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Stephanie Catlin-Rakoski

The College at Brockport, scat1028@brockport.edu

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Stephanie Catlin-Rakoski

Therapist's Perceptions of Self-Care

State University of New York, College at Brockport

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Abstract

Mental health professionals experience tremendous work-related stressors due to the emotionally demanding nature of the role they play in their client's lives. The goal of this research was to identify relationships between a therapist's level of engagement in self-care activities, and compassion satisfaction, burnout, and secondary traumatic stress. Forty-six mental health therapists were surveyed on their reported engagement in self-care activities and their overall professional quality of life. Relationships were found regarding an increase in self-care and a decrease in the level of burnout and secondary traumatic stress a therapist reported, as well as a positive relationship between higher levels of self-care and an increase in compassion satisfaction.

Therapist's Perceptions of Self-Care

Make sure you take good care of yourself; eat well, get enough rest, stay active.

Counselors emphasize wellness to their clients on a daily basis. Carl Rogers, a prominent figure in the history of counseling stated, "I have always been better at caring for and looking after others than I have in caring for myself" (Rogers, 1995, p. 80). An effective counselor is required to constantly be present with their client's emotions while simultaneously balancing their own emotions such as counter-transference, or personal experiences that are not work-related (Cummins, Rogers, & Jones 2007). Counselor wellness is directly related to the overall quality of care a client receives (Lawson, 2007). It is important to examine personal wellness to fully understand the implications of not being well. This includes secondary traumatic stress, vicarious traumatization, compassion fatigue, and professional burnout (Newell & MacNeil, 2010). Also important to examine is the role self-care plays in re-establishing or maintaining wellness (Williams, Richardson, Moore, Eubanks Gambrel & Keeling, 2010). When counselors are not well, they cannot offer the quality services that clients need, and their own personal quality of life may begin to suffer as well (Lawson, 2007).

Professional Quality of Life

Professional quality of life is directly linked to the positive and negative aspects of the role as a helper (Stamm, 2010). The positive aspects of the role are what contribute to compassion satisfaction, while the negative aspects make up compassion fatigue (Saakvitne & Pearlman, 1996; Stamm, 2010). Compassion fatigue is further broken down into two parts: burnout and secondary traumatic stress (Stamm, 2010) or vicarious traumatization (Saakvitne & Pearlman, 1996). Professional quality of life can be quite complex because it is comprised of the

therapist's personal characteristics, the work environment, and the therapist's level of exposure to trauma in the workplace (Stamm, 2010).

Burnout

A therapist's job is about relationships and connections. The nature of the profession promotes therapists to have a professional, empathic connection with their clients. When this relationship becomes disregulated in some way, problems arise. This emotional disregulation has come to be known as burnout (Maslach, 2003). Burnout is a "process, not an event," that affects a person's wellbeing on several dimensions including physical, emotional, behavioral, professional, and interpersonal (Salston & Figley, 2003). Researchers have noted three key dimensions of burnout: overwhelming exhaustion, feelings of cynicism and detachment from the job, and a sense of ineffectiveness and lack of accomplishment (Jenaro, Flores & Arias, 2007; Maslach, 2003). Exhaustion is the therapist's emotional and physical stress response to the physical demands of the job. Cynicism refers to the person's response to the work that he or she does, and inefficacy is the therapist's internalized manifestation of how they perform in their role as helper (Maslach, 2003). Physically, burnout manifests in therapists as fatigue, headaches, persistent colds, and hypertension. (Rosenberg & Pace, 2006). Emotionally, therapists tend to feel hopeless, anxious and irritable. Maslach, Schaufeli & Leiter (2001) also described therapists dealing with burnout as having lower self-concept, and tending to distance themselves from clients.

Counselor impairment is a problem that impacts the work they do with their clients (Lawson, 2007). A survey was conducted of a random sample of American Counseling Association (ACA) members on counselor impairment. Most counselors reportedly are aware of

a colleague they would consider impaired (63.5%). Of those impaired counselors, supervisors (54.3%) and colleagues (64.2%) were also aware of the impairment. Of the reported cases, the majority of the impaired counselors did not receive disciplinary action (77.8%) or therapeutic intervention (73.7%). Counselors believe that impairment presents a significant risk to the counseling profession (75.7%). Counselors were not aware of programs addressing counselor impairment in their state (82.7%), and the statistics did not change significantly (84.6%) when ACA included only counselors in states that actually do have an impairment program (American Counseling Association website, 2004).

Newell and MacNeil (2010) discussed burnout as occurring as a direct effect of the clients with whom therapists work, and the nature of the issues they bring to therapy. Others (Barak, Nissly & Levin, 2001; Maslach & Leiter, 1997; Stamm, 1997) proposed therapist burnout is a result of the workplace environment, including: large caseload size, low salaries, demanding schedules, availability or quality of supervision, the stress of meeting the demands of the institution (such as, policies and procedures), and poor on-the-job training. Individual factors such as poor relationships with co-workers, difficulty connecting with clients, and individual personality and coping skills can lead to therapist burnout (Newell & MacNeil, 2010). Various negative professional behaviors can be considered early signs of burnout including, taking excessive days off from work, arriving late for work, feeling tired frequently, not following through on job-related responsibilities such as paperwork, and showing evidence of poor client care (Newell & MacNeil, 2010).

There are several distinct personality characteristics that could potentially make a therapist more prone to experience burnout at some point in his or her career (Maslach, et al., 2001). For example, people who do not require a sense of control over events, those who are

not very open to change, and people with an external locus of control, tend to score high on the exhaustion dimension of the Maslach Burnout Inventory (MBI; Maslach, et al., 2001). Research has shown that individuals with high exhaustion scores could be considered a stress-prone individual (Maslach, et al., 2001).

