

## Prevention-Based Training for Licensed Professional Counselor Interns

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**R**esearch indicates there is a need for counselors to become educated early in their careers about the risks associated with compassion fatigue and related constructs. I conducted four prevention-based trainings in different venues that investigated how compassion fatigue, compassion satisfaction, burnout, self-efficacy, empathy, personal distress, self-awareness, and non-reactivity impacted Licensed Professional Counselor Interns compared to a self-study control group. There was a significant difference in levels of empathy and self-awareness in participants who completed the trainings in comparison to those in the control group, but no significant differences between groups on any of the other dependent variables. Implications for further research and training are discussed.

*Keywords: compassion fatigue, prevention-based trainings, counselor interns*

Counseling can be difficult and is often full of uncertainty (Rak, MacCluskie, Toman, Patterson, & Culotta, 2003; Solway, 1985). This can become extremely taxing for counselors, as the self is the main instrument used in their work (Figley, 1995). This continued strain, left unaddressed, can lead to compassion fatigue. Compassion fatigue is a state of tension and preoccupation with a client (Figley, 2002a) that has an interactive, or synergistic, effect among primary traumatic stress, secondary traumatic stress, and burnout symptoms in the life of an afflicted counselor (Rank, Zaparanick & Gentry, 2009). Research on compassion fatigue indicates that

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counselor education alone may not be enough preparation to protect professionals from experiencing it (Bush, 2009). Specifically, research specifies a need for counselors to be further educated about the risks and the strategies that can serve as protective factors (Eastwood & Ecklund, 2008). Recovery from compassion fatigue can take several months, and prevention education is a logical conclusion (Ruysschaert, 2009). Compassion fatigue prevention is paramount, especially for new professionals (Bush, 2009; Campbell, 2007; Craig & Sprang, 2010; Figley, 2002a, 2002b; Gentry, 2002; Jacobson, 2006; Sprang, Clark, & Whitt-Woosley, 2007; Van Hook & Rothenberg, 2009; Webb, 2006).

Figley's seminal work indicates that compassion fatigue is an occupational hazard of the counseling profession (Figley, 1995, 2002a, 2002b, 2004). Symptoms of compassion fatigue may include a sense of helplessness, isolation, and confusion, which can be experienced as though the counselor is disconnected from the actual events causing the symptoms (Eastwood & Ecklund, 2008). Unattended compassion fatigue may lead to a plethora of undesirable outcomes, including premature exit from the profession, boundary violations, and ethical violations. Counselors who are unable to make sound clinical decisions because they are unaware they are impacted by compassion fatigue can be harmful to clients (Alkema, Linton, & Davies, 2008; Eastwood & Ecklund, 2008).

In a study spanning mental health, law, healthcare, religion, and education, Tehrani (2007) found that 60% of the professionals who participated felt overwhelmed and 64% of them endorsed the belief that the world is a dangerous place, both indicators of compassion fatigue. Sprang et al. (2007) examined a varied group of mental health professionals, including trauma counselors, agency counselors, and case managers, and found that all professionals in the study showed some indicators of compassion fatigue. Even with compassion fatigue identified as a potential detriment to the counseling profession (Adams, Figley, & Boscarino, 2008; Alkema et al., 2008; Figley, 1995, 2002a, 2002b, 2004; Gentry, 2002; Jacobson, 2006), the literature review revealed no studies on using prevention-based training to educate new counseling professionals about the risks of and prevention of compassion fatigue.

Several reviewed studies called for a prevention-focused training to provide professional counselors with evolving knowledge of protective factors (Alkema et al., 2008; Campbell, 2007; Figley, 1995, 2002a, 2002b; Gentry 2002; Leon et al., 1999; Mitchell, 1996; Sprang et al., 2007). Experts agree that immersion in the knowledge of protective factors could be the key to preventing compassion fatigue from developing. These protective factors include: self-care, ethics, healthy boundaries, supportive work environment, humor, supervision, relaxation techniques,

sense of self-efficacy, and self-regulation (Alkema et al., 2009; Baranowsky, 2002; Craig & Sprang, 2010; Dutton & Figley, 2002; Gentry, 2002; Gentry, Baranowsky, & Dunning, 2002; Hoffman, 2009; Ruyschaert, 2009; Valent, 2002).

