

The Relationship Between Resilience and Compassion Fatigue in Counselors

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Recent studies have attempted to understand the stresses and risks associated with providing mental health counseling. These stresses have been conceptualized as vicarious stress or trauma (Bride, 2004; Collins & Long, 2003), burnout (Figley, 1995), and compassion fatigue (Collins & Long, 2004; Figley, 1995; Pearlman & Saakvitne, 1995). All of the conceptualizations have in common the theme that mental health workers are vulnerable to physical and psychological consequences when dealing with the traumatic life events of others. This vulnerability, according to Figley (1995), is the natural consequence of behaviors and emotions resulting from knowing about and listening to the narratives about a traumatizing event experienced by a significant other. These consequences are thought to be cumulative, and should vary in intensity depending on helper characteristics and the characteristics of the client population. This condition can be serious and produces symptoms similar to posttraumatic stress disorder (PTSD).

In their review, Collins and Long (2003) clarified the similarities and differences in how these consequences have been conceptualized. "A synthesis of these descriptions demonstrates that the term 'compassion fatigue' can be used interchangeably with the term 'secondary traumatic stress'" (p. 421). This condition is serious enough that counselors may themselves be in need of assistance to cope with the effects of listening to others' traumatic experiences (Figley, 1995; Pearlman & Saakvitne, 1995). Other authors have suggested that compassion fatigue may have a less negative connotation (Figley, 1995).

Burnout is conceptualized as being a syndrome of physical, emotional, and mental exhaustion (Maslach, Jackson, & Leiter, 1996; Pines & Aronson, 1988). The literature seems to maintain a distinction between compassion fatigue and burnout, and self-report measures have been developed to assess them.

Bride (2004) reviewed 17 quantitative studies that addressed the impact of providing "psychosocial services to traumatized populations" on mental health

workers, including the possible risk and protective factors that can affect experience of compassion fatigue and burnout. According to Bride, the most commonly studied variables include age, gender, exposure levels, training, occupation, personal trauma history, and trauma symptoms. The results of his examination reveals mixed results, with no clear patterns with respect to demographics, exposure, or the type of clients. It was suggested that there is some consistency regarding personal trauma, that "personal trauma history, particularly in childhood, is a significant risk factor" (p. 42).

The purpose of this study was to examine if the experience of personal trauma is associated with several of the psychological consequences of secondary trauma, specifically depression, anxiety, and coping ability. In addition, other demographic characteristics were examined for their relationship to the experience of personal trauma as well as the ability to cope.

Methods

The instruments were the Compassion Satisfaction and Fatigue Test (CSF; Stamm, 2002), Trauma Recovery Scale (TRS; Gentry, 1999), Burns Anxiety Inventory (BAI; Burns, 1999), and Burns Depression Checklist (BDC; Burns, 1999). They were distributed to 197 professional counselors, graduate counseling students, and mental health workers. The instruments were collected immediately upon completion. All instruments were completed in 2004.

The CSF consists of 66 questions broken down into three scales: compassion satisfaction, burnout, and compassion fatigue. Reported psychometric information was based on a pooled sample of 370 people. Multivariate analysis of variance did not provide evidence of differences based on country of origin, type of work, or sex when age was used as a control variable (Stamm, 2002). The mean age was 35.4, and the median was 36%. Gender was broken down as 56% female, 33% male, with the remainder being unknown. The

countries of origin of the sample were the United States (rural-urban mix) 43%, Canada (urban) 8%, South Africa (urban) 35%, and Internet (unknown origin) 13%. The alpha score for the compassion satisfaction scale was .87, for the burnout scale .90, and for the compassion fatigue scale .87.

