction, according to scoring procedures (Stamm, 2005).

Generally, counseling interns' scores in this study are higher than the normed sample ($M = 37, SD = 7$) on the compassion satisfaction subscale (Stamm, 2005).

An itemization of the survey responses reveal specific percentages of participants. Fifty-four percent of participants answered 'very often' to question 3; "I get satisfaction from being able to help other people." Furthermore, 10% answered 'somewhat often' and 34% answered 'often' to the same question about their satisfaction from helping others. Fifty percent of participants answered 'somewhat often' to question 16, "I am pleased with how I am able to keep up with helping techniques and protocols," yet 16% answered 'a few times' and 3% answered 'rarely'. Furthermore, 75% answered 'often' or more frequently to question 18, "My work makes me feel satisfied." However, 3% answered 'a few times' and 1% answered rarely on the same question. Overall, 97% of participants believed they could make a difference through their work (question 22), but 3% 'rarely' believed they could make a difference. Means, standard deviations, frequencies, and percentages are presented in Table 4.

Table 4
Means, Standard Deviation, Percentages on Compassion Satisfaction

Group	M	SD	Min.	Max
Compassion Satisfaction	39.29	6.711	17	50
Score	Frequency		Percent	
17.00	1		1.5	
21.00	1		1.5	
27.00	1		1.5	
28.00	1		1.5	
29.00	1		1.5	
30.00	1		1.5	

31.00	2	2.9
32.00	3	4.4
34.00	3	4.4
35.00	4	5.9
36.00	1	1.5
37.00	4	5.9
38.00	3	4.4
39.00	4	5.9
40.00	5	7.4
41.00	4	5.9
43.00	9	13.2
44.00	6	8.8
46.00	3	4.4
47.00	3	4.4
48.00	2	2.9
49.00	3	4.4
50.00	1	1.5

Research Question 3: What are counseling interns’ burnout levels as measured by the Professional Quality of Life (III-R) Scale?

The third research question was answered by totaling responses to questions 1, 4, 8, 10, 15, 17, 19, 21, 26, and 29 according to the scoring manual (Stamm, 2005). The average score on the burnout scale among participants is 18.96 ($SD= 5.58$) with scores ranging from 7 to 33. According to scoring procedures (Stamm, 2005), if individuals’ scores are above a 28, they may want to reflect on the factors at work that make them feel ineffective in their role. The scores on the burnout subscale among participants are lower than the normed sample ($M = 22, SD = 6.8$) (Stamm, 2005). Counseling interns’ average scores on the burnout scale ($M = 18.95, SD = 5.58$) are slightly higher than their average score on the compassion fatigue scales ($M = 9.53, SD = 5.61$).

Several survey items on the burnout subscale yielded responses that demonstrate possible burnout symptoms. Where 56% of participants responded ‘often’ on question 4, “I feel connected to others;” 1% answered ‘rarely’ to the feeling connected to others.

Additionally, 16% of participants answered 'a few times' or more frequently to question 8, "I am losing sleep over a person I help's traumatic experiences." Nine percent of participants answered 'a few times' to question 10, "I feel trapped by my work as a helper." Furthermore, 34% of participants answered 'somewhat often' or higher to question 19, "Because of my work as a helper, I feel exhausted." Twenty-five percent of participants answered 'somewhat often' or more frequently to question 21, "I feel overwhelmed by the amount of work or size of my caseload." Similarly, 27% of participants answered 'somewhat often' or more frequently to question 26, "I feel bogged down by the system. Means, standard deviations, frequencies, and percentages are presented in Table 5.

Table 5
Means, Standard Deviation, and Percentages On Burnout

Group	M	SD	Min.	Max
Burnout	18.96	5.58	7	33

Score	Frequency	Percent
7.00	2	2.9
10.00	1	1.5
11.00	1	1.5
13.00	7	10.3
14.00	4	5.9
15.00	3	4.4
16.00	7	10.3
17.00	3	4.4
18.00	6	8.8
19.00	6	8.8
20.00	4	5.9
21.00	2	2.9
22.00	4	5.9
23.00	5	7.4
24.00	2	2.9
25.00	1	1.5
26.00	2	2.9
28.00	2	2.9
29.00	3	4.4
32.00	1	1.5
33.00	1	1.5

MANOVA Results

A MANOVA was conducted to assess inter-group differences between compassion fatigue, compassion satisfaction, and burnout, with age, years of experience, and direct client hours. The multivariate between-subject tests showed that age was significantly related to compassion fatigue. There was no significant relationship between age and compassion satisfaction or burnout. In addition, there was no significant

difference among years of experience or age plus years of experience and any of the dependent variables. MANOVA results are presented in table 6.

Table 6
MANOVA Results

	Dependent Variables	Type II Sum of Squares	df	Mean Square	F	Significance
Age	Compassion Satisfaction	77.045	4	19.261	.562	.691
	Compassion Fatigue	328.489	4	82.1222	2.885	.033
	Burnout	119.922	4	29.980	1.030	.403
Years of Experience	Compassion Satisfaction	13.755	1	13.755	.401	.530
	Compassion Fatigue	70.678	1	70.678	2.483	.122
	Burnout	61.902	1	61.902	2.127	.152
Age * Years of Experience	Compassion Satisfaction	244.075	4	61.019	1.780	.150
	Compassion Fatigue	115.328	4	28.832	1.013	.411
	Burnout	195.571	4	48.892	1.680	.172

Counseling Interns' Perceptions of Wellness

The Counselor Interns' Perceptions of Wellness (CIPW) Survey which measures counseling interns' perceptions of their program's wellness education, knowledge and policies, and perceptions of their internship experiences was used to answer research questions 4, 5, and 6. Responses to the 5-point Likert scale ranged from Strongly Agree to Strongly Disagree.

Research Question 4: What are counseling interns' perceptions of their counselor education programs' wellness education and curriculum?

The fourth research question, “What are counseling interns’ perceptions of their program’s wellness education?” was answered by responses to questions one through twelve on the Counselor Interns’ Perceptions of Wellness (CIPW) Survey. Question 11, “I would prefer additional training regarding counselor wellness” was reverse scored to assure that this negatively keyed item and the other positively keyed items were consistent with each other, in terms of what an “agree” and “disagree” imply. The average scores among participants on wellness education are 41.74 ($SD=6.38$) with scores ranging from 21 to 57 of a possible range of 60. Interesting responses to several questions were noted. "Strongly agree" and "agree" responses and "strongly disagree" and "disagree" are collapsed in the description of these responses. While 89% of counseling interns agreed that counselor wellness education is an important component of counselor training (question 1), 66% agreed that they have had the opportunity to learn about it in their counselor education programs (question 2). Furthermore, only 46% agreed that their counselor education programs have offered education on counselor wellness (question 3). Thirty-six percent of interns agreed that their programs offered education in specific wellness strategies; however, 26% disagreed (question 4).

Forty-seven percent of counseling interns surveyed agreed their counselor education programs adequately educated them about burnout, whereas 38% disagreed (question 5). Only 35% of interns surveyed agreed that their counselor education programs adequately educated them about compassion fatigue, and 52% disagreed (question 6). Whereas 62% of interns surveyed agreed that they have been educated about the personal and professional risks associated with being a counselor, it is important to note that 20% disagreed and believed they were not prepared (question 7). Similarly,

47% of interns agreed they were prepared to face the personal and professional challenges associated with the counseling profession as a result of their wellness training, yet 14% disagreed with this important concept (question 10). Sixty-six percent of interns surveyed agreed that the philosophy of their counselor education programs encourages wellness and balance in students, yet 37% agreed and 35% disagreed that the *requirements* of their programs encourage wellness and balance in students (questions 8 and 9). In addition, 84% of interns surveyed agreed that would prefer additional training regarding counselor wellness (question 11). Lastly, question 12 asked participants to give examples of recommendations encouraged by their counselor education programs to promote wellness. A description of these responses is presented in chapter five.

Frequencies and percentages per survey question are presented in Table 7.

Table 7
Frequencies and Percentages on Wellness Education per Survey Question

SURVEY QUESTIONS	LIKERT SCALE	FREQUENCIES	PERCENTS
1. Counselor wellness education is an important component of counselor training.	SA=	39	57
	A=	22	32
	N=	4	6
	D=	3	4
	SD=	0	0
	NA=	0	0
2. I have had the opportunity to learn about counselor wellness in my counselor education program.	SA=	15	22
	A=	30	44
	N=	11	16
	D=	11	16
	SD=	1	1
	NA=	0	0

3. My counselor education program has offered education focused on counselor wellness.	SA=	8	12
	A=	23	34
	N=	14	21
	D=	19	28
	SD=	2	3
	NA=	2	3
4. My counselor education program has offered education in particular wellness strategies (exercise, relaxation techniques, and social activities).	SA=	3	4
	A=	22	32
	N=	25	37
	D=	15	22
	SD=	3	4
	NA=	0	0
5. My counselor education program adequately educated me about burnout.	SA=	6	9
	A=	26	38
	N=	10	15
	D=	24	35
	SD=	2	3
	NA=	0	0
6. My counselor education program adequately educated me about compassion fatigue	SA=	5	7
	A=	19	28
	N=	9	13
	D=	31	46
	SD=	4	6
	NA=	0	0
7. My counselor education program adequately educated me about the personal and professional risks associated with the counseling profession.	SA=	12	18
	A=	30	44
	N=	12	18
	D=	13	19
	SD=	1	1
	NA=	0	0
8. The philosophy of my counselor education program encourages wellness and balance in students.	SA=	15	22
	A=	30	44
	N=	15	22
	D=	7	10
	SD=	1	1
	NA=	0	0
9. The requirements of my counselor education program encourages wellness and balance in students	SA=	6	9
	A=	19	28
	N=	19	28
	D=	21	31
	SA=	3	4
	NA=	0	0
10. I am prepared to confront the personal/professional challenges associated with the counseling profession as a result of my wellness training.	SA=	2	3
	A=	30	44
	N=	26	38
	D=	9	13
	SD=	1	1
	NA=	0	0

11. I would prefer additional training regarding counselor wellness	SA=	25	37
	A=	32	47
	N=	8	12
	D=	3	4
	SD=	0	0
	NA=	0	0

Research Question 5: Is there a positive relationship between counselor interns' perceptions of wellness and compassion satisfaction and a negative relationship between counselor interns' perceptions of wellness and compassion fatigue and burnout?