In response to suggestions in the literature that prevention-based trainings be used with new counseling professionals (Craig & Sprang, 2010; Gentry, 2002; Jacobson, 2006; Leon et al., 1999; Mitchell, 1996; Myers & Wee, 2002; Pearlman & Saakvitne, 1995), the current study utilized Charles Figley's compassion fatigue educator training materials as a four-hour prevention-based training for Licensed Professional Counselor Interns. The compassion fatigue literature revealed that prevention is the best approach (Ruyschaert, 2009) and that providing trainings may alleviate symptomology (Alkema et al., 2008; Eastwood & Ecklund, 2008).

### **Purpose of the Study**

The purpose of this study was to determine if a four-hour prevention-based training affected compassion fatigue in Licensed Professional Counselor Interns compared to a self-study control group. The overall research question for the study was: Will the four-hour prevention-based training affect compassion fatigue, compassion satisfaction, burnout, awareness, non-reactivity, self-efficacy, empathy and personal distress in Licensed Professional Counselor Interns

compared to a self-study control group?

### **Method**

This study examined the effects of a four-hour compassion fatigue prevention-based training intervention that focused on items the literature indicated to be protective factors: education about compassion fatigue and compassion satisfaction, self-awareness, self-efficacy (self vs. other validation), and self-care. The audience for these trainings was Licensed Professional Counselor Interns. The study was based on an experimental design, with a treatment group and a self-study control group. The two groups were measured on the dependent variables before and after the experimental group was exposed to the treatment.

### **Participants**

The selection of participants was conducted by contacting the Texas State Board of Examiners of Professional Counselors to procure a list of Licensed Professional Counselor Interns. The Texas State Board of Examiners of Professional Counselors had a listing of 2,436 Licensed Professional Counselor Interns. I obtained a random number generator at [www.random.org](http://www.random.org) and applied this to the list. This software generated a list of 1,263 Licensed Professional Counselor Interns to invite to participate in the study. The Licensed Professional Counselor Interns were contacted via telephone and

Facebook and invited to participate in the study. Those sixty respondents who desired to participate received an informed consent statement and specific information pertaining to the study via email.

The present study ( $N=60$ ) was comprised of a treatment group ( $n=31$ ) and a control group ( $n=29$ ). This sample size was selected to maximize normal distribution and minimize generalizability error. The method of random sampling was used to select the sample and conduct the study; however, participants were allowed to self-select into the control or experimental group.

### Instrumentation

There were four instruments included in this study. *The Professional Quality of Life Scale, Version 5* (Stamm, 2009) measured participants' pre and post compassion satisfaction, compassion fatigue, and burnout. The *Interpersonal Reactivity Index* (Davis, 1980) was used to measure participants' empathy and personal distress levels. *The Five Factor Mindfulness Questionnaire* (Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006) was used to measure participants' acting with awareness and nonreactivity levels. Finally, the *Counselor Activity Self-Efficacy Scales* (Lent, Hill, & Hoffman, 2003) was used to measure participants' perception of self-efficacy.

**Professional Quality of Life Scale Version 5 (ProQOL).** ProQOL is composed of three discrete subscales (Stamm, 2009). The first

subscale measures compassion satisfaction. Higher scores on this subscale represent greater satisfaction gained from one's work with helping others (Bride, Radey, & Figley, 2007). The second subscale measures burnout. A high score on this subscale represents a greater risk for burnout. The third subscale measures compassion fatigue/secondary traumatic stress. High scores indicate increased levels of compassion fatigue/secondary traumatic stress (Bride et al., 2007; Stamm, 2009).

The ProQOL is a 30-item self-report instrument that measured the frequency one has experienced each item in the previous 30 days. Each item is attached to a 6-item Likert scale (0 = never, 1 = rarely, 2 = a few times, 3 = somewhat often, 4 = often, 5 = very often; Bride et al., 2007; Stamm, 2009). Scoring is done by summing responses for each 10-item subscale. Five of the items require reverse scoring prior to score computation. The subscale scores are not combined to find a total score (Bride et al., 2007; Stamm, 2009). Thus, a score of 33 or below on the compassion satisfaction scale may imply job dissatisfaction. The procedures for the burnout scale recommend that a score below 18 reflects positive feelings about one's ability to be effective in her work, and scores above 27 could indicate the respondent does not feel effective. With regard to the compassion fatigue/secondary trauma scale, scores above 17 are considered to reflect a potential

problem in this domain (Bride et al., 2007; Stamm, 2009).

