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The Mindfully Attached Therapist: Factors that Predict and Prevent the Development of Compassion Fatigue

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THE MINDFULLY ATTACHED THERAPIST: FACTORS THAT PREDICT AND PREVENT THE DEVELOPMENT OF COMPASSION FATIGUE

THESIS

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ABSTRACT OF THESIS

THE MINDFULLY ATTACHED THERAPIST: FACTORS THAT PREDICT AND PREVENT THE DEVELOPMENT OF COMPASSION FATIGUE

Characterized as a loss of empathy, compassion fatigue is experienced by many in the helping professions. Also known as secondary traumatic stress, compassion fatigue occurs when those in the helping professions experience trauma through interacting with the traumatic experiences of the people they are helping. Previous literature has found the development of compassion fatigue to be inevitable due to the amount of empathy those professionals must utilize on a daily basis. Mindfulness practices, such as Mindfulness Based Cognitive Therapy (MBCT) and Mindfulness Based Stress Reduction (MBSR) have been found to be a helpful learning tool for those in the helping professions to reduce their levels of stress. Using a convenience sample of 74 therapists, the present study utilized attachment as a framework for exploring factors of predicting and preventing compassion fatigue. Attachment styles in romantic relationships was predicted to be associated with the development of compassion fatigue, while mindfulness levels were predicted to be preventative in the development of compassion fatigue. Findings indicated that levels of compassion fatigue were higher for females, and that higher levels of mindfulness was associated with lower levels of compassion fatigue for both males and females. Implications for therapists, supervisors, and therapists-in-training are addressed.

KEYWORDS: compassion fatigue, secondary traumatic stress, burnout, attachment, mindfulness

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May 6, 2014

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This thesis is dedicated to those in the helping professions who, despite the difficult nature of their work, continue to persevere in order to help those around them.

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Chapter 1

Introduction

An effective therapist empathizes with a clients' suffering, and in doing so, helps the client move forward. At times, even the most seasoned therapist may become overwhelmed after listening to the traumatic experiences of clients. The therapist may feel isolated from the outside world, or feel there is no longer meaning in life due to a client's trauma or victimization. Feeling defeated by the client's trauma, and unable to continue on with work, is considered normal from time to time. There is hope in being worn down because of client trauma; feeling exhausted from empathizing with one's clients symbolizes the ability to be present with them and be an effective therapist. According to one therapist, exhaustion from helping allows for healing in and through participating in community (Stamm, 1999). However, compassion fatigue may lead to increased traumatic symptoms the therapist experiences due to his or her work, which may contribute to decreased effectiveness as a therapist.

Compassion Fatigue Defined

Figley (1995) first defined *compassion fatigue* as secondary traumatic stress disorder which was later amended to its current definition. The role of many helping professions, whether in medicine, emergency response, or therapy, is to emphatically suffer alongside a client in order to aid in their recovery processes. Compassion fatigue occurs when a helper's empathy and suffering with a client leads to distress (Figley & Kleber, 1995). The onset of compassion fatigue happens quickly and is most likely to happen when the therapist is empathetically overexerting him or herself (Negash, & Sahin, 2011). Symptoms for compassion fatigue are nearly identical to the symptoms of

Post Traumatic Stress Disorder (PTSD). The key difference between compassion fatigue and PTSD is who has experienced the traumatic event (Figley, 1995). An individual experiencing PTSD has had a traumatic event happen directly to him or her, while the individual with compassion fatigue is experiencing trauma through the lens of the person he or she is helping. Symptoms of both PTSD and compassion fatigue include attempts to avoid or distract oneself from the traumatic event directly or indirectly experienced, re-experiencing the traumatic event, or a state of heightened arousal (Figley, 1995). For the therapist, these symptoms may include remembering trauma of past clients, being unable to get traumatic images clients have experienced from their minds, and disruption in the therapists' personal life (Figley, 2002). Despite quick onset, findings have indicated that recovery from compassion fatigue can happen in a short amount of time (Negash, & Sahin, 2011).

Related terminology. Compassion fatigue is a relatively new construct being studied amongst the helping professions; several terms related to helper stress emerged in the literature around the same time. Although all are related to stress and exhaustion in the helping professions, previous findings have indicated that the symptoms of each are different (Figley, 1995). It is important to recognize the differences in each definition related to helper stress, in order to ensure standardized measurement and increased understanding when designing future studies.