The fifth research question was answered by conducting a Pearson Correlation analysis with questions twenty-nine through forty-one of the Counselor Interns' Perceptions of Wellness (CIPW) Survey and questions 1-30 on the Professional Quality of Life (ProQOL). Examples of questions from the CIPW are, "I believe I have a large caseload of clients" and "I take an ample amount of breaks during my work day." There was a significant relationship between perceptions of wellness education and compassion satisfaction; as counselor interns' perceptions of their programs' wellness education increased, compassion satisfaction levels also increased ($r(61) = .281, p = .026$). There was a significant negative relationship between perceptions of wellness education and burnout; as counselor interns' perceptions of the programs' wellness education increased, their burnout levels decreased ($r(62) = -.347, p = .005$). There was also a significant relationship between compassion fatigue and burnout; as counseling interns' compassion fatigue levels increased, so did their burnout levels ($r(62) = .501, p = .000$). Lastly, there was a significant relationship between compassion satisfaction and burnout; as counselor interns' compassion satisfaction levels increased, their burnout levels decreased ($r(63) = -.635, p = .000$). However, there was no significant relationship between compassion satisfaction and compassion fatigue ($r(60) = -.133, p = .303$), nor was there a significant

relationship between wellness education and compassion fatigue ($r(59) = .183, p = .158$). Intercorrelations, means and standard deviations are presented in Table 8. More interpretation of these results will be addressed thoroughly in chapter five.

Table 8
Intercorrelations, Means and Standard Deviations for Wellness Education with Compassion Fatigue, Compassion Satisfaction, and Burnout

Variable	WE	CS	CF	Burnout
1. Wellness Education	--	.281*	.183	-.347***
2. Compassion Satisfaction	--	--	-.133	-.635***
3. Compassion Fatigue	--	--	--	.501***
4. Burnout	--	--	--	--

Note. * $p < .05$, *** $p < .001$

Research Question 6: Are counseling interns aware of their counselor education programs' nonacademic retention and dismissal policies?

The sixth research question was answered by responses thirteen through twenty on the Counselor Interns' Perceptions of Wellness (CIPW) Survey. Questions 19 "I have had concerns about the wellness of one or more of my peers in my counselor education program" and 20 "I am aware of a student being dismissed from my counselor education program for nonacademic reasons (impairment, mental health issues, conflict, and poor clinical skills)", were reverse scored in order to provide consistency regarding what "agree" and "disagree" implied. . "Strongly agree" and "agree" responses and "strongly disagree" and "disagree" were collapsed in the description of these responses. Knowledge and Policies scores ranged from a minimum of 14 and a maximum of 26. The average score among participants on knowledge and policies is 20.51 ($SD= 2.88$). Fifty-one

percent of counseling interns surveyed agreed that their counselor education programs presented them with student policies regarding dismissal and remediation; however, 11% disagreed (question 13). Interestingly, 12% of participants disagreed that their counselor education program adequately outlines expected student behaviors (question 14). Although 95% of interns surveyed agreed that their counselor education programs efficiently evaluated them in academic areas, 75% agreed that their programs efficiently evaluated them in nonacademic areas (questions 15 and 16). While 29% of interns surveyed agreed that their counselor education programs adequately educated them about preventing impairment, 30% disagreed (question 17). In addition, 53% of interns agreed that a representative from their programs recommended or required that they seek personal counseling during their training and only 35% disagreed (question 18). An alarming 75% of interns agreed that they have had concerns about the wellness of one or more of their peers in their programs and only 13% disagreed (question 19). Surprisingly, 22% of interns were aware of a student being dismissed from their counselor education programs for nonacademic issues (question 20). More interpretation is presented in chapter five. Frequencies and percentages per survey item are presented in Table 9.

Table 9
Frequencies and Percentages on Knowledge and Policies per Survey Question

SURVEY QUESTIONS	LIKERT SCALE	FREQUENCIES	PERCENTS
13. My counselor education presented me with student policies regarding dismissal and remediation	SA=	13	19
	A=	22	32
	N=	10	15
	D=	18	26
	SD=	5	7
	No Answer=	0	0
14. My counselor education	SA=	15	22

program adequately outlines expected student behaviors.	A=	31	46
	N=	13	19
	D=	6	9
	SD=	2	3
	NA=	1	1
15. My counselor education program efficiently evaluates me in academic areas.	SA=	16	24
	A=	48	7
	N=	3	3
	D=	1	1
	SD=	0	0
NA=	0	0	
16. My counselor education program efficiently evaluates me in nonacademic areas (supervision, quality of counseling skills, personal characteristics related to counseling).	SA=	16	24
	A=	35	51
	N=	13	19
	D=	2	3
	SD=	2	3
NA=	0	0	
17. My counselor education program sufficiently educated me about preventing impairment.	SA=	5	7
	A=	15	22
	N=	27	40
	D=	1	1
	NA=	0	0
18. A representative of my counselor education program recommended or required that I seek personal counseling at a point during my training	SA=	15	22
	A=	21	31
	N=	8	12
	D=	15	22
	SD=	9	13
NA=	0	0	
19. I have had concerns about the wellness of one or more of my peers in my counselor education program.	SA=	19	28
	A=	32	47
	N=	8	12
	D=	9	13
	SD=	0	0
NA=	0	0	
20. I am aware of a student being dismissed from my counselor education program for nonacademic reasons (impairment, mental health issues, conflict, and poor clinical skill).	SA=	2	3
	A=	13	19
	N=	8	12
	D=	22	32
	SD=	23	34
NA=	0	0	

Summary

Chapter four presented the results of the study. The data collection procedures resulted in a 10% total response rate of programs surveyed. Demographic findings were discussed then counseling interns' levels of compassion satisfaction, compassion fatigue, and burnout as measured by the Professional Quality of Life (ProQOL III-R). The results indicated that overall, counseling interns' compassion fatigue levels were below the scale's average, compassion satisfaction levels were slightly higher than the scale's average, and burnout levels were below the scale's average. However, the results also indicated that a large percentage of students were at risk for compassion fatigue (14%) and burnout (10%). Furthermore, 16% of participants in this study scored below the cutoff of 32 on the compassion fatigue subscale implying that these students may not gain satisfaction from the new helping roles or gain satisfaction from different areas of their lives.

Counseling interns' perceptions of their counselor education program's wellness education, knowledge and policies, and internship experiences were discussed as measured by the Counseling Interns' Perceptions of Wellness Survey (CIPW). Overall, responses indicated that while counseling interns had strong beliefs about counselor wellness, their perceptions of their own wellness education were not always favorable. In general, counseling interns in this study seemed to have some understanding of their programs' nonacademic retention and dismissal policies, but a large number seemed concerned about preventing impairment and the wellness of themselves and peers. It is important to note that results indicated a positive relationship exists between wellness education and compassion satisfaction, and between compassion fatigue and burnout.

Results further demonstrate that negative relationships exist between compassion satisfaction and burnout, and wellness education and burnout. Additional interpretations of these results and implications and recommendations for the counselor education profession are discussed in Chapter 5.

CHAPTER FIVE: DISCUSSION

This chapter contains discussion and interpretations of the findings of this study. It also presents implications for counselors and counselor educators and directions for future research.

Review of the Research Questions and Methodology

The purpose of this study was to (a) assess counseling interns' perceptions of their programs' wellness education, (b) assess counseling interns' levels of compassion satisfaction, compassion fatigue, and burnout and (c) to determine the relationship between counseling interns' levels of compassion satisfaction, compassion fatigue, burnout and their perceptions of their programs' wellness education.

The following research questions were answered:

1. What are counseling interns' compassion fatigue levels as measured by the Professional Quality of Life (III-R)?
2. What are counseling interns' compassion satisfaction levels as measured by the Professional Quality of Life (III-R)?
3. What are counseling interns' burnout levels as measured by the Professional Quality of Life (III-R)?
4. What are counseling interns' perceptions of their counselor education programs' wellness education and curriculum?
5. Is there a positive relationship between counselor interns' perceptions of wellness and compassion satisfaction and compassion fatigue and burnout?
6. Are counseling interns aware of their counselor education programs' nonacademic retention and dismissal policies?