The creators reported the internal consistency and reliability approximations for the subscales as .87 for the compassion satisfaction scale, .72 for the burnout scale, and .80 for the compassion fatigue/secondary trauma scale (Bride et al., 2007; Stamm, 2009).

**Interpersonal Reactivity Index (IRI).** The Interpersonal Reactivity Index was designed by Davis (1980) to assess empathy in social settings multi-dimensionally. The index utilizes theoretical underpinnings from Hoffman's (1977) theoretical model of the development of social tendencies and empathy which contends that the ability for gaining perspective parallels a developmental alteration from self-oriented to other-oriented (Bentley, 2007).

The IRI is a 28-item self-report measure containing four subscales exploring facets of empathy (Davis, 1980). The subscales consist of seven items evaluated on a Likert-type scale ranging from 0 (does not describe me well) to 4 (describes me very well). Davis (1980) felt the empathic concern and perspective taking subscales reflected the most sophisticated levels of empathy. The empathic concern subscale measures the inclination to respond to others' distress with sympathy and compassion. The perspective taking subscale assesses the propensity to espouse others' point of view (Bentley, 2007; Davis 1980).

The fantasy subscale measures the inclination for one to use imagination to transform

emotions and behaviors into those of characters in books and movies (Bentley, 2007; Hatcher, Favorite, Hardy, Goode, Deshelter, & Thomas, 2005). The personal distress scale correlates negatively with the other subscales (Davis, 1980) and measures the proclivity to become anxious when facing distressing feelings in others.

The internal reliabilities consistency reliabilities were established by Davis (1980) for the four subscales range from .70 to .78. Reliabilities for the subscales (empathic concern .80; personal distress .75; fantasy .82; perspective taking .79) were established by Pulos et al. (2004). Davis (1980) found test-retest reliabilities to range from .62 to .71 over a two month period and .50 to .62 for over a two-year period (Bentley, 2007; Davis & Franzoi, 1991).

Construct validity was measured by evaluating the IRI with the Hogan Empathy Scale (Hogan, 1969) and the Emotional Empathy Scale (EETS) (Mehrabian & Epstein, 1972). Both the personal distress and empathic concern scales were significantly associated with the Hogan ( $r = -.33$  and  $r = .60$ ) and EETS ( $r = .24$  and  $r = .52$ , respectively) scales (Bentley, 2007).

**Five Factor Mindfulness Questionnaire (FFMQ).** The Five Factor Mindfulness Questionnaire is a blend of self-report mindfulness questionnaires embodying the shared knowledge among researchers on mindfulness and how it is effectively utilized (Baer et al.,

2006). The objective of the FFMQ is to offer clarification of the competencies found to be factors of an overall construct of mindfulness.

The FFMQ measures five factors of mindfulness: observing, describing, acting with awareness, nonjudging, and nonreactivity (Baer et al., 2006). These five factors comprise the total mindfulness score, which reflects a comprehensive mindfulness measure. The FFMQ utilizes a 5-point Likert-type scale (1 = never or very rarely true, 5 = very often or always true). Questions are answered by participants based on what best describes items generally true for them (Baer et al., 2006). The amalgam estimate of reliability was 0.96 with the alpha coefficients was: observing 0.83, describing 0.91, acting with awareness 0.87, nonjudging 0.87, and nonreactivity 0.75 (Baer et al., 2006). The inter-factor correlations varied from 0.15 to 0.34 (Baer et al., 2006). A confirmatory factor analysis investigated the five-factor structure to determine if it could be copied in an independent sample while investigating convergent and divergent validity (Baer et al., 2006). The FFMQ was reduced from 115 items to 39 items to augment internal consistency and develop a manageable length for the instrument. The FFMQ consists of items that resulted in the highest loadings on the five factors and, also, loaded on a lone factor (Baer et al., 2006).