Personal risk factors for burnout include gender, age, marital status, and education level (Maslach, et al., 2001). Females score higher on the exhaustion scale of the MBI, and males tend to score higher on the cynicism scale of the same measure; males, however, report higher overall burnout than females (Rosenberg & Pace, 2006). Younger therapists and novice therapists tend to be more susceptible to burnout than their older and more experienced colleagues (Adams, Matto & Harrington, 2001; Nelson-Gardell & Harris, 2003; Vredenburg, Carlozzi & Stein, 1999). Unmarried, single therapists tend to be at greater risk for burnout than their married or divorced colleagues. Finally, as a therapist's level of education increases, risk for burnout also increases, suggesting that perhaps people with higher degrees have greater work responsibilities, and thus greater work-related stress (Abu-Bader, 2000; Maslach, et al., 2001). A therapist's personal trauma history may also increase his or her likelihood of burnout (Cunningham, 2003; Nelson-Gardell & Harris, 2003). While the aforementioned personal factors may contribute to burnout, work environment-related factors and client trauma-related factors are considered more significant causes of burnout, suggesting that burnout is more of a social issue, rather than a personal issue (Maslach, et al., 2001).

Secondary Traumatic Stress, Vicarious Trauma, and Compassion Fatigue

It is the therapist's duty to be present with his or her clients through their struggles. An individual who has experienced trauma needs a strong therapeutic alliance with his or her

therapist just as much as a client without a history of trauma (Sheehy Carmel & Friedlander, 2009). Counseling a client, who presents with a particularly traumatic story, puts the therapist at risk of becoming emotionally disregulated (Figley, 2002; Sprang, et al. 2007; Sheehy Carmel & Friedlander, 2009). Therapists who treated clients who committed sex crimes, reported many negative emotional consequences from their work (Sheehy Carmel & Friedlander, 2009). The results suggest that clients presenting with potentially traumatic presenting problems have strong adverse emotional affects on the therapist. The therapists who experienced these negative emotional outcomes also experienced difficulties connecting with their clients, and similar difficulties with their personal relationships.

Secondary Traumatic Stress, Vicarious Traumatization, and Compassion Fatigue are used synonymously in the literature to describe the negative psychological reactions counselors may experience when repeatedly exposed to their client's traumas (Rothschild & Rand, 2006). Each term, however, has distinct characteristics (Newell & MacNeil, 2010).

Secondary traumatic stress. Secondary traumatic stress is defined as “ the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other (or client) and the stress resulting from helping or wanting to help a traumatized or suffering person (or client)” (Figley, 1995, p. 7). According to the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, text revision; *DSM-IV-TR*, (American Psychiatric Association, 2000), secondary traumatic stress disorder results from learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or a close associate” (p. 463) and can be diagnosed as Post Traumatic Stress Disorder. The symptoms of secondary traumatic stress are caused by repeated exposure to the client's suffering due to a traumatic experience, as well as the therapist's continuous display of

empathy (Newell & MacNeil, 2010). According to Figley (1995), burnout, compassion fatigue, and compassion satisfaction, all impact therapists who encounter secondary traumatic stress.

Vicarious traumatization. McCann and Pearlman (1990) referred to vicarious traumatization as the therapist changing his or her cognitive schemas and aspects of personality following prolonged exposure to traumatic material. Vicarious traumatization is characterized by symptoms including anxiety, disconnection, social isolation and avoidance, depression, and negatively changing beliefs about self and others, including safety and trust, and changes in spiritual beliefs (Cunningham, 2003; Pearlman & Saakvitne, 1995; Sprang, et al., 2007).

Vicarious traumatization and secondary traumatic stress are very similar in their origin (Newell & MacNeil, 2010). How the therapist experiences the trauma (his or her clients present with), is what differentiates the two. Vicarious traumatization is characterized by the therapist's changes in cognitions, such as his or her thoughts and beliefs about the world. Secondary traumatic stress is more closely related to the behavioral, observable Post Traumatic Stress Disorder symptomology such as intrusive thoughts and nightmares, rather than cognitive changes (Newell & MacNeil, 2010).

Compassion fatigue. Compassion fatigue is a combination of the symptoms of secondary traumatic stress and professional burnout (Adams, et. al., 2006; Bride, et. al., 2007; Figley, 1995; Newell & MacNeil, 2010). Pfifferling & Gilley (2000) defined it as physical, emotional, and spiritual depletion, accompanied by the presence of emotional pain. The onset may be gradual, over time, and due to prolonged empathy-giving to highly traumatized clients (Figley, 2002b; Rothschild & Rand, 2006). Vicarious traumatization or secondary traumatic stress however, is characterized by rapid onset (Newell & MacNeil, 2010). Prolonged responses of empathy, in addition to other work demands, exacerbate compassion fatigue in the therapist

(Figley, 1995; Figley, 2002b). Compassion fatigue can be experienced without the presence of secondary traumatic stress (Newell & MacNeil, 2010). Simply stated, compassion fatigue is a job hazard for anyone in the helping profession (Alkema, et al., 2008).

Several personal as well as organizational risk factors can put a therapist more at risk of experiencing vicarious traumatization, secondary traumatic stress, or compassion fatigue. Therapist's pre-existing anxiety or mood disorder, or personal experience with trauma, may put him or her at greater risk for experiencing these aforementioned conditions (Dunkley & Whelan, 2006; Gardell & Harris, 2003; Lerias & Byrne, 2003; Newell & MacNeil, 2010). Therapists with particularly high caseloads of traumatized clients and inadequate trauma training (Lerias & Byrne, 2003; Newell & MacNeil, 2010; Pearlman & MacIan, 1995), as well as those with maladaptive coping strategies (Dunkley & Whelan, 2006; Farrell & Turpin, 2003; Newell & MacNeil, 2010; Schauben & Frazier, 1995) may be more susceptible as well.

Several organizational risk factors exist for developing vicarious traumatization, secondary traumatic stress, and compassion fatigue. The setting and its bureaucratic restrictions, ineffective or insufficient supervision, lack of community resources, lack of professional treatment team support, and the effect of the agency culture on the therapist all put him or her at greater risk for developing these conditions (Catherall, 1999, 1995; Dunkley & Whelan, 2006; Farrell & Turpin, 2003; Newell & MacNeil, 2010).

There are several things a therapist can do to combat the effects of compassion fatigue (Chrestman, 1999). Supervision and consultation, balance within life roles (Cerney, 1995), training for new and experienced therapists (Chrestman, 1999), perceived coping ability (Follette, et al., 1994), and social support (Chrestman, 1999; Harris, 1995) can prevent the

negative effects of vicarious traumatization, secondary traumatic stress, and compassion fatigue. The following strategies can be used to combat the effects of secondary trauma: journaling about intrusive dreams, progressive relaxation, imagery, physical activity, healthy diet, drawing on spiritual strengths, and seeking out any interests that bring the therapist pleasure (Salston & Figley, 2003).