This study used a Web-based survey research design. The survey was sent out to the program liaisons of 209 counselor education programs throughout the United States and distributed by those liaisons to all full-time counseling students engaged in their clinical internships. Twenty counselor education programs responded (68 respondents). The survey included the 30-item Professional Quality of Life (III-R) and the 41-item Counseling Interns Perceptions of Wellness (CIPW). The response rate was 10% of programs surveyed. A non-experimental, descriptive, correlation design was used.

Profile of Participants

Respondents in the study can be described as follows: average age of 33 years with a minimum age of 23 and a maximum age of 60, 86.8% female, 82.4% Caucasian, 5.9% African American, 4.4% Hispanic, and 4.4% other ethnicity. The participants spent a minimum of zero hours per week in direct contact with clients and a maximum of 60 hours per week in direct contact with clients. Of the participants, the minimum responses to the ideal number of hours per week to spend in direct contact with clients were 3 and the maximum response was 60 ($M = 16.26$, $SD = 9$, $I9$). Interns' responses to direct contact hours reflect a broad range of their perceptions about wellness, professional balance, and expectations as counselors. Furthermore, both the overinvolved and underinvolved counselor can reflect signs of impairment. The premise of this study is to discuss how counselor educators can teach counseling interns about finding a balance between their personal and professional lives and how they can help them understand that trainee wellness should be as much as a priority to them as their therapeutic skills and relationship with clients. Ultimately, counseling students' education about wellness can protect them from potential professional stressors and hazards.

Summary of Results and Conclusions

The results of this study are summarized below.

Research Question 1: What are counseling interns' compassion fatigue levels as measured by the Professional Quality of Life (III-R)?

Participants in this study had an average score of 9.53 (SD 5.61) on the compassion fatigue scale of the ProQOL with scores ranging from 2 to 25. The scores from the current study are significantly lower than the normed sample ($M = 13$, $SD = 6.3$) on the compassion fatigue subscale (Stamm, 2005) and similar to previous studies (Lawson, 2007). Again, according to scoring procedures (Stamm, 2005), participants that scored above a 17 could be at risk for compassion fatigue and may want to examine factors at work that may be troubling or upsetting them or examine other reasons for the higher score. Lower scores (below 17) suggest participants have less of a risk for compassion fatigue. Counseling interns in this study seemed to fall under the scale's average in their compassion fatigue levels, which could imply less impairment. However, it is important to note that just over 14% of participants scored above the cutoff on the compassion fatigue subscale and were definitely at risk for compassion fatigue. These statistics are higher than the normed sample of 13 ($SD = 6$). Implications addressing the risk of compassion fatigue are addressed later in the chapter.

In addition to the risk of compassion fatigue, individual survey items pose concern for counseling interns. Forty-six percent (46%) of participants answered 'a few times' to question 2, "I am preoccupied with more than one person I help." Forty-three percent (43%) of participants answered 'a few times' or higher on question 5, "I jump or

am startled by unexpected sounds.” Forty-two percent (42%) of participants answered ‘a few times’ or higher on question 7, “I find it difficult to separate my private life from my life as a helper.” In addition, fifteen percent of participants answered ‘a few times’ to question 9, “I think that I might have been infected by the traumatic stress of those I help.” Twenty-five percent (25%) of participants answered positively on question 11, “Because of my helping, I feel on edge about various things.” Sixteen percent answered ‘a few times’ or higher to question 13, “I feel depressed as a result of my work as a helper.” Lastly, 16% of participants answered ‘a few times’ on question 14, “I feel as though I am experiencing the trauma of someone I have helped.” These responses pose concern in participants as compassion fatigue comes about abruptly (Figley, 1995), so a lower score in this study does not necessarily indicate that these interns are not at risk or that compassion fatigue could appear later. Although 14% of participants appeared to be at risk for compassion fatigue, all students are vulnerable to the effects of caregiving.

These responses illustrate that many counseling interns in this study are experiencing signs of impairment and may not realize the seriousness of their responses. Among the many explanations for these responses, one is that it seems counseling interns believe that being in the helping profession means that they have to take work home with them and be consumed with their clients' lives and experiences. These particular survey questions basically summarize symptoms of compassion fatigue. It is apparent that a large number of counseling interns in this study are feeling the stressors of working with clients and struggling with how to manage their feelings and strike a balance between home and work. Their responses reveal that they may be internalizing clients' experiences. On some levels these interns are only in the beginning stages of their work

as helpers and face many more professional obstacles as they move into their counseling careers. Furthermore, if these interns are not identified as being at risk for compassion fatigue and offered remedial interventions, they could graduate and move into the profession impaired and put future clients at risk. This also makes them vulnerable to ethical violations. Before this happens, gatekeeping can be at its best and educators can use these teaching moments to process with students and move them to awareness and insight about their behaviors.

In addition to the above responses, 51% of participants reported they were helping clients who had a history of sexual abuse and 60% of participants reported working with child abuse victims. These are not surprising results as they coincide with findings published in a study that demonstrated community agency counselors reporting more than half of their clients suffered a traumatic event (Lawson, 2007). These numbers could indicate a risk for these participants according to other studies that found that compassion fatigue was higher among clinicians working with sexually abused clients (Cunningham, 2003; Kassam-Adams, 1995; Nelson-Gardell & Harris, 2003) and higher in helpers who were working with child abuse victims (Conrad & Kellar-Guenther, 2006). Furthermore, working with traumatized clients predicted levels of compassion fatigue (Adams, Figley, & Boscarino, 2008; Cunningham, 2003; Figley, 1995; Kassam-Adams, 1995; Nelson-Gardell & Harris, 2003; McCann & Pearlman, 1990b; Munroe, 1995; Pearlman & MacIain, 1995) and burnout (Sprang et. al., 2007).

Fifty percent (50%) or half of the participants in this study, 'agreed' or 'strongly agreed' that they had experienced a traumatic incident. This history could put counseling interns at a higher risk according to studies that a history of personal trauma increased

risk for compassion fatigue (Cunningham, 2003, Nelson-Gardell & Harris, 2003). Additionally, 86.8% of participants in this study are female. This information supports studies that report that more females are at a significant risk for compassion fatigue (Brady et. al., 1999; Kassam-Adams, 1999; Meyers & Cornille, 2002; Schauben & Frazier, 1995). Notably, the number of hours interns worked per week ranged from 0 to 60. Nineteen percent of participants reported working 25 or more hours in direct contact with clients per week. These counseling interns could be at a higher risk based on a study that suggests that predictors of compassion fatigue include exposure factors, such as long work hours and length of assignment (Boscarino, Figley, & Adams, 2004). While previous studies showed significance between number of hours worked and compassion fatigue, a MANOVA analysis in the current study did not demonstrate significance. Another possible risk for the counseling interns in this study is related to years of professional experience. However, 53 participants had 3 or less years of counseling experience. Yet, higher years of professional experience were associated with a decreased potential for compassion fatigue and vicarious traumatization (Pearlman & MacJan, 1995). Once more, a MANOVA analysis completed for the current study did not demonstrate a significant relationship between compassion fatigue and years of experience.

Organizational factors like supportive work environments and sufficient supervision lessened the incidence of compassion fatigue (Boscarino et. al., 2004; Ortlepp & Friedman, 2002). Therefore, lower scores among counseling interns in this study could reflect a supportive counselor education program and efficient supervision. Although the research on levels of compassion fatigue in counseling students is scarce, a

study with graduate students who were treating victims of sexual abuse was conducted and found that a combination of therapist gender, personal history of trauma, and exposure to victims of sexual abuse predicted symptoms of compassion fatigue (Kassam-Adams, 1999). As age increased, risk for compassion fatigue and burnout decreased (Adams, Matto, & Harrington, 2001). A MANOVA analysis conducted for the current study demonstrated that age was significantly related to compassion fatigue. We know in this study that counseling intern's ages ranged from 23 years of age to 60. Hence, in this study it was not counseling interns' years of professional experience that protected them from compassion fatigue, it was their age. It is possible that qualities such as maturity, life experiences, personal flexibility, objectivity, and acceptance of oneself can shield older interns from the effects of compassion fatigue.

The findings of this study correspond with findings from a previous study determining the relationship between compassion fatigue, burnout, and compassion satisfaction among mental health providers (Sprang, et. al., 2007). The sample of mental health providers scored very similarly on the burnout and compassion fatigue subscales as counseling interns in this study. Importantly, the Sprang et. al. (2007) study expands the current literature by exploring compassion fatigue, compassion satisfaction, and burnout in a sample of clinicians whose exposure to traumatized clients is more similar to that of the general population of clinicians. This current study also assesses students working with clients who have a variety of personal problems in addition to traumatized clients. It also supports the belief that compassion fatigue and burnout can occur in all clinicians.

Research Question 2: “What are counseling interns’ compassion satisfaction levels as measured by the Professional Quality of Life (III-R)?”

The average score on this compassion satisfaction scale among participants is 39.29 ($SD = 6.71$) with scores ranging from 17 to 50. These results are similar to a previous study that assessed the wellness and wellness strategies of ACA members (Lawson 2007). Participants in the current study scored higher than the normed sample ($M = 37, SD = 7.3$) on the compassion satisfaction subscale (Stamm, 2005). According to scoring procedures (Stamm, 2005), if individuals’ scores are below 32 on this scale they may either find problems with their job or possibly gain satisfaction from activities other than their professional work. It is important to note that approximately 16% of participants scored below the cutoff of 32 on the compassion satisfaction subscale implying that these students could find difficulty in their new role as a helper or gain satisfaction from other areas of their lives.