**Counselor Activity Self-Efficacy Scale (CASES).** The Counselor Activity Self-Efficacy Scale (Lent et al., 2003) was designed to

measure self-efficacy in counseling in three areas: helping skills performance, ability to manage the counseling process, and ability to handle difficult counseling situations (Bentley, 2007). The CASES is comprised of 31 questions that allow participants to self-report their confidence in their abilities to implement counseling skills with clients in timeframe of next week and rate confidence on a Likert-type scale ranging from 0-9 (0 = no confidence at all, 9 = complete confidence (Bentley, 2007). The measure conceptualizes counseling self-efficacy around three domains: helping self-efficacy, session management self-efficacy, and challenges of counseling self-efficacy (Bentley, 2007; Lent et al, 1998; Lent, Hoffman, Hill, Treistman, Mount, & Singley, 2006).

Reliability approximations for the subscales ranged from .79 (helping self-efficacy) to .94 (session management and challenges of counseling), affording evidence of internal consistency (Bentley, 2007). The reported results support the scales signify clear, yet related, constructs of self-efficacy in counseling (Lent et al., 1998).

### **Prevention-Based Training Intervention**

The four-hour prevention-based trainings offered in different venues were constructed around Charles Figley's training materials, which are based on prior research conducted in the field (Figley, 2004). The four-hour trainings consisted of educating participants about compassion fatigue, causes, symptoms,

at-risk factors, and protective factors. Participants participated in experiential self-awareness activities that included writing letters to themselves, self-assessments, and intimate group discussions about the meaning of self-care as it is relevant to their individual lives. Next, participants were lead through the steps of creating personalized self-care plans. Finally, the training ended with a guided relaxation activity.

### Procedures

Once IRB approval was attained, I utilized the Licensed Professional Counselor Interns Roster from the Licensed Professional Counselor website to identify individuals for inclusion in the research. I trained four people using a standardized procedure and script to help contact potential participants. I also utilized the social network of Facebook to contact some of the Licensed Professional Counselor Interns on the list. The same information given to those receiving phone calls was included in the message on Facebook. The follow-up packet informed the potential participants about the purpose of the study, potential risks, and the voluntary nature of their participation.

I administered the four hour prevention-based trainings and distributed to the control group a self-study intervention consisting of reading two assigned articles on different topics from the *Journal of Creativity in Mental Health*. The control group was offered the same

intervention as the experimental group upon completion of the study. Once groups were determined, I emailed all participants the pre-tests: Professional Quality of Life Scale Version 5 (Stamm, 2009), Interpersonal Reactivity Index (Davis, 1980), Five Factor Mindfulness Questionnaire (Baer et al., 2006), Counselor Activity Self-Efficacy Scales (Lent et al., 2003), and the Demographic Survey. These scales were completed independently and emailed or faxed back to me.

Members of the treatment group attended a four-hour prevention-based training that was offered in different locations in Texas. Three trainings were face-to-face, and one was conducted via live broadcast utilizing a university's Virtual College. The training was simultaneously broadcast to 2 campuses.

Two weeks post training, each participant was administered a post-test via email. The post-test was comprised of the same instruments used in the pre-test.

### Data Analysis

After ensuring data met assumptions for repeated measures analysis, a multivariate analysis of variance (MANOVA) was performed to indicate differences between experimental and control groups. A MANOVA was chosen because the number of multiple dependent variables (i.e., compassion fatigue, compassion satisfaction, burnout, self-efficacy, empathy, personal distress, acting with awareness, and non-reactivity).

**Table 1**

*Descriptive Statistics*

Factor	Group	N	Pre-Test M	SD	Post-Test M	SD
Personal Distress	Treatment	31	9.5	4.94	9.2	4.09
	Control	29	9.4	4.14	10	4.73
Empathy	Treatment	31	21.40	4.29	22.23	3.62
	Control	29	18.21	4.63	17.52	4.97
Self-Efficacy	Treatment	31	6.41	1.09	6.7	.93
	Control	29	6.53	1.08	6.63	1.13
Awareness	Treatment	31	27.93	5.73	28.42	4.65
	Control	29	26.79	5.11	25.43	4.69
Nonreactivity	Treatment	31	23	5.43	23.74	5.78
	Control	29	22.59	3.97	23.59	3.97
Compassion	Treatment	31	37.64	7.61	38.84	6.86
Satisfaction	Control	29	40.66	5.27	41.82	5.41
Compassion	Treatment	31	21.10	4.92	20.35	4.73
Fatigue	Contro	29	20.48	4.59	19.69	5.38
Burnout	Treatment	31	22.77	6.90	22.16	5.78
	Control	29	22.03	5.95	20.17	4.79