Compassion Satisfaction

Much of the existing research seems to be focused on the negative effects of working with traumatized clients (e.g., compassion fatigue and burnout), rather than on the positive aspects that providing this level of compassion can bring to a therapist's life (Radey & Figley, 2007). The continuous empathy and compassion a therapist provides for his or her clients does not always have negative effects on the therapist; positive outcomes are also possible, including compassion satisfaction. Compassion is defined by the Merriam-Webster Online Dictionary as the "awareness of the suffering of another, coupled with the wish to relieve it." Compassion satisfaction describes the pleasure one gains by helping other people, and the security in one's own ability to positively affect another person's well-being (Stamm, 2002, 2005). Trauma training can significantly increase compassion satisfaction and decrease compassion fatigue and burnout among therapists (Sprang et al., 2007). Having a positive affect, optimism, having and utilizing social resources, good health, and a balanced life (Radley & Figley, 2007) were also found to increase compassion satisfaction. Female therapists who sought personal counseling and supervision, while working with traumatized clients, reported more positive psychological effects from their work (Linley & Joseph, 2007; Radey & Figley, 2007). Individual self-care, as well as organizational self-care, has the potential to greatly increase a person's likelihood of

experiencing higher levels of compassion satisfaction and lower levels of compassion fatigue (Jenaro et al., 2007; Radey & Figley, 2007).

Self-Care

Self-care can be defined as the behavioral actions a person takes to decrease the amount of stress, anxiety, and emotional reactions he or she experiences while working with clients in a therapeutic setting (Williams, et al., 2010). Gentry (2002) suggested self care is to compassion fatigue, as seat belts are to driving an automobile. While Gentry's analogy referred to a therapist's professional life, the absence of self-care can have negative effects on one's personal life as well (Williams et al., 2010). It is imperative for therapists to learn and practice the skills necessary to attend to all of the needs a person has in his or her life including personal, familial, emotional, and spiritual needs, all the while attending to the needs of the client (Figley, 2002; Stamm, 1999). In order to defend against professional burnout, Maslach (2003) suggested setting attainable professional goals, keeping lunch and coffee breaks as personal time, maintaining physical health through rest and relaxation, and nurturing close, positive relationships with friends and family. Therapists experiencing burnout symptoms sometimes invest more energy into their work, blurring professional or personal boundaries and increasing the likelihood of burnout. Many people report falling victim to destructive behaviors in times of high stress and anxiety, such as overeating, spending beyond their means, and/ or drug or alcohol abuse, as means to self-soothe and ease the demand of the job that are not being met through their efforts (Gentry, 2002).

Self-awareness, or an unbiased examination and reflection on one's personal experiences and behaviors, is thought to be the basis of self-care (Baker, 2002, 2003; Brady et al., 1995;

Shapiro, Brown, & Biegel, 2007). Another dimension of self-care that some people find effective include artistic forms of self-expression, such as drawing, painting, cooking or engaging in outdoor activities (Hesse, 2002). Nurturing one's spiritual dimension is also a critical aspect of self-care. Attending church regularly, mindfulness activities, yoga, and/ or personal counseling are all spiritual self-care strategies (Gardell & Harris, 2003; Hesse, 2002). School-aged children receiving a four-week mindfulness training program in school, rated higher on post-test scales related to measures of mindfulness and psychological well-being when compared to the control group. Notably, the students who practiced the mindfulness techniques outside of school noted even higher levels of mindfulness and psychological well-being (Huppert & Johnson, 2010). Regular exercise routines, aerobic or anaerobic, have been found to be one of the most important aspects of self-care (Gentry, 2002). Anshel, Brinthaup, and Kang (2010) found marked improvement in mental well-being, after implementing a ten-week physical fitness regimen. As physical fitness increased, (cardiovascular fitness, muscular strength, and body composition), overall mental well-being increased as well in terms of anxiety, depressed mood, positive well-being, self-control, general health, and vitality. Utilizing family and friends for critical emotional and social support can also be key steps in a therapist's personal self-care plan (Figley & Barnes, 2005; Phipps & Byrne, 2003; Stamm, 1999).

Professional organizations take self-care very seriously, as evidenced by distinct statements in each discipline's Code of Ethics about the therapist's own issues interfering with the therapeutic relationship. The American Counseling Association (ACA) Code of Ethics clearly states that counselor self-care is a professional responsibility, stating that a counselor's role is to "maintain and promote [counselor's] emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities." (p. 9). Simply stated, self-care is an

ethical duty, necessary to provide best possible treatment to clients. In addition to ACA, the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2009) requires counselor education programs to implement wellness-learning objectives into their course curriculums, maintaining that graduates of these programs should demonstrate wellness in clinical practice.

Wellness

The World Health Organization (WHO) defined wellness as “physical, mental, and social well-being, not merely the absence of disease,” dating as far back as 1947 (WHO, 1958, p.1). A few years later, WHO defined optimal health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (WHO, 1964, p.1). Wellness encompasses several dimensions of a person, not simply physical health (Myers & Sweeney, 2005; Lawson, Venart, Hazler & Kottler, 2007). Prilleltensky and Prilleltensky (2003) suggested that wellness operates on the balance of three levels: (1) the personal level, which emphasizes the personal need to have control over one’s life, leading to personal empowerment; (2) the relational level, which emphasizes the concern for people, and honoring diversity; and (3) the collective level, which mirrors social justice and equality among people, and emphasizes economic well-being, safety and security.

The Wheel of Wellness model established five life tasks, demonstrated by the image of a wheel. The five tasks are: spirituality, self-regulation or self-direction, work and leisure, friendship, and love (Hattie, et al., 2004; Myers, et al., 2000; Sweeney & Witmer, 1991; Witmer & Sweeney, 1992; Witmer, et al., 1998). The assessment tool used to measure the components of this model is called the Wellness Evaluation of Lifestyle (WEL; Myers, 1998; Myers, et al.,

1996). After many years of conducting research using the WEL, Myers and Sweeney (2005) revised the Wheel of Wellness and named the new model the Indivisible Self. They identified five factors that comprise the Indivisible Self, including “Essential Self,” “Social self,” “Creative Self,” “Physical Self,” and “Coping Self” (Myers & Sweeney, 2005). The new model emphasizes *whole* and *integrated components of self* across the lifespan, rather than discrete components of self (Myers & Sweeney, 2005; Tanigoshi, Kontos & Remley, 2008).