Generally, counseling interns in this study derive satisfaction from their overall internship experiences and gain satisfaction from working with clients. These results correspond with Skovholt’s (2001) notion that novice counselors tend to rely on external experiences, while seasoned counselors rely more on their internal experiences. His research explored characteristics of novice counselors and he proposed that they depend on their inner experiences such as their own expectations of counseling and personal encounters. According to Skovholt, more seasoned counselors have more realistic expectations of the counseling process and tend to be more objective with clients. So, the counseling interns in this study may gain compassion satisfaction from their job duties as counseling interns and their new helping role. This belief is supported by answers to

question 3, “I get satisfaction from being able to help other people.” Eighty-eight percent (88%) of participants answered ‘often’ or ‘very often’ to this question. Furthermore, 90% of counseling interns in this study answered ‘often’ or ‘very often’ to question 12, “I like my work as a helper.”

Moreover, research has examined whether helping professionals can be at risk for compassion fatigue and still have high levels of compassion satisfaction. A common belief is that although individuals believe they have compassion fatigue, they can still enjoy their work and feel positive benefits from it (Stamm, 2002). This assumption is that compassion satisfaction plays an important role in mitigating burnout and reducing compassion fatigue. The participants in this study have higher compassion satisfaction scores and lower levels of burnout and compassion fatigue, which support this belief.

Research Question 3: What are counseling interns’ burnout levels as measured by the Professional Quality of Life (III-R)?”

The average score on the burnout scale among participants is 18.96 ($SD= 5.58$) with scores ranging from 7 to 33. Once again, the results from the burnout subscale are similar to previous scores on this scale (Lawson, 2007; Sprang, et. al., 2007). The scores on the burnout scale of participants are significantly lower than the normed sample ($M = 22, SD = 6.8$). According to the scoring procedures, if individuals’ scores are above a 28, they may want to reflect on the factors at work that make them feel ineffective in their role (Stamm, 2005). A score above 28 may also reflect individuals’ moods and the need for a break from work. However if the high score persists, it may be a cause for concern and should be addressed. If individuals’ scores on the burnout scale are below 19, they

may feel effective in their role and have optimistic feelings about their job and their abilities as a professional (Stamm, 2005).

Counseling interns' average scores on the burnout scale are slightly higher than their average score on the compassion fatigue scales. This may reflect the stressors of the internship experience and the demanding challenges of the counseling context that face inexperienced interns (Skovholt, 2001). Because burnout appears little by little (Maslach, 2000) interns' scores in this study may reflect this assumption.

It is important to mention that 10% of participants in this study scored above the cutoff of 28 on the burnout subscale and are at risk for burnout. This is very concerning in that these participants have not yet entered the field and experienced further job stressors related to being a helper. Likewise, burnout has been associated with forms of job withdrawal such as absenteeism and even turnover. It is also associated with reduced commitment to the job or organization. Furthermore, burnout has been associated with poor health and increased levels of stress (Maslach, Schaufeli, & Leiter, 2001).

To illustrate the potential risk for burnout in these counseling interns, a few survey items on the burnout subscale should be addressed. Sixteen percent (16%) of participants answered 'a few times' or higher to question 8, "I am losing sleep over a person I help's traumatic experiences." Seventy-four percent (74%) of counseling interns in this study answered 'a few times' or more frequently to question 19, "Because of my work as a helper, I feel exhausted." Furthermore, 57% of participants responded 'a few times' or higher to question 21, "I feel overwhelmed by the amount of work or the size of my caseload I have to deal with." Lastly, 66% of participants answered 'a few times' or more frequently to question 26, "I feel bogged down by the system." These

responses are startling because such a large number of interns in this study seem overwhelmed and stressed as a result of their work as helpers. As we know, burnout appears slowly (Maslach, 2000) and the overall percentages for these responses are already high. Interns in this study may be more tolerant of this stress rather than seeking healthier options. It seems that counselor education programs surveyed could more effectively address interns' caseloads and ways they can establish healthier boundaries.

Some studies have speculated that time pressure (e.g. heavy caseloads) and personality conflicts are associated with higher burnout levels (Huberty & Huebner, 1988; Pazin, 2000). It is possible that these counseling interns are experiencing some increase in their burnout levels due to an overload in clients and how they perceive themselves as clinicians. Additionally, greater responsibility, heavier course load, and less social support have also been associated with higher levels of burnout (Pazin, 2000). Although 89% of students 'strongly agreed' or 'agreed' to having support outside their counselor education program, the issues of their course load was not addressed in this study. However, 36% of participants agreed they have a large caseload of clients and 53% believed they worked long hours. Furthermore, almost 9% of participants spent 30 or more hours in direct contact with clients during their internship.

Regardless, counseling interns in this study overall scored just below a 19 on the burnout scale, which indicates that on average they were at a low risk for burnout. These scores are similar to previous studies (Sprang et. al., 2007). A possible explanation for the low burnout rates in this study could be that the risk of burnout was decreased due to their higher levels of compassion satisfaction (Conrad & Kellar-Guenther, 2006). Autonomy and control also seem to alleviate the effects of burnout (Abu-Bader, 2001).

Therefore, it is possible that counseling interns' levels of self-sufficiency and feelings of competence in their program could produce lower levels of burnout. Similarly, a sense of mastery was associated with lower burnout levels, as well as being single, having fewer negative life events and traumatic events in the past year (Adams, Figley, & Boscarino, 2008). Age is also a protective factor of burnout, wherein older clinicians were less vulnerable to aspects of burnout (Huberty & Huebner, 1988; Lloyd & King, 2004). The average age of participants in this study is 33 years, with ages ranging from 25 to 60 years old. Nevertheless, there was no significant relationship between age and burnout based on a MANOVA analysis in the current study. Additionally, a supportive work environment and adequate supervision mitigate the occurrence of burnout (Boscarino et al., 2004; Ortlepp & Friedman, 2002). This current study found that 88% of counseling interns felt that they had at least one supportive professor in their program and 91% of participants agreed that they had at least one supportive colleague.

By and large, counseling interns are not older, do not have a sense of mastery in their craft, and are often not autonomous in their work. Yet, surprisingly these interns were not burnt out. It seems interns in this study feel supported by their programs and are most likely addressing issues related to their helping roles in supervision. It is possible that they are enjoying their new roles as counselors and becoming more independent and more confident in their therapeutic skills at this stage of their programs.

Research Question: 4. "What are counseling interns' perceptions of their programs' wellness education and curriculum?"

The responses to questions one through twelve on the Counselor Interns' Perceptions of Wellness (CIPW) Survey answered this research question. The average

score among participants on wellness education is 41.74 ($SD=6.38$) with scores ranging from 21 to 57.

Specific survey questions will be discussed in more detail to illustrate results of the descriptive statistical analysis. Interesting responses to several questions were noted. "Strongly agree" and "agree" responses and "strongly disagree" and "disagree" were collapsed in the description of these responses. Seventeen percent of counseling interns disagreed with question 2, "I have had the opportunity to learn about counselor wellness in my counselor education program." Furthermore, 31% of participants disagreed to question 3, "My counselor education program has offered education focused on counselor wellness." Although 36% of participants agreed that their program was educating them about burnout, 38% disagreed (question 5). Thirty-five percent of participants agreed that their counselor education program adequately educated them about compassion fatigue; however, 52% disagreed with this question (question 6). Thirty-seven percent of counselor interns agreed with the statement, "The requirements of my counselor education program encourage wellness and balance in students." However, 35% disagreed (question 9). Similarly, 66% of participants agreed that the *philosophy* of their counselor education program encourages wellness and balance in students, 11% disagreed (question 8). Whereas, 47% of counseling interns agreed that they feel prepared to confront the personal and professional challenges associated with the counseling profession as a result of their wellness training (question 10), 38% of participants were neutral about this question. Lastly, 84% of counselor intern participants agreed that they would prefer additional training regarding counselor wellness (question 11). The responses to these questions demonstrate that counseling interns in this study do not

know as much about wellness as they would like to know. Their responses show that there are some inconsistencies between programs' student expectations and programs' viewpoints about trainee wellness. That is, what programs teach and what they expect from students are contradictory.

Question 12, "Please give examples of recommendations encouraged by your counseling program to promote counselor wellness" resulted in interesting answers. Answers ranged from simple and vague, such as "self-care", "exercise", "regular sleep", "good nutrition", "take time for yourself", to more specific such as "personal counseling", "education on compassion fatigue", "know the warning signs of burnout and compassion fatigue", "supervision", "expect stressful times during the semester", "find ways to leave clients' issues at the office", and "careful awareness of work overload". However, none of the participants mentioned specific wellness classes or other curricula geared towards wellness. This is not surprising when examining some of the interns' unfavorable perceptions of their programs' wellness education and curriculum.