The TRS (Gentry, 1999) is a three-part multipurpose self-report clinical instrument that was originally developed in 1995 at West Virginia University's School of Medicine. Part I was added in 1997 to allow respondents to determine if they met the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV*; American Psychiatric Association, 1994) Criterion A for posttraumatic stress disorder. Part II asks respondents to indicate whether they have experienced any of the 20 listed traumatic experiences and the number of times they have experienced these events. Part III functions as a baseline/outcome measure for individuals with PTSD. It is a Likert-scaled 11-item instrument. The respondent is asked to provide a mark on a 100mm line that best represents his or her experience relative to that item during the previous week. The TRS utilized a convenient sample of 91 university students in Florida and 56 mental health professionals from Oklahoma for a total of 147. Of this sample 63.9% (94) responded affirmatively that they met Criterion A, from the *DSM-IV*, for PTSD. The validity for Part II is questionable and will not be discussed in this article. The alpha score for Part III is .88. The TRS achieved significant validity when compared with other instruments such as the Impact of Events Scale (IES).

The Burns Anxiety Inventory (BAI; Burns, 1999) is a self-report that measures 33 symptoms of anxiety which fall into the categories of anxious feelings, anxious thoughts, and somatic manifestations of anxiety. The scores of 498 outpatients seeking treatment for mood disorders suggested excellent reliability and internal consistency with an alpha score of .94. The BAI scores correlated highly with the anxiety subscale of the Hopkins Symptom Checklist (Green, Walkey, McCormick, & Taylor, 1988).

The Burns Depression Checklist (BDC; Burns, 1999) asks respondents about 15 common symptoms of depression including sadness, low self-esteem, and hopelessness. This instrument was designed to be used to track client progress between therapy sessions. The BDC was validated in an unpublished pilot study with a group of 50 outpatients being treated for mood disorders. The subjects completed the BDC and the Beck Depression Inventory (Beck & Steer, 1993) at the same time. Test administration was reversed in half of the subjects to prevent bias based on order of administration. Most subjects had almost identical

scores on both tests. At this time the BDC is recommended for clinical use only as it has not been used in formal research studies.

Results

A total of 197 sets of self-report data were collected in 2004. There were 45 men (22.84%) and 152 women (77.16%). About 25.4% were single; 51.3% were married; 19.8% were divorced; and the remaining 3.5% were separated, widowed, or other. In this sample, 53.3% were Caucasian; 39.1% were African American; and the remaining 7.1% were other ethnic backgrounds. The mean age was 40.79 ($SD = 9.68$). About 67.7% of the participants had a master's degree or higher level of education. Over 80% identified themselves as currently working in a helping profession. The remainder were graduate counseling students.

Of particular interest in this sample was the report that 65.5% of the sample reported at least one event that was characterized as a traumatic event on the TRS. There were no significant differences in the reporting of trauma between men and women (chi-square [1] = 0.037, $p = 0.85$); marital status (chi-square [2] = 1.158, $p = 0.56$); profession (chi-square [1] = 0.183, $p = 0.67$).

Differences in age, and scores on the Total Coping Inventory, Burns Depression Inventory, and Burns Anxiety Inventory between participants who had, versus who had not, experienced trauma were examined using t-tests. Participants who had experienced trauma were slightly older than those who had not (mean ages = 41.44 and 39.00, respectively); and had rated themselves as slightly lower in coping (mean coping scores = 84.49 and 87.49, respectively), as slightly more depressed (Burns Depression Inventory mean scores 2.00 and 2.69, respectively), and as slightly more anxious (Burns Anxiety Inventory mean scores 1.33 and .95, respectively). The t-test for differences between means on the anxiety measure approached significance ($t = 1.94$, $p = .06$), while the other differences were nonsignificant ($\geq .07$).

Discussion

The results of this study suggest that the prior experience of trauma in mental health professionals does not necessarily coincide with experience of psychological consequences such as compassion fatigue, burnout, anxiety and depression. Further, demographic characteristics of age, marital status, and profession are not associated with the presence or absence of trauma. This tends to be consistent with published data.

The data related to compassion satisfaction suggest that mental health professionals and graduate students, whether meeting the conditions for Criterion A of the *DSM-IV* for PTSD or not, may have at least as high a degree of compassion satisfaction as the general population.

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