The *Essential Self* is comprised of spirituality, gender identity, cultural identity, and self-care. Alfred Adler, a leading figure in the world of psychotherapy, said that spirituality was a vital part of holism and wellness (Mansager, 2000). Distinctly different from religion, spirituality has been connected with quality of life and wellness (Myers & Sweeney, 2005; Day-Vines & Holcomb-McCoy, 2007). The Essential Self is where a person finds his or her existential meaning of life. Gender and cultural identity are identified as the “filters” through which people view their experiences, as well as their interactions with other people in the world.

The *Creative Self* is comprised of a person’s thinking, emotions, control, work, and positive humor (Myers & Sweeney, 2005). Simply stated, the Creative Self is what makes each person unique in social situations. Myers and Sweeney identified previous research, which revealed that one’s cognitions affect one’s emotions, which affect one’s body. Correspondingly, the way a person experiences an emotion has the capacity to influence the way he or she thinks about a similar situation. Control is the perceived personal ability to have an effect on the events one experiences throughout life (Myers & Sweeney, 2005). According to Donald Super, work is a critical element in human experience that can enhance a person’s ability to live life fully (Niles & Harris-Bowlsbey, 2005). Finally, humor can increase physical and mental functioning (Kuiper & Nicholl, 2004).

The *Coping Self* includes the elements of leisure, stress management, self-worth, and realistic beliefs which help a person manage his or her responses to negative life events. Engagement in leisure activities, or behaviors that allow a person to escape the negative aspects of his or her life for a brief time, is considered helpful to the coping process (Myers & Sweeney, 2005). Mindfulness, or the ability to hold both positive and negative experiences in awareness, has been shown to be a necessary skill for coping and, ultimately, counselor wellness (Baker, 2002; Skovholt, 2001). Mindfulness allows a therapist to bring attention to psychological needs, and allows the therapist to adjust his or her behaviors to get those needs met (Brown & Ryan, 2003). Shapiro, et al., (2007), investigated a mindfulness-based stress reduction program (MBSR) that taught graduate-level counseling psychology students techniques such as sitting meditation, body scan, yoga, and informal mindfulness practices. They found a decline in perceived stress, negative affect, anxiety, and rumination; as well as an increase in positive affect and self-compassion (Shapiro, et al., 2007). Norcross and Guy (2005) suggest that 75% of all mental health professionals have engaged in personal therapy at some point throughout his or her career to manage stress, seek personal growth, or improve interpersonal skills.

The *Social Self* includes both friendship and love, which often exist on a continuum. It is often difficult to discern between a relationship with a significant other and a relationship with a friend. What is clear is that close relationships enhance a person's quality of life and overall wellness (Shurts & Meyers, 2008). Myers and Sweeney (2005) suggested that family support, either biological, or chosen, is the most critical type of relationship, stating that healthy family support directly affects a person's overall wellness. Sinclair and Myers (2003), found social wellness to be the most highly rated wellness factor by college students.

Finally, *Physical Self*, including exercise and nutrition, may be the most widely emphasized and researched component of the self, often over-stated in its importance and in effect, neglecting the other components of the self in trying to attain holistic wellness (Myers & Sweeney, 2005). Biddle, Fox, Boucher, and Faulkner (2000) conducted an extensive review of the existing literature, and found that exercise is directly correlated with overall well-being. Also, exercising for enjoyment because a person desires to exercise has significant positive effects on mental well-being as well (Thogersen-Ntoumani & Fox, 2007).

The Indivisible Self has been described using five major components that comprise the whole self. From a systems perspective, a person has the ability to have a positive or negative effect on the environment, as does the environment on the person. Therefore, the Indivisible Self cannot be completely understood without examining it in different contexts such as local, institutional, global, and chronometrical (Myers & Sweeney, 2005). The *local context*, which concentrates on a person's sense of safety, is comprised of a person's family, neighborhood, and community. The *local context* is the one with which most people have the most contact (Myers & Sweeney, 2005).

The *institutional context*, is closely tied to policies and laws. In terms of the Indivisible Self, the *institutional context* includes education, religion, government, business and industry, which affect people directly and indirectly, and often powerfully (Myers & Sweeney, 2005).

The *global context* includes world events, politics, culture, and the environment. These types of events are often made personal through the invasive nature of the media, for example, the persistent media coverage of the tragedy on September 11, 2001 (Myers & Sweeney, 2005).

Finally, the *chronometrical context*, simply stated, the lifespan, emphasizes the fact that people change and develop over time. For example, if a person decides to make choices that promote wellness and a healthy lifestyle at a young age, he or she is more apt to make similar choices later in life. Movement of time throughout the lifespan is seen as perpetual, positive, and purposeful (Myers & Sweeney, 2005).

Simply stated, from a holistic perspective, each component of the Indivisible Self interacts in one way or another with each other, and contributes to overall well-being. Likewise, the different contexts presented by Myers and Sweeney (2005) affect the whole person positively or negatively, directly, or indirectly. Strengths in any component of the holistic view of the self can be fostered to improve other areas of functioning to enhance the overall well-being of the individual.

Self-Care Strategies

Physical. The physical dimension of self-care is broadly defined as an activity that involves physical activity (Carroll, Gilroy, & Murra, 1999) or bodily movement in which the result is expending energy, such as sports, household activities, or exercise (Henderson & Ainsworth, 2001). Physical activity has been shown to demonstrate a decrease in anxiety and depression symptoms (Callaghan, 2004), as well as increase the health component of quality of life (Lustyk, Widman, Paschane, & Olson, 2004). These positive effects on well-being may increase women's satisfaction with body functioning and their overall ability to cope with stresses of daily living (Anderson, King, Stewart, Camacho, & Rejeski, 2005).

Psychological. A therapist seeking out his or her own personal counseling, or treatment for an impairment (Norcross, 2005) is a demonstration of psychological self-care (Coster &

Schwebel, 1997; O'Connor, 2001). Due to the demanding nature of the counseling relationship requiring the therapist to provide help to a client with a psychological problem, it is suggested that the therapist seek out the benefits of counseling as well (Richards, Campenni, & Muse-Burke, 2010). Personal counseling has been known to enhance personal and professional development, as well as self-awareness (Mackey & Mackey, 1994; Macran, Stiles, & Smith, 1999).