Burnout. Symptoms of burnout are varied depending on the individual and his or her working environment. Burnout can happen in any employment situation; over a long period of time, an individual gets tired of his or her position or the organizational challenges associated with the job. Increased sick days spent away from the job,

increased accidents or mistakes while working, a change in mood affecting interpersonal relationships, and general dislike of being at work are a few symptoms of burnout that have been observed. Specific causes of burnout amongst the helping professions are exhaustion from balancing client's trauma, potential organizational demands the helper or therapist is experiencing, and the therapist's personal needs (Figley & Kleber, 1995). Findings have indicated that recovery from burnout takes longer than compassion fatigue, because it is the result of emotional exhaustion and its onset is more gradual than the onset of compassion fatigue (Figley, 1995; Negash, & Sahin, 2011). Burnout, and the emotional exhaustion linked with it, can often happen simultaneously with compassion fatigue. However, the main component of burnout is exhaustion, while compassion fatigue is characterized as a loss of empathy due to experiencing secondary trauma from the work that is being conducted with traumatized clients (Figley, 1995).

Vicarious traumatization. As the study of compassion fatigue expanded to fields across the helping professions, it was used synonymously with other terms measuring different constructs. Vicarious traumatization involves the therapist changing cognitive schemas or worldviews because he or she is overwhelmed by client trauma. A therapist experiencing vicarious trauma may view the world more negatively, or have a more negative perception about others in the world (McCann, & Pearlman, 1990). Pearlman and MacIan (1995) also found that therapists experiencing vicarious traumatization had a disruption in their perceptions of themselves. Change in schemas about self and the world cause the vicariously traumatized therapists to change their behaviors to reflect the new world views they have developed. A vicariously traumatized individual may feel the need to dominate relationships outside therapy, because of the helplessness he or she

feels in the ability to prevent a client from re-experiencing trauma in therapy (McCann & Pearlman, 1990).

Countertransference. Countertransference has also been used to describe fatigued responses to stress of having traumatized clients; the client's trauma may remind the therapist of someone in their past. Figley and Kleber (1995) viewed countertransference as a negative consequence of therapy, but not necessarily a result of fatigued empathy that is associated with compassion fatigue. In many therapy training programs, countertransference is looked at as something to avoid; conversely, compassion fatigue is the direct result of empathy fatigue in the therapist. If handled properly in supervision and with therapist self-awareness, countertransference is, many times, avoidable. Compassion fatigue can happen to a therapist who is doing his or her job in the correct way, and may not be avoided because of the empathy required when helping others who are traumatized and the relatively quick onset (Figley, 1995).

Silencing response. Finally, the silencing response has been described as a symptom that happens concurrently with compassion fatigue. In the silencing response, the therapist does not explore the client's trauma due to the therapist's own compassion fatigue, which hinders the therapeutic process for both client and therapist (Barnowsky, 2002). The silencing response is more likely to occur in therapists who experienced personal trauma but have not processed or recovered from their trauma. Therapists may listen to a clients' trauma, remember their own trauma and avoid exploring the clients' trauma because it reminds the therapists of their own personal trauma (Barnowsky, 2002).

Chapter 2

Literature Review

Predictors of Compassion Fatigue

Compassion fatigue is detrimental to the therapist's ability to effectively engage with clients due to strains on his or her empathy. Several studies have been conducted in order to explore predictors of compassion fatigue. Although concrete predictors have emerged, there are contradictory findings as to what factors actually predict whether or not a therapist will develop compassion fatigue.

Age and sex. Age has been found to predict whether or not a therapist experiences compassion fatigue. Younger therapists and mental health practitioners are more likely to develop symptoms of compassion fatigue than older, more seasoned workers (Craig & Sprang, 2010; Sprang, Clark, & Whitt-Woosley, 2007; Sprang, Craig, & Clark, 2011). Sex also plays a role; findings have indicated that females are more at risk of developing compassion fatigue than males (Craig & Sprang, 2010; Kassam-Adams, 1999; Leiter & Harvie, 1996; Negash & Sahin, 2011; Sprang et al., 2007). There are several explanations for why this finding is occurring. Male therapists have been found to be less likely to develop emotional exhaustion than female therapists (Leiter & Harvie, 1996). Several studies have found that male therapists are more likely to disengage emotionally from their clients, which may lead to less emotional exhaustion due to a lack of empathy (Eriksson et al., 2009; Figley, 2002). Knowing when to disengage emotionally from clients at times when the therapist is feeling fatigued may lead to preservation of energy. However, it can be argued that emotionally disengaging from clients may cause the therapist to depersonalize him or herself from the client,

causing the therapist not to be present with the client in session. A few studies have found that therapists most at risk for developing compassion fatigue are young females working in an agency setting (Negash, & Sahin, 2011; Sprang et al., 2007). However, in a study of child welfare workers, Sprang et al. (2007) found that males reported more compassion fatigue and burnout symptoms, but the authors hypothesized that the finding may be related specifically to child welfare workers.