Several authors agree that counselor wellness education is a critical component to counselor education programs and a concept that counselor educators should teach counseling students (Coster & Shwebel, 1997; Figley, 1995; Hesse, 2000; Munroe, 1995; Myers, Mobley & Booth, 2003; Roach, 2005; Rosenbloom, Pratt, & Pearlman, 1995; Savicki & Cooley, 1982; Salston & Figley, 2003; Witmer & Young, 1996; Yassen, 1995). Meanwhile, it has also been found that graduate school learning and experiences were important to the well functioning of helping professionals, as well as learning how to balance personal and professional issues (Coster & Shwebel, 1997). Unfortunately, many counseling interns in this study did not have an overall favorable perception of their

counselor education programs' wellness education and curriculum. The question of their preparedness as counselors remains vague and uncertain.

Research Question: 5. "Is there a positive relationship between counseling interns' perceptions of wellness education and compassion satisfaction and a negative relationship between counseling interns' perceptions of wellness education and compassion fatigue and burnout?"

The responses to questions twenty-nine through forty-one of the Counselor Interns' Perceptions of Wellness (CIPW) Survey and 1-30 on the Professional Quality of Life (ProQOL) answered this research question.

There are a number of interesting findings within this research question that will be discussed individually. There is a positive relationship between counseling interns' perceptions of their programs' wellness education and compassion satisfaction ($r(61) = .281, p = .026$). Specifically, counseling interns who believed their counselor education program was favorably educating them about wellness also had high levels of compassion satisfaction and found pleasure and fulfillment from their roles as counseling interns. The participants' beliefs and confidence in their programs' ability to educate them about how to care for themselves personally and professionally seems to have a positive influence on their overall feelings about their abilities as a counselor. These results coincide with other theories that if a person has a positive belief system, then perhaps they are more resilient and resistant to the influence of negative factors (Pearlman & Sackvitne, 1990).

There is a negative relationship between wellness education and burnout; as counseling interns' perceptions of their program's wellness education increased, their

levels of burnout decreased ($r(62) = -.347, p = .005$). Similar to the significant relationship between compassion satisfaction and wellness education, counseling interns who believed their counselor education program was favorably educating them about wellness and similar topics, were students who had overall low burnout levels. However, counseling interns who had less confidence in their counselor education programs and believed they were unfavorably educated about wellness had higher burnout levels. It seems, counseling interns' trust and faith in their programs' abilities acts as a buffer from their current level of distress. These results correspond with a similar study that stated that if a person's belief system is being preserved in a positive way, then perhaps that person's hardiness is enhanced (Pearlman & Sackvitne, 1990). That is, counseling interns perceptions about their programs' abilities to adequately educate them gave them a sense of well-being in their methods of dealing with stressors.

A significant positive relationship exists between compassion fatigue and burnout; as counseling interns' levels of compassion fatigue increased, their burnout levels also increased ($r(62) = .501, p = .000$). As a result, if counseling interns are at risk for compassion fatigue, they are also at risk for burnout and possible impairment and distress. One study suggests that both compassion fatigue and burnout are associated with increased psychological problems and impairment (Adams, Figley, & Boscarino, 2008). . Interestingly, counseling students with low levels of compassion fatigue significantly correlated with students who do not burn out. Therefore, students' lack of knowledge in the areas of wellness and impairment could be detrimental to their overall well-being and competency as a future counselor. If their counselor education programs are not educating students about compassion fatigue and burnout, they may not understand the

warning signs and not be able to seek the help they need to care for themselves, their clients and avoid ethical violations. Meanwhile, counseling students who are knowledgeable about compassion fatigue and ways to prevent or resolve it will have the means to prevent burnout and promote counselor longevity.

A significant negative relationship exists between compassion satisfaction and burnout; as counseling interns' levels of compassion satisfaction increased their burnout levels decreased ($r(63) = -.635, p = .000$). Again, these results are similar to previous studies (Conrad & Kellar-Guenther, 2006; Wee & Myers, 2003). Therefore, students that believed they were helping others and enjoyed their roles as counseling interns had lower levels of burnout. On the contrary, students who gained less enjoyment and fulfillment from their roles as interns were students who had higher burnout levels. The pleasure interns received from their work as counseling interns managed to reduce their feelings of being overwhelmed and often depleted from this type of work.

Although some of the predictions were supported, there was not a significant correlation between compassion satisfaction and compassion fatigue ($r(60) = -.133, p = .303$). This is an interesting finding since there was a strong significant correlation between compassion satisfaction and burnout. Furthermore, there was no significant correlation between compassion fatigue and wellness education ($r(59) = .183, p = .158$). Yet, there was a significant negative relationship between burnout and wellness education. The only explanation for this is that compassion fatigue comes about swiftly and often unexpectedly. Only empathic counselors can suffer the effects of compassion fatigue because they have opened themselves up to the experiences of the client and must completely engage to truly be an effective helper (Figley, 2002). The connection between

counselor and client that must be present for compassion fatigue to arise is a powerful and formidable one. Therefore, compassion satisfaction, finding satisfaction in the role as counselor and working therapeutically with clients, may not be enough to protect clinicians from compassion fatigue. Furthermore, the reason that there is not a significant relationship between compassion fatigue and wellness education may be the result of similar complicated themes. That is, it is not enough for students to have a strong perception of their wellness education to rid themselves of the effects of vicarious trauma. Regardless of their beliefs about their programs ability to provide wellness education, this may not reduce possible symptoms of compassion fatigue once they leave their internships and their supportive environment is gone.

Research Question: 6. “Are counseling interns aware of their counselor education programs’ nonacademic retention and dismissal policies?”

Responses to questions thirteen through twenty on The Counseling Interns’ Perceptions of Wellness (CIPW) Survey answered this research question. The average score among participants was 20.51 (*SD* 2.88) with scores ranging from 14 to 26. "Strongly agree" and "agree" responses and "strongly disagree" and "disagree" were collapsed in the description of these responses. Thirty-two percent of participants disagreed with the statement (question 13), “My counselor education program presented me with student policies regarding dismissal and remediation.” Twelve percent disagreed with question 14, “My counselor education program adequately outlines expected student behaviors” and 19% were neutral.

Overall, many counseling interns in the current study were not knowledgeable of their counselor education programs’ retention and dismissal policies. Nevertheless, we

know gatekeeping is the professional responsibility of counselor educators to determine if a counseling student should enter the profession (Moore & Urwin, 1991) and the inattention to gatekeeping policies raises questions about the welfare of the students' clients (Gaubatz & Vera, 2002). The lack of participants' understanding about these gatekeeping policies raises concern because the counseling interns are unsure about their programs' expectations regarding their personal and professional behaviors. These students don't seem to understand that their attitudes and behaviors about wellness during their training will be brought into their professional world. Without clear and concise rules and expectations, students may not take responsibility for their academic and non-academic actions. This could lead to opportunities for avoiding serious issues that need to be addressed personally and monitored by educators. Eventually, this avoidance could result in unnecessary harm to their clients and other ethical violations.

Researchers have called the counseling profession to action. The need to create and implement formalized gatekeeping policies and to define specific procedures of dismissal and retention policies is clear (Bemak, Epp & Keys, 1999; Biaggio, Gasparikova-Krasnec, & Bauer, 1983; Brady & Post, 1991; Davenport & Kerewsky, 2004; Vacha-Haase, Davenport, & Kerewsky, 2004). The literature also shows that an integral component of gatekeeping is student awareness and understanding of these nonacademic policies, which will help guide their graduate education (Baldo, Softas-Nall & Shaw 1997; Frame & Stevens-Smith 1995; Knoff & Prout 1985; Lumadue & Duffy 1999; Oklin & Gaughlin 1991; Vaccha-Haase, et. al., 2004). The lack of awareness of a number of the participants in this study show that they need more detailed information to guide them through their degree programs.

An alarming 75% of counseling interns reported they had concerns about the wellness of one or more of their peers in their counselor education program (question 19) and 22% were aware of a student being dismissed from their counselor education program for nonacademic reasons, such as impairment (question 20). These results seem to echo previous studies such as Vacha-Haase et. al. (2004) that reported 52% of the programs surveyed had dismissed one student per year over the course of 3 years, approximately 18 impaired students a year. Similarly, Boxley, Drew & Rangel's (1986) study stated that 66% of internship sites surveyed reported students with impairments over the previous 5 years. Other research has found that students that were viewed by counselor educators as impaired may have completed counseling programs without receiving any remediation for problems (Gaubatz & Vera, 2002). It seems the participants in this study were aware that fellow classmates were having difficulty and exhibiting signs of distress and possible impairment. It raises questions about the opportunities educators had to observe the behaviors of the same students in order to identify red flags and directly address their problems. It is important that counseling students have specific and objective ways to approach educators about peer concerns.

Many authors have discussed the harmful effects on clients as negative consequences of students with impairments remaining in counselor education programs. These include: projecting personal issues on clients, countertransference, rescuing clients, creating dependency in clients, overinvolvement with clients, underinvolvement with clients (Bemak, Epp & Keys, 1999; Emerson & Markos, 1991; Enochs & Etbach, 2004; O'Connor, 2001). Yet, in the current study, a large number of counseling interns had concerns about peers and their abilities to counsel clients in the future. However,

impairment does not always lead to dismissal from programs. It may lead to remediation and other restorative interventions. For example, 53% of participants agreed that a representative of their counselor education program recommended personal counseling at some time during their training (question 18).

