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WHEN THE CLINICIAN IS BURDENED: CLINICIAN'S TRAUMA HISTORY, RESILIENCY AND THE IMPACT ON COMPASSION FATIGUE

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**WHEN THE CLINICIAN IS BURDENED: CLINICIAN'S
TRAUMA HISTORY, RESILIENCY AND THE IMPACT ON
COMPASSION FATIGUE**

By

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DISSERTATION

Submitted in Partial Fulfillment of the
Requirements for the Degree of

**Doctor of Philosophy
Family Studies**

The University of New Mexico
Albuquerque, New Mexico

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DEDICATION

This dissertation is dedicated to my mom, Judy Akana, in appreciation for her support and love for me, and her constant pursuit of love and wellness for our family. Thank you mom, I absolutely could not have done this (or life) without you!

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“Life is not about the destination, but the journey”- Unknown

This is one step of my journey in pursuing what I believe to be God’s will in my life. I believe that God put it on my heart as a child to pursue my Ph.D. At the time I didn’t know in what; however, academia has always been a desire and passion of mine. I thank God for His grace and love in my life and planting a desire in my heart for His will for me to be a Marriage and Family Therapist and to be a part of others’ lives in such an intimate way. This journey has been amazing and there are so many people that have supported me throughout, with ideas, love, patience, guidance and support.

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ABSTRACT

This dissertation study was motivated by the desire to understand the relationship between a clinician's prior traumatic experiences and the degree to which trauma may alter the personal impact of their work with clients in the form of perceived compassion fatigue. The methodology used in this study was designed to gather information about the relationship between 1) a clinician's trauma and current levels of compassion fatigue and compassion satisfaction, and 2) the relationships between a clinician's trauma and compassion fatigue when moderated by mindfulness, subjective vitality, psychological well-being and sleep. Regression results indicated that mindfulness, subjective vitality and psychological well-being were statistically significantly related with compassion fatigue and compassion satisfaction. Additionally, the results of this study provided empirical evidence that mindfulness and subjective vitality independently moderated the relationship between clinician's prior trauma and experience of compassion fatigue and compassion satisfaction.

Keywords: Compassion Fatigue, Resiliency, Clinician Trauma, Subjective Vitality, Mindfulness

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CHAPTER ONE

Introduction

“Every client takes a piece of you with them” is a phrase commonly shared within the mental health field. This phrase means that clinical professionals bring their hope, energy, empathy and life to the people they work with. This can be depleting for the clinician and it is no surprise that clinicians can eventually burn out.

The professional life of a clinician is not routine, linear, or consistent. Due to the nature of this work, mental health professionals can experience the satisfaction of witnessing the success of a couple effectively working on their marriage in one session, and, in contrast, may experience a client discussing their sexual abuse trauma in the next session. Clinicians meet with an array of clients and encounter a variety of problems and experiences brought by those clients. Over time this can take a toll on the vitality, rigor and effectiveness of therapy. Clinicians can experience energy depletion, exhaustion and negative self-perceptions that influence their self-esteem and effectiveness.

Unfortunately, these pervasive sources of stress are endemic to therapeutic practice, and because of the constant encounter with tough stories, clinicians are susceptible to compassion fatigue (Figley, 1995; 2002) if self-care is not intentionally sought.

In addition to these impairments that come from professional activity, mental health providers have a personal history that may include trauma and that can also impact how they cope with stress. Trauma can include a variety of struggles such as death and loss, divorce or separation, physical abuse, sexual abuse, emotional abuse, neglect, illness or injuries among others. Individuals with trauma have shown to have an increased risk

of mental health diagnoses (Cecil, Viding, Fearon, Glaser, & McCrory, 2017), substance abuse (Gielen, Krumeich, Tekelenburg, Nederkoorn, & Havermans, 2016; Ullman, Relyea, Peter-Hagene, & Vasquez, 2013), and physical health diagnoses (Pacella, Hruska & Delahanty, 2013; Afifi, Mota, MacMillan, & Sareen, 2013). Clinicians share these vulnerabilities, in addition to being at an increased risk for compassion fatigue (Hensel, Ruiz, Finney & Dewa, 2015; Figley, 2002).

The accumulation of personal and professional strain makes the clinician vulnerable to compassion fatigue. How do clinicians cope with the burdens they carry from clients they serve? What are the mechanisms of resiliency used by clinicians to protect them from burning out? How can clinicians remain healthy, competent and energized to continue helping clients? And how do clinicians' personal histories exacerbate their vulnerability to compassion fatigue? These are the questions this study seeks to understand.

Definition of Terms and Concepts

This section will outline the terms that will be considered for this study. Further review of these terms and their various definitions in the research will be discussed in the literature review in chapter 2.

Clinicians. The decision-making process of seeking mental health services can bring about confusion around which professional services one seeks. Because of this confusion it is important to provide a definition here about clinicians. Although there are very different theoretically underpinnings to each of the counseling professions (Counselors, Social Workers and Marriage and Family Clinicians), in the end, these

professionals all do the same thing-- help people therapeutically. With this being said, for the purposes of this study it is not important to differentiate licensure, and throughout this study the different professionals will be referred to as clinicians for consistency throughout.

Past Trauma History. Trauma can include anything negative in a person's life that has a substantial impact in their life. Taken from the Early Childhood Trauma Questionnaire (Pennebaker & Susman, 2013), the definition of past trauma history includes anything that clinicians may have experienced in their past (before the age of 17 and within the past 3 years) that relates to family issues, issues of abuse/neglect and/or death or other traumatic events that may have occurred in the past (Bernstein, Stein, Newcomb, Walker, Pogge, Ahluvalia, & Zule, 2003; Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards, & Marks, 1998).

Transference and Countertransference. These two terms are used in the counseling literature to describe the projection of emotions and feelings between the clinician and client within the therapeutic relationship and will be revisited in the discussion relative to the findings of this study. Transference and Countertransference date back to Freud in his discussion of psychoanalytic theory and the importance of transference in treatment (Freud, 1912). Transference is the unconscious experience of feelings, attitudes, emotions and other dynamic processes at work in the interpersonal relationship in the present moment and in the therapy relationship projected onto clinicians. Counter-transference is a consequence of transference and are feelings or emotions experienced by clinicians triggered by relationships with clients. These

unconscious feelings can cause concerns in the therapeutic relationship if not attuned to their presence by the clinician.

Compassion Fatigue (CF). Compassion Fatigue is defined as the negative aspect, involving such feelings as exhaustion and indifference, of providing care to others. It is through the accumulation of interactions with others, combined with a clinician's desire to alleviate their client's distress, that the clinicians can develop the fatigue that comes with carrying the burdens of others. Derived from the concept of job burnout, compassion fatigue was developed through Figley's (2002) research on the emotional aspects of job stress with "high touch" professions that include doctors, nurses, EMT workers and, for the purposes of this research, clinicians. Figley (2002) identifies two components of compassion fatigue—burnout, secondary traumatic stress.

Compassion Satisfaction (CS). Compassion Satisfaction is defined as the positive aspects of caring for and helping others. Compassion Satisfaction is the pleasure felt through the work a clinician engages in (Stamm, 2010).

Resiliency. Resiliency is the ability of a person to bounce back from adversity. It is the ability of a person to show a positive outcome despite hard or difficult experiences or situations that to others may have caused distress or the development of psychopathology (Rutter, 1999). Resiliency factors can include innate protective factors such as personality traits/dispositional traits (Campbell-Sills, Cohan, & Stein, 2006; Smith, 2006) and in the current conceptual framework, resiliency is understood as a product of four specific protective factors: mindfulness, vitality, psychological well-being and sleep.

Self-care. Self-care is one's intentional care of themselves to restore their well-being and can be defined as the "ability to refill and refuel oneself in healthy ways" (Gentry, 2002, p. 48). There are various definitions and explanations of what it means for someone to engage in self-care, and as a result there is no consensus on what self-care is. There are different ways that someone can engage in self-care: physical care, psychological care, spiritual care and support, among others (Richards, Campenni & Muse-Burke, 2010). Self-care for this study is considered to be a way that a clinician works towards preventing distress.

Mindfulness. There are several definitions of mindfulness that are explored in the review of the literature. Simply defined, Brown and Ryan (2003) recognize dispositional mindfulness as an open, non-judgmental awareness of the present moment. Mindfulness as being aware, attuned, and accommodating to the present will be considered a mechanism of resiliency in this study. When one is mindful, one is better attuned to one's own psychological need and subsequently more apt to engage in self-care and self-protective processes. This in turn transforms the clinician-client dynamic, thus preserving the integrity of the therapeutic process for the client as a consequence of protecting the integrity of the self for the clinician.

Subjective Vitality. Subjective vitality is a specific psychological experience of possessing feelings of aliveness, enthusiasm and positive energy (Ryan and Frederick, 1997). Possessing vitality will be measured as a means of resiliency in this research, because vitality is associated not only with having autonomous experiences but also with being personally expressive (Ryan and Frederick, 1997), both being instigators of

motivation.

Psychological Wellbeing and Wellness. Wellbeing is a broad construct that includes not only one's emotional responses (moods and emotions), but also judgments and evaluation of one's life satisfaction (Diener, Shu, Lucas & Smith, 1999).

Furthermore, wellness involves actively making choices to create and maintain balance and to prioritize health of mind, body and spirit (Venart, Vassos, Pitcher-Heft, 2007).

Psychological wellbeing includes several variables such as self-acceptance, feeling of purpose, physical health, autonomy, positive social interactions, and environmental mastery, all of which make up one's wellbeing (Ryff, 1995). This definition will be the one used for this study.

Sleep. Sleep is an important aspect of wellness and therefore is being referenced in this research as a protective factor against compassion fatigue. For the purposes of this research, sleep is actually defined as a clinician's perception of their daytime sleepiness. Sleep or sleepiness has not been a component of previous studies of clinicians with compassion fatigue.

Statement of the Problem

In the field of mental health, practitioners face consistent wear and tear on themselves for the work they do. The activities they engage in has a cumulative effect on their compassion fatigue (Thompson, Amatea & Thompson, 2014). This study focuses on the temporal connection between experiences of trauma prior to entering the profession and the possible moderating factors that may ameliorate compassion fatigue in clinicians.

In the 1970's, the American Psychological Association studied the prevalence of impairment among psychologists, the finding of which resulted in development of active programs to assist impaired psychologists in 22 states in the United States and in Canada (Coster & Schwebel, 1997). Additionally, the ACA created a task force specifically on impaired counselors in 1991 (Lawson, Venart, Hazler & Kottler, 2007). The task force described three avenues for addressing the needs of struggling counselors. The first initiative focused on enhancing the education of all counselors to prevent impairment; the second initiative focused on securing quality resources, interventions and treatments; and the third initiative aimed at advocating for addressing broader issues surrounding impairment in the organization's professionals and the specific needs of counselors experiencing impairment (ACA, 2010).

Empirical studies in the area of burnout for the general population of professionals began in the 1970s with Freudenberger (1974) and Maslach (1976, 1978). In the field of mental health, several other terms have been explored in describing clinician burnout. These are described in the literature review; however, they all allude to an imperative need for professionals to take care of themselves. Specifically, Sadler-Gerhardt and Stevenson (2011) examined the prevalence of resiliency and burnout in counselors and found that the high risk of counselor impairment speaks to the importance of having strategies and resources for intervention for the health of the profession. Their call for self-care is of critical importance for the broad spectrum of mental health professionals in today's society.

Professional associations take a strong stance on the importance of clinicians

being aware of impairment as a result of their personal and/or professional lives.

Professional associations provide ethical codes to make sure impairment does not impact clients; therefore, at the core of all ethical codes in the therapy profession is the responsibility to do no harm, to benefit others, and to pursue excellence in their profession (American Psychological Association (APA) 2005, American Association of Marriage and Family Therapy (AAMFT, 2015). Specifically, AAMFT's code of ethics (2001) promulgates the importance of self-care, stating:

Marriage and Family Therapists seek appropriate professional assistance for their personal problems or conflicts that may impair work performance or clinical judgment (p.1).

Additionally, The American Counseling Association (ACA) code of ethics (2005) specifically identifies self-care as a professional responsibility, stating:

Counselors engage in self-care activities to maintain and promote their emotional, physical, mental, and spiritual wellbeing to best meet their professional responsibilities (p.9).

Both the AAMFT and the ACA emphasize the need for clinicians to continuously pursue self-care in order to maintain excellence in the profession.

Described in the Social Work Ethical Codes as promulgated by the National Association of Social Workers (NASW), self-care is noted as it relates to impairment of colleagues in section 2.09:

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 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 (NASW, 2008).

Impairment of the self is noted in section 4.05, which states:

Social workers should not allow their own personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties to interfere with their professional judgment and performance or to jeopardize the best interests of people for whom they have a professional responsibility....Social workers whose personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties interfere with their professional judgment and performance should immediately seek consultation and take appropriate remedial action by seeking professional help, making adjustments in workload, terminating practice, or taking any other steps necessary to protect clients and others (NASW, 2008).

These associations' stance on self-care, declared through their ethical codes, voices the importance of clinicians caring for themselves, not only for personal growth and wellness, but also for the therapeutic relationship and the health and development of their clients. Therefore, it is important that clinicians foster an appreciation and ability to be attuned to the self as well as to the needs of their clients. In being aware, clinicians are able to establish self-care strategies that can prevent and ameliorate symptoms of compassion fatigue and other related forms of impairment. In order to address this problem, humanism and resiliency theory will be used as the theoretical lens to understand this study.

Theoretical Framework

Humanism is the overall lens that frames the proposed study through understanding the impact of emotions and feelings of clinicians on their work and the self. Resilience encompasses the protective factors serving as a buffer to the emotions and feelings clinicians encounter. Therefore, Resiliency Theory is the more specific theoretical framework used to understand the relationship between the clinician's

personal trauma history and compassion fatigue, along with protective factors that might ameliorate that relationship.

First, humanist psychologists recognize that humans have the ability to reach their full potential and that it takes an interaction with the self to reach that potential. The field of humanistic psychology emphasizes the importance of feelings and emotions as well as the meaning of the self in terms of observation of oneself and one's relations with others (AHP, 2014).

Humanistic psychology acknowledges that the mind is strongly influenced by determining forces in society and in the unconscious, and that some of these are negative and destructive. Humanistic psychology nevertheless emphasizes the independent dignity and worth of human beings and their conscious capacity to develop personal competence and self-respect. This value orientation has led to the development of therapies to facilitate personal and interpersonal skills and to enhance the quality of life (AHP, 2014, para. 2).

A humanistic stance is important as a perspective for this research as the clinician engages in their own work of handling compassion fatigue; but it is also important in a clinician's work with clients, to allow the client to engage in their own healing process supported through therapy, which can only be done when the clinician is well and able to be present with the client.

Second, resiliency theorists seek to understand what keeps people going in the face of adversity (Engle, 1967; Rutter, 1985, 1987, 1999, 2006; Werner, 1989). This theory will be used in order to focus on understanding how protective factors and self-care strategies that clinicians engage in prevent or reduce compassion fatigue. Thus, this theory will be applied to describe how clinicians, in the midst of stress, are able to continue on. Moreover, Luthar and Cicchetti (2000) describe that when a researcher

applies the resilience framework, attention should be given to positive outcomes rather than to positive adaptation in general. They describe that empirically derived knowledge about vulnerability and protective mechanisms should specifically connect to particular risk conditions. When applying resiliency to interventions, a strengths perspective should be employed as one's deficits are also being examined to better understand the links between vulnerability and protective factors (Luthar & Cicchetti, 2000).

Humanism prompts the shared meaning and understanding of emotions and feelings of all of us. We have and share emotions and feelings and that is what makes us human. Resiliency theory further supports this by unfolding the individual differences among us that we as humans possess as strengths that move us through difficulties.

Guiding Assumptions

The present study is based on the following guiding assumptions:

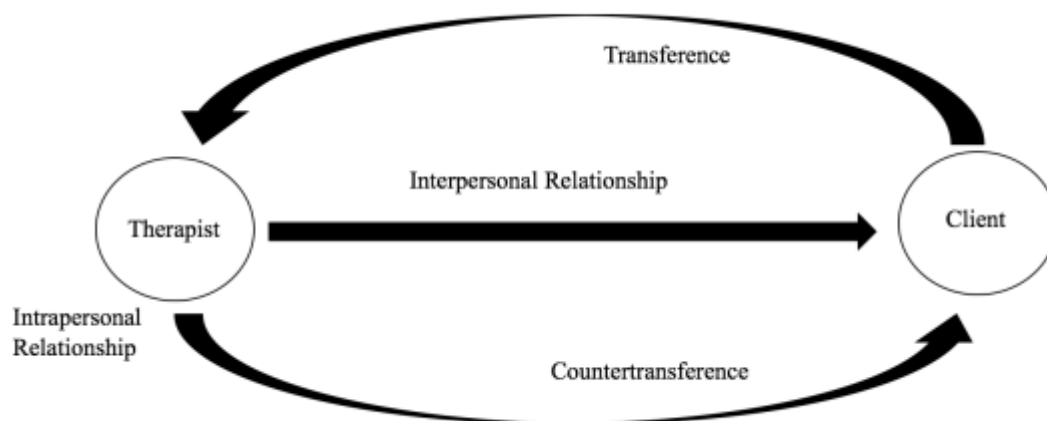
- Compassion fatigue is a consequence of all therapeutic practice and therefore all clinicians have some level of compassion fatigue (Figley, 2002; Craig & Sprang, 2010).
- There is a cumulative effect of clients on the clinician. When a clinician has several clients it may increase a clinician's compassion fatigue (Rosenberg, & Pace, 2006; Lawson, 2007). Having a client that does not have trauma may not add to the compassion fatigue; however, it does not take away compassion fatigue either.
- Compassion fatigue is sum of experiences of job burnout that are related to the everyday stress or administrative work which includes paperwork, secondary

traumatic stress is derived from the therapeutic, interpersonal and psychosocial work.

- Compassion satisfaction is a self-reported assessment of one's degree of satisfaction with one's capacity to provide support to one's clients.
- Sleep is a protective factor that inhibits the formation of compassion fatigue because sleep has many benefits (Roberts, 2008; El-Sheikh, Tu, Erath, & Buckhalt, 2014; Steptoe, O'Donnell, Marmot, & Wardle, 2008; Ryff, Singer, & Love, 2004).
- Mindfulness is a psychological process that protects one from the effects of stress (Brown & Ryan, 2003; Davis & Hayes, 2011); specifically, the benefits for clinicians include a decrease in stress, state and trait anxiety, rumination and negative affect (Shapiro, Brown & Biegel, 2007).
- Vitality is a self-perception that serves as an indicator of health and motivation. One's vitality is enhanced by activities that satiate one's essential psychological needs (Ryan and Deci, 2008). Therefore, vitality, as an indicator of energy is a protective factor.
- A clinician having engaged in energy-sustaining behaviors is less likely to have developed high levels of compassion fatigue.
- Psychological well-being is an indicator of a clinician's general mental health and has a positive relationship with vitality (Ryff & Singer, 1996), and is subsequently a protective factor.

- The relationship between the client and clinician is embedded in an ecology of its own. Each mental health agency has its own culture and structure and each session has its own circumstances, all of which impact clinicians differently and therefore differentially impacts the development of job stress (Yassen, 1995).
- Transference and counter-transference may develop a clinician's susceptibility and vulnerability to their emotions and thereby impact the clinicians feeling of compassion fatigue (See Figure 1 below).

Figure 1. Transference - Countertransference Dynamic



Objectives of the Study

The first goal for this study is to explore the relationship between clinicians' past history of trauma and current feelings of compassion fatigue and compassion satisfaction. To date, few studies have examined the relationship between trauma and compassion fatigue (Follette, Polusny, & Milbeck, 1994; Hensel, Ruiz, Finney and Dewa, 2015). The second goal of this study is to explore possible protective factors that may improve or attenuate the negative consequences of prior trauma and its tendency to increase the

likelihood to develop compassion fatigue or to positively impact compassion satisfaction. Namely, mindfulness, sleep, vitality and psychological well-being as protective factors will be examined in this study.

CHAPTER TWO

Literature Review

This literature review outlines the importance of exploring protective factors for clinicians against latent vulnerabilities to compassion fatigue and as a way to support compassion satisfaction. First, the theoretical framework for this study will be presented. The next section will include research exploring resiliency and protective factors, including self-care strategies and dispositional factors. Third, the impact of a clinician's past trauma experiences on their emotions. Evidence of the impact of compassion fatigue on a clinician and client will be provided in the fourth section. To conclude, an integrative model is presented that connects the variables presented throughout this review of the literature.

Theoretical Framework

This section will focus on humanism as an overarching theoretical framework with Resiliency Theory being the more specific lens to view this study. This section will examine how humanistic psychology is an important aspect of understanding the therapeutic process and specifically the importance of a clinician's awareness of their past trauma history and the impact on the therapeutic relationship. Resiliency Theory is elaborated on to further explain how clinicians may utilize specific strategies to respond to past trauma.

Humanism

The former President of the American Humanism Association, Edd Doerr wrote, "Humanism recognizes that life is more than cognitive and appreciates the full range of

human emotion, from the varied reactions to life's tragedies to the wonder and awe at our natural self and surroundings" (Doerr, 2002, para 6.). Humanism is more than just being intellectual; it encompasses all of what it is to be human, including having emotions. Humanists take a non-judgmental stance to the human experience. Using humanism as the overarching framework and exploring within the clinicians' experiences of compassion fatigue positions the researcher to be as unbiased as possible about experiences of clinicians as they disclose possible past trauma and the impact such struggles may have on their feelings of compassion fatigue. Humanism also provides a perspective to the clinicians themselves, promoting a non-judgmental awareness of their emotions and feelings as they encounter these while working with clients.

Humanism began its roots with Abraham Maslow and has now developed as an approach that clinicians and other professionals alike use to view their work and interact with others (Froh, 2004). Humanistic psychology originated in 1950's-1960's (Elkins, 2009), although a deeper probe of the extant literature reveals early discussions emphasizing the centrality of human experience as the focus of psychological inquiry (Dewey, 1904). As a response to behaviorism, humanistic psychology grew to be a major force in American psychology and was further advanced through Carl Rogers being elected the president of the American Psychological Association and his subsequent influence on the client-centered therapy approach (Elkins, 2009). Humanism is a general framework that describes the similarities of human experience and existence. As a more specific lens to better understand the impact of one's individual factors and the process by which these internal structures impact one's resilience, Resiliency Theory will be

applied as the contextual lens to study sleepiness, psychological well-being, mindfulness and vitality and the role they each play in mediating resilience and self-care of clinicians.

Resiliency Theory

Resilience is a relative resistance to psychologically risky experiences (Rutter, 1999). Described differently, resiliency is the ability of a person to bounce back from struggles or adversity. Resilience refers to the dynamic process that comes from positive adaptation within the experience of significant adversity (Luthar, Cicchetti & Becker, 2000). For this research study, resilience is constituted by the factors within clinicians that protect them against the encountered struggles with clients. More specifically, resilience is associated with the protective factors that clinicians facing trauma may possess. Subsequently, this may assist them in helping maintain their professional role as clinicians.

Early research with resiliency began in the late 1960's with Engle (1967) in a paper titled "Children Who Work." Research on resiliency began with studies of children having experienced stress and trauma over their life span and protective factors that serve as a defense to the risks associated with trauma experienced in life (Greene, Galambos & Lee, 2004). Michael Rutter is one of the leading researchers in the area of resilience with his articles beginning in the 1980's. His research area primarily focused on protective factors of resiliency (Rutter, 1985; 1987) along with application and implications for Resiliency Theory (Rutter 1999; 2006). Additionally, the construct of resiliency has been evaluated further with implications for researchers (Luthar, Cicchetti, & Becker, 2000) as

well as to better understand the application of research for interventions and to apply to social policy Luthar & Cicchetti, (2000).