**Results**

The overall research question was: Will the four-hour prevention-based training affect compassion fatigue, compassion satisfaction, burnout, awareness, non-reactivity, self-efficacy, empathy and personal distress in Licensed Professional Counselor Interns

compared to a self-study control group? Multivariate analysis of variance (MANOVA) was conducted with an alpha level set at the .05. Descriptive statistics for the dependent variables are in Table 1. The MANOVA yielded the following statistics: Wilk's Lambda = .75,  $F(8, 51) = 2.11$ ,  $p < .06$ , partial eta

squared = .249. Though it was very close to the required alpha level, there was no statistically significant difference in scores between treatment and control groups,  $F(8, 51) = 2.11, p < .06$ , Wilk's  $\Lambda = 0.75$ , partial  $\eta^2 = .24$ . The post hoc ANOVAs were conducted, even though the omnibus was not statistically significant, as the focus of the study was on group differences.

Follow-up univariate ANOVAs showed statistically significant differences upon pre-test for empathy scores and upon post-test for empathy and awareness scores. A Bonferroni adjustment was used to accommodate for eight dependent variables ( $.05/8 = .006$ ). There was a statistically significant difference in awareness post-test scores based on treatment group,  $F(1, 58) = 6.48, p < .02$ , partial  $\eta^2 = .10$  with a close to moderate effect size. There was a statistically significant difference in empathy post-test scores between treatment and control groups,  $F(1, 58) = 17.76, p < .001$ , partial  $\eta^2 = .23$ . There was a statistically significant difference in empathy pre-test scores based on treatment group,  $F(1, 58) = 7.78, p < .01$ , partial  $\eta^2 = .11$  with a close to moderate effect size. A repeated measures ANOVA on the empathy scores of the treatment groups showed no main effect but there was a statistically significant interaction effect,  $F(1, 58) = 8.27, p < .01$ , Wilk's  $\Lambda = 0.87$ , partial  $\eta^2 = .12$  with a close to moderate effect size. The treatment group's mean empathy score increased from pre-test (mean = 21.42) to post-

test (mean = 22.23) while the control group's mean empathy score decreased from pre-test (mean = 18.21) to post-test (mean = 17.52). In this study, statistical significance was noted when effect sizes were moderate (partial  $\eta^2 = .13$ ) to large (partial  $\eta^2 = .26$ ).

The overall MANOVA results indicated the treatment and control groups were not significantly different from each other upon pre-test. As the results were close and I thought the non-significant outcome was due to sample size issues, I decided to run a post hoc analysis. This measure indicated there were significant differences upon post-test. These post hoc analyses indicated that, after the four-hour prevention-based training, the treatment group reported significantly different levels of empathy and self-awareness than the control group; however they were not significantly different in compassion fatigue, compassion satisfaction, burnout, self-efficacy, personal distress, and non-reactivity

## Discussion

It is important to emphasize the fact that, due to the limited sample size and non-significant overall MANOVA RESULTS, these findings are preliminary. However, the Licensed Professional Counselor Interns did express greater levels of awareness after engaging in the training in comparison with the control group. The four-hour prevention-based training may have provided participants with greater awareness of the constructs

measured by the four instruments. Attending the training may also have increased the interns' awareness of the struggles they experienced in the field, normalized these feelings for them, and elicited more honest, thoughtful answers on the post tests. The Licensed Professional Counselor Interns may have become more self-aware about how the work they do affects them based on the conversations during the trainings. This, in turn, may have affected their perception of the answers to the questions on the measurements. The trainings and normalizing conversations that ensued with other struggling Licensed Professional Counseling Interns may have served to help them with self-awareness and the ability to be honest with themselves about how much and how deeply impacted they really are by their work (Gentry, 2002).