The literature unmistakably and repeatedly reports that educators should teach ways to prevent impairment in students (Bockrath, 1999; Forest, Elman, Gizara, & Vacha-Haase, 1999; Hesse 2000; Munroe 1995; Myers, Mobley & Booth 2003; Roach 2005; Rosenbloom, Pratt & Pearlman 1995; Savicki & Cooley 1982; Skovholt, 2001; White & Franzoni 1990; Yassen 1995). Yet 30% of participants in the current study did not agree that their counselor education programs were adequately educating them about preventing impairment (question 17). Evidently, some of the counselor education programs in this study were not addressing the prevention of impairment with their students. It seems that the counselor education programs overlooked their duty to train their students (Munroe, 1995). Regrettably, groups of counseling interns with impairments are ill-prepared to enter the counseling world and serve clients. Ethical standards and issues surrounding due process, addressed in chapter two, are in jeopardy as students with impairments enter the field of counseling.

Implications for Counseling Interns and Counselor Educators

The results of this study have implications that are valuable to counseling programs, counseling interns, counselor educators, counselors, and professional counseling organizations.

1. Although overall the counseling interns in this study were not at high-risk for compassion fatigue and burnout, there were a substantial number of interns who scored

above the cutoff of 17 for compassion fatigue (14%) and above the cutoff of 28 for burnout (10%) and were at risk for compassion fatigue and burnout. Counselor educators should be extremely alarmed by this number because it represents students that were impaired with compassion fatigue and/or burnout during their internship and most likely entered the counseling profession without any remediation for these serious problems. Imagining the possible harm that could be done to these students' clients by way of ethical violations, boundary issues, repeat traumatization, increase in stress levels, inability to provide objective counseling, lack of empathy, and so forth, is startling. Counselor educators have opportunities to assess their interns' levels of wellness before they enter the counseling profession. This vital task must be accomplished while interns are in their training programs and when they have the support they will need to resolve impairment issues.

2. Overall, compassion satisfaction scores among counseling interns in this study were high. However, there were a number of interns that were below the cutoff of 32 for compassion satisfaction (16%) and did not find satisfaction from their role as an intern and counselor trainees. We know that high compassion satisfaction scores can reduce compassion fatigue and mitigate burnout (Stamm, 2002), so there is great importance in identifying increased compassion satisfaction as a goal of counselor education programs. It is understood that educators in these programs can not make counseling interns feel satisfaction from their work, but they can assist in developing compassion satisfaction over the course of interns' training. Compassion satisfaction is the pleasure you receive from doing therapeutic work and from helping others (Stamm, 2005). Counseling students could attain higher levels of compassion satisfaction through education on how

to lower their anxiety, reduce stressors, improve coping skills, and understanding impairment. Novice counselors do not always enjoy their work due to unrealistic expectations (Skovholt, 2001). It is the role of counselor educators to provide a very clear picture of counselors' roles and highlight the successes and failures. This task will enable students to face the challenges of their counselor jobs with clarity, responsibility, and confidence.

3. A small number of respondents in this study agreed that their counselor education program was positively educating them about wellness. Yet, a large number of interns had neutral perceptions and some viewed their counselor education programs as doing a poor job of educating them about wellness. It is unsure if the counselor education programs surveyed in this study were *not* addressing wellness, but there were a number of interns that perceived their programs were not focusing on this critical topic adequately. Furthermore, to not address counselor wellness during counselor training could lead to counselor impairment by creating an unrealistic expectation that wellness does not require attention and effort to maintain. We know the opposite is true and that counselor educators have the arduous task of training counseling students about their wellness responsibilities. More importantly, educators have to teach students how to nurture themselves and make wellness a high priority. They have to find their own balance between teaching students and their gatekeeping responsibilities. Monitoring and evaluation of students is a function of gatekeeping, but it may be time to redefine gatekeeping. To be more comprehensive in programs' gatekeeping duties, educators should provide opportunities for students to monitor and evaluate their counselor education programs. Understanding the perceptions of their own students could enhance

their gatekeeping policies and allow educators to create an environment of trust, respect, and fairness.

4. Overall, if counseling interns believed their counselor education programs were favorably educating them about wellness, then their compassion satisfaction levels were high and burnout levels low. If counseling students' compassion satisfaction levels were high, their burnout levels were low. This is supported by research that states that education mitigates burnout (Abu-Bader, 2000). Therefore, it is possible that students' knowledge and training can protect them from the negative effects of burnout. There also seems to be a connection between these students' views of their programs and their overall compassion satisfaction. If they had confidence in their programs' abilities to educate them about wellness topics, they felt more pleasure from their role as interns. It seems, trust in their programs' competency can increase students' compassion satisfaction. Furthermore, the results of this study suggest that counselor education programs influence how their students view the profession and their roles as future counselors. Counselor educators inspire counseling interns through curriculum, supervision, and internships and can greatly affect the tone that is set about the counseling profession and the positive and negative aspects of being a counselor. If a programs' tone is centered on wellness and preparing students for the realities of the profession, these students' compassion satisfaction can improve and they will gain more contentment from their choice to join the field of counseling. In addition, the more they enjoy their roles as interns and increase their compassion satisfaction levels they are at a reduced risk for compassion fatigue and burnout.

5. There was a significant relationship between compassion fatigue and burnout; as compassion fatigue increased, so did burnout levels. Interestingly, compassion fatigue typically comes about abruptly, but burnout occurs over time. These results are quite troubling for a number of reasons. If counselor education programs are graduating counseling interns with impairments then the responsible gatekeepers, counselor educators, have failed at the gatekeeping function of their jobs. They have not adequately protected nor cared for the troubled counseling interns or their future clients. If counselor trainees are not being educated about compassion fatigue and burnout then they will not know that this can, and possibly has affected them. Counselor education programs must incorporate coursework on compassion fatigue, burnout, and other hazards of the profession into their curriculum. The proposed wellness curriculum is not just a class here or there or even brief training about these topics. These programs need to infuse wellness education and impairment prevention into every detail of their counselor training and the counselor educators must model it for the students. It is clear that those who had good self-care practices seemed to be less at risk for the negative effects of caregiving (Stamm, 2002). Counseling students need to know that the choices they make about their own wellness and self-care practices can help safeguard them from the potential risks of providing counseling.

6. Numerous students surveyed were unaware of their counselor education programs' nonacademic retention and dismissal policies, even though this is a CACREP standard. It is evident that students' lack of knowledge about remediation and dismissal can lead to severe problems for counselor education programs (Gaspar v. Bruton, Greenhill v. Bailey, and Shuffer v. Trustees of California State Universities & Colleges).

Counselor education programs need to take every opportunity to make their students aware of formal and informal gatekeeping policies. It needs to be discussed in every arena of their training programs, not just in a student manual. Classroom settings should be used to demonstrate and role-play scenarios about possible counselor impairment. Supervisory settings could provide opportunities to discuss and review gatekeeping policies and the need for possible remediation, such as personal counseling. This preventative education may reduce the stigma surrounding impairment and the consequences of reporting an impaired peer. Counseling students need to know that there is an established process regarding these policies because it is a reality in our programs and in our profession. The principle that impairment is a possibility for any counseling intern or counselor is an important message that needs to be taught in graduate training.

7. Even though the majority of counseling interns in this study were not at risk for compassion fatigue and burnout, a considerable number of interns were. It seems important that counseling interns be screened and their levels of wellness and/or levels of possible impairment be examined throughout their graduate training, especially during their internship. During this critical time of counselor training it is imperative to identify possible impairment issues. This is when counseling interns are providing therapeutic services to clients and can do harm if they are not well. The ProQOL can be used to screen students' compassion satisfaction, compassion fatigue, and burnout levels and can also be used to establish future goals for individual students and for the counseling program. Counselor educators could identify which students are in jeopardy of impairment and design interventions to prevent further impairment. It would be interesting to give the ProQOL to students at the beginning of counselor training, during

internship, and at the end of training to determine when compassion satisfaction and potential impairment were higher for these students. This information could assist in developing appropriate nonacademic retention and dismissal policies.

8. Again, overall compassion satisfaction levels among counseling interns in this study were high, but the 16% who scored lower than the cutoff are the target for future recommendations. We know that students in this study with high compassion satisfaction were also students with low burnout levels. High compassion satisfaction and low impairment among students should be the ultimate goal for counseling programs and educators. Once more, it is necessary for counselor educators to use an instrument such as the ProQOL to screen counseling interns' levels of compassion satisfaction. Counselor educators would be able to look at overall and individual compassion satisfaction scores and determine how they could help students improve their outlook about their helping roles and their clinical work and in the end establish new program goals and gatekeeping policies. This could also provide educators with opportunities to counsel students with low compassion satisfaction and help them determine if the helping profession is a right fit for them.