Norman Garmezy (1971) focused on primary prevention as it relates to resiliency and coined the term “invulnerable” to refer to children who, after facing many risks from the environment, were not considered “vulnerable” to the adverse effects of their adversity. Later, Luthar and Cicchetti (2000) described that referring to children, or people in general, as “invulnerable” implies that one is no longer at risk, which does not allow for risk to be the developmental process that it is; one may encounter risk at different stages of life in various ways.

Another prominent researcher in resiliency research is Emmy Werner. Werner and her colleagues (1989) explored resiliency factors with a diverse population of children and several protective factors were noted for these children. This study was a 30-year longitudinal study (ages 1, 2, 10, 18, 32) with high risk children. The researchers explored the impact of these children’s environments on their health and found several children did well despite their difficult situations (Werner, 1989). More recently, Ann Masten has explored resiliency in children and youth (Masten, 2014a; Masten, 2014b), and, Masten and along with several colleagues have specifically examined the impact of homelessness (Cutuli, Ahumada, Herbers, Laffavor, Masten, & Oberg, 2017) and the role of family resiliency with these children (Herbers, Cutuli, Monn, Narayan, & Masten, 2014; Herbers, Cutuli, Supkoff, Narayan, & Masten, 2014). In addition to research on children and their families, research on resiliency has considered protective factors for adults as well (Smith-Osborne, 2007; Friberg et. al, 2003; Bonanno, 2005). With

experiences of trauma occurring at any time, a life span approach to resiliency is essential (Rutter, 2007). A clinician's encounter with trauma could occur anytime over the life cycle and its impact would likely be lasting.

Although children and adults experience a variety of responses to stress and trauma, research documents both environmental and genetic influences on the ways that one deals with difficult experiences (Rutter, 1999). Resiliency can be divided into 5 groupings of variables: 1) personality, 2) affect regulation, 3) coping, 4) ego defenses and 5) using resources and protective factors to assist in coping (Agaibi & Wilson, 2005). All or some of these variables may be present for clinicians.

Richardson (2002) described three waves of Resiliency Theory development in research. The first wave was in response to the question about the characteristics that keep people from succumbing to negative behaviors when faced with hardship, which specifically include the identification of resilient qualities. The second wave incorporated the process of how one copes and the resilient characteristics of the individual. The third was the discovery of resilience itself, which is the motivating force for those encountering struggles to endure and prevail.

Resiliency Theory is conceptualized by risk factors, vulnerability factors and protective factors. The risk factors include the event(s) or situation (s) for which there is evidence of risk of psychopathology for those that have experienced it. Vulnerability factors include personal traits or predispositions functioning as protective factors that either increase or foster resistance which then possibly moderates the effects of risk factors (Smith-Osborne, 2007). Rutter (1987) describes protective mechanisms operating

in one of four ways: 1) reducing risk impact, 2) reducing the negative chain reactions, 3) promoting resiliency traits and 4) setting new opportunities for success.

One limitation to this theory is that it is restricted to those that have experienced adversity (Smith-Osborne, 2007). Therefore, resiliency theory cannot then be applied to clinicians who do not report any experience with trauma in their past, even if trauma has occurred in the past.

Resiliency

In this section, resiliency and self-care will be reviewed. The oxygen mask metaphor so often referenced comes to mind: before the aircraft ascends, safety precautions are directed to adults who are told to put their oxygen mask on first, and then on the child next to them. The safety provisions suggest an awareness for adults to care for themselves first so the child will have someone to care for them. Parallels for clinicians can be derived. If clinicians are depleted, not tending to their needs and suffering themselves, how can they have the emotional capacity to help others?

Resiliency of Clinicians

Wellness is a process and outcome. It is an overarching goal for life, a day-to-day and minute-by-minute way of consciousness (Myers & Sweeny, 2005). A clinician's wellness provides the foundation for his or her own work with clients (Venart, Vassos, Pitcher-Heft, 2007). There are several studies documenting the instigators of burnout in counselors (Bakker, Van Der Zee, Lewig, & Dollard, 2006; Jenkins, & Baird, 2002; Pearlman, & Mac Ian, 1995); however, few have identified specific attributes of the resilient clinician.

Using a grounded theory approach, Clark (2009) sought to identify resiliency traits in Marriage and Family Therapists specifically. Clark (2009) found that resilient Marriage and Family Therapists engaged in an intentional process of resiliency, and therapists worked at keeping themselves healthy and functioning by taking proactive measures to identify and correct the problem (Clark, 2009). The findings pointed towards therapists being intentional about keeping themselves healthy and functioning. Additionally, conclusions supported the idea that therapists who work in a supportive environment, experienced personal growth and greater self-awareness (Clark, 2009). Furthermore, Clark (2009) constructed a theory of therapist resilience which incorporates the integration of self with practice and greater trust the practice of therapy. Clark's study points to the value of mindfulness of therapists. Specifically, mindfulness about personal health in relation to one's work environment and the self.

Building Resiliency

Incorporating wellness and self-care strategies can be difficult. Aside from the client contact hours, those who work to help others have a variety of other tasks to complete which include documentation in the form of treatment plans and progress notes and preparation for other sessions along with the daily life tasks.

As clinicians, one of the main components of treatment is developing coping strategies with clients. Coping strategies are aimed at clients finding ways to deal with inevitable emotions and feelings that come up from life's various circumstances. While therapists are easily able to tell others to care for themselves, it is difficult to maintain that state of care for themselves. It is important, however, for a clinician to identify

coping strategies to build resiliency against the constant burden of other's struggles. The idea underlying resiliency is that it is a buffer against the adverse effects of stressful situations. To date, self-care recommendations for clinicians have consisted of reactive methods to coping with vicarious trauma, secondary traumatic stress, and compassion fatigue; however, primary preventative methods are important to attenuate the effects of working with trauma (O'Halloran & Linton, 2000).

Williams et al. (2010) noted that specific self-care techniques for counselors and mental health professionals are rarely discussed in the literature. Mindfulness as a practice is often reported as having positive effects on clinicians' overall wellness (e.g., Dorian & Killebrew, 2014; Christopher & Maris, 2010), and self-efficacy (Greason & Cashwell, 2009); however, specific strategies remain unclear. One exception is Williams et al. (2010) that suggests several ways that counselors can engage in self-care. These self-care methods included music, balance, mindfulness, self-hypnosis and spirituality. The researchers found they personally benefited from participation in each of the activities as well as noted the self-care strategies benefited their practice as clinicians (Williams et al., 2010).

Research has explored self-care and resiliency strategies of clinicians that promote wellness, and academics have offered suggestions and examples in their writings. Venart, Vassos and Pitcher-Heft (2007) offer several suggestions and strategies for promoting wellness for clinicians. These strategies include celebrating personal accomplishments and the rewards of the work, engaging in life-long learning, nutrition, grounding through our senses (i.e., being in-tune with physical cues), healing through

movement and music, self-reflection and awareness, expressing emotion, factors bolstering and challenging cognitive health, sharing the journey with clients, getting involved in something greater than yourself, friends and family, personal therapy, colleague and peer support groups and supervision. These strategies, although helpful to promoting wellness, involve clinicians having vitality, the absence of which can be a barrier. Self-care can be a daunting task as a clinician begins the process of building personal wellness.

Norcross (2000), similarly, through his research and review of self-care literature, compiled a list of self-care strategies for clinicians. These include: 1) recognize the hazards of psychological practice, 2) think strategies as opposed to techniques or methods, 3) begin with self-awareness and self-liberation, 4) embrace multiple strategies traditionally associated with diverse theoretical orientations, 5) employ stimulus control and counterconditioning when possible, 6) emphasize the human element, 7) seek personal therapy, 8) avoid wishful thinking and self-blame, 9) Diversify, Diversify, Diversify, and, 10) appreciate rewards. A common thread that I notice with all of these strategies is a necessity for a clinician to be intentional and thoughtful, even mindful, about their self-care selection and the impact this has on personal wellness.

Additionally, Skovholt, Grier & Hanson (2001) offered six avenues for self-care for career counselors: maximizing professional success, creating and sustaining an active, individually designed development method, increasing professional self-understanding, creating a professional greenhouse at work, minimizing ambiguous professional loss, and focusing on one's needs for balanced wellness. Skovholt (2012) added to these six

avenues for self-care for counselors, and offered ten essential resiliency tasks for counselors, the first of which is to develop self-care skills. Through these self-care skills, the remaining tasks can occur: develop abundant sources of energy, relish the joy of the work as a positive energy source, search for the empathy balance, develop sustaining measures of success and satisfaction, create a greenhouse at work, avoid too many one-way caring relationships in one's personal life, use one's own physical health as a source for positive energy, engage in a long term continual focus on the development of self, and, finally, have fun and joy in one's life. For success, counselors must bring their whole self to the process. Many of these point to a clinician more apt to perceive high vitality. This can be extremely difficult when clinicians are experiencing high levels of compassion fatigue.

Common to all of these self-care strategies, is the idea that individuals are engaging in healthy tasks that move them from an unhealthy place to a place of wellness. Unfortunately, some clinicians engage in psychological numbing as a way to escape the emotions and feelings that come with the present moment/reality. This prevents them from practicing self-care strategies that would lead them to more effective coping and stress reduction. Some clinicians confuse psychological numbing (DSM-5) with self-care. People will shop, watch TV or drink to distract themselves from feeling and thinking. In and of themselves these are not entirely detrimental; however, psychological numbing does not restore the inner self. Self-care on the other hand, can restore emotions and energy.

Lawson and Myers (2011) found that counselors engaged in self-care activities or what the researchers call career-sustaining behaviors (CSBs)— such as spending time with their family, having a sense of humor, maintaining work-personal life balance and professional identity— showed higher wellness scores as well as reported higher positive professional quality-of-life factors. Self-care, as the literature has reflected, is imperative. As research demonstrated above, self-care not only promotes personal wellness, but is crucial to clients' success and wellbeing.

Research points to a long list of self-care activities and strategies that clinicians can engage in; however, when one is already experiencing compassion fatigue, it may be difficult to summon up the energy to begin any of the tasks described. Clinicians can be too exhausted to begin their path towards wellness. Research in the area of protective factors is an effort to promote clinicians' engagement in self-care at an underlying level so that perhaps, over time, they may acquire the energy to work towards additional self-care strategies.

Protective Factors

From the perspective of positive psychology (Yates & Masten, 2004), Resilience Theory purports that certain considerations serve as protective factors for individuals experiencing adversity (stress/trauma). Protective factors are discussed in Resiliency Theory as factors that contribute to a person overcoming adversity (Rutter, 1985). There are a variety of protective factors cited in research, such as personality traits (Campbell-Sills, Cohan, & Stein, 2006), social supports (White, Bruce, Farrell & Kliwer, 1998; Dumont & Provost, 1999), volunteering (Greenfield & Marks, 2004), and socio-

economic variables (Clauss-Ehlers, 2008), among others (Simeon, Yehuda, Cunill, Knutelska, Putnam, & Smith, 2007). However, for the purposes of this study, dispositional mindfulness, subjective vitality, psychological well-being, and sleep quality will be examined as intra-psychological protective factors for clinicians.

Mindfulness has been well researched and documented as a way for a person to decrease anxiety and stress along with a variety of other, more general, positive health-related outcomes (Shapiro, Schwartz & Bonner, 1998; Siegel, Germer, Olendski, 2008). Because of this, mindfulness is an important concept to study in the area of protective factors of clinicians. Subjective vitality is associated with feelings of energy and being alive. Individuals with higher subjective vitality scores show feelings of control and autonomy over personal situations, and those who report lower feelings of vitality may struggle with self-efficacy and relatedness (Ryan & Frederick, 1997). Psychological wellbeing is an overall term for several aspects of wellbeing (such as autonomy, environmental mastery, personal growth, positive relations, purpose in life and self-acceptance), and high psychological wellbeing scores show a strong relationship with general life satisfaction (Diener, et. al., 1999). Finally, sleep has been widely researched in interdisciplinary studies, and overall research has shown the importance of sleep for health and wellbeing (Medina, Lederhos, & Lillis, 2009). With all of these protective factors having been documented in the literature in support of general health and wellbeing, I am exploring the potential implications for clinicians to protect against compassion fatigue.

Mindfulness

In the recent past, mindfulness has been introduced into our Western culture (Richards, Campenni & Muse-Burke, 2010). Borrowed from the Buddhist teachings, mindfulness has developed as a means not only to help clients (Baer, 2003), but to help counselors as well (Rothaupt & Morgan, 2007).

Research in the area of mindfulness began at Harvard Medical School in the 1960's by Herbert Benson. As a cardiologist, Benson studied Transcendental Meditation™ and wrote a book called *The Relaxation Response* (1975) (Benson, Beary, & Carol, 1974; Benson & Klipper, 1992). Through his research, Benson found that a quiet environment, repetition of a sound, a passive attitude and watchful breathing are means to relieve stress, pain and other symptoms (Benson, Greenwood & Klemchuck, 1975). Although Benson's approach was slightly different than that of mindfulness meditation, his results parallel research on mindfulness meditation, which shows that it reduces symptoms of anxiety and depression (Shapiro, Schwartz & Bonner, 1998).

The American Psychiatric Association in 1977 presented the need for further exploration of the clinical effectiveness of mindfulness and meditation. As a result, several have documented its efficacy (Germer, 2004; Feltman, Robinson, & Ode, 2009; Godfrin & Van Heeringen, 2010; Barnhofer, Duggan & Griffith, 2011; Bowlin & Baer, 2012). Among the leading researchers in the area of mindfulness is Kabat-Zinn, who is credited with the development of the Mindfulness Based Stress Reduction Program. Additionally, Kirk Brown and Richard Ryan (2003) developed the Mindfulness and Attention Awareness Scale; and Ruth Baer and colleagues (2006), developed the Five

Facet Mindfulness Questionnaire in order to measure mindfulness— among other researchers that have explored the construct of mindfulness and its benefits (Brown, Ryan & Creswell, 2007; Baer, 2003).

There are several definitions of mindfulness, as it can mean different things to different people. Mindfulness has made a surge in the research and is emerging as a new focus in many fields. Particularly, Brown, Ryan & Creswell (2015) reported 3,000 published studies in 2004 to over 15,000 published mindfulness studies in 2014; as a result, a consensus definition of it has yet to be achieved (Dimidjian & Linehan, 2003). Baer, Smith, Hopkins, Krietemeyer & Toney (2006) suggest that mindfulness is a multi-faceted construct with relationships to a number of other variables. At its very basic level though, mindfulness is an open, non-judgmental awareness of the present moment (Ryan & Brown, 2003). Most definitions of mindfulness incorporate three elements that are present in both psychotherapy and Buddhist literature: 1) Awareness; 2) Of present experience; 3) With acceptance (Germer, 2004).

Kabat-Zinn, describes mindfulness as, “paying attention in a particular way: on purpose, in the present moment, and non-judgementally” (Kabat-Zinn, 1994, p.4). Additionally, mindfulness refers to the cultivation of a conscious attention on a moment-to-moment basis and is characterized by an open and receptive aptitude (Marlatt & Kristeller, 1999). The opposite of these definitions being mindlessness: a condition of being on “autopilot.”

Mindfulness has been associated with self-awareness; however, differences have been noticed between the two. Self-awareness is believed to be “knowledge about the

self” (Brown & Ryan, 2003), and mindfulness is a knowledge and awareness about oneself and one’s experience in the present moment (Hirst, 2003, Kabat-Zinn, 1994). Brown and Ryan argue that awareness and attention, as psychological processes are inherently intertwined. They claim that, “attention continually pulls ‘figures’ out of the ‘ground’ of awareness, holding them focally for varying lengths of time” (Brown & Ryan, 2003, p. 822). Awareness is powerful; therefore, by becoming aware and paying attention to surroundings, one can disentangle the web of emotions and underlying psychological anxieties, allowing one to self-regulate (Siegel, et. al., 2008).

Mindfulness is complex and an interrelated variable with several positive outcomes for individuals and specifically for mental health clinicians; however, for the purposes of this research the definition of mindfulness that will be used is the aforementioned definition from Ryan and Brown’s (2003): an open, non-judgmental awareness of the present moment. Therefore, as clinicians are being assessed for mindfulness, it is not an assessment of an established practice but a current state of being.

Vitality

Cummins, Massey & Jones (2007) have called attention to the fundamental emotional challenge to clinicians, specifically, they argue that to be a counselor, one must summon up the energy to be present minded while engaging with the client and their emotions, while also maintaining the self with all the impactful outside elements. Vitality then, is that energy that a counselor feels. It is a subjective experience of individuals that is based on one’s construal of self as autonomous, competent, and engaged relative to the situative factors that dynamically challenge individuals. Ultimately, vitality reflects

individuals well-being (Ryan & Frederick, 1997). It is the feeling of being really “alive,” the opposite of feeling drained. Likewise, those who report higher levels of vitality will feel a sense of control and purpose, and a lack of conflicts; those who report a lesser feeling of vitality may feel that they are lacking in efficacy, autonomous or relatedness (Ryan & Frederick, 1997). It is through paying attention to one’s feelings and the pursuing wellness that self-care practice will promote an increase in one’s level of vitality, providing a clinician with the necessary energy to engage with their client’s emotions.

Few studies allude to vitality in clinicians’ pursuit of wellness (Skovholt, et. al., 2001), and although the goal of caring for oneself may be for the goal of a more vital life, research exploring mental health clinicians’ subjective vitality has not been studied. Vitality in clinicians is being explored to address this gap and to better understand the relationship of vitality with a clinicians’ past trauma history and their feelings of compassion fatigue.

Psychological Wellbeing

Psychological wellbeing is considered a protective factor for this study because of the underlying benefits of wellbeing in general. An integral part of self-care is the pursuit of wellness. Wellness has been a concept talked about in the literature as not only related to physical health but also to mental health. Venart and colleagues (2007) describe the variety of wellness models and the importance of a holistic approach to wellness, which includes physical health, emotions, intellect, interpersonal relationships and spirituality. Subjective wellbeing is a measurement of one’s wellbeing or wellness. Subjective

wellbeing encompasses not only emotional responses but also cognitive responses to one's satisfaction with life (Diener, et. al., 1999). Furthermore, satisfaction with life is an assessment of global life satisfaction and does not tap into specific constructs (Diener, Emmons, Larsen & Griffen, 1985); however, overall life satisfaction can relate to wellness described above, in that if one is not satisfied in these areas one will not be satisfied with life in an overall way.

Wellness is a pursuit that many clinicians have noted as a struggle. Even Carl Rogers wrestled with this balance of self-care and client-care and described that he has always been better at caring for and looking after others than he is in caring for himself (Rogers, 1995). Oftentimes counselors have their own personal history of trauma and life stressors, which can increase the likelihood of a counselor experiencing vicarious trauma (Pearlmann & Mac Ian, 1995). Moreover, counselors that have a history of abuse have difficulty when attempting to set and maintain boundaries with clients and getting creative in how to present and keep boundaries with clients (Yassen, 1993). With this in mind, it is imperative that a counselor be aware of their struggles and pursue wellness in all areas to maintain balance and life satisfaction. One must nurture their wellness and this takes a clinician making an honest account of their health, balance and self-care consistently through their practice (Venart, et. al., 2007).

Sleep

Sleep has been well researched and documented in its protection against stress, psychological issues, even marital satisfaction (Medina, Lederhos, & Lillis, 2009; Troxel, Robles, Hall & Buysse, 2007) for the general population. It has been shown that trauma

survivors have poorer sleep (Cuddy & Belicki, 1992; Chambers & Belicki, 1998; Sadeh, 1996; Clum, Nishith, & Resick, 2001), and poor sleep is consistent with PTSD symptoms (American Psychiatric Association, 2013). Sleep impacts one's resilience: those that sleep better, tend to be more resilient (Chambers & Belicki, 1998), and, likewise, those that struggle with sleeping, for a variety of reasons, may be at risk for psychopathology and mental health concerns (Lee, et al., 2015). Additionally, there are studies pointing to the relationship between sleep and psychological disorders (Storch, et al., 2008; Stein, et al, 2001; Mick, Biederman, Jetton & Faraone, 2000), and one study in particular showed that individuals with decreased sleep had an increase in incidence of unethical conduct (Barnes, Schaubroeck, Huth, & Ghumman, 2011).

Review of the literature on sleep has shown that sleep deprivation has been documented as an epidemic in the United States (Puterbaugh, 2011) and is common among workers in general (Swanson et al., 2010). Furthermore, there are work-related implications for the common worker, such as absenteeism, occupational accidents (Swanson et al., 2010) and, more specifically, burnout (Rosen et al., 2006; Peterson et al., 2008; Vela-Bueno et al, 2008). Several articles note the impairment created by lack of sleep on medical professionals (Gaba & Howard, 2002; Leung & Becker, 1992; Jha, Duncan & Bates, 2001) and on medical residents and performance (Asken & Raham, 1983; Samkoff & Jacques, 1991; Howard, Gaba, Rosekind & Zarcone, 2002); however, such literature does not exist for mental health clinicians and therapists. Sleep is essential to functioning. Sleep deprivation can impact circadian rhythm and thus impact other aspects of a person's life (Dijk & Archer, 2009). Although mental health professionals

are not commonly requested to work night shifts, extended hours at agencies or one's private practice to accommodate individuals that work during the day may increase work hours in addition to all of the paperwork and documentation (Rupert & Morgan, 2005).

Research has documented that clinicians with secondary traumatic stress, vicarious trauma and compassion fatigue have similar symptoms to people with Post Traumatic Stress Disorder (Figley, 1995, 1999; McCann & Pearlman, 1990); therefore, it is assumed that therapists may also encounter sleep disturbances similar to those of people with Post Traumatic Stress Disorder, which may include having difficulty with falling asleep, staying asleep, or both, in addition to restlessness at sleep and nightmares (Spoormaker & Montgomery, 2008).

To date there have not been any articles found that have explored the impact of sleep disturbance on mental health clinicians. More specifically, daytime sleepiness as used in this study has not been explored in the relationship to clinicians' susceptibility to compassion fatigue. Further research in the area of sleep, sleepiness and sleep disturbance needs to be undertaken.

Trauma History of Clinicians

This section of the literature review will present research on trauma and the impact of clinicians' past history of trauma on their experiences of vicarious trauma, secondary traumatic stress and more specifically, compassion fatigue.

The Impact of Trauma

The impact of trauma has been widely researched in the past few decades, and is being examined further with regards to how trauma impacts neurobiology. More

specifically, how early childhood trauma impacts the developing person across the lifespan. Dr. Bruce Perry is one of the leading researchers in the area of early childhood trauma and has written several articles and books documenting his findings and experiences as a psychiatrist who works extensively with victims of trauma. One of the most substantial findings is that from the very beginning of a person's life, beginning in-utero, stress and trauma can impact the developing fetus (Perry, 1997; Perry 2009). A mother's chronic stress has a significant impact on a baby's brain development and thus can have an impact throughout the person's life. Research has shown that chronic stress experienced by the mother while pregnant can have an impact on the fetus' cortisol levels that carry into childhood. Children under stress have been shown to have an increased resting heart rate when compared to children whose mothers were not under chronic stress (Perry, 2009). Thus at the very beginning of life, a clinician may have a predisposition to stress and have an increased susceptibility to stress, anxiety and depression, increasing their risk of developing compassion fatigue.

Several studies have documented the impact of past trauma on current levels of physical and emotional health. The Adverse Childhood Life Experiences Study was one of the first studies to develop a questionnaire to look at the specific events of childhood and how they impact a person's health in adulthood (Felitti et al., 1998). This study, along with many others, has noted the psychological and physical impact of trauma in the general population (Drapeau & Perry, 2004; Kim, Talbot & Cicchetti, 2009; Colman & Widom, 2004; Chapman, et al., 2004; among countless others) and with clinicians (Elliot & Guy, 1993; Follette, Polusny & Milbeck, 1994; Ghahramanlou & Brodbeck, 2000).