Research indicates that counselors are frequently resistant to admitting they are experiencing emotional struggles (Figley, 1995). Furthermore, they may be hesitant to seek help (Gentry, Baranowsky, & Dunning, 2002). The measurements utilized in this study asked thought provoking questions and invited the participants to practice more honest, open self-reflection. This could have led to a more realistic view of work attitudes and acceptance that they are facing emotional struggles, therefore influencing responses related to personal distress, self-efficacy, compassion satisfaction, compassion fatigue, and burnout

**Implications for research.** The impact compassion fatigue has on novice counselors is imminently important in the field of counseling. Further studies need to be conducted utilizing prevention-based training to understand whether the training is indeed a viable tool that can assist new counseling professionals in avoiding the detrimental impact of compassion fatigue. These studies need to consider the best format for conducting the prevention-based trainings and how to sustain the effects. Finally, more research should be conducted to isolate the risk and protective factors that impact the experience of compassion fatigue for counselor interns.

**Limitations.** A limitation was that the sample of 60 may have represented atypical Licensed Professional Counselor Interns in Texas who were either exceptionally committed to learning or feeling negative effects of being in the field. The low acceptance to participate rate, as evidenced by 1,263 Licensed Professional Counselor-Interns having been invited and only 60 accepting the invitation, resulted in a smaller than desirable sample size. Furthermore, these results may not be generalizable to the Licensed Professional Counselor Interns population as the instruments relied on self-report regarding perceptions of these constructs. Participants may have been motivated to present themselves in a more positive light, potentially lacking self-objectivity.

The scales utilized in this study were completed by the participants away from the

researcher; thus, participants were not able to ask clarifying questions. The possibility of not understanding the questions or language of the scales cannot be ruled out. The researcher cannot be positive that the participants took the time to contemplate and reflect on each question prior to answering.

Another limitation is that participants could have been influenced by the material utilized and peers in their perception and experience of the trainings. Further research should address this issue and the fact that two of the trainings were delivered via live, interactive video streaming. This may have influenced the participants' opinion of the training as opposed to the students who attended face-to-face, on-site training.

### Conclusion

The results from the present study indicate that the four-hour prevention-based training did not impact the constructs with the exception of empathy and awareness. The awareness and personal honesty that was invited during the four-hour prevention-based trainings could have influenced this outcome. Implications for this study suggest more research is needed to elucidate this matter.

As stated earlier, the counseling profession is full of uncertainty (Rak et al., 2003; Solway, 1985) and it can seem overwhelming for a Licensed Professional Counselor Intern to manage mastering all of the counselor competencies (Skovolt & Ronnestad, 2003). New counselors should know how to protect themselves from compassion fatigue (Stamm, 2009)

and educating new counseling professionals about this potential occupational hazard (Figley, 1995) is an important process that needs to be addressed within the counseling profession. New counselors need multiple layers of support the first few years in the field (Skovolt & Ronnestad, 2003). Ideally, thorough education about compassion fatigue (Figley, 1995) should begin in graduate programs. This should continue throughout the supervision process where new counselors are developing habits they will have throughout their careers. The results of this study could provide new counseling professionals with knowledge of protective factors that can help prevent compassion fatigue. Thus, new counseling professionals can be available to a greater degree to serve clients more effectively and retain enjoyment in their work.