9. The connection between the wellness of counseling students and gatekeeping is evident; well students are the responsibility and should be a high priority for counselor educators and counseling programs. It is not the role of counselor educators to make them well, yet to educate them about wellness, assess their wellness levels, provide possible remediative interventions, and make important choices about students' abilities as future counselors. Likewise, students need to trust the capacity of their counselor education programs' abilities to teach wellness education and preventative techniques for

caregiving issues, such as burnout and compassion fatigue. Students' perceptions of their programs' abilities to provide this complete education in the current study varied. It is time for counseling programs and educators to enhance current gatekeeping policies and include a wellness evaluation for individual programs. Counseling programs would be evaluated by students prior to entering internship to determine how well educators are teaching wellness and like issues to these students. We know from this current study that students who believed their programs were efficiently educating them about wellness were students with high compassion satisfaction and low burnout levels. If their burnout levels were low, often their compassion fatigue levels were also low. It is critical for counseling programs to find a way to assess their students' perceptions as a means of establishing their commitment to the counseling profession. Additionally, counseling programs need to develop an approach to improving students' compassion satisfaction and lessen their risks to compassion fatigue and burnout. The easiest and most efficient way for students to have a voice throughout this process is to include an evaluative tool that allows students to assess their counseling programs. The evaluation component will help students feel invested in their programs, and demonstrate the importance of the gatekeeping process as part of comprehensive training and education.

10. It is important for counseling students to be well and to practice self-care activities to be less vulnerable to the potential risks of providing counseling. The results of this study imply that students with high compassion satisfaction had low levels of burnout and were students that had a favorable perception of their programs' wellness curriculum. Apparently, counselor education programs and educators need to move in the direction of improving their wellness education and curriculum. Counselor education

programs could evaluate current practices and target successful wellness interventions. A wellness curriculum would include courses on wellness, impairment, compassion fatigue and burnout. Course objectives would include demonstrations and role plays regarding how these issues arise in counseling, what these problems look like, and how the student could gain awareness of the problems, how to improve hardiness and coping skills. Personal and professional growth would be encouraged through journaling, video role plays, educators' stories, challenging books, role plays on how to ask for help, resource manuals provided to direct students where to go for help, and the signs and symptoms of compassion fatigue, burnout and other impairment issues. Supervision would target students' unrealistic expectations surrounding their roles as counselors and factors that could prohibit them from being truly effective counselors. Supervisors can discuss how the student's sense of achievement and disengagement skills can help reduce the effects of compassion fatigue. Extensive courses need to be devoted to these topics, not all of these topics being briefly discussed in one course.

Directions for Future Research

1. Several students in this study were not aware of their programs' nonacademic retention and dismissal policies. Future researchers may survey counselor education programs to determine if they have formal gatekeeping policies and compare those results to those of their counseling students. This information could effectively help programs develop improved protocol for disseminating these policies to students.

2. There needs to be more research that assesses counseling students' levels of wellness and possible impairment. Furthermore, research needs to be done on different sub-disciplines of counselors, such as school counselors, addictions counselors, etc. Their

levels of compassion satisfaction, compassion fatigue, and burnout need to be assessed in order to better prepare them for the stressors of their jobs.

3. A cutoff needs to be developed for the Counselor Interns' Perceptions of Wellness Survey to determine exact scores for interns. This process will begin with validating the CIPW and establishing its psychometric properties.

4. This study measured compassion satisfaction, compassion fatigue, and burnout at one point in time during participants' internship. It is recommended that future researchers screen students at different times during their program to identify possible impairment in their students and develop remedial interventions. Furthermore, the CIPW was only administered at one time during participants' internship. Again, gaining students' perceptions at various points during their programs could be beneficial to educators and help them modify goals.

5. Data in the current study was collected online for 2 weeks at the end of the spring semester. Initial information about the survey was submitted to all program liaisons and then distributed to counseling interns. It is recommended for future researchers to acquire interns' email information prior to data collection and directly send information to the students. In addition, it is recommended that data collection begin earlier within the semester and for a longer period of time to improve the response rate.

6. To improve the response rate it is proposed that future researchers recruit participants through counseling organizations such as ACA, at conferences, and/or through direct contact with counseling interns at various CACREP accredited counseling training programs.

Limitations

There were certain limitations of this study, which need to be addressed. This study measured compassion fatigue, compassion satisfaction, and burnout at one point in time during counseling students' clinical internships. Similarly, counseling students' perceptions of their counselor education programs' wellness education was assessed only during the students' internship phase of their counseling programs. Another limitation of this study was that data collection was limited to two weeks at the end of the spring semester and collected only from counseling students who responded within that time limit. Furthermore, the demographics of the program were not compared to those of the sample due to poor responses. Therefore, non-response bias was not addressed to determine if the groups were representative of counseling students. Lastly, this study is limited to counseling students who were capable of using the Internet and volunteered to participate.

Summary

The current study assessed counseling interns' levels of compassion fatigue, compassion satisfaction, and burnout. The study also assessed counseling interns' perceptions of their counselor education programs' wellness education and examined the relationship between these perceptions and their levels of compassion fatigue, compassion satisfaction, and burnout. The results suggest that, although counseling interns in this study were not at risk for compassion fatigue and burnout, a large percentage of them were at risk during a significant time of their counseling training. Furthermore, counseling interns had overall high levels of compassion satisfaction, but there was a considerable amount of interns with low levels. On average, counseling

interns had favorable perceptions of their programs' wellness education, but there were a large amount of students who believed their programs were not adequately educating them about counselor wellness. There were positive relationships between interns' perceptions of their programs' wellness education and compassion satisfaction; and between compassion fatigue and burnout. There were negative relationships between wellness education and burnout and compassion satisfaction and burnout. Noticeably, how interns regard their internship experiences and wellness training, program success, and academic world impact their compassion satisfaction, compassion fatigue, and burnout levels. Further results from the current study suggest that a number of interns were not knowledgeable about their programs' nonacademic and retention policies and most had concerns about the impairment of their peers. It seems that interns' perspectives of their counselor education programs' wellness curriculum and nonacademic experiences not only shapes their beliefs about the benefits of their programs, but can also influence their wellness. This current research has begun to fill in the gaps between the literature on wellness, impairment, gatekeeping, and compassion fatigue by offering a glimpse of counseling students' perceptions of their wellness and the wellness education presented by their counselor education programs. It has reinforced the need to establish new goals for students and counselor education programs regarding wellness and compassion satisfaction and for identifying new gatekeeping policies. This study has also strengthened the notion that counselor impairment occurs during training and many students enter the professional counseling world carrying this impairment with them. It is the responsibility of counselor education programs, counselor educators, and counseling

students alike to find balance between teaching and practicing, and between our wellness and the mental health of the clients we help.

APPENDIX A
Email Announcement: Request for Dissertation Assistance

Greetings! My name is Vanessa Bowles and I am a doctoral candidate in Counselor Education at Virginia Tech. I am inviting you to participate in a study regarding CACREP counseling interns' perceptions of their program's wellness education and assessing their levels of compassion satisfaction, compassion fatigue, and burnout.

As a CACREP liaison, your assistance is needed to gather information for this study, and would be greatly appreciated. You will be asked to 1) complete a [short survey](#), and 2) forward The Counseling Interns' Perceptions of Wellness Survey and The Professional Quality of Life (ProQOL) instrument link to your program's counseling interns. The information that will be collected in this study is important to your program. Programs with more than 5 counseling interns who participate will receive data regarding how your counselor education program compares to the national average. Please cut and paste the following letter in your email and submit to all counseling interns in your counseling program.

Dear Counseling Intern:

I know this is a busy and exciting time for you! Before you head out for graduation I am inviting you to participate in an important study regarding counseling interns' perceptions of wellness and compassion fatigue and burnout. The benefits of participating in this exciting study includes giving you an opportunity to reflect on your perceptions of your counselor education program and helping to enrich our understanding of wellness, compassion fatigue, and burnout. All information regarding participants and their responses will be kept confidential and participation is completely voluntary. You may discontinue your participation at any time without penalty. It will take approximately 30 minutes to completed The Counseling Interns' Perceptions of Wellness Survey and The Professional Quality of Life (ProQOL) instrument. Thank you for your cooperation in this research study!

APPENDIX B

ProQOL - R III

PROFESSIONAL QUALITY OF LIFE

Compassion Satisfaction and Fatigue Subscales – Revision III

Helping others puts you in direct contact with other people's lives. As you probably have experienced, your compassion for those you help has both positive and negative aspects. We would like to ask you questions about your experiences, both positive and negative, as a helper. Consider each of the following questions about you and your current situation. Write in the number that honestly shows how often the statement has been true for you in the last 30 days.

0=Never 1=Rarely 2=A Few Times 3=Somewhat Often 4=Often 5=Very Often

- _____ 1. I am happy.
- _____ 2. I am preoccupied with more than one person I help.
- _____ 3. I get satisfaction from being able to help people.
- _____ 4. I feel connected to others.
- _____ 5. I jump or am startled by unexpected sounds.
- _____ 6. I have more energy after working with those I help.
- _____ 7. I find it difficult to separate my private life from my life as a helper.
- _____ 8. I am losing sleep over a person I help's traumatic experiences.
- _____ 9. I think that I might have been "infected" by the traumatic stress of those I help.
- _____ 10. I feel trapped by my work as a helper.
- _____ 11. Because of my helping, I have feel "on edge" about various things.
- _____ 12. I like my work as a helper.
- _____ 13. I feel depressed as a result of my work as a helper.
- _____ 14. I feel as though I am experiencing the trauma of someone I have helped.