Clinicians battle with these same internal struggles that are exacerbated when they work with people with trauma, or who have a similar past as the clinician. This counter-transference of the clinicians' trauma on to the client's experiences can then impact the clinical work, creating withdrawal, boundary issues, and other vulnerabilities in the therapeutic process (Canfield, 2005).

Clinicians bring their conscious and unconscious traumas with them to sessions (Figley, 1995). Pope & Feldman-Summers (1992) estimated that one-third of all mental health professionals had experienced childhood abuse. Although a more recent estimation has not been found in the literature thus far, this phenomenon is discussed in the therapy and counseling profession. It is not uncommon, however, to hear in conversation among clinicians and counselors that many clinicians go into the field because of unresolved issues from their past. Sometimes these traumas lead clinicians to work with a specific population because of their own history. This interaction could have caused a clinician to project their own trauma onto their clients, and, thus, may cause counter-transference that could potentially compound the clinician's traumas (Valent, 2002).

Clinician Trauma

Just like everyone else in the world, clinicians have struggles in life. Unfortunately, oftentimes these issues for clinicians are amplified in their interactions with their clients. Research has seen inconsistencies in the symptomology of the clinicians and the impact of their past on their current trauma symptoms; however, there is evidence to suggest that clinicians' past trauma impacts their current wellbeing (Dunkley & Whelan, 2006; Follette, et. al., 1994; Ghahramanlou & Brodbeck, 2000;

Hensel, et. al., 2015).

Ghahramanlou & Brodbeck (2000) studied psychological distress and secondary trauma with counselors working with sexual assault victims and found that personal trauma history and younger age significantly predict higher levels of secondary trauma intensity. Additionally, Pearlman & Mac Ian (1995) explored vicarious trauma in trauma clinicians and found that trauma clinicians with a personal trauma history showed more negative effects from the work than those without a personal history. Trauma work appeared to affect those without a personal trauma history in the area of other-esteem. Similarly, Follette, Polusny, & Milbeck, (1994) surveyed mental health and law enforcement professionals and found that those with childhood trauma reported significantly higher levels of symptoms associated with having secondary trauma symptoms in their profession. More recently, Hensel, Ruiz, Finney and Dewa (2015) found that clinicians with a personal history of trauma was risk factor associated with secondary traumatic stress. These studies alone highlight the importance the role a clinician's past history of trauma plays in their susceptibility of developing later trauma symptoms as a response to their client's trauma.

Further studies identified similar results. Specifically, Nelson-Gardell & Harris (2003) explored the relationship between childhood trauma of child-welfare workers and their reports of secondary traumatic stress and found a link between the child-welfare worker's personal trauma history and symptoms of secondary traumatic stress, showing an increased risk for workers with personal trauma histories. Dunkley & Whelan (2006) found that there is a relationship between childhood trauma history on vicarious trauma.

VanDeusen and Way (2006) examined the relationship between childhood maltreatment history and vicarious trauma effects, and the evidence supported the idea that those with a childhood maltreatment history showed significant struggles with disrupted cognitions about trust or and intimacy with others when compared to clinicians with less severe maltreatment histories.

In all realms of life, individuals are a product of their history. Our past experiences impact our future actions in many ways. With clinicians, it is through experiences with others that our past can be brought to the surface when they are triggered in the therapy sessions with clients. This process of being triggered oftentimes occurs through the transactional process of the therapeutic relationship by the dynamics of transference and countertransference. The concepts of transference and countertransference date back to Freud in his discussion of psychoanalytic theory and the importance of transference in treatment (Freud, 1912). While counter-transference may lead to vulnerabilities, it can have positive effects on the relationship with clients as well. Counter-transference is the necessary tool by which a clinician is able to empathize and engage with the client (Jones, 2004). Furthermore, Jones (2004) described that these concepts are not isolated to the therapy relationship, but happen in all relationships. For the purposes in this study, however, these concepts are related strictly to the therapeutic relationship. Counter-transference can serve as a hindrance to the therapeutic process if not realized or if appropriate assistance has not been sought to deal with the emotions. These emotions can be an additional burden leading to compassion fatigue.

The clinician's trauma—both past and recent— may have an impact on the clinician's mindfulness, vitality, psychological wellbeing and sleep. The ability of the clinician to manage in each of these areas through their self-care activities provides a defense to the relationship between the clinician's past trauma and their susceptibility to compassion fatigue, which includes secondary traumatic stress and burnout and compassion satisfaction. It is though the clinician's internal process—their intrapersonal relationship and their resiliency factors— that allows them to look inward and determine their own needs, thus engaging in self-care strategies that promote their own wellness.

There are not many studies that have examined the personal history of trauma of clinicians, which, as those studies that do exist highlight, is an important aspect of treatment and a clinician's susceptibility to compassion fatigue. Additionally, these studies point to the importance of clinicians with past trauma being informed and prepared for the occupation they have chosen. Knowing more about the relationship between past trauma and compassion fatigue and the impact of clients on clinicians is of utmost importance to maintain the health of the profession and decrease clinician turnover.

Compassion Fatigue and Compassion Satisfaction

Compassion fatigue has become a prominent explanation of the impact clients have on clinicians. The development of research specifically on the term “compassion fatigue” with clinicians began with Charles Figley; however, its origins date back to the discovery of work-related stress in general, which includes occupational stress and burnout, secondary traumatic stress disorder, vicarious trauma and counseling exhaustion.

Because of this, it is important that compassion fatigue continue to be an important area of research requiring further consideration as to its specific application with clinicians.

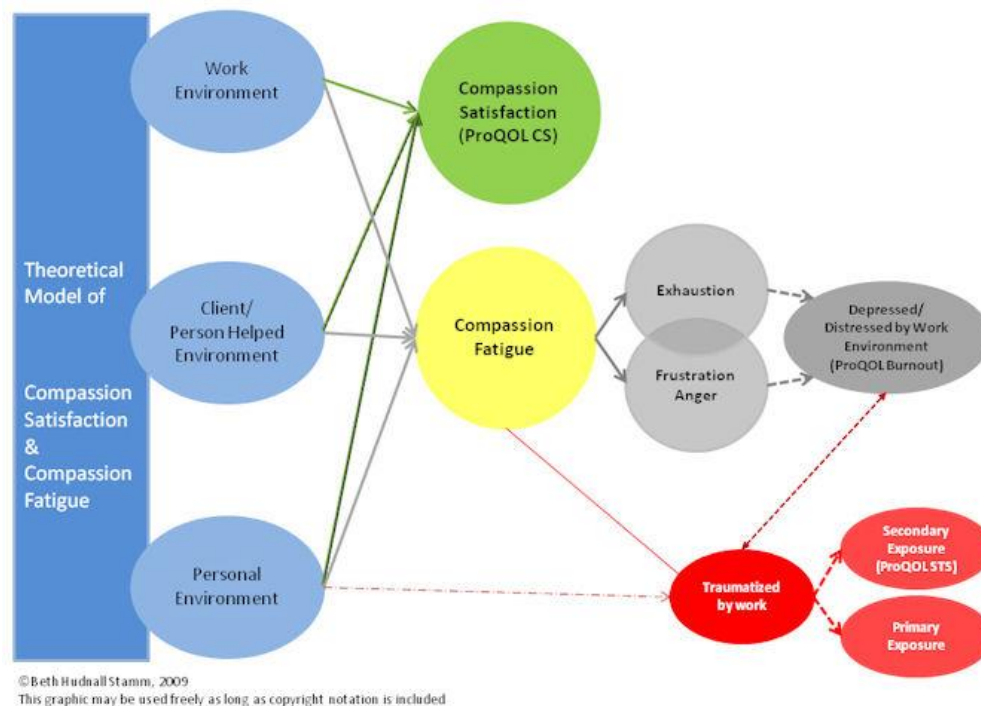
Compassion and Compassion Fatigue

The concept of compassion fatigue was introduced in the literature to explicitly address the struggle and strain of caregiving on the caregiver. Although the term “compassion fatigue” was not fully defined at the time, it has now been studied as it relates to a variety of helping professions, specifically clinicians; it describes the fatigue of the daily work that encompasses being a clinician. The meaning of “compassion” is “to bear suffering,” and like other forms of fatigue, compassion fatigue reduces our capacity or our interest in bearing the suffering of others (Figley, 2002). Figley also recognizes that compassion fatigue is a form of caregiver burnout. He defines it as, “a state of tension and preoccupation with the traumatized patients by re-experiencing the traumatic events, avoidance/numbing of reminders persistent arousal associated with the patient... it is a function of bearing witness to the suffering of others” (Figley, 2002, p.1435). For Figley (2002) the liability of clinicians’ compassion and empathy toward others is the resultant specific fatigue. It is a byproduct of the journey clinicians experience as they walk along the path of suffering with their clients.

Compassion is a very specific form of caring. One study pointed out that compassion is even more specific than empathy, and that compassion involves a clinician feeling the client’s suffering, identifying with and like the client they are working with, involving the client in their process and having established rapport with the client (Vivino et al., 2009). The clinician’s ability to engage the client in this way creates a safe place

for therapeutic work to take place. Over time, the clinician, through this compassionate engagement, may be vulnerable to compassion fatigue and struggle with continuing to maintain this connection with clients. The cumulative exposure to clients' detailed reports of trauma and their emotions impacts a clinician's emotions and personal perception of their trauma as well (McCann & Pearlman, 1990). Conversely, compassion satisfaction is defined as the positive feelings associated with caring and helping. Compassion satisfaction is a subjective assessment of providing compassion to others (Stamm, 2002). Stamm (2009) provides a Theoretical Model of Compassion Satisfaction and Compassion Fatigue (please see Figure 2 below). This model demonstrates how the three key environments of the actual work situation of the clinician, the environment of the clinician and client relationship, and the personal environment of the clinician, and how these environments impact clinicians positively (Compassion Satisfaction) and negatively (Compassion Fatigue) (Stamm, 2009).

Figure 2. Compassion Fatigue- Compassion Satisfaction Model



Within the helping professions, counseling and psychotherapy are considered a “high touch” profession, “high touch” meaning that a person is engaged with other people in some way that includes an emotional connection. “High touch” professions include counselors, nurses, teachers and social workers (Skovholt, Grier & Hanson, 2001). These “high touch” professions are more prone to compassion fatigue. Compassion fatigue has been documented to affect hospice workers (Alkema, Linton, Davles, 2008), nurses (Sabo, 2006; Yoder, 2010), chaplains and clergy (Roberts, Flannelly, Weavery & Figley, 2003), and child protective services staff (Cornille & Meyers, 1999; Conrad & Keller-Guenther, 2006). Additionally, those who work in non-human care, such as veterinarians and animal control staff, also experience compassion fatigue (Rank, Zaparanick, Gentry,

2009). Rager (2005) even offers suggestions for self-care against vicarious trauma for the qualitative researcher.

Stress has been a part of working since the beginning of time; however, it was not until after the rise of capitalism and the industrial revolution, with the increase in competition, that workers began working longer hours and taking work home with them (Angerer, 2003). This new phenomenon prompted a new field of study and thus researchers delved into the struggles of work-family balance/spillover (Kopelman, Greenhaus, Connolly, 1983; Cooke & Rousseau, 1984; Greenhaus & Beutell, 1985) and burnout (Fruehdenberger, 1974; Maslach 1978). Moreover, as a response to the increased growth in the human service industry, people turned to professionals for help with their personal problems (Maslach, 1978), which prompted specificity of research in these areas for the helping professions.

In 1958, one of the first studies looking at occupational stress and its effects on the body was presented. As a response to the increase in coronary heart disease in males, Friedman, Rosenman, Carroll and Tat (1958) studied 40 male accountants over 6 months and took blood samples and studied serum cholesterol levels and blood clotting. The results of the study showed an acceleration of blood clotting time during times of intense occupational stress, such as an upcoming deadline, and normal blood clotting during times of calm. Additionally, accountant's levels of serum cholesterol were highest during times of severe stress and lowest at times of less stress (Friedman, Rosenman, Carroll & Tat, 1958). The awareness of the physical impacts of stress through these results spurred

on the research in this area and moved in the direction of studying increased stress over time and the development of job burnout.

Research in the area of burnout has been around since the 1970's (Freudenberger, 1974; Maslach, 1976). Freudenberger initially coined the term "burnout" and describes it as, "to fail, wear out or become exhausted by making excessive demands on energy, strength or resources" (Freudenberger, 1974). Maslach expanded on burnout and created a way to measure general burnout in a broad range of individuals working in health and social service occupations (Maslach, 1976). Maslach & Jackson (1982) present a 3-part construct of job burnout, which includes emotional exhaustion, depersonalization and a reduced sense of personal accomplishment, all of which impact an individual's physical and mental health. Burnout is an ongoing process within any working person; however, for the helping profession and, specifically, for clinicians, there are several terms that are synonymous with the term "burnout" and have been widely researched: counseling exhaustion, occupational stress, psychological stress, vicarious trauma, secondary traumatic stress and compassion fatigue.

Only more recently have the concepts of secondary traumatic stress (STS) and vicarious trauma (VT) been introduced to the literature as referring to the impact of client's trauma on the emotional well-being of the clinician (Devilly, Wright & Varker, 2009; Figley 1993). Emerging literature in this field is beginning to shed light on the incidence rates of mental health counselors manifesting secondary traumatic stress symptoms (Figley, 1995; Canfield, 2005; Devilly, Wright, & Varker, 2009; Craig & Sprang, 2010). Using the Frederick Reaction Index (Frederick, 1987), Wee & Myers

(2002) found that 64.7 percent of Oklahoma trauma workers showed to have symptoms of PTSD. Additionally, 60.5 percent of mental health workers in the Northridge Earthquake met criteria for PTSD (As cited in Figley, 2002). In the 80's it was estimated that 10-15% of mental health practitioners will succumb to burnout during the course of their careers (Kahill, 1986). With the increase in research, evidence is accruing that it is common for those in the mental health profession to experience some form of therapy-related stress.

Vulnerabilities to Feelings of Compassion Fatigue

“It costs to care for others” (Sadler-Gerhardt & Stevenson, 2011). Clinicians are exposed to a variety of issues, many of which are traumatic events experienced by the client. It is important for a client to feel connected to the clinicians and to feel understood (Norcross & Wampold, 2011). This requires investment by the clinicians and a process of the clinician walking through the trauma with the client. This active engagement of the clinician can be quite exhausting as well as traumatic. As a result of this exposure, it is not uncommon for the clinician to experience secondary or vicarious trauma (Trippany, White Kress & Wilcoxon, 2004; Figley, 2002). Self-care is an important aspect of clinician's ability to cope and to prevent vicarious trauma before compassion fatigue sets in.

Clinicians more often than not have more than one client in a day and strive to be fully present in all sessions. Over time the engagement of the clinician in consistent empathy can diminish the physical and psychological resources of the clinician (Sadler-Gerhardt & Stevenson, 2011; Figley, 2002). As clinicians we must bring “our emotional

self, our intellectual self, our energetic self, our hopeful self, our ethical self, our knowledgeable and competent self, our sensitive self, our emotionally courageous self, our trusting self, our confident self, and more and more” (Skovholt, 2012, p. 137).

The clinician-client relationship should be a one-way helping relationship focused on just the client’s needs (Skovholt, Grier & Hanson, 2001). It is important, therefore, for clinicians to be in tune with their own needs. In a nationwide study in the late 1980’s, 749 psychologists participated in a survey assessing the impact of clinician’s personal distress on their clients. Results from that survey showed that 74.3% reported experiencing “personal distress” over the past 3 years and 36.7 indicated that it decreased the quality of care with their client’s. It has also been reported that 4.6 % resulted in inadequate treatment (Guy, Poelstra & Stark, 1989). Furthermore, impaired clinicians have a potential to actually cause harm on clients (Coster & Schwebel, 1997; Lawson, Venart, Hazler & Kottler, 2007). Therefore, when self-care is not regularly sought out, compassion fatigue can develop, leading to depersonalization of clients, among other symptoms.

Although not the same as compassion fatigue, extensive research has explored precursors to feelings of burnout and are similar enough to compassion fatigue that it is important to note these studies. Personality factors have been examined as a variable and researchers found that individual personality factors are strongly associated with the level of job burnout they will experience (Swider & Zimmerman, 2010). In addition, social support (LaRocco, House & French, 1980; Kahill, 1986) and cognitive coping ability (Skovholt, 2001) have shown a relationship with burnout. Also, contradicting the theory

that vicarious trauma predicts burnout, Devilly, Wright & Varker (2009) found that work-related stressors best-predicted clinician's distress. Conversely, in a sample of substance abuse counselors, supervision and job autonomy served as a protective role against counselor emotional exhaustion (Knudsen, Ducharme & Roman, 2008).

Maslach (1978) outlined several client factors that contribute to staff burnout: type of client problems (severity/trauma-my words), personal relevance of client problems (counter-transference- my words), rules governing staff-client relationship (boundaries-my words), client stance (internal locus of control vs. external- my words), client reactions to the staff. Additionally, several hazards were outlined by Skovholt, Grier & Hanson (2001); these include that clients have an unsolvable problem that must be solved, that all clients are not "honors students," that there is often a readiness gap between them and "us," that clinicians struggle with an inability to say no, that they must have constant empathy, interpersonal sensitivity and one-way caring, and that clinicians have elusive measures of success and normative failure.

Symptoms of Compassion Fatigue

With any emotional or physical health concern it is important to know the symptoms. The symptoms of compassion fatigue parallel many of the symptoms of PTSD, such as anxiety, depression, withdrawal, avoidant, exhaustion, preoccupation with trauma, self-harm, suicidal thoughts (American Psychiatric Association, 2013; Figley, 2002). Specifically, the symptoms discussed related to compassion fatigue described by Valent (2002) are feelings of being burdened, rejecting victims, anguish for not having prevented damage or death, not having done enough, having neglected their

responsibilities. Figley (2002) notes a compilation of symptoms of compassion fatigue and places them in one of seven categories. The categories include cognitive, emotional, behavioral, spiritual, personal relations, somatic and work performance. These categories speak to the potential pervasiveness of compassion fatigue in one's life and the variety of areas this burnout can impact; however, knowing the symptoms aids in understanding the impact and the treatment of compassion fatigue.

With this research in mind, it is of utmost importance to gain better understanding in the underlying factors that contribute to clinicians' development of compassion fatigue. It is imperative that research in this area is focused on clinicians with past trauma because of the strong inclination of those who have had trauma to want to help others with their trauma. Clinicians with past trauma must be informed and prepared for the occupation they have chosen. Knowing more about the relationship between past trauma and compassion fatigue and the impact of clients on clinicians is of utmost importance to maintain the health of the clinician and the health of the profession, protect clients, and decrease clinician turn-over. We cannot eliminate trauma; however, we can better understand the protective factors of clinicians' guarding against compassion fatigue.

Summary and Integration

The client-clinician relationship is the most important aspect of the therapy experience (Lambert & Barley, 2001; Horvath, 2001; Norcross, 2010); however, compassion and empathy on the part of the clinician can cause clinicians to be more vulnerable to compassion fatigue as well (Figley, 2002). The therapeutic relationship is a powerful relationship where clinician and client engage in a meaningful sharing and

hearing of the client's deepest struggles. The therapeutic process is the dynamic characteristics of the two individuals (or more if a family is present) at work. This process includes the client's and clinician's communication patterns and emotions that are divulged throughout the encounter. Through this process, over time, a significant rapport is established, deepening the relationship and prompting the therapy to actually take place. To get to this place requires vulnerability on both parties, not only to trust the other, but in that trust, to feel connected. Because of this, therapy is not a one-way transaction. Even with the client being the primary sharer of life experiences, the clinician empathically works to understand the client at great lengths, drawing on personal experiences—shared with the client or not—which give the clinician meaning-making material for the client.

This dynamic dance of meaning-making and understanding between clinician and client is described less strikingly through the terms “transference” and “counter-transference” in the counseling literature, and creates an increased susceptibility to the clinician's compassion fatigue. “Transference” is used to describe the unconscious experience of feelings, attitudes, emotions and other dynamic processes at work in the interpersonal relationship in the present moment and in the therapy relationship projected from the client onto clinician (Jones, 2004). These unconscious feelings can cause issues in the therapeutic relationship if the clinician is not attuned to their presence. “Counter-transference” is thus a consequence of transference and consists of feelings or emotions experienced by clinicians triggered by relationships and interactions with clients (Jones, 2004).

To address this vulnerability, clinicians find ways to engage in self-care strategies; however, some may not serve as effective as others. Furthermore, general self-care strategies may come too late to prevent clinician's emotions from being triggered in the first place. A clinician can then become impaired. Impairment is not simply an end-all situation. More common manifestations of impairment among professionals in the field are those that tend to fluctuate based on a variety of daily circumstances and interactions with clients. This impairment is developed through the accumulation of triggers, or "counter-transference" within the therapeutic relationship and the social dynamic between counselors and clients. Subsequently, it is the summation of "counter-transferences" that result from the culmination of stress-producing effects on the clinician from their work with clients. This tendency, combined with a pervasive lack of protective factors and attunement to oneself for self-care, is what may lead to perceived compassion fatigue. However, clinicians that are attuned to their emotions and feelings and engage in self-care may be at an advantage of experiencing compassion satisfaction.

Resiliency Theory suggests there are protective factors within individuals that serve to keep them moving forward, and clinicians specifically must possess resiliency factors because of their ability to engage in the therapeutic relationship with clients experiencing their own trauma, oftentimes over the course of several years. Because of this ability to engage at this intensity with clients, clinicians may begin to develop a variety of negative work-related outcomes, more specifically compassion fatigue. Clinician resiliency factors are countless, though an individual's ability to reflect on and be mindful about the impact their clients are having on them, engaging in tasks that

produce vitality, working towards healthy psychological well-being and maintaining good sleep, can serve as protective factors against experiencing compassion fatigue.

Research Design

This research study was meant to better understand this relationship of clinician past trauma and clinician's potential susceptibility to compassion fatigue and compassion satisfaction. This investigation also examined the degree to which psychological processes defined as resiliency, attenuate this relationship. This study examined 4 resiliency factors: mindfulness, vitality, psychological well-being and sleepiness to answer the following research questions: 1) Is there a relationship between a clinician's history of trauma and compassion fatigue and compassion satisfaction and 2) Does mindfulness, vitality, psychological wellbeing and/or sleep attenuate the relationship between a clinician's history of trauma and compassion fatigue and compassion satisfaction?

Hypotheses

1. Compassion satisfaction, burnout, and secondary traumatic stress as measured by Professional Quality of Life will be predicted by past trauma (before the age of 17) as measured by Childhood Trauma Questionnaire.
2. Compassion satisfaction, burnout, and secondary traumatic stress as measured by Professional Quality of Life will be predicted by recent trauma (within the last 3 years) as measured by Childhood Trauma Questionnaire.
3. Compassion satisfaction, burnout, and secondary traumatic stress as measured by Professional Quality of Life will be predicted by aggregated trauma (past

trauma— before the age of 17) and (recent trauma—within the last 3 years) as measured by Childhood Trauma Questionnaire.

4. Compassion satisfaction, burnout, and secondary traumatic stress as measured by Professional Quality of Life will be predicted by mindfulness as measured by the Mindfulness Attention and Awareness Scale.
5. Compassion satisfaction, burnout, and secondary traumatic stress as measured by Professional Quality of Life will be predicted by subjective vitality as measured by Subjective Vitality Scale.
6. Compassion satisfaction, burnout, and secondary traumatic stress as measured by Professional Quality of Life will be predicted by psychological well-being as measured by Ryff's Psychological Wellbeing Scale.
7. Compassion satisfaction, burnout, and secondary traumatic stress as measured by Professional Quality of Life will be predicted by sleepiness scores as measured by the Epworth Sleepiness Scale.
8. Mindfulness as an element of resiliency will moderate the relationship between past, recent and aggregated trauma and outcomes of compassion satisfaction, burnout and secondary traumatic stress.
9. Subjective Vitality as an element of resiliency will moderate the relationship between past, recent and aggregated trauma and outcomes of compassion satisfaction, burnout and secondary traumatic stress.