## References

- Adams, R. E., Figley, C. R., & Boscarino, J. A. (2008). The Compassion Fatigue Scale: Its use with social workers following urban disaster. *Research on Social Work Practice, 18*, 238-250. doi:10.1177/1049731507310190
- Alkema, K., Linton, J., & Davies, R. (2008). A study of the relationship between self-care, compassion satisfaction, fatigue, and burnout among hospice professionals. *Journal of Social Work in End-of-Life & Palliative Care, 4*, 101-119. doi:10.1080/15524250802353934
- Baer, R., Smith, G., Hopkins, J., Krietemeyer, J., & Toney, L. (2006). Using self-report assessment methods to explore facets of mindfulness. *Assessment, 13*, 27-45. doi:10.1177/1073191105283504
- Baranowsky, A. B. (2002). The silencing response in clinical practice: On the road to dialogue. In C.R. Figley (Ed.), *Treating Compassion Fatigue* (pp. 155-170). New York: Routledge.
- Bentley, P. (2007). *Mindfulness and counseling self-efficacy: The mediating role of attention and empathy*. (Doctoral dissertation.) Retrieved from <http://libres.uncg.edu/edocs/etd/1398/umi-uncg-1398.pdf>
- Bride, B., Radey, M., & Figley, C. (2007). Measuring compassion fatigue. *Clinical Social Work Journal, 35*, 155-163. doi:10.1007/s10615-007-0091-7
- Buchheld, N., Grossman, P., & Walach, H. (2001). Measuring mindfulness in insight meditation (vipassana) and meditation-based psychotherapy: The development of the Freiburg Mindfulness Inventory (FMI). *Journal for Meditation and Meditation Research, 1*, 11-34.
- Bush, N. J. (2009). Compassion fatigue: Are you at risk? *Oncology Nursing Forum, 36*, 24-28.
- Carlson, L. E., & Brown, K. W. (2005). Validation of the Mindful Attention Awareness Scale in a cancer population. *Journal of Psychosomatic Research, 58*, 29-33. doi:10.1016/j.jpsychores.2004.04.366
- Campbell, L. (2007). Utilizing compassion fatigue education in hurricanes Ivan and Katrina. *Clinical Social Work Journal, 35*, 165-171. doi:10.1007/s10615-007-0088-2
- Carey, J. C., Fox, E. A., & Spraggins, E. F. (1988). Replication of structure findings regarding the Interpersonal Reactivity Index. *Measurement and Evaluation in Counseling and Development, 21*, 102-105.
- Cliffordson, C. (2002). The hierarchical structure of empathy: Dimensional organization and relations to social functioning. *Scandinavian Journal of Psychology, 43*, 49-59. doi:10.1111/1467-9450.00268
- Craig, C. D., & Sprang, G. (2010). Compassion satisfaction, compassion fatigue, and burnout in a national sample of trauma treatment therapists. *Anxiety, Stress, & Coping, 23*, 319-339. doi:10.1080/106158009085818
- Davis, M. (1980). A multidimensional approach to individual differences in empathy. *JSAS Catalog of Selected Documents in Psychology, 10*, 85-102.
- Davis, M. H., & Franzoi, S. L. (1991). Self-awareness and self-consciousness. In V. Derlega, B. Winstead, & W. Jones (Eds.), *Personality: Contemporary Research and Theory*, (pp. 313-347). Chicago, IL: Nelson-Hall Publishers.
- Eastwood, C. D., & Ecklund, K. (2008). Compassion fatigue risk and self-care practices among residential treatment center childcare workers. *Residential Treatment for Children & Youth, 25*, 103-122. doi:10.1080/08865710802309972
- Figley, C. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorders in those who treat the traumatized*. London, England: Brunner-Routledge.
- Figley, C. (2002a). Compassion fatigue: Psychotherapists' chronic lack of self-care. *Journal of Clinical Psychology/In Session, 58*, 1433-1441. doi:10.1002/jclp.10090