Spiritual. Spirituality is defined as “a developmental process that is both active and passive wherein beliefs, disciplines, practice, and experiences are grounded and integrated to result in mindfulness (non-judgmental awareness of present experiences), heartfulness (experience of compassion and love), and soulfulness (connections beyond ourselves)” (Cashwell, Bentley, & Bigbee, 2007, p. 67). Spiritual self-care strategies include mindfulness, self-hypnosis, music, and balance (Esch, et al., 2003; Juslin, et al., 2008; Schure, et al., 2008; Williams, et al., 2010). A growing body of research suggests the need for a stress reduction program that emphasizes mindfulness to enhance overall well-being (Baer, 2003; Grossman, Niemann, Schmidt, & Walach, 2004). The mindfulness-based stress reduction program (MBSR; Kabat-Zinn, 1990) is based on the premise of mindfulness, or non-judgmentally focusing on the present moment, as a way to reduce distress and augment well-being (Baer, 2003; Bishop, 2002; Grossman, et al., 2004).

Support. Professional support systems, including supervision, consultation, and professional education; and personal support systems, including relationships with partner, friends, and family, are critical elements of a therapist's self-care (Coster & Schwebel, 1997; O'Connor, 2001; Stevanovic, & Rupert, 2004). Coster and Schwebel (1997) found that mental health professionals indicated that professional support gave them valuable input into different

client situations, thus reporting professional support to be their main reason for their overall well-being. Speaking openly with colleagues has also been suggested as a way to combat burnout, as well as individual counseling, possibly with some form of desensitization program (Figley, 2002). Educating therapists about burnout and self-care strategies may help a therapist recognize the symptoms in him or herself or a colleague, thus minimizing potential maltreatment of clients (Figley, 2002).

Conclusion

According to researchers (e.g., Lawson, et al., 2007; Cashwell, Bentley & Bigbee, 2007; Shapiro, et al., 2007), providing therapy can have a tremendous effect on the therapist's personal, emotional, and occupational well-being. It is important to address the effects of compassion fatigue and the therapist's level of involvement in self-care activities. Maintaining personal wellness contributes to the therapist's ability to best serve his or her clients (Alkema, Linton & Davies, 2008; Cummins, Massey & Jones, 2007). Salston & Figley (2003) emphasized the importance of supervision and consultation, balancing one's home, self, and work roles, and the utilization of social supports (such as friends, family members, and colleagues) for supporting personal well-being. Engagement in ongoing personal reflection and self-awareness are considered imperatives for therapists to combat the negative effects of job stressors (Cummins, Massey & Jones, 2007). Paying closer attention to the compassion satisfaction that is derived from the work therapists do, could more effectively combat the negative effects that come with their role in the therapeutic relationship with their clients (Sheehy Carmel & Friedlander, 2009).

One way to effectively address burnout is to teach self-care in counselor training programs (Newell & MacNeil, 2010). From an agency perspective, regularly administering

assessments to get a clear understanding of where the employees are in terms of professional quality of life and the different dimensions including vicarious traumatization, secondary traumatic stress, compassion fatigue, and burnout (Newell & MacNeil, 2010; Rosenberg & Pace, 2006) could decrease the negative effects of therapist impairment. Should indicators of impairment be discovered, an agency could develop a support group for the employees to openly discuss work-related experiences (Catherall, 1999; Pearlman, 1999; Rosenberg & Pace, 2006).

There seem to be a number of possible reasons why counselor wellness has not been examined in the recent years, such as counselors not being aware of what wellness really is, feeling shame or guilt for struggling with wellness, professional priorities, systemic dysfunction, and fear of repercussions for not performing their jobs well (Lawson, et al., 2007). Generally speaking, some broad themes rationalizing the lack of literature or research on the topic include: Counseling is still a relatively new profession; counselors have been busy establishing themselves among other helping professions rather than dealing with impairment or wellness issues. Counselors may also be lacking knowledge about prevention and interventions for counselor impairment as well as the parallel that exists between client impairment and symptomology, and the manifestations of impairment in the therapist (Lawson, et al., 2007; Kottler & Hazler, 1996).

Previous research conducted by Alkema, Linton, and Davies (2008) yielded results similar to the hypotheses in their research on hospice care professionals (HCPs). Significant negative correlations were found between compassion satisfaction and burnout, as well as compassion satisfaction and compassion fatigue (secondary traumatic stress). Overall, they found a trend of negative correlations between burnout and all dimensions of self-care. Due to the nature of this correlational design, causal relationships cannot be predicted, however results

suggest that if HCPs practice self-care on a variety of dimensions, it may increase their ability to manage symptoms of compassion fatigue (secondary traumatic stress) and burnout (Alkema, Linton & Davies, 2008).

The purpose of this research is to find out if a relationship exists between a therapist's reported level of engagement self-care (physical, psychological, emotional, spiritual, workplace, and balance), and his or her overall professional quality of life (in terms of compassion satisfaction, burnout, and secondary traumatic stress). It is hypothesized that there will be a direct positive relationship between the participant's level of self-care and his or her compassion satisfaction. Also hypothesized is that as the participant's scores on the self-care subscales increase, his or her scores on burnout and secondary traumatic stress will decrease. Analysis of the data collected will also determine if any specific dimensions of self-care affect any of the subscales on the ProQOL-5 measure (compassion satisfaction, burnout, or secondary traumatic stress). This researcher was particularly interested in finding specific dimensions of self-care that influenced compassion satisfaction, burnout, and secondary traumatic stress. This study was correlational in nature with the specific goal of exploring self-care issues in the helping profession and making suggestions for ways in which therapists can address work-related stress and optimize work-related satisfaction.

Previous research conducted by Alkema, Linton, and Davies (2008) yielded results similar to the hypotheses in their research on hospice care professionals (HCPs). Significant negative correlations were found between compassion satisfaction and burnout, as well as compassion satisfaction and compassion fatigue (secondary traumatic stress). Overall, they found a trend of negative correlations between burnout and all dimensions of self-care. Due to the nature of this correlational design, causal relationships cannot be predicted, however results

suggest that if HCPs practice self-care on a variety of dimensions, it may increase their ability to manage symptoms of compassion fatigue (secondary traumatic stress) and burnout (Alkema, Linton & Davies, 2008).