Type of client. Much of the literature has found that type of clients in the caseload significantly affects whether or not therapists develop symptoms of compassion fatigue. Therapists with higher caseloads of client trauma and PTSD are more likely to develop compassion fatigue (Brady, Guy, Poelstra, & Brokaw, 1999; Craig & Sprang, 2010; Figley, 2002; Sprang et al., 2007). Findings have been mixed about whether one particular client trauma is more likely to lead to the therapist developing compassion fatigue than other types of client trauma. Meldrum, King, and Spooner (2002) studied community mental health specialists working on interdisciplinary teams. They found that mental health professionals with clients dealing with threats of death or physical harm were more likely to develop compassion fatigue. Schauben and Frazier (1995) found that therapists with higher percentages of survivors of sexual abuse in their caseloads experienced higher the levels of PTSD and vicarious traumatization. Sprang, et al. (2007) found that having a caseload with higher percentages of PTSD predicted whether the therapist developed compassion fatigue and burnout.

Time. Length of time working in the field with a traumatized client caseload has also been found to be a risk factor of developing compassion fatigue (Chrestman, 1999; Craig, & Sprang, 2010; Eriksson et al., 2009; McCann & Pearlman, 1995). In their study

of therapists specializing in international trauma treatment, Pearlman and MacIan (1995) found that newer therapists were more likely to develop symptoms of both PTSD and vicarious traumatization. They noted that the likelihood of developing those symptoms increased if the newer therapists were not being supervised. Brady et al. (1999) found that the current hours spent weekly with clients who had PTSD impacted whether or not female psychotherapists developed symptoms of compassion fatigue. Interestingly, the study also measured the cumulative amount of hours that the psychotherapists had spent over the course of their careers working with trauma clients. Therapists who had a higher amount of cumulative hours working with trauma clients throughout the course of their careers also reported higher levels of PTSD symptoms.

Work setting. Several studies have pointed to organizational factors that affect whether the therapist develops compassion fatigue. Therapists working in an agency setting have been found to be more likely to develop compassion fatigue. In their study of mental health workers, Craig and Sprang (2010) found that people working in inpatient and community mental health centers reported higher levels of compassion fatigue. Sprang et al. (2011) found that child welfare workers reported more burnout than other mental health professionals. Likewise, mental health professionals working in direct service have been found to experience higher levels of compassion fatigue than those who are administrators (Figley, 2002).

Therapists working in an agency may not have as much autonomy as those working in private practice; this could lead to the development of burnout, emotional exhaustion, and compassion fatigue. Therapists practicing privately have been found to experience higher job satisfaction and fewer symptoms of compassion fatigue (Negash &

Sahin, 2011). However, there are circumstances that may make therapists practicing privately more vulnerable to developing compassion fatigue. In their evaluation of mental health workers across Australia, Meldrum et al. (2002) found that workers practicing in rural areas were more likely to develop compassion fatigue than those working in metropolitan centers. Although therapists practicing privately may seem immune compassion fatigue, PTSD, or other symptoms commonly reported, those who live in rural areas may not have access to resources they and their clients need to combat the development of compassion fatigue (Sprang et al., 2011).

Preventing Compassion Fatigue

Several factors that may decrease symptoms of compassion fatigue or prevent against it development have been explored in the literature. The literature has identified both external buffers, related to training and organizational approaches, as well as internal factors unique to individual therapists.

External factors. Receiving specialized trauma training has been found to serve as a protective factor against the development of compassion fatigue. Mental health professionals who have received specialized trauma training have reported higher levels of compassion satisfaction and decreased levels of compassion fatigue (Craig & Sprang, 2010; Sprang et al., 2007). Along with receiving specialized trauma training, mental health professionals who utilize evidence-based practices shown to work effectively with traumatized populations reported decreased levels of compassion fatigue (Craig & Sprang, 2007). Having a network of social and organizational support also contributes to less compassion fatigue; Eriksson et al. (2009) found that international humanitarian aid

workers experienced less compassion fatigue when they felt external support from both their social networks as well as their employers.

Internal factors. Internal factors unique to each individual are also a source of support when working with traumatized populations. Whether or not therapists are satisfied in their work may affect the likelihood of their becoming fatigued in their helping role. Although many therapists experience symptoms of PTSD when they have an increased caseload of traumatized clients, findings have indicated that they also feel a high level of achievement and satisfaction in their work. Compassion satisfaction has been defined as feelings of accomplishment, despite difficulties that may emerge from challenging work (Stamm, 2002). Lee, Lim, Yang, and Min Lee (2011) found feeling a sense of personal accomplishment and satisfaction with one's work is a factor that prevents psychotherapists from developing burnout.