- Figley, C. (2002b). *Treating compassion fatigue*. New York, NY: Routledge.
- Figley, C. (2004). *Compassion fatigue educator course workbook: An all-day training course*. Florida State University, Tallahassee, Florida and the Green Cross Foundation.
- Gentry, J. E. (2002). Compassion fatigue: A crucible of transformation. *Journal of Trauma Practice*, 1, 37-61.
- Gentry, J. E., Baranowsky, A., & Dunning, K. (2002). The Accelerated Recovery Program (ARP) for compassion fatigue. In C.R. Figley (Ed.), *Treating compassion fatigue* (pp. 123-138). New York, NY: Routledge.
- Hatcher, S., Favorite, T., Hardy, E., Goode, R., Deshelter, L., & Thomas, R. (2005). An analogue study of therapist empathic process: Working with difference. *Psychotherapy: Theory, Research, Practice, Training*, 42, 198-210. doi:10.1037/0033-3204.42.2.198
- Hoffman, M.L. (1977). Empathy, its development and prosocial implications. *Nebraska Symposium on Motivation*, 25, 169-217.
- Hoffman, P. (2009). Addressing compassion fatigue. *Healthcare Executive*, September/October 40-42.
- Hogan, R. (1969). Development of an empathy scale. *Journal of Consulting and Clinical Psychology*, 33, 307-316.
- Jacobson, J. (2006). Compassion fatigue, compassion satisfaction, and burnout: Reactions among employee assistance professionals providing workplace crisis intervention and disaster management services. *Journal of Workplace Behavioral Health*, 21, 133-152. doi:10.1300/J490v21n03\_08
- Leon, A., Altholz, J., & Dziegielewski, S. (1999). Compassion fatigue: Considerations for working with the elderly. *Journal of Gerontological Social Work*, 31, 43-62. doi:10.1300/J088v32n01\_04
- Lent, R. W., Hackett, G., & Brown, S. D. (1998). Extending social cognitive theory to counselor training: Problems and prospects. *The Counseling Psychologist*, 26, 295-306.
- Lent, R. W., Hill, C. E., & Hoffman, M. A. (2003). Development and validation of the Counselor Activity Self-Efficacy Scales. *Journal of Counseling Psychology*, 50, 97-108.
- Lent, R.W., Hoffman, M.A., Hill, C.E., Treistman, D., Mount, M., & Singley, D. (2006). Client-specific counselor self-efficacy in novice counselors: Relation to perceptions of session quality. *Journal of Counseling Psychology*, 53, 453-463.
- Mehrabian, A., & Epstein, N. (1972). A measure of emotional empathy. *Journal of Personality*, 40, 525-543.
- Mitchell, J. T. (1996). Surviving trauma treatment. [Review of the book *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*, by C. R. Figley]. *PsycCRITIQUES*, 41, 1120-1121. doi:10.1037/003215
- Myers, D. & Wee, D. (2002). Strategies for managing disaster mental health worker stress. In C.R. Figley (Ed.), *Treating compassion fatigue* (pp. 181-212). New York, NY: Routledge.
- Pearlman, L.A., & Saakvitne, K.W. (1995). Treating therapists with vicarious traumatization and secondary traumatic stress disorders. In C.R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 150-176). New York, NY: Routledge.
- Pulos, S., Elison, J., & Lennon, R. (2004). The hierarchical structure of the interpersonal reactivity index. *Social Behavior and Personality*, 32, 355-360.
- Rak, C., MacCluskie, K., Toman, S., Patterson, L., & Culotta, S. (2003). The process of development among counselor interns: Qualitative and quantitative perspectives. *Canadian Journal of Counselling*, 37, 135-150.

- Rank, M., Zapanick, T., & Gentry, J. (2009). Nonhuman-animal care compassion fatigue: Training as treatment. *Best Practices in Mental Health Journal*, 5, 39-61.
- Ruysschaert, N. (2009). (Self) hypnosis in the prevention of burnout and compassion fatigue for caregivers: Theory and induction. *Contemporary Hypnosis*, 26, 159-172. doi: 10.1002/ch
- Skovholt, T., & Ronnestad, M. (2003). Struggles of the novice counselor and therapist. *Journal of Career Development*, 30, 45-58. doi: 10.1023/A:1025125624919
- Solway, K. (1985). Transition from graduate school to internship: A potential crisis. *Professional Psychology: Research and Practice*, 16, 50-54.
- Sprang, G., Clark, J., & Whitt-Woosley, A. (2007). Compassion fatigue, compassion satisfaction, and burnout: Factors impacting a professional's quality of life. *Journal of Loss and Trauma*, 12, 259-280. doi:10.1080/15325020701238093
- Stamm, B. H. (2009). *Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL)*. Retrieved from <http://www.isu.edu/~bhstamm>
- Tehrani, N. (2007). The cost of caring: The impact of secondary trauma on assumptions, values, and beliefs. *Counseling Psychology Quarterly*, 20, 325-339.
- Van Hook, M.P., & Rothenberg, M. (2009). Quality of life and compassion satisfaction/fatigue and burnout in child welfare workers: A study of the child welfare workers in community based care organizations in central Florida. *Social Work & Christianity*, 36, 36-54.
- Webb, K. (2006). Talk to someone who cares, why don't you?: Psychotherapists experiencing distress. [Review of the book *Help for the helper: The psychophysiology of compassion fatigue and vicarious trauma* by B. Rothschild (with M. L. Rand)]. *PsycCRITIQUES*, 51, 253. doi:10.1037/a0003300

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