Method

This research is correlational in nature. It is designed to measure the relationship between self-care and professional quality of life. Each of these two variables has multiple dimensions. Self-care includes six dimensions including physical self-care, psychological self-care, emotional self-care, spiritual self-care, workplace self-care, and balance. Professional quality of life encompasses compassion satisfaction, burnout, and secondary traumatic stress. This study is designed to detect relationships among each of these dimensions. This section will include the participants chosen for the research, the materials used, and the procedure by which the research design was performed.

Participants

Participants in this study were chosen based on a convenience sample of 46 therapists working in a community mental health agency. To administer the assessments, this researcher attended an interdisciplinary staff meeting in two urban, and one suburban satellite location sites under the same agency. The sample was comprised of various disciplines of mental health professionals, including marriage and family counselors, social workers, and mental health counselors. Considering the relatively small sample size, demographic information was not acquired to protect confidentiality.

Materials

Two instruments were used to collect data for this research project; the Professional Quality of Life Assessment (Stamm, 2009), and the Self Care Assessment Worksheet (Saakvitne & Pearlman, 1996). Both of these instruments were used previously in the research conducted on Hospice Care Professionals by Alkema, Linton & Davies (2008). The assessments are described below.

Professional Quality of Life Assessment (ProQOL5). The Professional Quality of Life Assessment (Pro-QOL 5), is based on Figley's (1995) depiction of Secondary Traumatic Stress Disorder. It is the most commonly utilized assessment to measure the positive and negative effects of trauma on the helper [therapist] (Stamm, 2010). This assessment has been revised several times from its original form, which consisted of 66 items. The current form contains 30 items, and has three subscales: Compassion Satisfaction, Burnout, and Secondary Traumatic Stress. Each subscale contains 10 items, and participants must rate each item on a 6-point scale (0 = never, 5 = very often) based on their experience in the past 30 days. Subscale scores range from 0 to 50, with higher scores indicating higher levels of Compassion Satisfaction, Burnout, and Secondary Traumatic Stress. Sample items from the Pro-QOL 5 include: "I get satisfaction from being able to help people" (Compassion Satisfaction), "I feel trapped by my job as a helper" (Burnout), and "I find it difficult to separate personal life from my life as a helper" (Secondary Traumatic Stress). Stamm (2010) reported that the construct validity is good, reporting "over 200 published papers" with nearly half of the published articles using the Pro-QOL, or one of its earlier forms (p. 13).

The compassion satisfaction score refers to the pleasure one gets from doing their work well (Stamm, 2009). The average score is 50 (SD 10; alpha scale reliability .88). About 25% of participants score over 57, and about 25% score below 43. Scoring in the higher range indicates

that the participant likely draws a significant amount of satisfaction from the work that they do. Scores that fall in the lower range may indicate that the participant either is not satisfied with the work they do, or that the participant draws satisfaction from other areas of their life besides work.

The burnout score represents feelings of hopelessness, difficulties handling one's work, and poor work performance (Stamm, 2009). The average score on this scale is 50 (SD 10; alpha scale reliability .75). About 25% of participants score above 57 and about 25% score below 43. If a participant's score is below 18, it most likely reflects a positive attitude about work, and feeling effective about the work one does with clients. A score above 57 indicates that the participant is at risk for burnout, and it may be a cause for concern.

The secondary traumatic stress score denotes secondary exposure to traumatic events through exposure to a client's trauma. The average score on this subscale is 50 (SD 10; alpha scale reliability .81), with 25% of participants scoring above 57, and 25% scoring below 43. Scores in the higher range do not necessarily signify a problem; the score is simply an indicator that the participant may want to examine how he or she feels about the work environment.

Self-Care Assessment Worksheet (SCAW). The Self-Care Assessment is a self-assessment tool developed to measure the dimensions of self-care that a person demonstrates or utilizes at a given time (Saakvitne & Pearlman, 1996). This assessment delineates the six dimensions of self-care: physical, psychological, emotional, spiritual, workplace or professional, and balance. Each of these six subscales contains a different number of items by which the respondent would rate from one to five in terms of how often he or she practices each activity (1 = never occurred to me; through 5 = frequently occurs). The higher the total score for each subscale, the more

engaged in that dimension of self-care the respondent indicates, and conversely, the lower the score, the less engaged the respondent indicates being. Sample items from the Self-Care Assessment include (a) get regular medical care for prevention (physical), (b) make time for self-reflection (psychological), (c) find things that make you laugh (emotional), (d) identify what is meaningful to you and notice its place in your life (spiritual), (e) take a break during the workday (workplace or professional), and (f) strive for balance among work, family, relationships, play, and rest (balance).

The Self-Care Assessment is not meant to be a diagnostic tool, or to demonstrate impairment in any way. It is designed to provide a description of how well the respondent is, or is not, engaging in self-care. This measure has not been tested for reliability or validity (Saakvitne & Pearlman, 1996).

Procedure

This researcher attended a staff meeting where a majority of the therapists at each of the three clinic sites (two urban sites and one suburban site) were in attendance. This researcher briefly explained the purpose of the study and defined the dimensions of the assessments measured. Participants were told that it would take 15-20 minutes to complete the assessments. Participants were also given the choice to self-score the assessments, or allow this researcher to score the assessments at a later date. Participants completed self-scoring if they were interested in knowing their level of engagement in self-care activities, and where their scores fell in relation to the mean scores on the ProQOL-5 (which were provided in the assessment packet handed out). Participation was completely voluntary and anonymous. Participants were shown gratitude for

their participation through complimentary biscotti and hot chocolate. All therapists present at the three staff meetings this researcher attended, completed the assessments.

Results

Correlational results for the ProQOL-5 and the SCAW are presented in Table 1.

Compassion satisfaction was significantly correlated ($p \leq .01$) with emotional self-care ($r = .557$), workplace self-care ($r = .512$), and balance ($r = .394$); and also correlated ($p \leq .05$) with psychological self-care ($r = .325$). Secondary traumatic stress was negatively correlated to physical self-care ($r = -.343$, $p \leq .05$). Data analysis revealed a strong negative correlation between burnout and all six dimensions of self-care ($p \leq .01$), physical self-care ($r = -.541$), psychological self-care ($r = -.542$), emotional self-care ($r = -.586$), spiritual self-care ($r = -.387$), workplace self-care ($r = -.614$), and balance ($r = -.557$).