10. Psychological Well-being as an element of resiliency will moderate the relationship between past, recent and aggregated trauma and outcomes of compassion satisfaction, burnout and secondary traumatic stress.
11. Sleep as an element of resiliency will moderate the relationship between past, recent and aggregated trauma and outcomes of compassion satisfaction, burnout and secondary traumatic stress.

CHAPTER THREE

Methodology

The primary purpose of this study was to explore the relationship between a clinician's past trauma history and the impact on compassion fatigue along with the resiliency factors that may attenuate this relationship. This chapter provides a detailed description of the methodology employed for this study. This chapter is organized into four sections that include: study sample, data collection procedures, variables and measures and data processing and analysis procedures.

Study Sample

Population Criteria

The study sample was restricted to clinicians and clinicians that have a mental health counseling license and have been practicing as a clinician for at least 2 years. Practicing as a clinician for 2 years was chosen because this is the required amount of time it takes before a clinician can become independently licensed. Clinicians with a mental health license could be Marriage and Family Therapists, Licensed Professional Clinical Counselors, Licensed Social Workers and Licensed Mental Health Counselors and Licensed Social Workers, as well as Psychologists and Psychiatrists that work therapeutically with individuals and families. To participate in this survey, clinicians were sent an email asking for participation. The email included a link to the online survey and they were asked to click the link if interested in participated, this link connected to the consent information and the survey. There were a total of 178 clinicians that completed the consent form to participate in this study; however, after eliminating

clinicians that did not complete the survey or did not meet criteria, there were a total of 113 participants (87 females, 26 males) in this study.

Data Collection Procedures

Sample Selection

Licensed mental health counselors, practicing in the profession for over two years were recruited for this study. Following approval from the University of New Mexico's Institutional Review Board, participants were recruited by email to agencies around New Mexico as well as by email to the NMAMFT, NMCA, AAMFT, ACA and NCFR listservs, LinkedIn posts, and through contacting clinicians by emails from their Psychology Today advertisements across the United States in order to obtain a national sample by way of internet survey (See Appendix 10). Additionally, the recruitment email requested to have recipients forward the email with the online survey link to others that may be interested; therefore, many participants may have been a product of the snowball method.

Procedure

The recruitment email was sent to with an overview of the study and information about participation requirements as well as participation criteria and a link to the survey. When the participant clicked the link to participate, they were presented with the informed consent. The informed consent provided the participant with information about the study, confidentiality and that they may discontinue their participation at any time. When the participant read the consent form and decided not to participate they were directed to a webpage thanking them for their interest. Upon giving consent (see

Appendix 9) however, the participants were asked to complete the compilation of questionnaires beginning with questions determining eligibility. If the individual did not meet the eligibility requirements they were directed to a webpage thanking them for their interest in participating and that they will not be asked the survey questions. When the participant met the eligibility criteria they were presented with the demographics questionnaire followed by a counter-balanced order of the following questionnaires: past trauma questionnaire, mindfulness questionnaire, psychological wellbeing questionnaire, subjective vitality questionnaire, sleep questionnaire and compassion fatigue questionnaire. There were 6 surveys developed in order to counter-balance the questionnaires to eliminate any order effects. This was done by using a specifically coded randomizer for this study. The survey was kept open for approximately 4 months (September 20, 2016-January 29, 2017).

Measures

In addition to the participant acceptance criteria questionnaire, several measures were used to test the hypotheses of this study: a short demographic questionnaire, the Adverse Childhood Experiences Questionnaire and the Childhood Trauma Questionnaire (Pennebaker & Susman, 2013), the Epworth Sleepiness Scale (Johns, 1991), the Psychological Wellbeing Scale (Ryff, 1989), the Subjective Vitality Scale (Ryan & Frederick, 1997), the Mindfulness Attention and Awareness Scale (Ryan & Brown, 2003) and the Professional Quality of Life Scale (Stamm, 2010; Figley, 1997).

Criteria Questionnaire

In order to determine eligibility, a criteria questionnaire (see Appendix 1) was given after informed consent and before the demographics questionnaire. The initial criteria questionnaire will include the following questions:

1. Are you a licensed mental health counselor, professional counselor or marriage and family therapist?
2. Are you experiencing any level of burnout, stress and/or compassion fatigue related to your work as a clinician?

Demographics Questionnaire

A demographics questionnaire developed by the researcher was used to collect specific information about the participants (see Appendix 2). The questions were asked for the following reasons: 1. For descriptive purposes; 2. As potential control variables (age may account for levels of vitality); and 3. For exploratory purposes. The demographics questionnaire included the following questions:

1. Age
2. Gender
3. Current Licensure
4. How long have you been practicing as a counselor/clinician?
5. Agency, contracted or private practice?
6. On a 1-5 scale (1 being low and 5 being high), how much do you agree with this statement: "I am currently experiencing compassion fatigue in my work with clients?"

Childhood Trauma Questionnaire

The Childhood Trauma Questionnaire was developed by Pennebaker & Susman (2013) to assess childhood traumatic events and recent traumatic events (see Appendix

3). This questionnaire has two components, a past traumatic events scale (before the age of 17) and a recent traumatic events scale (within the last 3 years). The instrument includes a total of 13 questions, six past traumatic events questions and seven recent traumatic events questions. Questions are asked about experiences prior to the age of 17 (e.g., did you experience... death, violence, sexual abuse, illness and general trauma?... If yes, how old were you), a Likert-scale asking about how traumatic the event was on a scale of 1-7 (7 being extremely traumatic), and how much did you confide in someone on a scale of 1-7 (7 being a great deal). Recent traumatic events include events that have occurred within the past 3 years. Questions are asked in a similar fashion (i.e., within the last three years did you experience... if yes, how traumatic was the event on a scale of 1-7 (7 being extremely traumatic) and how much did you confide in someone on a scale of 1-7 (7 being a great deal)). Evidence of validation of this questionnaire was found through correlational studies (Nickel et al., 2011; Whitelock, Lamb, & Rentfrow, 2013; Goldberg, Pachasoe & Keith, 1999; Entringer, Kumsta, Hellhammer, Wadhwa, & Wüst, 2009); however, because each item is separate in the occurrence of the traumatic event and its level of stress, reliability statistics and internal consistency have not been reported in the literature (Szentágotai-Táatar, et al., 2015). Notwithstanding, the calculated internal consistency reliability for past and recent trauma had a Cronbach's alpha of .45.

Epworth Sleepiness Scale

The Epworth Sleepiness Scale measures a person's general level of daytime sleepiness (see Appendix 4). This scale is comprised of 8 questions on a 4-point rating scale from 0-3 assessing sleepiness in different settings and the likeliness of falling asleep

in these settings. The person taking the questionnaire is asked to rate 0= would never dose, 1=slight chance of dozing, 2= moderate chance of dosing and 3=high chance of dozing (Johns, 1991). In order to determine reliability of the scores, the test-retest method and showed that the scores were highly correlated ($r=.82$). Additionally, this scale showed a high level of internal consistency (Cronbach's $\alpha=.88$) (Johns, 1991).

Three questions were added pertaining to sleep about the person's perception of the participants' sleepiness: How much do you agree with following statements: 1) I feel sleepy most of the time. 2) I feel that I struggle with falling asleep and 3) I feel that I struggle with staying asleep.

Mindfulness Attention and Awareness Scale (MAAS)

The Mindfulness Attention and Awareness Scale (see Appendix 5) was developed as a way of assessing one's state of being present in the moment. This scale was developed by Ryan and Brown (2003). This scale is 15 questions on a 6-point likert scale and yields a single score. This scale is shown to be reliable with a Cronbach's α of .82 using inter-rater reliability methods. MAAS scores also showed both convergent and discriminate validity. Convergent validity was shown with positive correlations with scores of self-regulation and divergent validity with scores of social anxiety (Brown & Ryan, 2003; MacKillop & Anderson, 2007).

Subjective Vitality Scale (VS)

The Subjective Vitality Scale was developed by Ryan and Frederick (2003) to assess the overall feelings of being alive and energetic (see Appendix 6). There are 7 questions on this scale with one of the questions negatively scored. These questions are

asked using 6-point-likert scale from “not at all true” to “always true.” The questions yield a single score. Developers showed inter-rater reliability with a Cronbach’s alpha of .84. They also showed evidence of validity through correlations with other scores of similar tests. Convergent validity was shown through the Vitality scores being positively correlated with scores of self-esteem and showed discriminate validity with negative correlations with scores of depression.

The Ryff Scales of Psychological Wellbeing Scale (RPWS)

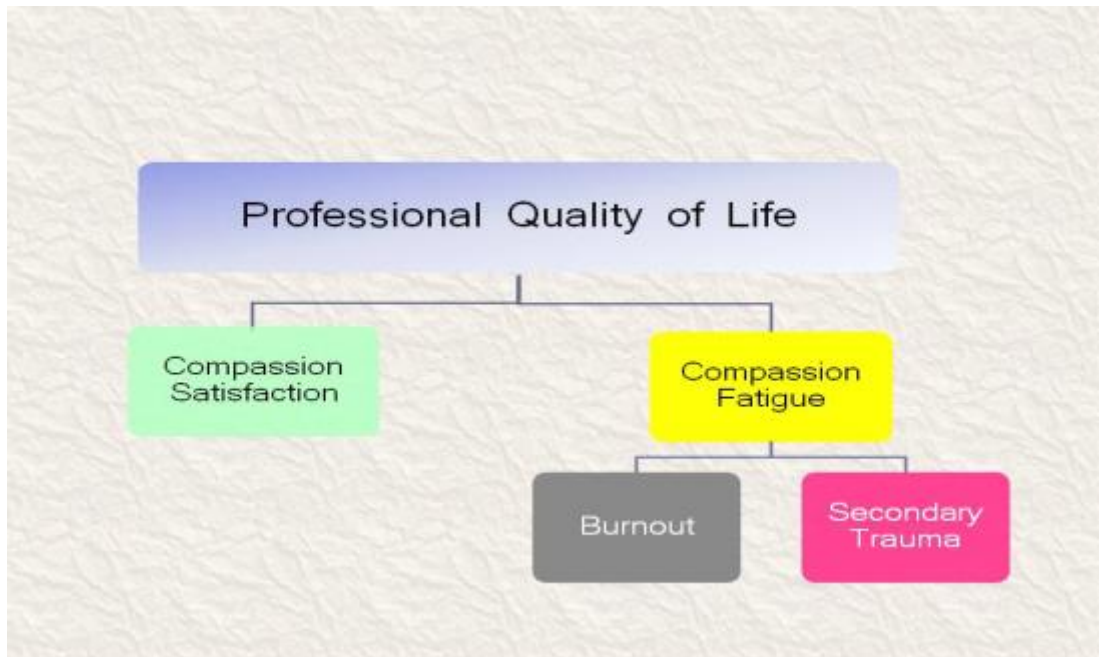
The Ryff Psychological Wellbeing scale (see Appendix 7) was developed by Carol Ryff (1989) and has 42 questions with a total of 6 subscales: self-acceptance, purpose in life, physical health, autonomy, feelings of positive relations with others and environmental mastery. Both the overall scores of the main scale and the scores of the subscales showed high reliability, with a Cronbach’s alpha for all subscales and the overall scale $>.80$. In order to determine reliability, Ryff used both inter-rater reliability and the test-retest methods. Additionally, Ryff described measures for insuring validity of the scores and validated the Psychological Wellbeing scores with other similar measures. Convergent validity was shown with positive correlations with other scores of measures of wellbeing and discriminant validity was shown through negative correlations with scores that do not show wellbeing.

Professional Quality of Life Scale (ProQOL)

The Professional Quality of Life Scale (see Appendix 8) has 30 questions presented on a 5-point-likert-scale, from never to very often. This is the fifth version of the scale and has been in use since 1995 with several revisions. The ProQOL was

developed to measure positive and negative effects of working with people who have experienced trauma and stressful events (Stamm, 2010). The measure originally named the Compassion Fatigue Self-Test by Charles Figley in the 1980's has gone through several revisions through the collaborative work of Figley (1995; 2002) and Stamm (2009) to what is now the latest version (Stamm, 2010). There are two scales for compassion fatigue: Burnout and Secondary Traumatic Stress and one scale for Compassion Satisfaction. Stamm (2010) provides a picture understanding of this assessment (please see Figure 3 below). Burnout is the part of compassion fatigue that encompasses feelings of unhappiness, disconnectedness and insensitivity to the work environment. Secondary Traumatic Stress is the other component of compassion fatigue that includes having a preoccupation with thoughts of the individual with whom the person has worked. Other aspects of STS include feelings of being trapped, on edge, exhaustion, overwhelmed, lack of sleep, forgetting important things all of which are a result of being impacted by the other person's trauma (Stamm, 2010). Compassion satisfaction is conceptually an inverse of compassion fatigue and is understood as the positive feelings a clinician encounters relative to the care and help they provide to their clients.

Figure 3. Professional Quality of Life



Data Processing and Analysis Procedures

Data Processing

Internal Review Board (IRB) approval was obtained before collecting data. There was no identifying information collected from the participants. Data was collected through use of Survey Monkey. Upon receiving surveys from 178 participants, the data was downloaded and the output provided to the investigator in Excel format. Preliminary screenings on the data set were completed included identifying any incomplete surveys, missing data and any errors in the data set. After eliminating the missing information and participants, 113 participants were included in the data set for analyses. In order to prepare the data for analysis, the written word data was coded, the open ended questions included in analyses were coded, as well as blank spaces in the data were filled in to be

neutral (i.e., in the subjective vitality questionnaire, one participant left a space empty and it was coded as “4” which is the middle of the scale). For participants that provided a range of number of clients or hours worked, (i.e., 15-20) the range was replaced with the average. The directions for each of the questionnaires were followed, which included reverse scoring of questions from the subjective vitality inventory, the psychological wellbeing questionnaire and the Professional Quality of Life Scale. Total scores for the instruments and the subscales were calculated: Mindfulness, Sleepiness, Subjective Vitality, Compassion Fatigue and Psychological Wellbeing. Additionally, the total number of reported past traumas, recent traumas and the combined past and recent trauma scores were calculated.

Data Analysis Procedures

Preliminary analyses were conducted on descriptive statistics and correlations among the variables. Next, reliability analyses were conducted to test the reliability of the scores for each of the following scales: Mindfulness, Subjective Vitality, Sleepiness, Psychological Wellbeing and Compassion Fatigue. All scores showed high reliability (Chronbach’s $\alpha > .70$). For each of the instrument used for this study, frequencies, percentages, and if appropriate, measures of central tendency (mean, median, mode) and measures of variability (standard deviation and range) were calculated. Before performing analyses to address the hypotheses and to better understand the meaning of the specific measure, correlations were obtained between all measures within and across variables (presented in the results section see Table 6). To prepare for the regression models for the moderation variables, independent and dependent variables were mean

centered for analyses. Because the analyses were completed separately for each predictor and outcome variable, there was no issue with multicollinearity. Similarly, Bronferroni adjustment was not needed due to completing one analysis at a time. Once the analysis were completed for the interaction effects, those that showed significance were plotted using Preacher's online utility (Preacher, Curran, & Bouer, 2006).

In order to explore my first three hypotheses, regression analyses were conducted to explore the relationship between a clinicians' trauma (past, recent and aggregated) experiences and compassion fatigue. In order to explore the next four hypothesis regression analyses were conducted to explore the relationship between mindfulness, subjective vitality, psychological well-being and sleep with compassion fatigue. In order to explore my remaining hypotheses, interaction terms were added to examine whether mindfulness, subjective vitality, psychological wellbeing, or sleep moderated the relationship between a clinicians' trauma and compassion fatigue.

CHAPTER FOUR

Analyses and Results

This chapter presents the results of the study from the analyses conducted. Findings are reported for 113 participants (87 females, 26 males) from across the United States and several countries. The descriptive statistics for the measures used in the study are presented and described below along with the results for the eleven hypotheses.

Descriptive Characteristics

Sample Characteristics

A total of 178 participants had agreed to the consent information, however a total of 113 participants completed the survey. The resulting sample then included 113 participants (87 females, 26 males). The mean age for clinicians in this study was 44. Clinicians reported caseload (clients per week), hours worked and years in practice are shown below (please see Table 1 below).

Table 1. Descriptive Information

	Age in years	Caseload	Hours worked per week	Years in practice
Mean	44.06	17.06	35.81	11.15
<i>SD</i>	13.83	9.85	15.70	9.96

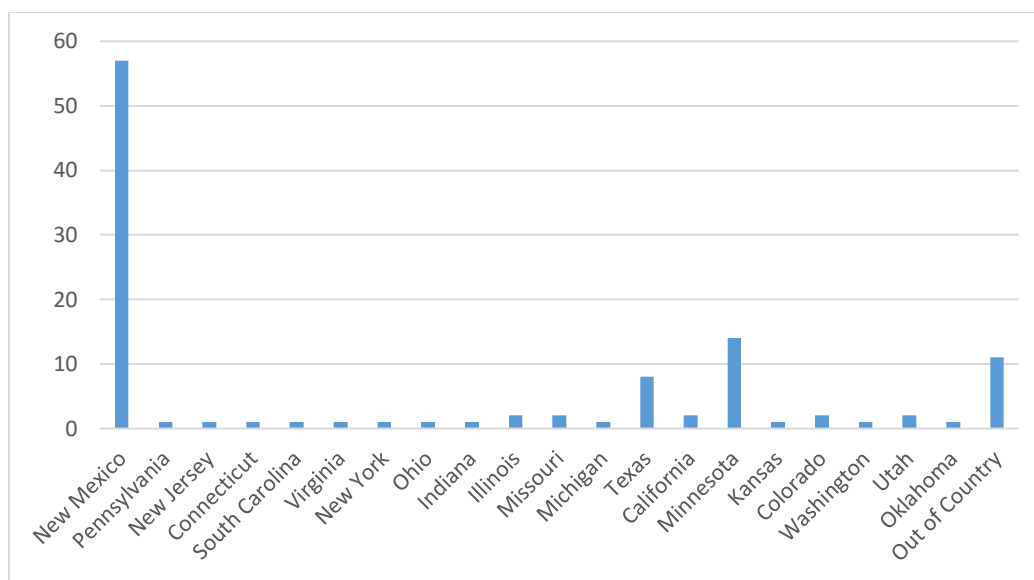
Additionally, clinicians reported family background information about their parents. The majority of clinicians reported that they are from a two parent home, however clinicians in this sample also came from divorced and single parent homes (please see Table 2 Below).

Table 2. Parent Household Composition of Clinicians

Parent Household Composition	<i>n</i>	%
Single Parent Home	18	15.8
Two Parent Home	89	89
Divorced/Separated Home	4	3.5

As illustrated in Figure 4, individuals that participated in this study represented 20 states, while an additional 11 participants represented the following countries (Italy, Beirut, United Arab Emirates, France, India, Iran, New Zealand, Brazil) (please see Figure 4 below).

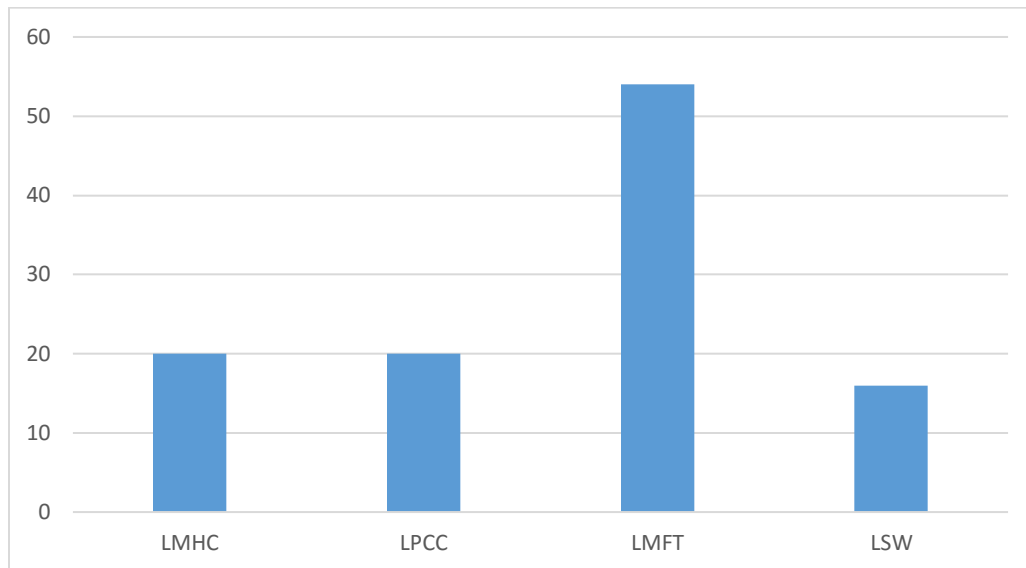
Figure 4. Clinicians Practicing Location



In terms of professional licensure, the majority of the participants for this study held a Marriage and Family Therapy license (please see Figure 5 below). In the United States, there are an estimated 48,000 Marriage and Family Therapists (AAMFT, 2017)

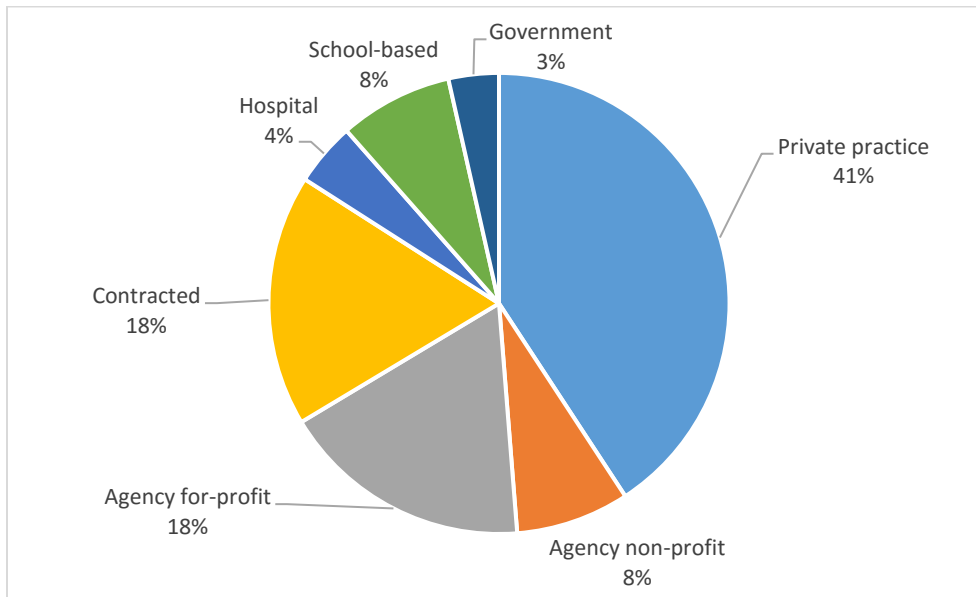
compared to more than 650,000 with a Social Work license (NASW, 2017) and more than 120,000 professional counselors (ACA, 2011).

Figure 5. Clinicians Current Licensure



As Figure 6 illustrates the majority of participants in this study (41%) reported that they are in private practice. Additionally, 26% of participants reported they work for either a non-profit or for-profit agency, the remaining clinicians in this study are either contracted workers or work in a school, hospital or for the government.