- _____ 15. I have beliefs that sustain me.
- _____ 16. I am pleased with how I am able to keep up with helping techniques and protocols.
- _____ 17. I am the person I always wanted to be.
- _____ 18. My work makes me feel satisfied.
- _____ 19. Because of my work as a helper, I feel exhausted.
- _____ 20. I have happy thoughts and feelings about those I help and how I could help them.
- _____ 21. I feel overwhelmed by the amount of work or the size of my caseload I have to deal with.
- _____ 22. I believe I can make a difference through my work.
- _____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I help.
- _____ 24. I plan to be a helper for a long time.
- _____ 25. As a result of my helping, I have sudden, unwanted frightening thoughts.
- _____ 26. I feel “bogged down” by the system.
- _____ 27. I have thoughts that I am a “success” as a helper.
- _____ 28. I can't remember important parts of my work with trauma victims.
- _____ 29. I am an unduly sensitive person.
- _____ 30. I am happy that I chose to do this work.

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<http://www.isu.edu/~bhstamm>. This form may be freely copied as long as (a) author is credited, (b) no changes are made, & (c) it is not sold.

APPENDIX C
COUNSELING INTERNS' PERCEPTIONS OF WELLNESS SURVEY (CIPW)

Questions 1 through 12 are about your perceptions of your counselor education program's wellness education. Wellness and wellness education refers to classes or other educational opportunities within your Counselor Education program that explains risks of the counseling profession and promotes wellness and self-care.

- 1) Counselor wellness education is an important component of counselor training.
 - Strongly agree
 - Agree
 - Neutral
 - Disagree
 - Strongly disagree

- 2) I have had the opportunity to learn about wellness in my counselor education program.
 - Strongly agree
 - Agree
 - Neutral
 - Disagree
 - Strongly disagree

- 3) My counselor education program has offered education focused on counselor wellness.
 - Strongly agree
 - Agree
 - Neutral
 - Disagree
 - Strongly disagree

- 4) My counselor education program has offered education in particular wellness strategies (exercise, relaxation techniques, social activities)
 - Strongly agree
 - Agree
 - Neutral
 - Disagree
 - Strongly disagree

- 5) My counselor education program adequately educated me about burnout.
 - Strongly agree
 - Agree
 - Neutral
 - Disagree
 - Strongly disagree

- 6) My counselor education program adequately educated me about compassion fatigue.
 - Strongly agree
 - Agree
 - Neutral
 - Disagree
 - Strongly disagree

- 7) My counselor education program adequately educated me about the personal and professional risks associated with the counseling profession.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly disagree

- 8) The philosophy of my counselor education program encourages wellness and balance in students.
- Strongly agree
 - Agree
 - Neutral
 - Disagree
 - Strongly disagree
- 9) The requirements of my counselor education program encourages wellness and balance in students.
- Strongly agree
 - Agree
 - Neutral
 - Disagree
 - Strongly disagree
- 10) I am prepared to confront the personal/professional challenges associated with the counseling profession as a result of my wellness training.
- Strongly agree
 - Agree
 - Neutral
 - Disagree
 - Strongly disagree
- 11) I would prefer additional training regarding counselor wellness.
- Strongly agree
 - Agree
 - Neutral
 - Disagree
 - Strongly disagree
- 12) Please give examples of recommendations encouraged by your counselor education program to promote counselor wellness.

Questions 13-20 are about gatekeeping. Gatekeeping refers to the education, evaluation, and monitoring of counseling students throughout the course of the program.

- 13) My counselor education program presented me with student policies regarding dismissal and remediation.
- Strongly agree
 - Agree
 - Neutral
 - Disagree
 - Strongly disagree
- 14) My counselor education program adequately outlines expected student behaviors.
- Strongly agree
 - Agree
 - Neutral

- Disagree
 - Strongly disagree
- 15) My counselor education program efficiently evaluates me in academic areas.
- Strongly agree
 - Agree
 - Neutral
 - Disagree
 - Strongly disagree
- 16) My counselor education program efficiently evaluates me in nonacademic areas (supervision, quality of counseling skills, personal characteristics related to counseling).
- Strongly agree
 - Agree
 - Neutral
 - Disagree
 - Strongly disagree
- 17) My counselor education program sufficiently educated me on preventing impairment.
- Strongly agree
 - Agree
 - Neutral
 - Disagree
 - Strongly disagree
- 18) A representative of my counselor education program recommended or required that I seek personal counseling at a point during my training.
- Strongly agree
 - Agree
 - Neutral
 - Disagree
 - Strongly disagree
- 19) I have had concerns about the wellness of one or more of my peers in my counselor education program.
- Strongly agree
 - Agree
 - Neutral
 - Disagree
 - Strongly disagree
- 20) I am aware of a student being dismissed from my counselor education program for nonacademic reasons (impairment, mental health issues, conflict, and poor clinical skills).
- Strongly agree
 - Agree
 - Neutral
 - Disagree
 - Strongly disagree

Questions 21-28 are demographic questions. Information collected will be kept confidential by the researcher and in no way will be used to identify you.

- 21) Name your current university.

- 22) What counseling track are you enrolled in?
 -School counseling
 -Community counseling
 -Mental Health Counseling
 -Student Affairs counseling
 -Marriage and Family
 -Other
- 23) Are you currently working or interning in a counseling position?
 -Yes
 -No
- 24) Please enter the number of years clinical experience you have prior to your enrollment in this counselor training program (any counseling related experience).

- 25) Please describe your previous clinical experiences.

- 26) What is your gender?
 -Female
 -Male
- 27) Please enter your age (numerically).

- 28) What is your ethnicity?
 -African-American
 -Asian/Pacific Islander
 -Caucasian
 -Hispanic
 -Native American
 -Other: _____

Questions 29 through 41 are about your perceptions of your clinical internship.

- 29) On average, how many hours per week do you spend in direct contact with clients?

- 30) What is your ideal number of hours per week to spend in direct contact with clients?

- 31) I believe I have a large caseload of clients in my internship.
 -Strongly agree
 -Agree
 -Neutral
 -Disagree
 -Strongly disagree
- 32) I believe I work long hours in my internship.
 -Strongly agree
 -Agree
 -Neutral

- Disagree
 - Strongly disagree
- 33) I feel pressure to improve my clinical skills.
- Strongly agree
 - Agree
 - Neutral
 - Disagree
 - Strongly disagree
- 34) I take an ample amount of breaks during my work day.
- Strongly agree
 - Agree
 - Neutral
 - Disagree
 - Strongly disagree
- 35) I have a tendency to take my clients' problems home with me.
- Strongly agree
 - Agree
 - Neutral
 - Disagree
 - Strongly disagree
- 36) I feel connected to my clients and my internship experience.
- Strongly agree
 - Agree
 - Neutral
 - Disagree
 - Strongly disagree
- 37) I have experienced a traumatic incident.
- Strongly agree
 - Agree
 - Neutral
 - Disagree
 - Strongly disagree
- 38) Which of the following presenting client problems have you experienced during your internship? Please check all that apply.
- Child abuse
 - Sexual abuse
 - Catastrophe
 - Illness
 - Major traumatic event (i.e. war, natural disaster)
 - Grief/loss
 - Domestic violence
 - Divorce
 - Family issues
 - Interpersonal conflict
 - Bullyinig
 - Self-injurious behavior (i.e. cutting)
 - Self-esteem
 - None of the above
- 39) I feel that I have at least one supportive colleague in my program.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly disagree

40) I feel supported by one or more of my professors in my counselor education program.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly disagree

41) I feel that I have enough support outside my counselor education program (i.e. family, friends).

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

APPENDIX D
Demographic Questionnaire

- 1) Please specify the number of students in each counselor track.
 - School counseling __
 - Community counseling__
 - Mental Health Counseling__
 - Student Affairs counseling__
 - Marriage and Family__
 - Other__

- 2) Please specify the number of students in your program that are working or interning in a counseling position. ____

- 3) Please specify the number of counseling students with clinical experience and the number of years those students have.

- 4) Please specify the number of males and females in your counseling program.
 - Female ____
 - Male ____

- 5) Please specify ages of counseling students. How many are in each age bracket.
 - 21-25 ____
 - 26-30 ____
 - 31-35 ____
 - 36-40 ____
 - Over 40 ____

- 6) Please specify the number of students in your counseling program in each ethnic group.
 - African-American ____
 - Asian/Pacific Islander ____
 - Caucasian ____
 - Hispanic ____
 - Native American ____
 - Other: ____

APPENDIX E
VT IRB Approval

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY
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Institutional Review Board

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VIRGINIA POLYTECHNIC INSTITUTE UNIVERSITY AND STATE UNIVERSITY

cc: File

DATE: April 25, 2007

MEMORANDUM

TO: Gerard F. Lawson

Vanessa W. Bowles

FROM: David M. Moore

IRB Exempt Approval: “Compassion Satisfaction, Compassion Fatigue, and Burnout: A Survey of CACREP Interns’ Perceptions of Wellness”, IRB # 07-239

I have reviewed your request to the IRB for exemption for the above referenced project. I concur that

the research falls within the exempt status. Approval is granted effective as of April 24, 2007.

As an investigator of human subjects, your responsibilities include the following:

1. Report promptly proposed changes in previously approved human subject research activities to the IRB, including changes to your study forms, procedures and investigators, regardless of how minor. The proposed changes must not be initiated without IRB review and approval, except where necessary to eliminate apparent immediate hazards to the subjects.
2. Report promptly to the IRB any injuries or other unanticipated or adverse events involving risks or harms to human research subjects or others.

SUBJECT:

FWA00000572(expires 1/20/2010)
IRB # is IRB00000667

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