TABLE 1. Correlation Between SCAW and ProQOL-5 Measures

| | PhySC | PsySC | EmoSC | SprSC | WkpSC | Bal | CS | BO | STS |
|-------|-------|-------|-------|-------|-------|------|------|-------|-------|
| PhySC | | ** | ** | | * | ** | | ** | * |
| r | 1 | .402 | .394 | .158 | .334 | .488 | .229 | -.541 | -.343 |
| p | - | .006 | .007 | .294 | .023 | .001 | .125 | .000 | .019 |
| PsySC | ** | | ** | ** | ** | ** | * | ** | |
| r | .402 | 1 | .638 | .588 | .567 | .473 | .325 | -.542 | -.252 |
| p | .006 | - | .000 | .000 | .000 | .001 | .027 | .000 | .091 |
| EmoSC | ** | ** | | ** | ** | ** | ** | ** | |

| | | | | | | | | | |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| r | .394 | .638 | 1 | .553 | .647 | .423 | .557 | -.586 | -.250 |
| p | .007 | .000 | - | .000 | .000 | .003 | .000 | .000 | .094 |
| SprSC | | ** | ** | | ** | | | ** | |
| r | .158 | .588 | .553 | 1 | .418 | .192 | .285 | -.387 | -.105 |
| p | .294 | .000 | .000 | - | .004 | .202 | .055 | .008 | .489 |
| WkpSC | * | ** | ** | ** | | ** | ** | ** | |
| r | .334 | .567 | .647 | .418 | 1 | .689 | .512 | -.614 | -.214 |
| p | .023 | .000 | .000 | .004 | - | .000 | .000 | .000 | .153 |
| Bal | ** | ** | ** | ** | ** | | ** | ** | |
| r | .488 | .473 | .423 | .192 | .689 | 1 | .394 | -.577 | -.262 |
| p | .001 | .001 | .003 | .202 | .000 | - | .007 | .000 | .079 |
| CS | | * | ** | | ** | ** | | ** | * |
| r | .229 | .325 | .557 | .285 | .512 | .394 | 1 | -.744 | -.303 |
| p | .125 | .027 | .000 | .055 | .000 | .007 | - | .000 | .041 |
| BO | ** | ** | ** | ** | ** | ** | ** | | ** |
| r | -.541 | -.542 | -.586 | -.387 | -.614 | -.577 | -.744 | 1 | .425 |
| p | .000 | .000 | .000 | .008 | .000 | .000 | .000 | - | .003 |
| STS | * | | | | | | * | ** | |
| r | -.343 | -.252 | -.250 | -.105 | -.214 | -.262 | -.303 | .425 | 1 |
| p | .019 | .091 | .094 | .489 | .153 | .079 | .041 | .003 | - |

** . Correlation is significant at the 0.01 level (2-tailed)

* . Correlation is significant at the 0.05 level (2-tailed)

r. Pearson Correlation

p. Significance (2-tailed)

Self-Care Assessment Worksheet

Mean scores for each of the self-care dimensions on the SCAW are demonstrated in Table 2. High scores on each dimension indicate a higher level of engagement in that particular dimension of self-care, and low scores indicate a lower level of engagement in that dimension. Spiritual self-care had the highest mean (M= 14.7880), followed by physical self-care (M= 11.006), and psychological self-care (M= 8.7913). Because there are a different number of questions on each dimension of the SCAW, direct comparison of scores between dimensions was not possible without manipulating the scores. To compensate for this, the researcher weighted each dimension's score on a percentage weight out of 100. This researcher added up the total possible score for all six dimensions on the SCAW, as well as the total possible score for each particular dimension. The possible score for each dimension was divided by the total possible score, thus giving a percentage weight. To find the scores that would be used in the correlation, this researcher multiplied the total attained score for each participant on each dimension by the percentage weight for that particular dimension. The percentage weights are represented in Table 3.

TABLE 2. Average Self-Care Assessment Worksheet Scores

| | N | Range | Minimum | Maximum | Mean | SD |
|-------------------------|----|-------|---------|---------|---------|---------|
| Physical Self-Care | 46 | 7.3 | 8 | 15.3 | 11.0065 | 1.35456 |
| Psychological Self-Care | 46 | 5.4 | 6.2 | 11.6 | 8.7913 | 1.15313 |

| | | | | | | |
|------------------------|----|-------|------|------|---------|---------|
| Emotional Self-Care | 46 | 4.2 | 4.05 | 8.25 | 5.7424 | .75211 |
| Spiritual Self-Care | 46 | 10.25 | 9.75 | 20 | 14.7880 | 2.31898 |
| Workplace Self-Care | 46 | 3.91 | 4.93 | 8.84 | 7.0070 | 1.08936 |
| Balance | 46 | .18 | .15 | .33 | .2434 | .04411 |

TABLE 3. Percentage Weight of Scores on the Self-Care Assessment Worksheet

| | |
|-------------------------|-----|
| Physical Self-Care | 20% |
| Psychological Self-Care | 20% |
| Emotional Self-Care | 15% |
| Spiritual Self-Care | 25% |
| Workplace Self-Care | 17% |
| Balance | 3% |

Professional Quality of Life Assessment (ProQOL-5)

Mean scores for the ProQOL-5 are presented in Table 4. The compassion satisfaction mean score (M=39.24) was significantly higher than the mean scores for burnout (M= 23.7) and secondary traumatic stress (M= 21.48).

TABLE 4. Average Professional Quality of Life Scores

| | N | Range | Minimum | Maximum | Mean | SD |
|----------------------------------|----|-------|---------|---------|-------|-------|
| Compassion Satisfaction | 46 | 24 | 25 | 49 | 39.24 | 6.023 |
| Burnout | 46 | 21 | 14 | 35 | 23.70 | 6.055 |
| Secondary Traumatic Stress | 46 | 24 | 13 | 37 | 21.48 | 5.545 |

In summary, burnout scores negatively correlated with all six dimensions of self-care, and compassion satisfaction was significantly correlated with four out of six dimensions of self-care. Secondary traumatic stress was negatively correlated with only one dimension of self-care, physical self-care. Spiritual self-care was the highest rated dimension of self-care, indicating a higher level of engagement in those activities than any of the other dimensions. Overall, data analysis supported this researcher's hypotheses.