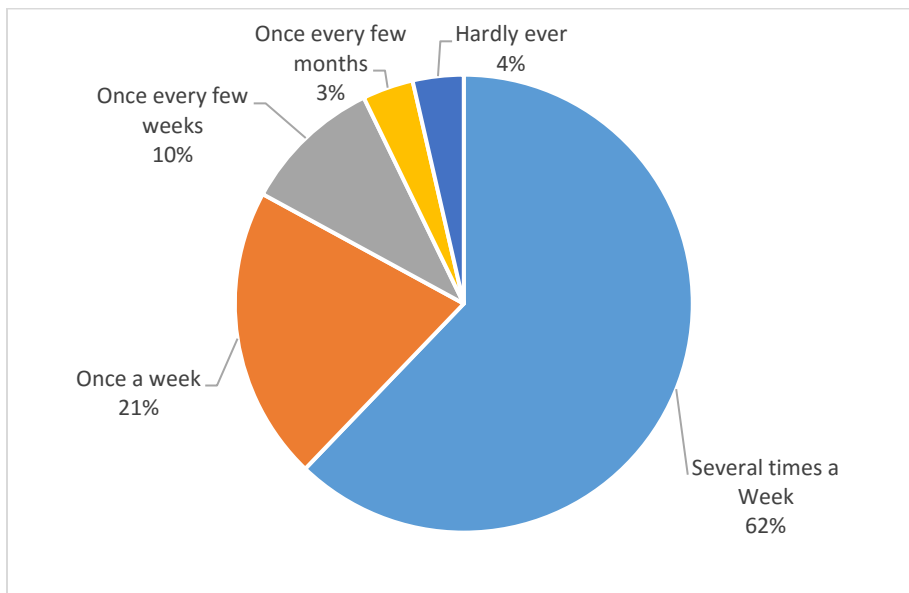
Figure 6. Type of Practice Where Participants Work



Clinicians' Self-Care

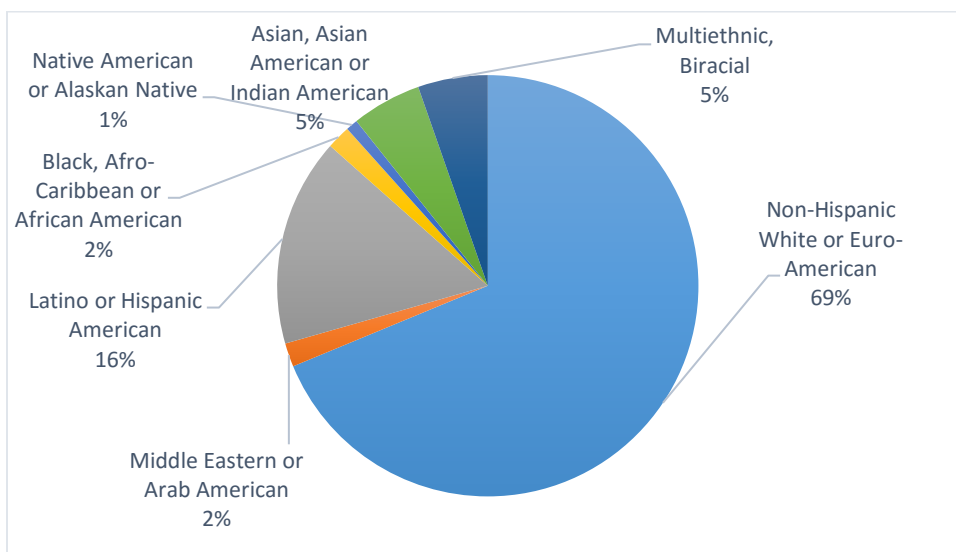
As part of the demographic assessment, subjects were asked to report any amount of stress or compassion fatigue they have experienced in their practice. Only 63.2% reported any amount of compassion fatigue and burnout. As a follow-up, subjects were also asked to report on their use of self-care activities. The majority of individuals (62%) reported using self-care activities several times a week, whereas, 21% reported using self-care strategies only once a week (Please see Figure 7).

Figure 7. Frequency that Clinicians Engaged in Self-Care



The majority of the participants for this study described themselves as Non-Hispanic White or Euro-American, however clinicians from diverse backgrounds were represented in this study (please see Figure 8 below).

Figure 8. Ethnicity Reported by Clinicians



Professional Quality of Life Scores of Clinicians

Compassion Fatigue was measured by the Professional Quality of Life Questionnaire (Stamm, 2009). A total of 113 clinicians completed this questionnaire. The majority of clinicians scored low on secondary traumatic stress and burnout. Additionally, the majority of clinicians scored average on compassion satisfaction (please see Table 3).

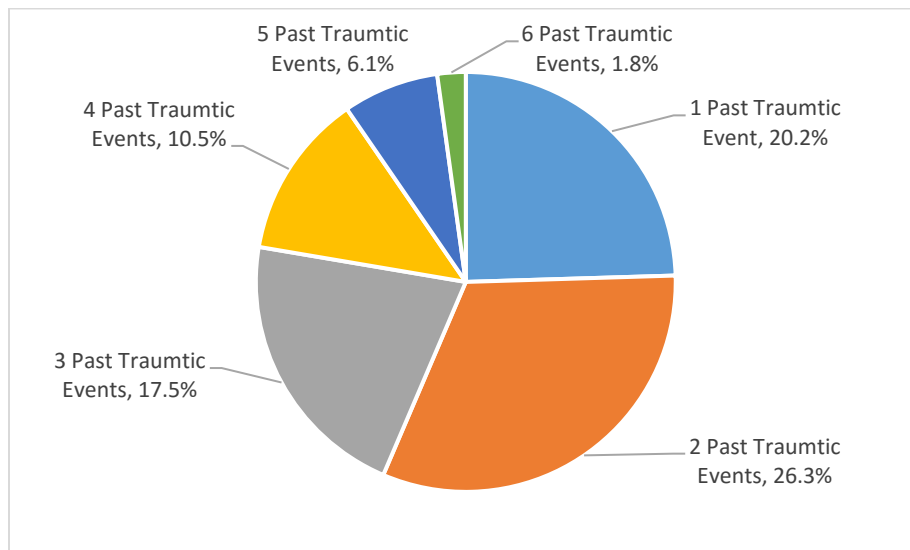
Table 3. Descriptive Statistics of Compassion Fatigue Scores

Variables	Possible Range	Maximum	Minimum	<i>M</i>	<i>SD</i>	High	Average	Low
Compassion Satisfaction	10-50	50	27	40.87	5.51	<i>n</i> =53	<i>n</i> =60	<i>n</i> =0
Secondary Traumatic Stress	10-50	39	12	21.59	5.28	<i>n</i> =0	<i>n</i> =47	<i>n</i> =66
Burnout	10-50	36	11	21.51	5.34	<i>n</i> =0	<i>n</i> =47	<i>n</i> =66

Number of Reported Trauma Experiences

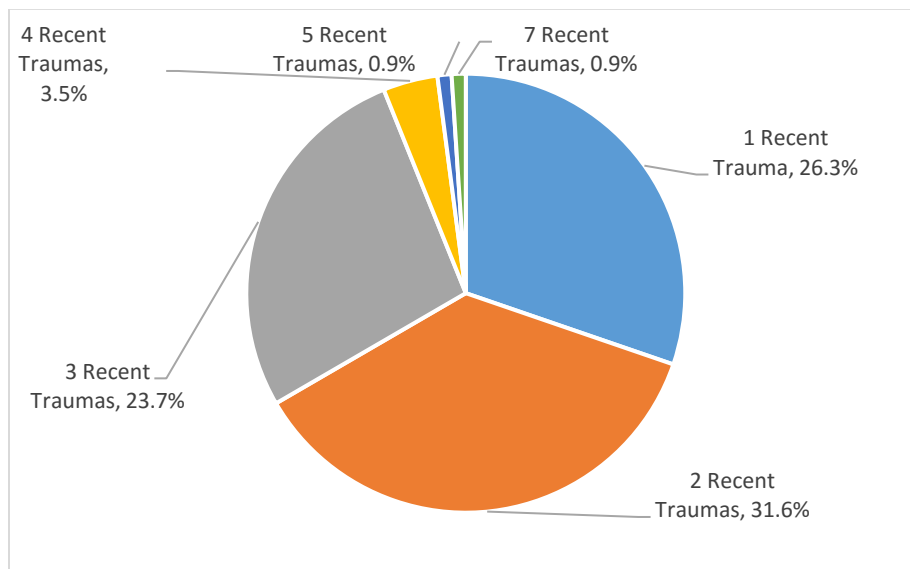
Of the 113 total subjects in this study, 111 clinicians reported having experienced a traumatic event specifically, 94 of the 113 reported past traumatic experiences prior to the age of 17, furthermore, several clinicians reported having more than 1 past traumatic experience and a few participants reported having experienced 6 traumatic experiences (please see Figure 9 below).

Figure 9. Number of Past Traumatic Experiences Reported by Clinicians



Additionally, 99 clinicians reported having at least 1 recent traumatic event, which occurred within 3 years prior to participating in this study, and several others reported having more than one traumatic experience (please see Figure 10 below).

Figure 10. Number of Recent Traumatic Events Reported by Clinicians



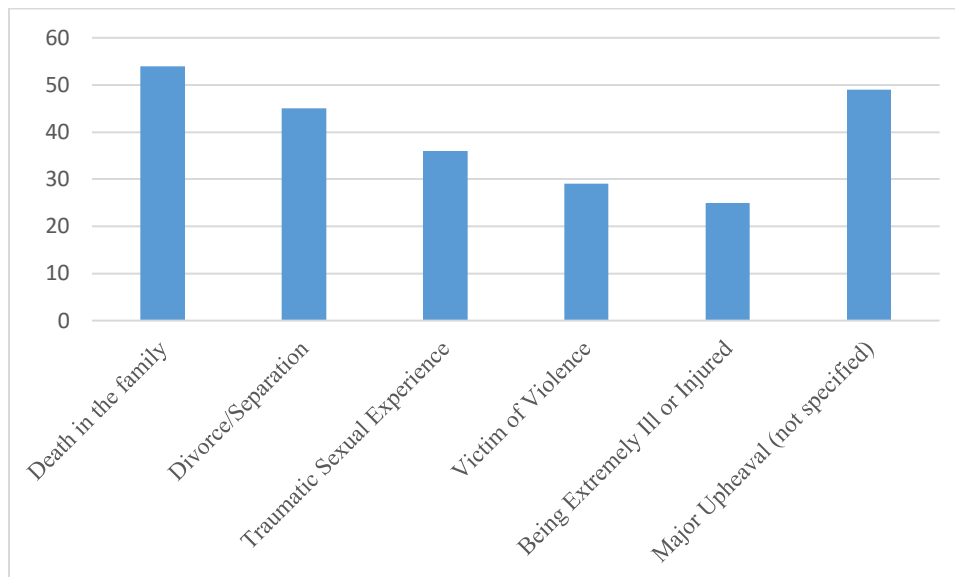
Past Traumatic Experiences Reported

Clinicians reported a wide variety of past traumatic events that they had experienced. The main traumatic event reported was experiencing a death in the family, this experience was reported by 54 clinicians. Clinicians reported experiencing several other past traumatic events based on the Childhood Trauma Questionnaire (please see Figure 11 below), and when asked about experiencing a major upheaval (not specified) before the age of 17, that shaped their life or personality significantly, clinicians shared several personal experiences that had a significant impact on their life.

Experiences included:

- Father was an alcoholic while growing up
- Mother being in an inpatient facility for alcoholism
- A friend being in a serious car accident
- A death of a close friend
- Being placed in special education and being treated differently until starting high school
- An uncle committing suicide
- Brothers were drug dealers
- Death of mother
- Parents remarrying
- Being worried that their father may rape them because of his alcohol abuse
- First time experiencing same-sex attraction
- High school teacher initiated romantic relationship with them which resulted in gossip and drama among teachers and students
- Moving within and outside of the united states.

Figure 11. Past Traumatic Events Experienced by Clinicians



Recent Traumatic Experiences Reported

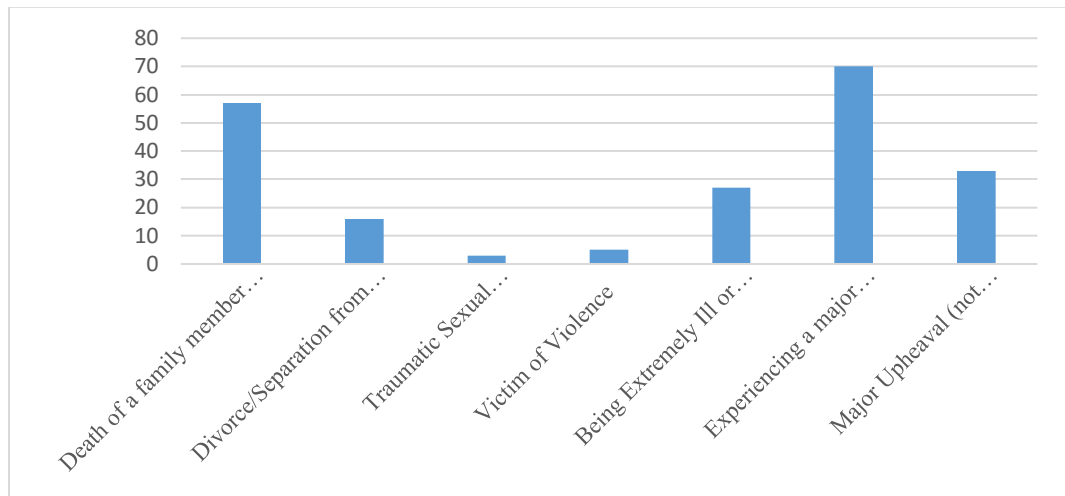
Clinicians also reported several more recent traumatic experiences, the majority of which reported that within the last 3 years, they had experienced the death of a very close friend or family member. Clinicians reported experiencing several other traumas based on the Recent Trauma Questionnaire (please see Figure 12 below), and when asked about experiencing a major upheaval (not specified) with the last 3 years that shaped their life or personality significantly, clinicians shared several personal experiences that had a significant impact on their life.

These descriptions included:

- Being told their new born baby had a tumor
- Their daughter tried to commit suicide
- Experienced extreme bullying from their supervisor
- Health issues with their spouse
- Struggles in marriage
- Miscarriages

- Having a baby
- Beginning a doctoral program
- Moving
- Death of a pet
- Child with a drug addiction

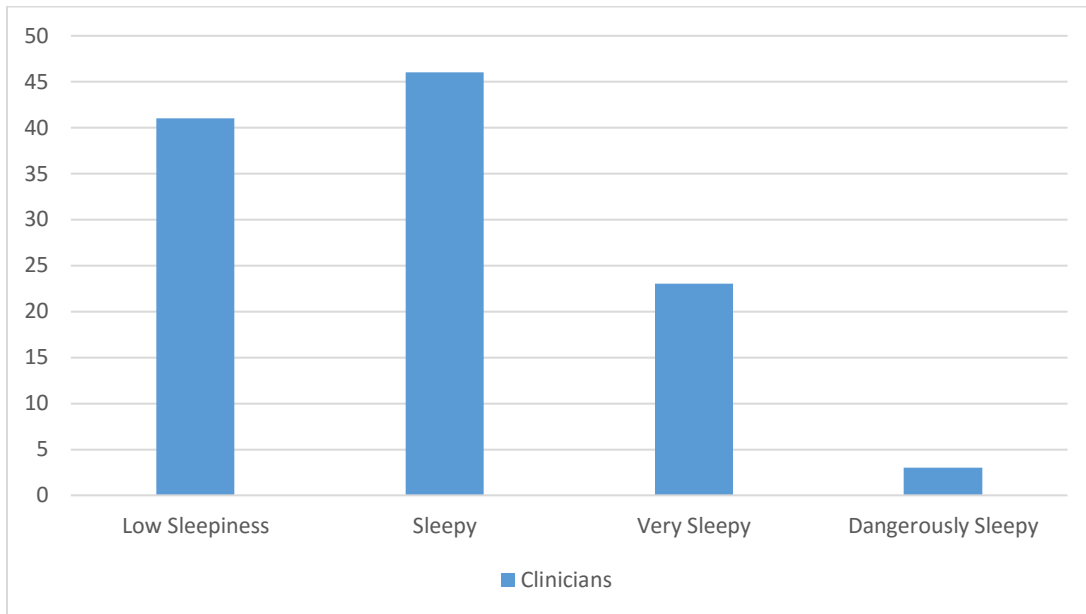
Figure 12. Recent Traumatic Events Experienced by Clinicians



Reported Sleepiness Scores

Sleepiness Scores were measured by the Epworth Sleepiness Scale; higher numbers indicate higher level of sleepiness. Clinicians reported sleepiness scores varied, and interestingly, 3 clinicians reported scores that indicated they were dangerously sleepy (please see Figure 13 below). These general results of the Epworth Sleepiness Scale showed that all clinicians indicated some level of sleepiness. This is significant because subjects were given the chance to select no chance of dozing, everyone selected some chance of dozing.

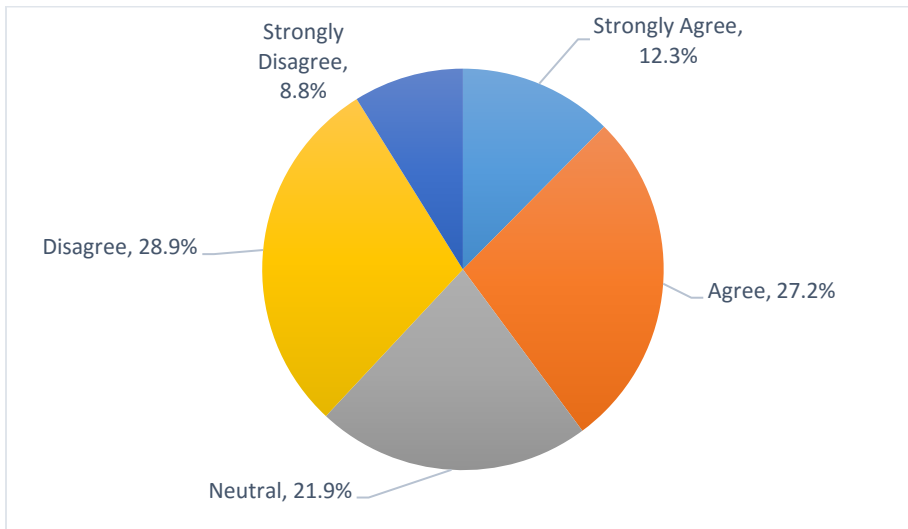
Figure 13. Clinician Report of Sleepiness



Further Sleep Questions

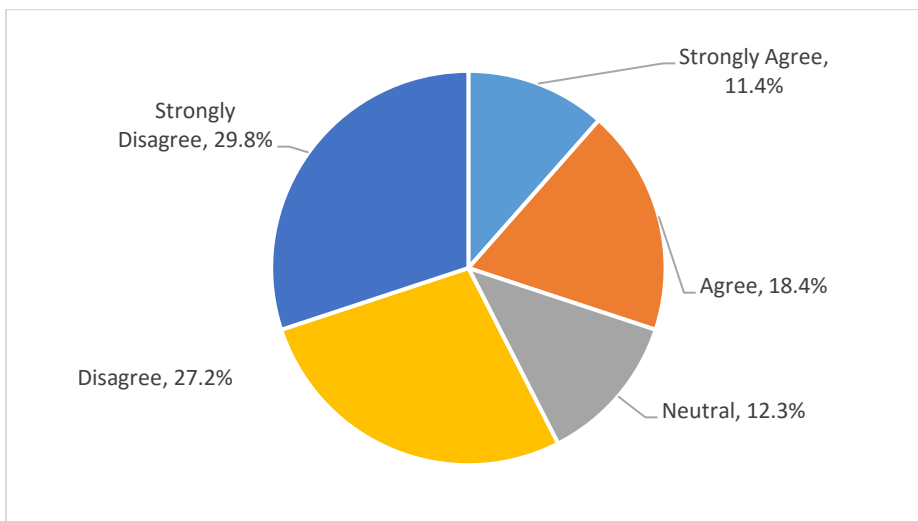
Additionally, based on the 3 additional sleep questions, clinicians indicated whether they felt tired all the time, struggles with falling asleep and struggles with staying asleep. The figures below show the clinicians level of agreement with these statements. Approximately 60% of participants either refute feeling tired or remain neutral, whereas about 40% report some degree of tiredness.

Figure 14. Self-reported Degree of Tiredness



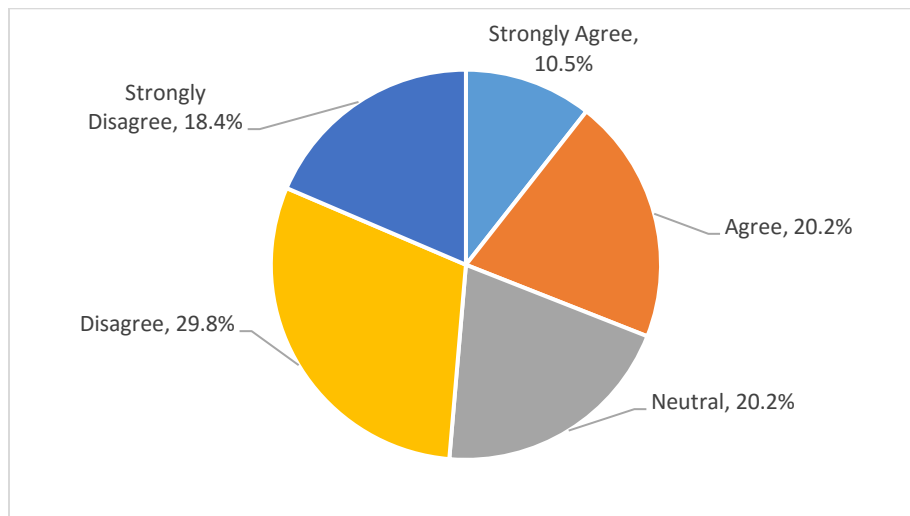
In regards to subjects self-reported struggles with falling asleep, a similar pattern emerged, specifically, 57% of the clinicians denied any struggle with falling asleep. Whereas approximately 12% remained neutral and approximately 40% reported some degree of struggle with falling asleep (please see Figure 15 below).

Figure 15. Self-reported Challenge of Falling Asleep



Approximately 48% of individuals denied having any struggle with staying asleep, while approximately 30% reported some level of difficulty in staying asleep (please see Figure 16 below).

Figure 16. Self-Reported Challenge of Staying Asleep



Clinicians Mindfulness Attention and Awareness Scores

Mindfulness Attention and Awareness scores were measured by the Mindfulness Attention and Awareness Scale (Brown & Ryan, 2003). The mean mindfulness score was 3.99 (SD=.88) (please see Table 4 for further descriptive statistics).

Reported Subjective Vitality

Subjective Vitality was measured using the Subjective Vitality Scale (Ryan & Frederick, 1997). The mean subjective vitality score was 4.39 (SD=1.22) (please see Table 4 for further descriptive statistics).

Table 4. Descriptive Statistics for Protective Factor Variables

Variables	Maximum	Minimum	<i>M</i>	<i>SD</i>
Mindfulness	5.60	1.60	3.99	.88
Vitality	6.86	1.86	4.39	1.22
Sleep	0	18	7.26	3.72
Psychological Well-being	226	114	188.97	12.25

Reported Psychological Wellbeing

Psychological Wellbeing was measured by Ryff (1989;1996) Psychological Well-Being Scales (42-item version). The mean score was 188.97 (SD= 12.25) for overall psychological well-being score (see Table 4 above). The Psychological Well-being questionnaire is comprised of six subscales: Autonomy, Environmental Mastery, Personal Growth, Positive Relations, Purpose in Life and Self-acceptance (Please see Table 5 for descriptive statistics for each of the subscales).

Table 5. Descriptive Statistics for Psychological Well-being Subscales

Subscales	Maximum	Minimum	<i>M</i>	<i>SD</i>
Autonomy	33	17	25.61	3.57
Environmental Mastery	37	16	29.75	4.70
Personal Growth	41	21	32.62	3.36
Positive Relations	42	18	34.11	5.50
Purpose in Life	42	16	33.92	5.08
Self-Acceptance	42	14	32.96	6.04

Correlation of Primary Study Variables

Means and standard deviations and bivariate correlations for all variables for the total sample are displayed in Table 6. All variables showed bivariate correlations with each other (please see Table 6).

Table 6. Correlations among Primary Study Variables

Variable	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.
1. Total Past Trauma	-									
2. Total Recent Trauma	.30**	-								
3. Total Past and Recent Trauma	.85**	.75**	-							
4. Sleep	-.10	-.04	-.09	-						
5. Mindfulness	.00	-.25**	-.14	-.30**	-					
6. Vitality	.07	-.16	-.03	-.18	.60**	-				
7. Psychological Wellbeing	-.01	-.12	-.07	-.19	.58**	.70**	-			
8. Compassion Satisfaction	-.04	.05	.00	-.05	.38**	.59**	.61**	-		
9. Burnout	.02	.07	.05	.17	-.56**	-.71**	-.71**	-.66**	-	
10. Secondary Traumatic Stress	.11	.08	.12	.15	-.46**	-.33**	-.38**	-.32**	.70**	-
<i>M</i>	2.11	1.87	3.97	7.26	3.99	4.39	188.97	40.87	21.51	21.59
<i>SD</i>	1.53	1.20	2.20	3.72	.88	1.22	23.25	5.51	5.34	5.28

* $p < .05$. ** $p < .01$. *** $p < .001$.

Regression Hypotheses (Hypotheses 1-7)

In order to test for the predictive validity of past trauma (before the age of 17) and recent trauma (within the last 3 years), mindfulness, vitality, psychological well-being and sleep on compassion satisfaction, burnout and secondary traumatic stress for clinicians, a general linear model was used along with a multivariate multiple regression analysis in order to determine the amount of variance in the three dependent variables (Compassion Satisfaction, Burnout and Secondary Traumatic Stress) from clinicians prior trauma and their scores on mindfulness, subjective vitality, psychological well-being and sleep.

Compassion Satisfaction

Multiple linear regression analysis was used to test a model for predicting clinicians' compassion satisfaction from both their past and recent trauma, mindfulness, vitality, psychological well-being and sleep. Basic descriptive statistics, bivariate correlations and regression coefficients are shown in Table 7. (please see Table 7 below). The seven predictor model accounted for 42% of the variance in compassion satisfaction, $F(6, 107) = 14.042$, $p < .001$. Several of the variables had a significant ($p < .05$) zero-order

correlation but only recent trauma, $t=2.151$, $p=.032$, subjective vitality $t=3.228$, $p=.002$, and psychological wellbeing $t=3.645$, $p=.001$ were significant. Therefore, if a clinician has higher psychological well-being a clinician may have more compassion satisfaction, likewise, vitality is a predictor of compassion satisfaction, and interestingly, clinicians with recent trauma also have greater compassion satisfaction.

Table 7. Zero-Order Correlations/Regression Results for Variables and Compassion Satisfaction

Variable	Zero-Order r										
	Sleep	Psychological Well-being	Vitality	Mindfulness	Past and Recent Trauma	Recent Trauma	Past Trauma	Compassion Satisfaction	b	t	p
Past Trauma								-.041	-.392	-1.405	.163
Recent Trauma						--	.296**	.054	.791	2.151	.034
Past and Recent Trauma					--	.750**	.854**	.001	0	0	.
Mindfulness				--	-.135	-.247	-.001	.379**	.085	.134	.894
Vitality			--	.596**	-.034	-.155	.072	.585**	1.584	3.228	.002
Psychological Well-being		--	.701**	.584**	.069	-.120	-.006	.610**	.092	3.645	.000
Sleep	--	-.192	-.175	-.303**	-.091	-.038	-.101	-.050	.140	1.192	.236

Intercept= 14.46, Adjusted $R^2=.42$, $p < .05$. ** $p < .01$. *** $p < .001$.

Burnout

Multiple linear regression analysis was used to test a model for predicting clinicians' burnout from both their past and recent trauma, mindfulness, vitality, psychological well-being and sleep. Basic descriptive statistics and regression coefficients are shown in Table 8. (please see Table 8 below). The seven predictor model accounted for 59% of the variance for compassion satisfaction, $F(6, 107)= 26.55$, $p<.001$. Several of the variables had a significant ($p<.05$) zero-order correlation, but only vitality $t= -4.296$, $p= .001$ and psychological wellbeing $t=-3.920$, $p=.001$ were significant. Based on this analysis, a clinician with higher psychological well-being show a decrease in burnout. Additionally, a clinician with higher vitality scores show a decrease in burnout.

Table 8. Zero-Order Correlations/Regression Results for Variables and Burnout

Variable	Zero-Order r							b	t	p
	Sleep	Psychological Well-being	Vitality	Mindfulness	Past and Recent Trauma	Recent Trauma	Past Trauma			
Past Trauma							--	.262	1.147	.254
Recent Trauma						--	.296**	-.342	-1.134	.259
Past and Recent Trauma					--	.750**	.854**	0	0	.
Mindfulness				--	-.135	-.247	-.001	-.932	-1.788	.077
Vitality			--	.596**	-.034	-.155	.072	-1.725	-4.296	.000
Psychological Well-being		--	.701**	.584**	.069	-.120	-.006	-.081	-3.920	.000
Sleep	--	-.192	-.175	-.303**	-.091	-.038	-.101	-.040	-.418	.677

Intercept= 48.64, Adjusted R²=.59, * $p < .05$, ** $p < .01$, *** $p < .001$.

Secondary Traumatic Stress

Multiple linear regression analysis was to test develop a model for predicting clinicians' burnout from their both past and recent trauma, mindfulness, vitality, psychological well-being and sleep scores. Basic descriptive statistics and regression coefficients are shown in Table 9. (please see Table 9 below). The seven predictor model accounted for 25% of the variance in secondary traumatic stress, $F(6, 107)= 5.583$, $p<.001$. Several of the variables had a significant ($p<.05$) zero-order correlation, but only mindfulness $t=-3.293$, $p=.001$ were significant. Therefore, clinicians with mindfulness showed a decrease in secondary traumatic stress.

Table 9. Zero-Order Correlations/Regression Results for Variables and Secondary Traumatic Stress

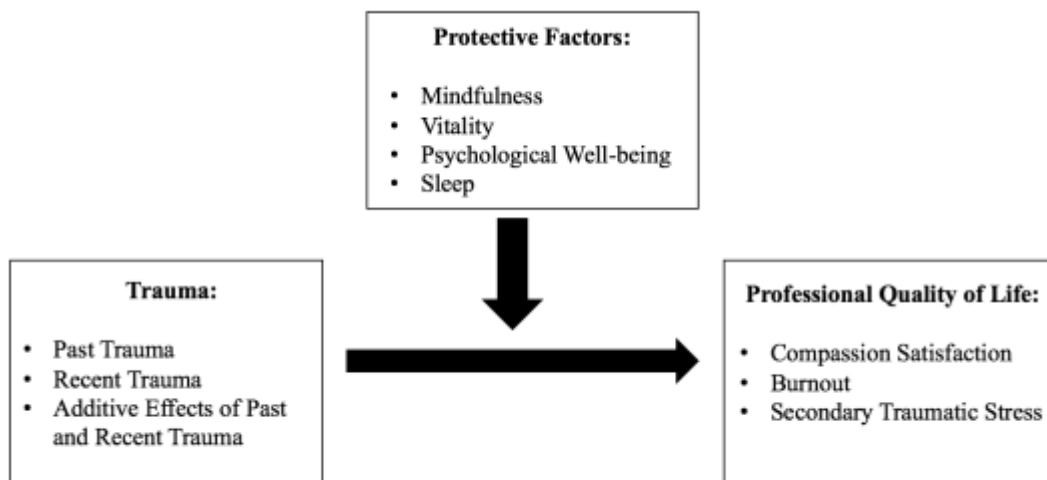
Variable	Zero-Order r							b	t	p
	Sleep	Psychological Well-being	Vitality	Mindfulness	Past and Recent Trauma	Recent Trauma	Past Trauma			
Past Trauma							--	.445	1.411	.161
Recent Trauma						--	.296**	-.258	-.621	.536
Past and Recent Trauma					--	.750**	.854**	0	0	.
Mindfulness				--	-.135	-.247	-.001	-2.371	-3.293	.001
Vitality			--	.596**	-.034	-.155	.072	-.062	-.112	.911
Psychological Well-being		--	.701**	.584**	.069	-.120	-.006	-.032	-1.109	.270
Sleep	--	-.192	-.175	-.303**	-.091	-.038	-.101	-.012	-.091	.928

Intercept= 37.08, Adjusted R²=.20, * $p < .05$, ** $p < .01$, *** $p < .001$.

Moderation Hypotheses (Hypotheses 8-11)

The remaining hypotheses (8-11) hypothesize the interaction effects of the protective factors as moderator variables. Figure 17 (please see Figure 17 below) depicts the model fit to examine the interactions effects of mindfulness, vitality, psychological well-being and sleep on the relationship between trauma and compassion fatigue and compassion satisfaction (Frazier, Tix & Barron, 2004). This section of the results reports a series of moderation analyses in order to determine whether mindfulness, subjective vitality, psychological well-being and sleep moderate relations between trauma and compassion fatigue and compassion satisfaction. Results indicated that mindfulness and subjective vitality moderated relations between trauma and compassion fatigue and compassion satisfaction, however psychological well-being and sleep did not.

Figure 17. Conceptual Model of Interaction Effects on Professional Quality of Life



Hypothesis 8. Trauma X Mindfulness in relation to Compassion Fatigue and Compassion Satisfaction

The eighth hypothesis for this study was that mindfulness would moderate relations between past, recent and total trauma and outcomes of compassion satisfaction, burnout and secondary traumatic stress. To address hypothesis 8, nine regression models were fit.

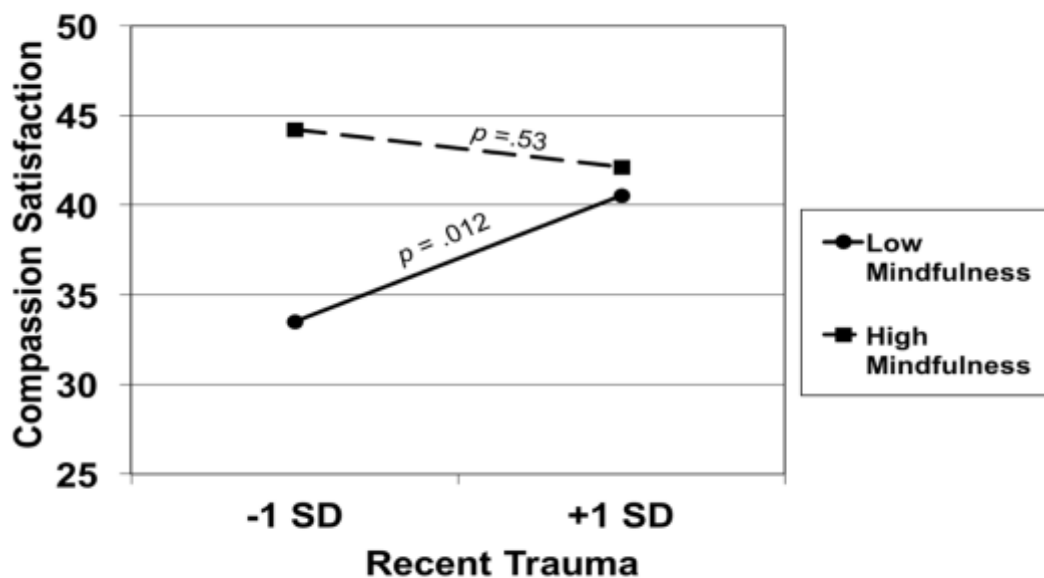
Multiple regression models were fit to investigate whether associations between trauma (past and recent trauma and the aggregated effect of past and recent trauma) and the outcome variables including compassion satisfaction, burnout and secondary traumatic stress varied by higher or lower levels of mindfulness. For each regression model, the predictor variable, moderator, and interaction term were entered into a regression model. The interaction between past trauma and mindfulness was not significantly related to compassion satisfaction ($B = -.330, \beta = -.093, p = .318$), burnout ($B = -.151, \beta = -.044, p = .615$) nor secondary traumatic stress ($B = -.224, \beta = -.066, p = .468$). The recent trauma and mindfulness interaction effect was not significantly related to secondary traumatic stress ($B = .547, \beta = .145, p = .123$). The past and recent trauma and mindfulness interaction effect was not significant for compassion satisfaction ($B = .146, \beta = .067, p = .386$), or burnout ($B = .200, \beta = .096, p = .290$), nor with secondary traumatic stress ($B = .100, \beta = .048, p = .609$).

Mindfulness moderated the relations between recent trauma and compassion satisfaction (Adjusted $R^2 = .131, B = -.854, \beta = -.217, p = .022$). As shown in Figure 18, testing of the simple slopes indicated that more recent trauma was related to higher

compassion satisfaction for clinicians with lower, but not higher mindfulness.

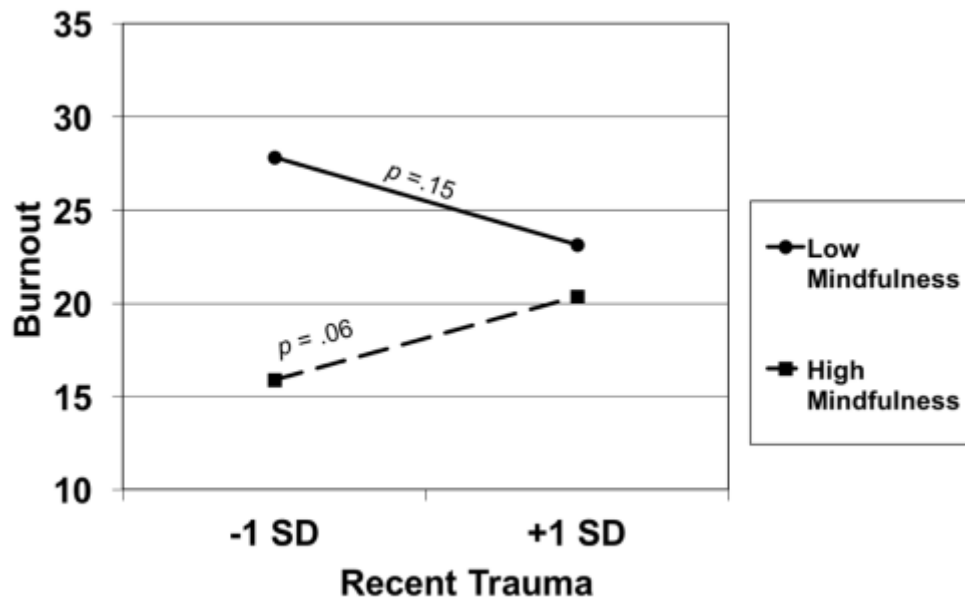
Interestingly, as depicted in the figure, individuals who experienced less recent trauma and had higher levels of mindfulness were observed as having the highest levels of compassion satisfaction (please see Figure 18 below).

Figure 18. Recent Trauma and Mindfulness in Relation to Compassion Satisfaction



Mindfulness also moderated relations between recent trauma and burnout (Adjusted $R^2=.233$, $B=.858$, $\beta = .334$, $p=.012$). Testing of the simple slopes indicated that neither slope was significant, however as shown in Figure 19, clinicians who were observed as having the lowest level of burnout were those who experienced less recent trauma (please see Figure 19 below).

Figure 19. Recent Trauma and Mindfulness in Relation to Burnout



Hypothesis 9. Trauma X Subjective Vitality in Relation to Compassion Fatigue and Compassion Satisfaction

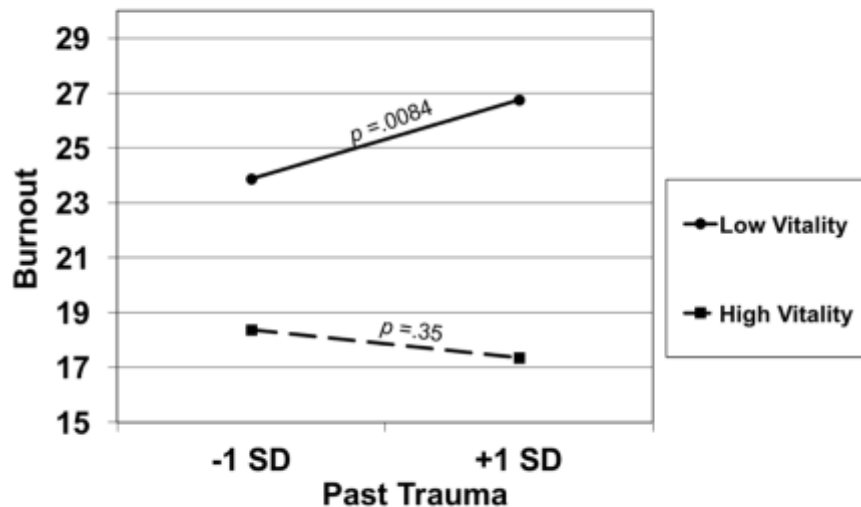
This study's ninth hypothesis was that subjective vitality would moderate relations between trauma (past, recent and total trauma and the aggregated past and recent trauma) and all three dependent variables (compassion satisfaction, burnout and secondary traumatic stress). In order to address hypothesis 9, nine regression models were fit.

Multiple regression models were fit to investigate whether associations between trauma (past and recent trauma and the aggregated effect of past and recent trauma) and the outcome variables including compassion satisfaction, burnout and secondary traumatic stress varied by higher or lower levels of subjective vitality. For each

regression model, the predictor variable, moderator, and interaction term were entered into a regression model. The interaction between past trauma and subjective vitality in relation to compassion satisfaction was not significant ($B = .251, \beta = .082, p = .287$). The recent trauma and subjective vitality interaction effect was not significant for compassion satisfaction ($B = .062, \beta = .017, p = .823$), nor for secondary traumatic stress ($B = -.479, \beta = -.142, p = .123$). The past and recent trauma and subjective vitality interaction effect was not significant in relation to compassion satisfaction ($B = .146, \beta = .067, p = .386$).

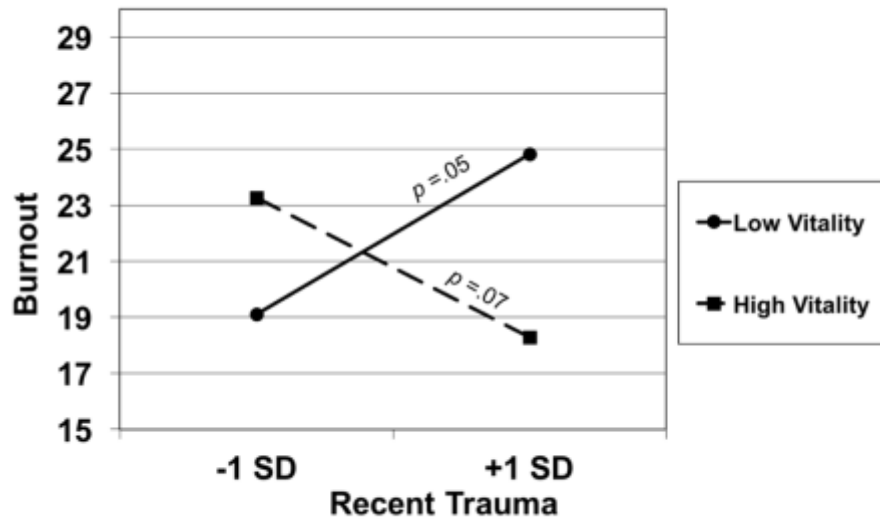
Subjective vitality moderated the relations between past trauma and burnout (Adjusted $R^2 = .501, B = -.499, \beta = -.168, p = .014$). As shown in Figure 20 testing of the simple slopes indicated that past trauma was related to burnout for clinicians with lower ($p = .0084$) but not higher vitality. Clinicians who experienced greater past trauma and had lower levels of vitality were observed as having higher levels of burnout (please see Figure 20 below).

Figure 20. Past Trauma and Vitality in Relation to Burnout



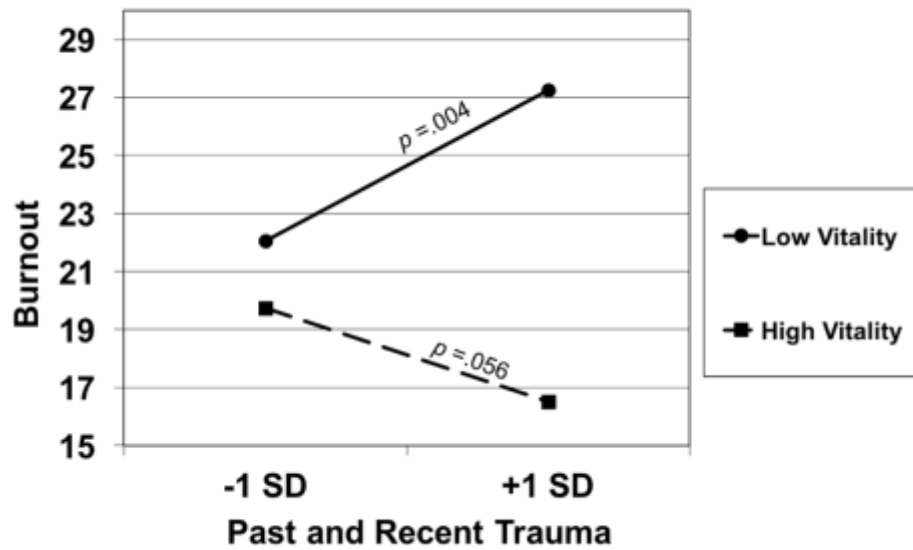
Subjective vitality moderated the relations between recent trauma and burnout (Adjusted $R^2=.498$, $B= -.499$, $\beta = -.168$, $p=.011$). As shown in Figure 21, testing of the simple slopes indicated that recent trauma was related to burnout for clinicians with lower ($p=.05$) but not higher subjective vitality. Clinicians with the highest level of burnout were those who reported experiencing greater trauma recently and who reported less subjective vitality (please see Figure 21 below).

Figure 21. Recent Trauma and Vitality in Relation to Burnout



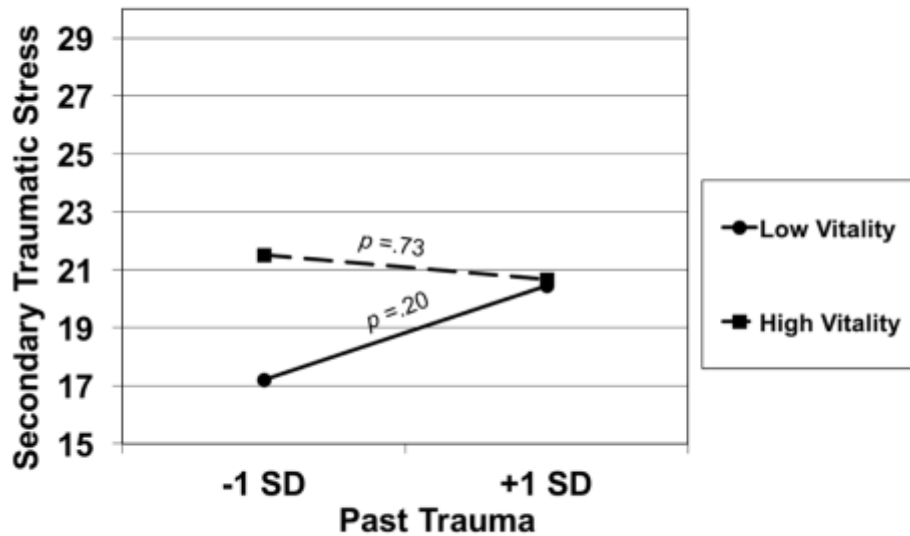
Subjective vitality also moderated the relations between recent and past trauma and burnout (Adjusted $R^2=.52$, $B= -.467$, $\beta = -.223$, $p=.001$). As shown in Figure 22, testing of the simple slopes indicated that past and recent trauma was related to burnout for clinicians with lower ($p=.004$) and higher subjective vitality ($p=.05$). Clinicians who experienced greater collective trauma and had lower levels of subjective vitality, were observed as having higher levels of burnout (please see Figure 22 below).