Discussion

This study was designed to explore the relationship between self-care, compassion satisfaction, burnout, and secondary traumatic stress among therapists in a community mental health clinic setting. It was hypothesized that therapists who engaged in multiple self-care activities would experience higher levels of compassion satisfaction and lower levels of burnout and secondary traumatic stress. Various interesting findings emerged during data analysis regarding these variables.

First, data analysis revealed a significant indirect relationship between burnout and all six self-care dimensions. This indicates that as the therapists' level of engagement in self-care increased, burnout decreased. Secondary traumatic stress was negatively correlated with physical self-care only, out of all six dimensions. These findings suggest that therapists who engage in a variety of self-care activities from different dimensions may be better equipped to combat the symptoms of burnout and secondary traumatic stress. Due to the correlational nature of the analysis, a causal relationship cannot be predicted between self-care and burnout and secondary traumatic stress. Future research should explore ways in which mental health agencies can assist their employees in engaging in a variety of self-care activities to increase compassion satisfaction (psychological self-care, emotional self-care, workplace self-care, and balance), and decrease burnout (all six dimensions) and secondary traumatic stress (physical self-care). There was no significant correlation found between compassion satisfaction and spiritual self-care or physical self-care. This finding suggests that while higher levels of engagement in self-care activities may prevent burnout and secondary traumatic stress, only psychological, emotional, workplace, and balance are predictive of increased compassion satisfaction. This may suggest some relation between self-care activities, but that not all of them specifically increase compassion satisfaction or decrease burnout or secondary traumatic stress.

Second, a significant ($p \leq .01$) indirect relationship was found between both compassion satisfaction and burnout ($r = -.744$), and compassion satisfaction and secondary traumatic stress ($p \leq .05$, $r = -.303$). It is notable that the strength of these relationships are different, suggesting that burnout and secondary traumatic stress are different constructs. Analysis also demonstrated a significant ($p \leq .01$) direct relationship between burnout and secondary traumatic stress ($r =$

.425), suggesting that they are related, but still different constructs. These results were expected and are consistent with other research done in this area.

The next finding was unexpected. Psychological self-care, emotional self-care, and workplace self-care were all directly correlated with all six dimensions of self-care. This suggests that therapists who care for themselves in one of these three areas are more likely to care for themselves in several other areas as well. Notable was that physical self-care did not significantly correlate with spiritual self-care; spiritual self-care did not significantly correlate with physical self-care or balance; and balance did not significantly correlate with spiritual self-care. Therefore, increased levels of engagement in some dimensions of self-care does not equate to increased levels of engagement in all dimensions of self-care.

Mean scores on the SCAW demonstrated that therapists engaged in more spiritual self-care activities than any other self-care dimension measured. This includes things like making time for reflection, praying, meditating, and being open to not knowing. The second-most engaged in self-care dimension was physical self-care. Physical self-care includes things like eating healthy, exercising, taking vacations, and getting massages. Finally, the third highest-rated self-care dimension was psychological self-care, which includes things such as making time for self-reflection, seeking your own personal psychotherapy, decreasing stress in your life, and listening to your thoughts, judgments, beliefs, attitudes, and feelings. Agencies can promote these and other self-care activities by providing their employees more opportunities for downtime throughout the day, free or low-cost memberships to fitness facilities, more paid time off days, and employee support groups to process work-related stress and experiences. To reiterate the nature of the correlational design, just because therapists engage in higher levels of

self-care activities that increase compassion satisfaction, does not necessarily mean that the same activities will decrease levels of burnout or secondary traumatic stress.

The compassion satisfaction mean score is in the average range according to the assessment's score ranges. According to the ProQOL-5, a score of 42 or higher indicates that the participants may find problems with their job, or they may derive satisfaction from activities other than their job. The mean score on the burnout subscale represents an average level of burnout reported by participants. According to the ProQOL-5, scores above 42 indicate problems relating to feelings of effectiveness in their job, while scores below 22 indicate positive feelings about their ability to be effective in the work that they do. Lastly, the mean score for the secondary traumatic stress subscale was in the low range (22 or less), indicating few negative symptoms experienced as a direct result of the trauma their clients present with in sessions.

The results of this research are informative; however this design is not without limitations. First, due to the relatively small sample size, results should be interpreted cautiously. In order to draw more definite conclusions regarding self-care, compassion satisfaction, and burnout, a much larger sample size is needed. Also, more informative data could be gathered through a qualitative design, getting information from therapists about their specific self-care practices, and experiences with compassion satisfaction, burnout, and secondary traumatic stress. Future research should utilize larger sample sizes and a mixed-method design of data collection to examine the different constructs.

The results of this research are also limited due to the correlational nature by which the data was analyzed. Correlation does not necessarily give way to a cause-and-effect type of relationship. While predictions can be made based on this research design and its findings, a

mixed method study could yield more in-depth information, and direct cause and effect relationships, should they exist.

Despite these limitations, the results of this research are useful in improving overall emotional health of therapists in the workplace. Based on the present findings, it is important for therapists and their employers to be more proactive in promoting emotional health and satisfaction in the workplace. This could include things like workshops that increase awareness of the importance of self-care, support groups where therapists can get together regularly to discuss work-related stresses and self-care, providing more professional development to expand therapist's resources to use with clients, and staff trainings that specifically address the topics of self-care, compassion satisfaction, burnout, and secondary traumatic stress. The objective would be to provide work a work environment that would foster compassion satisfaction and diminish burnout and secondary traumatic stress. This would not only benefit the therapists employed in the agency, but also benefit the clients they serve by maintaining better emotional health of the therapists. It is important that therapists advocate for themselves and their particular needs in this area, and to get involved in developing and implementing such programs or changes in the work environment.

The findings of this research suggest a correlational relationship between self-care, compassion satisfaction, burnout, and secondary traumatic stress. Future research should build upon these findings and explore ways to increase self-care on all dimensions. Continued research in this and related areas is critical to improve therapist emotional health and workplace satisfaction in a community mental health agency.

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