Figure 22. Past and Recent Trauma and Vitality in Relation to Burnout



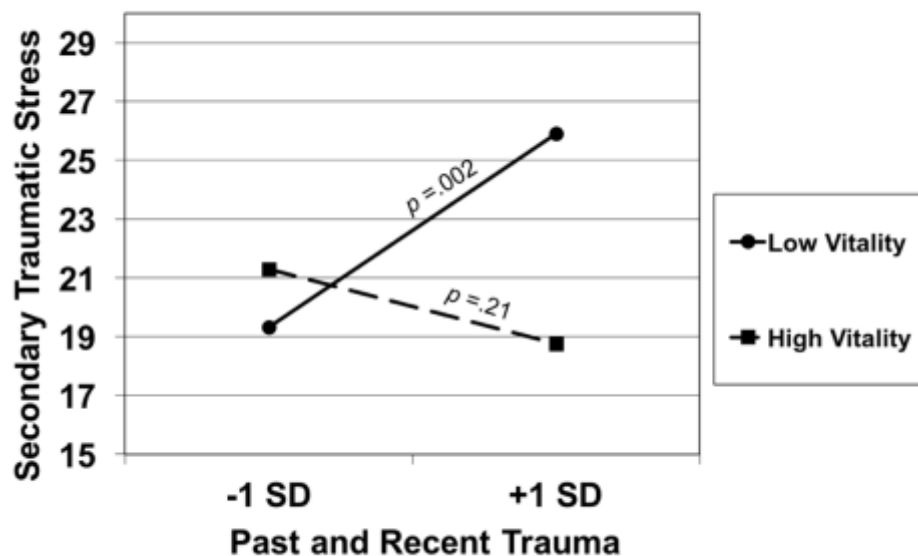
Additionally, subjective vitality moderated the relations between past trauma and secondary traumatic stress (Adjusted $R^2=.164$, $B= -.709$, $\beta = -.241$, $p=.006$). As shown in Figure 23, testing of the simple slopes indicated that the slopes for the interactions were not statistically significant (please see Figure 23 below).

Figure 23. Past Trauma and Vitality in Relation to Secondary Traumatic Stress



Finally, subjective vitality moderated the relations between past and recent trauma and secondary traumatic stress (Adjusted $R^2=.163$, $B= -.519$, $\beta = -.250$, $p=.005$). As shown in Figure 24, testing of the simple slopes indicated that past and recent trauma among clinicians was related to secondary traumatic stress for clinicians with lower ($p=.002$) but not higher subjective vitality. Clinicians who experienced greater collective past and recent trauma and had lower levels of subjective vitality were observed as having higher levels of secondary traumatic stress (please see Figure 24 below).

Figure 24. Past and Recent Trauma and Vitality in Relation to Secondary Traumatic Stress



Hypothesis 10. Trauma X Psychological Well-being in relation to Compassion Fatigue and Compassion Satisfaction

The tenth hypothesis for this study was that psychological well-being would moderate relations between trauma (past, recent and the aggregated past and recent trauma) and all three dependent variables (compassion satisfaction, burnout and secondary traumatic stress). In order to address hypothesis 10, nine regression models were fit.

Multiple regression models were fit to investigate whether associations between trauma (past and recent trauma and the aggregated effect of past and recent trauma) and the outcome variables including compassion satisfaction, burnout and secondary traumatic stress varied by higher or lower levels of psychological well-being. For each

regression model, the predictor variable, moderator, and interaction term were entered into a regression model. The interaction between past trauma and psychological well-being was not significantly related to compassion satisfaction ($B = -.008$, $\beta = -.079$, $p = .383$), burnout ($B = .000$, $\beta = -.003$, $p = .972$), nor, secondary traumatic stress ($B = -.012$, $\beta = -.120$, $p = .210$). The interaction between recent trauma and psychological well-being was not significantly related to compassion satisfaction ($B = -.029$, $\beta = -.164$, $p = .084$), burnout ($B = .023$, $\beta = .134$, $p = .161$), nor secondary traumatic stress ($B = -.001$, $\beta = -.004$, $p = .966$). The interaction between past and recent trauma and psychological well-being was not significantly related to compassion satisfaction ($B = -.015$, $\beta = -.166$, $p = .085$), burnout ($B = .006$, $\beta = .068$, $p = .479$), nor with secondary traumatic stress ($B = -.011$, $\beta = -.125$, $p = .224$).

Hypothesis 11. Trauma X Sleep in Relation to Compassion Fatigue and Compassion Satisfaction

The eleventh, and final hypothesis for this study was that sleep would moderate relations between trauma (past, recent and aggregated past and recent trauma) and the three outcomes (compassion satisfaction, burnout and secondary traumatic stress). To address hypothesis 11, nine regression models were fit.

Multiple regression models were fit to investigate whether associations between trauma (past and recent trauma and the aggregated effect of past and recent trauma) and the outcome variables including compassion satisfaction, burnout and secondary traumatic stress varied by higher or lower levels of sleep. For each regression model, the predictor variable, moderator, and interaction term were entered into a regression model.

The interaction effect of past trauma and sleep was not significantly related to compassion satisfaction ($B = -.018, \beta = -.019, p = .840$), burnout ($B = -.077, \beta = -.086, p = .363$) nor, secondary traumatic stress ($B = -.124, \beta = -.139, p = .138$). The recent trauma and sleep interaction effect was not significantly related to compassion satisfaction ($B = -.118, \beta = -.091, p = .343$), burnout ($B = .087, \beta = -.069, p = .463$), nor secondary traumatic stress ($B = .111, \beta = .090, p = .345$). The past and recent trauma and sleep interaction effect was not significantly related to compassion satisfaction ($B = -.042, \beta = -.063, p = .513$), burnout ($B = -.018, \beta = -.027, p = .772$), nor with secondary traumatic stress ($B = -.035, \beta = -.054, p = .567$).

Summary

Regression results indicated that mindfulness, vitality and psychological well-being were statistically significantly related with compassion fatigue and compassion satisfaction. The results of this study provided empirical evidence that mindfulness and vitality independently moderate the relationship between clinician's prior trauma and their tendency to experience compassion fatigue. In the next chapter a discussion of these findings relative to the conceptual framework will be presented.

CHAPTER FIVE

Discussion

This current dissertation study was motivated by the desire to understand the relationship between a clinician's prior traumatic experiences and the degree to which trauma may alter the personal impact of their work with others in the form of perceived compassion fatigue and compassion satisfaction. Furthermore, this study focused on examining a clinician's inner resources that impact the relationship between prior traumatic experiences and their manifestation as compassion fatigue or compassion satisfaction. The methodology used in this study was designed to gather information about the relationship between 1) a clinician's trauma and current levels of compassion fatigue and compassion satisfaction and, 2) how the relationships between trauma and compassion fatigue/compassion satisfaction, when moderated by mindfulness, vitality, psychological well-being and sleep, are attenuated. Each moderation variable is assumed to operate as a protective factor. Understanding protective factors for clinicians is important because of the possibility of burnout, which is pervasive in the profession (Figley, 2002). This chapter will review the overall findings of the series of analyses conducted to test hypotheses developed in this dissertation and will discuss how the findings extend the extant literature in this field. Implications for clinicians and their practice, along with the limitations and suggestions for further research, are also presented.

Trauma, Resilience, and Compassion Fatigue and Compassion Satisfaction

Multivariate linear regression analyses were used to develop a model for predicting a clinician's compassion fatigue and compassion satisfaction from past and recent trauma, mindfulness, vitality, psychological well-being and sleep scores. These direct-effects analyses revealed several statistically significant predictors of a clinician's compassion fatigue and compassion satisfaction. Specifically, direct-effects of recent trauma, mindfulness, vitality and psychological well-being on compassion fatigue and compassion satisfaction were discovered; mindfulness predicted secondary traumatic stress; and subjective vitality and psychological well-being predicted burnout and compassion satisfaction.

Predicting Compassion Fatigue and Compassion Satisfaction: Trauma

It was hypothesized that a clinician's trauma (past and recent) would predict compassion fatigue (burnout, secondary traumatic stress) and compassion satisfaction. Past trauma, and aggregated past and recent trauma, did not show significant relations to any of the compassion fatigue or compassion satisfaction scales; however, interestingly, recent trauma was positively related to clinician's compassion satisfaction scores. Clinicians that had more recent trauma showed higher compassion satisfaction levels. This is inconsistent with the literature on trauma and the impact trauma may have on clinicians, specifically in the area of risk factors. Yet, one possible explanation for this finding is that clinicians with recent trauma may feel that they are attuned to their current emotions, having been able to process the trauma differently than if the trauma occurred before the age of 17, a different developmental stage (Perry, Pollard, Blakley, Baker &

Vigilante, 1995; Pynoos, Steinberg & Piacentini, 1999; Dunn, Nishimi, Powers & Bradley, 2017). This may allow the clinician to feel empathetic towards the client, with the clinician ultimately finding fulfillment in providing services to their clients. In this light, the fact that recent trauma was a significant predictor of compassion satisfaction, while past trauma was not, may be a result of a clinician processing or reflecting on their trauma in a more current emotional state.

Post traumatic growth has been more recently introduced in the literature relative to survivors of trauma and those with PTSD for a variety of traumatic experiences such as natural disasters (Dursun, Steger, Bentele & Schulenberg, 2016), cancer survivors (Cafaro, Iani, Costantini & Di Leo, 2016), as well as survivors of socio-political genocide (Knobler, Knobler, Cohen & Abramowitz, 2016; Blackie, Jayawickreme, Hitchcott & Joseph, 2017). Understanding the role of developmental age and the occurrence of trauma impacting post traumatic growth is a more recent contribution to the field and has shown inconclusive evidence as to the role of age at the time of the event and post traumatic growth (Patrick & Henrie, 2016). This area of post traumatic growth in clinicians as a contributor to compassion satisfaction and other positive outcomes within the therapeutic relationship with clients, should be further explored in light of the current findings of this study, as it relates to timing of the traumatic experience in a clinician's past.

Predicting Compassion Fatigue and Compassion Satisfaction: Mindfulness

Consistent with the literature, mindfulness has a positive effect on symptomology of mental health concerns for the general population (Teasdale, Segal, Williams, Ridgeway, Soulsby, & Lau, 2000; Grossman, Niemann, Schmidt, & Walach, 2004,

Hofmann, Sawyer, Witt, & Oh, 2010; Godfrin & Van Heeringen, 2010), for individuals that experience trauma as a result of their occupation (Smith, et al., 2011; King, et al., 2013; Goodman, & Schorling, 2012), and, specifically, with practicing mental health clinicians (Shapiro, Brown, & Biegel, 2007; McGarrigle, & Walsh, 2011). The results of this study found strong evidence that mindfulness impacts a clinician's experience with secondary traumatic stress as a facet of compassion fatigue. In particular, the multivariate regression analyses revealed that in the full model, mindfulness was a statistically significant predictor of the variance for secondary traumatic stress, but not for burnout or compassion satisfaction.

Mindfulness-based practice in general has been shown to decrease anxiety, decrease depression symptoms, and increase positive emotions and outcomes (Bergeron & Dandeneau, 2016; Garland, Gaylord & Park, 2009; Davidson, et al., 2003), including self-compassion (Neff, 2016). In light of the evidence found in this study, which concurs with the literature regarding mindfulness, there appears to be a unique relationship between mindfulness as a disposition and one's experience of secondary traumatic stress. This relationship was not found with burnout or compassion satisfaction. Generally speaking, it may be the case that mental health clinicians would benefit from incorporating mindfulness-based techniques in order to lessen the impact of the susceptibility to secondary traumatic stress through encounters with their clients. However, further examination of the relationship mindfulness shares with secondary traumatic stress relative to clinicians' prior traumatic experiences is needed; this is discussed in the next section (moderation analyses).

Predicting Compassion Fatigue and Compassion Satisfaction: Subjective Vitality

The results supported the hypothesis that subjective vitality would be a statistically significant predictor of compassion fatigue and compassion satisfaction. Specifically, the multivariate regression analysis found that subjective vitality was a significant predictor of both clinician burnout and compassion satisfaction. Previous research has yet to examine this relationship; however, subjective vitality is shown to relate to one's sense of agency, self-actualization and personal well-being, and is also an indicator of a person's "health of spirit" (Ryan & Frederick, 1997). Additionally, Nix, Ryan, Manly & Deci (1999) argue that vitality is related to motivation, both intrinsic and extrinsic, in different ways, and this may have an impact on one's experiences of being either drained, depleted or on the other hand, feeling vital. Their study explored these factors and the results suggested that engaging in autonomous or self-regulated activities maintained or enhanced subjective vitality. As this article suggested, understanding the mechanisms of restorative environments is imperative in better understanding vitality (Nix, Ryan, Manly & Deci, 1999). Generally speaking the level of compassion satisfaction should be inversely related to burnout, meaning that a person who has high compassion satisfaction would be less likely to report job burnout; however, the literature has yet to provide empirical evidence of this inverse relationship. Therefore, the current study may be pointing to a very important role that subjective vitality plays in determining a clinician's compassion satisfaction and propensity for job burnout.

The application of the results of this study are that subjective vitality and its relations to burnout and compassion satisfaction should be understood within the context

of the clinician's environment and the degree to which they feel they have control within their environment, and thus motivation. Additionally, higher subjective vitality appears to show relations with lower levels of burnout and higher levels of compassion satisfaction; and, therefore, it is important that vitality be further explored as it relates to practicing mental health clinicians.

Predicting Compassion Fatigue and Compassion Satisfaction: Psychological Well-being

Evidence from this study also supported the hypothesis that psychological well-being would be a predictor of compassion fatigue and compassion satisfaction.

Specifically, psychological well-being accounted for the variance in burnout and compassion satisfaction as dependent variables in a multivariate regression analysis. Clinicians with higher psychological well-being scores showed lower burnout scores; and, likewise, clinicians with higher psychological well-being scores showed greater compassion satisfaction. This finding suggests that clinicians who pursue wellness and psychological health are more apt to work effectively with their clients while avoiding the personal toll on themselves through the transference and counter-transference dynamic that may lead to burnout. Research on psychological well-being has explored the relationship between several indicators of psychological well-being, such as income (Kaplan, Shema & Leite, 2008), age (Ryff & Singer, 1998), socio economic factors (Marmot et al., 1998), physical health (Scully, Kremer, Meade, Graham, & Dudgeon, 1998), and work-related stress (Terry, Nielsen & Perchard, 1993). Because all

of these factors are related to psychological well-being, this construct is multifaceted, and it is evident that the relationship with burnout and compassion satisfaction is complex.

The current study extends our understanding of how psychological well-being may function in preventing job burnout and increasing compassion satisfaction in the work on clinicians. It further supports the widely held understanding that clinicians need to maintain their own personal health and well-being in order to be an effective, responsive and attuned clinician. The findings of the current study demonstrate that when a clinician may encounter compounding life factors that impact one's psychological well-being, they may be susceptible to compassion fatigue. With this relationship in mind, it prompts the question, "what does it look like for a clinician to be well?" and from a resiliency model/positive psychology perspective, who are the "well" clinicians, and how are they pursuing wellness? In order to address these questions, the current study also subjected the construct of psychological well-being as a potential moderator to one's prior traumatic experiences relative to their practice. Further discussion of this is provided in the next section (moderation analyses).

Predicting Compassion Fatigue and Compassion Satisfaction: Sleep

Conflicting with the hypothesis for this study, sleep was not a predictor of compassion fatigue or compassion satisfaction for clinicians. In this study, clinicians' self-reported experiences of dozing in various situations may not have accurately depicted the experiences because individuals may not be cognizant of their tendency to doze. Though this study did not reveal evidence that sleep-related struggles statistically relate to clinicians' self-reported compassion fatigue, there is reasonable evidence in the

sleep literature to warrant further exploration of this relationship. Specifically, the extant research on sleep and its positive effects on both mental and physical health and wellness strongly warrants further exploration of the influence of sleep in determining clinician's experience of compassion satisfaction, burnout and secondary traumatic stress (Chambers & Belicki, 1998; Lee, et al., 2015; Storch, et al., 2008; Stein, et al, 2001; Mick, Biederman, Jetton & Faraone, 2000).

Moderation Analyses for Examining Resiliency Factors

For the second set of hypotheses, a series of multiple regression analyses were fit to examine whether mindfulness, vitality, psychological well-being and sleep moderated the association between trauma (past, recent and aggregated) and compassion fatigue and compassion satisfaction. Mindfulness and vitality both showed significance in moderating this relationship.

Mindfulness as a Resiliency Factor

Research in the area of mindfulness has shown mindfulness as a variable that moderates relationships between neuroticism and anger (Feltman, Robinson & Ode, 2009), neuroticism and depression (Barnhofer, Duggan & Griffith, 2011), self-control and psychological functioning (Bowlin & Baer, 2012), and rumination and uncontrollability of rumination (Raes, & Williams, 2010). Thus, mindfulness has been widely studied as a self-regulatory mechanism (Vago, 2012; Tang, et al., 2007; Howell, Digdon, & Buro, 2010). To add to the literature on mindfulness as a moderator and potentially self-regulatory mechanism for clinicians, this study demonstrated that mindfulness significantly moderated the relationship between recent trauma and burnout.

Specifically, clinicians with lower levels of mindfulness showed higher burnout scores. Additionally, this study found that mindfulness moderated the relationship between recent trauma and compassion satisfaction. Clinicians with lower levels of recent trauma and higher levels of mindfulness showed the highest levels of compassion satisfaction. Using Luthar and Chicciti (2000) as an explanation, mindfulness and lower reports of trauma are considered a “dual protection,” in that clinicians that reported less trauma and higher mindfulness scores had higher levels of compassion satisfaction. Specifically, mindfulness in this study was shown to be a “protective reactive” factor (Luthar and Chicciti, 2000), because higher levels of mindfulness along with the lower incidences of reported recent traumatic events creates a stronger protection than if mindfulness is burdened by a clinician’s traumatic experiences. This was an unexpected finding and further illustrates the importance of a strength-based perspective when exploring resiliency factors among clinicians.

Subjective Vitality as a Resiliency Factor

Confirming the hypothesis that vitality would operate as a moderator for the relationship between trauma and compassion fatigue, vitality showed a significant interaction effect on the relations between trauma (both past trauma, recent trauma and aggregated past and recent trauma) and burnout, as well as on the relations between trauma (past trauma and past and recent trauma aggregated) and secondary traumatic stress. A series of multiple regression analyses to understand the proportion of variance explained by this interaction on the three dependent variables (compassion satisfaction, burnout and secondary traumatic stress) found that subjective vitality as a moderator

accounted for (50%, 49%, 52%, 16% and 16%) of the variance in these dependent variables respectively. This evidence supports the existing literature on vitality as a factor that promotes positive outcomes (Allen & Kiburz, 2012; Ryan & Deci, 2000). To elaborate further on the influence of subjective vitality and its role as a moderator with trauma and compassion fatigue and compassion satisfaction, previous research has explored vitality as a moderator of the relations between life satisfaction and subjective happiness (Uysal, Satıcı, Satıcı, Akin, 2014); and as a mediator of the relations between internet addiction and subjective happiness (Akin, 2012). This current study had found, similarly, that subjective vitality plays an important role in perhaps attenuating the likelihood that prior trauma will eventually lead to a clinician's experience of secondary traumatic stress and eventual job burnout. To be clear, its design of the current study limits our ability to fully understand this relationship, whereas a longitudinal design will allow for a clearer understanding of how subjective vitality operates as a resiliency factor in preventing secondary traumatic stress and burnout.

Psychological Well-being as a Resiliency Factor

Though psychological well-being was shown to have a relationship on burnout and compassion satisfaction in the multivariate regression analysis discussed earlier, the follow-up analysis that tested psychological well-being as a moderator of the relationship between trauma and compassion fatigue and compassion satisfaction unfortunately was not significant. Psychological well-being may be a product of mindfulness and vitality (Brown & Ryan, 2003) in clinicians and therefore on its own as a moderator does not impact this relationship. Ryan and Deci (2000), operating under a self-determination

theory framework, provide strong empirical support that subjective vitality and mindfulness are the foundation of overall psychological well-being. As discussed above, both mindfulness and subjective vitality independently moderated the relationship between trauma and facets of compassion fatigue and compassion satisfaction, and therefore it may be the case that the psychological well-being instrument in this study lacked the required precision. Further investigation of indicators of psychological well-being is warranted in order to fully test its effect in influencing the relationship between trauma and compassion fatigue. However, according to more recent theoretical formations, specifically that of Brown and Ryan (2000), mindfulness plays an important role with psychological well-being. Additionally, psychological well-being is a construct that derives from several indicators of wellness. This study explored overall well-being and, therefore, the six indicators of wellness (Ryff, 1989) were not investigated on their own as moderators between the relationship of trauma and compassion fatigue and compassion satisfaction.

Sleep as a Resiliency Factor

Sleep was examined as a moderator of the relationship between past, recent and aggregated trauma and the outcome variables of secondary traumatic stress, burnout, and compassion satisfaction. The absence of meaningful effects of sleepiness on a clinician's compassion fatigue and compassion satisfaction conflicted with hypotheses and research supporting the overall ideas of sleep as a positive influence on a variety of individual outcomes. In reviewing the literature, sleep or sleepiness has not been explored with mental health clinicians; unfortunately, because the findings here were not significant,

this study offers very little to the scarce literature in the field. Knowing the mental and physical health benefits of sleep, this variable is worth exploring further in future studies with professionals working in the field of mental health. Even though this study did not reveal sleep as significant as a moderator for a clinician's trauma and compassion fatigue and compassion satisfaction, research exists that supports this relationship. In particular, Gaba and Howard (2002) found that fatigue among medical clinicians negatively impacted patient safety. Additionally, studies have also examined this relationship of sleep with poor performance and impairment with doctors, nurses and medical residents (Asken & Raham, 1983; Howard, Gaba, Rosekind & Zarcone, 2002; Jha, Duncan & Bates, 2001; Leung & Becker, 1992; Samkoff & Jacques, 1991). The implications of these findings can be applied to mental health clinicians as well. Therefore, it is important to better understand the specific experiences of mental health clinicians, in terms of their traumatic history and sleep activity, that may inform us about the ethical and effective treatment of their clients (Chambers & Belicki, 1998; Clum, Nishith, & Resick, 2001; Cuddy & Belicki, 1992; Sadeh, 1996).

Implications for Clinicians and Practice

Each of the protective factors studied in this dissertation help add to the literature regarding protective and risk factors for practicing clinicians. The factors may be bi-directional, meaning that a clinician with trauma may struggle with these resiliency factors, in part because of their trauma, or, on the other hand, having these resiliency factors naturally can serve as a protective factor against the negative impact of trauma. Furthermore, these resiliency factors may protect against susceptibility to compassion

fatigue. Conversely, someone with compassion fatigue may have difficulty being proactive in maintaining self-care strategies promoting each of these, in part because of their symptoms of compassion fatigue. The protective factors discussed and examined in this research are both a process and a product. Because this dissertation did not specifically study a coping skill or self-care strategy that promotes any of these protective factors, the results are left open to interpretation about how one might develop these protective factors. Therefore, further research is prompted by these findings.

In light of the current findings, several implications for practice should be considered for both the individual clinician and for a mental health agency practice collectively. Most importantly, the Professional Quality of Life Inventory showed that all clinicians in this sample had some level of burnout and secondary traumatic stress (low and average scores), and therefore clinicians should be aware of the consequences of compassion fatigue personally, the impact on their own mental health, and professionally, the potential negative impact on clients. With this in mind it is imperative that clinicians engage in self-care strategies. The self-care strategies that the clinician participates in should be intentional and promote vitality and incorporate a mindful, contemplative and reflective process. These strategies may include yoga, exercise, journaling, a mindfulness practice, or even attending counseling. Furthermore, clinicians should be careful not to engage in mind-numbing activities to deal with stress, prompting a disassociation from the present moment or body sensations.

As mental health agencies are large employers of clinicians, and oftentimes clinicians in agency settings have the higher caseload and work related stress, agencies

should promote and support clinician self-care. Most importantly, CEO's, supervisors and staff should be aware of the symptoms of compassion fatigue in order to be able to recognize it before a clinician is unable to manage. Promoting clinician self-care may include agencies providing psychoeducation for clinicians and staff about the importance of self-care to prevent burnout. Also, agencies may provide health days throughout the year, with self-care options for the clinicians to take part in to learn, experience and thus hopefully implement into their personal lifestyle. Agency support of clinician self-care may include allowing clinicians to have time off for mental health days if needed, without guilt, supporting a positive work environment, allowing for autonomy within the work day, flexibility in work hours to accommodate for work-family balance, and encouraging and supporting clinicians to go to the gym during the lunch hour. Additionally, agencies should be aware that for clinicians exhibiting symptoms of compassion fatigue, The Accelerated Recovery Program (Gentry & Baranowsky, 2002) was developed to educate, support and assist clinicians in working through these struggles, and has been shown to significantly decrease symptoms in clinicians. Agencies promoting these strategies are not only helpful to the clinician, but to the agency itself (preventing turnover), to the clients, and to the helping profession at large.

Lastly, social service educational institutions and related professional associations should continue promoting self-care as a critical component of the education and development of a practicing clinician. In counselor training programs, the negative consequences of compassion fatigue should be discussed, as well as the ethics of engaging in an intentional self-care practice and developing that practice while preparing

to be a clinician. Counseling training programs should emphasize the management of counter-transference outlined by ((Van Wagoner, Gelso, Hayes, & Diemer, 1991): self-insight, integration, empathy, anxiety management and conceptualizing ability)), in order to prepare clinicians for the vulnerabilities and risks that come with working with clients.

Clinicians must attend continuing education units (CEUs) and, in practice, complete at least 3 CEUs in ethics training. With this in mind, it is imperative that ethics training includes information around self-care strategies and educational topics related to healing the healer, and research on different mindfulness-based practices (Barnett, Baker, Elman, Schoener, 2007; Cummins, Massey, & Jones, 2007; Sadler-Gerhardt, & Stevenson, 2011).

Limitations

The research and implications should be considered with the following limitations in mind. The proposed research design is limited in several ways. First, due to the design of the study, one potential threat is “location threat.” Each person engaging in these surveys will be in a different place, and as a result this can impact their feelings and emotions while answering some of the questions. This is important in empirical research because one’s environment influences one’s subjective reality.

The trauma questionnaire addressed major and significant traumas and did not address chronic and less significant traumas occurring over time. It may be the case that these potential sources of trauma may influence one’s personality and development. This study did not assess chronic trauma or accumulated trauma, and therefore the conclusions drawn are specific to the traumas measures by the questionnaire.

Additionally, this study did not ask about specific daily lifestyle stressors, family supports, family dynamics, work-related supports, specific financial stressors, or income levels, which may have explained some proportion of variance in participants' self-reported compassion fatigue.

Although self-selection is more often than not a limitation of all research, it is important to note that the very nature of someone willing to participate in the proposed study, may have more time, energy, resiliency and other influential attributes, thus impacting the results, making the results not generalizable to others. Anderson and colleagues (2009) discussed the nature of volunteer participants and described that one's sample, by nature of the fact that participants are volunteering to be a participant, comes with specific unique characteristics.

Furthermore, all assessments/questionnaires administered will generate self-reported data. All data obtained are constrained by situated conditions in which participants select to complete the measures on their computers. One such factor is a participant's own subjective construal of each item. Finally, with internet and possible mail survey delivery methods, it is not possible to verify that persons completing the survey are in fact the intended participants (Wright, 2009). Future research should utilize multiple methods and diverse samples to continue exploring factors that protect clinicians from burnout.

Directions for Further Research

As Dr. Virginia Shipman once said, "the outcome of research should always produce more questions." With this being said, the results of this dissertation study pose

several questions that remain for future research, specifically in the area of understanding proactive self-care techniques that promote vitality and mindfulness because of their significance with compassion fatigue and compassion satisfaction. Research should explore how and what self-care strategies may promote development of resiliency functioning before impairment (Luther, Cicchetti, 2000), for practicing clinicians and for clinicians in training.

Research has already sought to understand mindfulness and its place with practicing mental health clinicians; however, additional research should explore ways that clinicians can engage in mindfulness-based strategies that can be implemented easily within their office setting and throughout their busy day. For example, in the 70's Kremer and Owen wrote about this lack of understanding of clinicians and their bodies and that medications are used to numb stomach issues or other body signals that may indicate stress (Kremer & Owen, 1979). Forty years later, clinicians continue the same prescriptions and continue to struggle with somatic stress symptoms. Therefore, further exploration of mindfulness-based strategies in developing a process that is effective in prompting feedback about the internal processes at work within clinicians is called for. It would be interesting and necessary, in order to address whether mindfulness is a predictor of compassion fatigue, that a similar study examine clinician's mindfulness using a longitudinal design.

With literature suggesting that, counselors with higher levels of perceived occupational stress report significantly greater personal strain and fewer coping resources than do counselors perceiving lower levels of occupational stress (Sowa, May & Niles,

1994) mindfulness-based practice may impact a counselor's perception of their stress. Research should further explore how this perception of stress impacts a clinician's intentional self-care practice or their proactive approach to self-care.

Vitality has not been a protective factor explored with mental health clinicians, and because of its significance in this study it is worth investigating further: Who are the clinicians with high vitality and what are the processes by which they become and remain vital? Exploring answers to these questions may give insights into developing further techniques and strategies for clinicians to engage in, protecting them from potential compassion fatigue.

In the area of psychological well-being, using the subscales as indicators for understanding components of psychological well-being, further exploration into the practice setting and context of the clinician would be critical. Exploring the question, what can agencies and clinics do to promote a clinician's feelings of autonomy and competence and to cultivate personal growth. Although external factors impact clinicians significantly (Venart, Vassos and Pitcher-Heft, 2007), agency environmental factors may promote overall wellness for clinicians as well (Yassen, 1995), and should be further understood in their impact of the wellness of clinicians.

This study did not provide any significance of effects of sleepiness on compassion fatigue or compassion satisfaction, yet because of the literature on the physiological and psychological benefits of sleep, sleep should further be examined for its impact on clinicians and their practice. For this study, clinicians answered questions about their levels of dozing; for future research, in addition to a subjective questionnaire asking

about clinicians' sleep, clinicians' sleep should be observed and monitored by using sleep bands to assess sleep patterns, wake minutes/hours in the night, and the total amount of sleep each night.

Conclusion

To conclude, Luthar and Chiccetti (2000) outline components of using resiliency theory as the theoretical framework in application to research. In this study this meant that in addition to the protective factors, which are indicators of positive adaption, compassion satisfaction was included in the analysis as a positive outcome for clinicians, along with risk outcome variables of burnout and secondary traumatic stress. Furthermore, the vulnerabilities of trauma are specifically addressed in this study as the influence associated with risk for clinicians' susceptibility to compassion fatigue. To specifically apply resiliency theory to interventions from this research, the implications of this study imply that clinicians should be mindful of the vulnerabilities that personal trauma may pose when working with clients. Specifically, clinicians should be mindful of the countertransference that takes place in the therapeutic relationship, posing a risk to clinicians being vulnerable to compassion fatigue. Lastly, Luthar and Chiccetti (2000) described that to use the resiliency theory as a framework, links need to be made between the identified protective factors and vulnerabilities. Although conceptual links through research have been identified for these protective factors against vulnerabilities, further research needs to explore the underlying processes at work for clinicians, and explore how these protective factors can be enhanced within clinicians through self-care strategies and coping skills—specifically what cultivates a mindful and vital clinician.

As a licensed Marriage and Family Therapist, I have worked with many clients over the years and have had the opportunity to learn about the psychological impact of professional practice. This has resulted in a confluence of my life history, and my own inner resiliency resources, allowing me to attain my goals for pursuing a doctoral education. I have learned that it is important for clinicians to care for themselves and to be intentional about self-care activities they engage in; it is also important to realize that self-care impacts the relationship dynamic between client and clinician. By completing this dissertation study, I feel prepared to impact my profession by continuing to pursue research in the area of clinician wellness and self-care in order to protect healers. Additionally, this dissertation study has led me to further advocate for mental health clinicians in the area of self-care, for those clinicians that I now work with, supervise, and will encounter in the future.

APPENDIX 1: Criteria Questionnaire

1. Are you a licensed mental health counselor, professional counselor or marriage and family therapist?
2. Which of the following best describes you? – LMFT, LPCC, LISW,
3. Are you experiencing any level of burnout, stress and/or compassion fatigue related to your work as a therapist?
4. Have you been working as a counselor or therapist or social worker for at least 2 years?
5. Are you experiencing any level of burnout, stress and/or compassion fatigue related to your work as a therapist?
6. How long (in years) have you been practicing as a therapist?
7. Do you practice and live in the United States?

APPENDIX 2: Demographics Questionnaire

1. Age
2. Sex
3. What is your ethnicity?
 - a. Non-Hispanic White or Euro-American Black, Afro-Caribbean, or African
American Latino or Hispanic American East Asian or Asian
American South Asian or Indian American Middle Eastern or Arab
American Native American or Alaskan Native Other (please specify)
4. Which of the following best fits the household you grew up in?-
5. What state do you live in?
6. Current Licensure
7. How would you describe your therapeutic modality or modalities? For example:
Art Therapist, Substance Abuse Counselor, Multisystemic Therapist (MST), Play
Therapist etc...
8. Which description best characterizes your practice as a clinician?
9. How many clients do you see in a typical work week?
10. How many hours a week do you work in a typical work week?
11. What is the predominate age group of the population you work with?
12. What is the predominate population you work with?
13. How much do you agree with the following statement? I have control over my
scheduling and my work calendar.
 - a. Strongly Agree Agree Neutral Disagree Strongly Disagree
14. How much do you agree with the following statement? I engage in self-care
strategies to decrease my stress.
 - a. Strongly Agree Agree Neutral Disagree Strongly Disagree
15. As a professional, do you engage in self-care activities?
 - a. Yes, No
16. If yes, how often do you engage in self-care activities?
 - a. Several times a week Once a week Once every few weeks Once every
few months Hardly ever

17. If yes, what do you do for self-care? _____
18. "Compassion Fatigue is a state experienced by those helping people in distress; it is an extreme state of tension and preoccupation with the suffering of those being helped to the degree that it can create a secondary traumatic stress for the helper." Based on this definition, how much do you agree with the following statement? "I have experienced compassion fatigue in the past 4 weeks..."
- a. Strongly Agree Agree Neutral Disagree Strongly

APPENDIX 3: Childhood Traumatic Events Scale

For the following questions, answer each item that is relevant. Be as honest as you can.
Each question refers to any event that you may have experienced prior to the age of 17.

1. Prior to the age of 17, did you experience a death of a very close friend or family member? _____ If yes, how old were you? _____
If yes, how traumatic was this? (using a 7-point scale, where 1 = not at all traumatic, 4 = somewhat traumatic, 7 = extremely traumatic) _____
If yes, how much did you confide in others about this traumatic experience at the time? (1 = not at all, 7 = a great deal) _____
2. Prior to the age of 17, was there a major upheaval between your parents (such as divorce, separation)? _____ If yes, how old were you? _____
If yes, how traumatic was this? (where 7 = extremely traumatic) _____
If yes, how much did you confide in others? (7 = a great deal) _____
3. Prior to the age of 17, did you have a traumatic sexual experience (raped, molested, etc.)? _____ If yes, how old were you? _____
If yes, how traumatic was this? (7 = extremely traumatic) _____
If yes, how much did you confide in others? (7 = a great deal) _____
4. Prior to the age of 17, were you the victim of violence (child abuse, mugged or assaulted -- other than sexual)? _____ If yes, how old were you? _____
If yes, how traumatic was this? (7 = extremely traumatic) _____
If yes, how much did you confide in others? (7 = a great deal) _____

5. Prior to the age of 17, were you extremely ill or injured?_____ If yes, how old were you?_____
- If yes, how traumatic was this? (7 = extremely traumatic)_____
- If yes, how much did you confide in others? (7 = a great deal)_____
6. Prior to the age of 17, did you experience any other major upheaval that you think may have shaped your life or personality significantly?_____If yes, how old were you?_____
- If yes, what was the event?_____
- If yes, how traumatic was this? (7 = extremely traumatic)_____
- If yes, how much did you confide in others? (7 = a great deal)_____

Recent Traumatic Events Scale

For the following questions, again answer each item that is relevant and again be as honest as you can.
Each question refers to any event that you may have experienced within the last 3 years.

1. Within the last 3 years, did you experience a death of a very close friend or family member?

If yes, how traumatic was this? (1 = not at all traumatic, 7 = extremely traumatic) _____

If yes, how much did you confide in others about the experience at the time? (1 = not at all, 7 = a great deal) _____

2. Within the last 3 years, was there a major upheaval between you and your spouse (such as divorce, separation)? _____

If yes, how traumatic was this? _____

If yes, how much did you confide in others? _____

3. Within the last 3 years, did you have a traumatic sexual experience (raped, molested, etc.)? _____

If yes, how traumatic was this? _____

If yes, how much did you confide in others? _____

4. Within the last 3 years, were you the victim of violence (other than sexual)? _____ If yes, how traumatic was this? _____

If yes, how much did you confide in others? _____

5. Within the last 3 years, were you extremely ill or injured? _____ If yes, how traumatic was this? _____

If yes, how much did you confide in others? _____

6. Within the last 3 years, has there been a major change in the kind of work you do (e.g., a new job, promotion, demotion, lateral transfer)? _____

If yes, how traumatic was this? _____

If yes, how much did you confide in others? _____

7. Within the last 3 years, did you experience any other major upheaval that you think may have shaped your life or personality significantly? _____

If yes, what was the event? _____ If yes, how traumatic was this? _____

If yes, how much did you confide in others? _____

APPENDIX 4: Epworth Sleepiness Scale

Name: _____ Today's date: _____

Your age (Yrs): _____ Your sex (Male = M, Female = F): _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the **most appropriate number** for each situation:

- 0 = would **never** doze
- 1 = **slight chance** of dozing
- 2 = **moderate chance** of dozing
- 3 = **high chance** of dozing

It is important that you answer each question as best you can.

Situation

Chance of Dozing (0-3)

Sitting and reading _____

Watching TV _____

Sitting, inactive in a public place (e.g. a theatre or a meeting) _____

As a passenger in a car for an hour without a break _____

Lying down to rest in the afternoon when circumstances permit _____

Sitting and talking to someone _____

Sitting quietly after a lunch without alcohol _____

In a car, while stopped for a few minutes in the traffic _____

THANK YOU FOR YOUR COOPERATION

APPENDIX 5: Mindfulness Attention and Awareness Scale

Day-to-Day Experiences

Instructions: Below is a collection of statements about your everyday experience. Using the 1-6 scale below, please indicate how frequently or infrequently you currently have each experience. Please answer according to what really reflects your experience rather than what you think your experience should be. Please treat each item separately from every other item.

1	2	3	4	5	6
Almost Always	Very Frequently	Somewhat Frequently	Somewhat Infrequently	Very Infrequently	Almost Never

I could be experiencing some emotion and not be conscious of it until some time later.	1	2	3	4	5	6
I break or spill things because of carelessness, not paying attention, or thinking of something else.	1	2	3	4	5	6
I find it difficult to stay focused on what's happening in the present.	1	2	3	4	5	6
I tend to walk quickly to get where I'm going without paying attention to what I experience along the way.	1	2	3	4	5	6
I tend not to notice feelings of physical tension or discomfort until they really grab my attention.	1	2	3	4	5	6
I forget a person's name almost as soon as I've been told it for the first time.	1	2	3	4	5	6
It seems I am "running on automatic," without much awareness of what I'm doing.	1	2	3	4	5	6
I rush through activities without being really attentive to them.	1	2	3	4	5	6
I get so focused on the goal I want to achieve that I lose touch with what I'm doing right now to get there.	1	2	3	4	5	6
I do jobs or tasks automatically, without being aware of what I'm doing.	1	2	3	4	5	6
I find myself listening to someone with one ear, doing something else at the same time.	1	2	3	4	5	6

1	2	3	4	5	6				
Almost Always	Very Frequently	Somewhat Frequently	Somewhat Infrequently	Very Infrequently	Almost Never				
I drive places on ‘automatic pilot’ and then wonder why I went there.				1	2	3	4	5	6
I find myself preoccupied with the future or the past.				1	2	3	4	5	6
I find myself doing things without paying attention.				1	2	3	4	5	6
I snack without being aware that I’m eating.				1	2	3	4	5	6

APPENDIX 6: Subjective Vitality Scale

Vitality Scale

Please respond to each of the following statements by indicating the degree to which the statement is true for you in general in your life. Use the following scale:

1	2	3	4	5	6	7
not at all			somewhat			very
true			true			true

1. I feel alive and vital.
2. I don't feel very energetic.
3. Sometimes I feel so alive I just want to burst.
4. I have energy and spirit.
5. I look forward to each new day.
6. I nearly always feel alert and awake.
7. I feel energized.

APPENDIX 7: Ryff's Psychological Well-Being Scales

Please indicate your degree of agreement (using a score ranging from 1-6) to the following sentences.

*Strongly
Disagree*

1

2

Strongly

3

4

Strongly

Agree

5

6

1. I am not afraid to voice my opinions, even when they are in opposition to the opinions of most people.
2. In general, I feel I am in charge of the situation in which I live.
3. I am not interested in activities that will expand my horizons.
4. Most people see me as loving and affectionate.
5. I live life one day at a time and don't really think about the future.
6. When I look at the story of my life, I am pleased with how things have turned out.
7. My decisions are not usually influenced by what everyone else is doing.
8. The demands of everyday life often get me down.
9. I think it is important to have new experiences that challenge how you think about yourself and the world.
10. Maintaining close relationships has been difficult and frustrating for me.
11. I have a sense of direction and purpose in life.
12. In general, I feel confident and positive about myself.
13. I tend to worry about what other people think of me.
14. I do not fit very well with the people and the community around me.
15. When I think about it, I haven't really improved much as a person over the years.
16. I often feel lonely because I have few close friends with whom to share my concerns.
17. My daily activities often seem trivial and unimportant to me.
18. I feel like many of the people I know have gotten more out of life than I have.

19. I tend to be influenced by people with strong opinions.
20. I am quite good at managing the many responsibilities of my daily life.
21. I have the sense that I have developed a lot as a person over time.
22. I enjoy personal and mutual conversations with family members or friends.
23. I don't have a good sense of what it is I'm trying to accomplish in life.
24. I like most aspects of my personality.
25. I have confidence in my opinions, even if they are contrary to
the general consensus.
26. I often feel overwhelmed by my responsibilities.
27. I do not enjoy being in new situations that require me to change
my old familiar ways of doing things.
28. People would describe me as a giving person, willing to share my
time with others.
29. I enjoy making plans for the future and working to make them a reality.
30. In many ways, I feel disappointed about my achievements in life.
31. It's difficult for me to voice my own opinions on controversial
matters.
32. I have difficulty arranging my life in a way that is satisfying to me.
33. For me, life has been a continuous process of learning, changing,
and growth.
34. I have not experienced many warm and trusting relationships with others.
35. Some people wander aimlessly through life, but I am not one of them
36. My attitude about myself is probably not as positive as most people
feel about themselves.
37. I judge myself by what I think is important, not by the values of
what others think is important.
38. I have been able to build a home and a lifestyle for myself that is
much to my liking.
39. I gave up trying to make big improvements or changes in my life
a long time ago.
40. I know that I can trust my friends, and they know they can trust me.

41. I sometimes feel as if I've done all there is to do in life.
42. When I compare myself to friends and acquaintances, it makes me feel good about who I am.

APPENDIX 8: Professional Quality of Life Scale

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

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

APPENDIX 9: Consent Form

When the Therapist is Burdened: Therapist's Trauma History, Resiliency and the Impact on Compassion Fatigue Informed Consent for Survey 9/08/16

Ashley Martin-Cuellar, from the Department of Individual, Family and Community Education under the supervision of Dr. David Atencio, is conducting a research study exploring the relationship between past trauma and current levels of compassion fatigue for licensed clinicians. You are being asked to participate in this study because you are a licensed clinician that has been working in the profession for at least 2 years.

DESCRIPTION: Your participation will involve taking an online survey. The survey should take about 25-30 minutes to complete. The survey questions include questions about whether you have experienced past traumas in your life, questions about work related stress, your sleep behaviors, questions about your view of your own mental health and the degree to which you are contemplative.

VOLUNTARY PARTICIPATION: Your involvement in the study is voluntary, and you may choose not to participate and you can refuse to answer any of the questions at any time. In order to withdraw from participation, you can click out of the survey and your responses will not be used in the study.

CONFIDENTIALITY: Data will be collected through survey monkey which is password protected and will be downloaded upon data collection completion. There will not be any identifying information collected and thus it will not be linked to your information. If published, the findings from this project will be presented in summary form and will not have any identifiable information.

BENEFITS: There are no direct benefits; however, possible benefits to the participants in this study include that you may benefit from engaging in reflective practice about their wellbeing, their attention in the present moment as well as their personal satisfaction and self-esteem about their vitality. Additionally, it is hoped that this research benefits the profession in furthering research in the area of self-care strategies that may alleviate compassion fatigue for clinicians.

RISKS: The anticipated risks of participating in this study are minimal; however, some individuals may experience discomfort or loss of privacy when answering questions around past trauma experiences as well as questions asking about current job related stress. Additionally, risk may involve bringing up emotions and feelings related to reflecting on the survey questions. If answering any of these questions makes you feel upset or uncomfortable contact a licensed clinician. You may also contact the AGORA crisis center available 24/7 at 855-505-4505.

CONTACT PEOPLE: If you have any questions about this research project, please contact Ashley Martin-Cuellar (acuellar@unm.edu) and/or Dr. David Atencio (atencio1@unm.edu). If

you have questions regarding your rights as a research subject, or about what you should do in case of any harm to you, you may call the UNM Office of the IRB (OIRB) at (505) 277-2644 or irb.unm.edu.

RESULTS OF THE STUDY: If you would like to receive a summary of the research results, please contact Ashley Martin-Cuellar (acuellar@unm.edu).

By clicking “YES” below you will be agreeing to participate in the above described research study. By clicking “NO” you are choosing not to participate in the survey.

APPENDIX 10: Email to Recruit Participants

Subject Line: Opportunity to Participate in Research

Dear _____,

My name is Ashley Martin-Cuellar and I am a licensed Marriage and Family Therapist working on my doctorate degree. I am conducting a research study about compassion fatigue with therapists. I am interested in examining challenges that burden therapists. The participation criteria to be in this study include that you are a licensed mental health clinician that has been working in the profession for at least 2 years.

If you agree to participate, this study will involve taking an online survey through Survey Monkey. The survey should take about 25-30 minutes to complete.

Please click this link to participate and you will be prompted with consent information:

<http://www.unm.edu/~acuellar/>

If you know of other licensed clinicians that fit the criteria and may be interested in participating, will you please forward my email?

Thank you for your time,
Ashley Martin-Cuellar, LMFT
Doctoral Candidate

Principal Investigator: *Dr. David Atencio & Ashley Martin-Cuellar*
Study Title: When the Therapist is Burdened
IRB-HSR # : 932985-1

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