While some therapists may experience compassion fatigue throughout their careers, others may not develop symptoms. Working with clients who are struggling with trauma or victimization can be exhausting, yet some therapists do not display symptoms of compassion fatigue. Brady et al. (1999) found that the higher the percentage of traumatized clients in a therapist's caseload, the higher their levels of reported spiritual well-being. Working with clients who are traumatized may force therapists to connect to something larger than themselves in order to be effective in their work. Some therapists may use internal resources, such as humor, to effectively cope with the secondary trauma they are likely to experience. Moran (2002) found that emergency workers used humor to reframe the trauma they were encountering because of their work. At times, working with populations experiencing intense trauma may force

therapists to evaluate the relationships they have; a therapist experiencing compassion fatigue may need to increase social connections in order to cope effectively. Gentry, Baranowsky, and Dunning (2002) found that increasing social connections was one way for a therapist to develop a support system that could assist the therapist in maintaining a good regimen of self-care. They also developed a training program helping therapists to recover from compassion fatigue and prevent it from developing in the future. One of the main foci of the program was for the therapist to learn to remain a non-anxious presence in the therapy room.

Importance of Treatment

Despite the large amount of trauma treatment many therapists administer in their practices, compassion fatigue remains a symptom of doing therapy that is not widely discussed. The implications and effects of compassion fatigue are overarching; compassion fatigue affects the therapists' relationships with family and friends outside of the therapy room, which can in turn affect how the therapist interacts with clients in session. Diagnosis and treatment of compassion fatigue is important, as compassion fatigue develops more quickly than burnout and normally takes less time to recover from (Figley, 1995; Gentry et al., 2002). Despite shorter recovery times, compassion fatigue affects the therapist's effectiveness in therapy. To prevent his or her compassion fatigue from getting worse, a fatigued therapist may not listen to the traumatizing experiences a client needs to work through in order to progress in therapy. The therapist may not want to deal with his or her own trauma surrounding either a personal experience, or compassion fatigue due to symptoms of PTSD he or she is experiencing (Barnowsky, 2002). As the work of a therapist is never fully completed, compassion fatigue may

continue to affect the therapist throughout his or her life. In order to provide the best care, and to ensure therapists are taking the best care of themselves, continued study of personal and external factors influencing the development of symptoms of compassion fatigue is necessary.

Theoretical Application

Attachment Theory. Several studies have focused on organizational influences of employers on compassion fatigue, while others have considered internal characteristics that may make an individual more vulnerable to developing compassion fatigue and burnout (Craig & Sprang, 2010; Figley, 1995; Malach-Pines, 2004; Sprang et al., 2007; Sprang et al., 2011). One theoretical model to consider when conceptualizing compassion fatigue is that of attachment theory.

Attachment style influences the way individuals perceive themselves as well as others, and affects how they interact with the world. Bowlby (1958) conceptualized attachment as developing between an infant and primary caregiver. Based on responses given by the primary caregiver, the infant develops internal working models of self and others. Ainsworth (1978) expanded on Bowlby's framework with her Strange Situation experiment. Mothers brought their infants into a room and left them alone; after being gone for a few minutes, the mothers returned to the room to offer comfort to the infant. Ainsworth classified three distinct attachment styles from the strange situation: secure, insecure-anxious, and insecure-avoidant. Secure infants were upset when their primary caregiver left the room; however, they explored the room independently and willingly sought comfort when their primary caregiver returned. The infants returned to the primary caregiver periodically, but were well adjusted and explored without clinging to

the caregiver (Bowlby, 1988). Insecure-Anxious infants did not calm down when their primary caregiver left the room, and were not easily comforted even when their primary caregiver returned and offered comfort. Insecure-Avoidant infants did not appear upset when their primary caregiver left the room, and did not seek support when their caregiver returned to the room.

Main and Solomon (1990) identified a forth attachment style, which they termed disorganized attachment. They observed disorganized attachment occurring in infants who had been previously classified as securely attached by the Ainsworth Strange Situation. Many of the disorganized infants had behavior patterns that would originally classify them as securely attached, such as crying for a caregiver or raising their arms to be picked up when the caregiver returned to the room. However, when the primary caregivers attempted to comfort the infants, the infants would display behavior that did not reflect the comfort they were receiving from their caregivers. Disorganized infants were observed placing their hands in front of their mouth or over their ears, freezing in the middle of the room when their caregiver entered, or holding themselves rigidly while their caregivers held them (Main and Solomon, 1990).

Attachment across the life cycle. The construct of attachment has been accepted and applied across the life cycle, often without empirical clarity (Werner-Wilson & Davenport, 2003). Securely attached individuals have compassion and empathy for others (Gillath, Shaver, & Mikulincer, 2005). Secure attachment is learned in infancy by recognizing and relying on the primary caregiver for support. Ainsworth's (1978) Strange Situation was only part of a larger conceptualization of attachment theory. The initial classification of three types of attachments was used when observing infants.

Follow up studies conducted with the same mothers and infants normally happened between 18 months and two years of the initial strange situation experience; less is known about the attachment styles of the infants and their caregivers in later years.

Bowlby hypothesized that as people aged and developed formal operational thought, they would form new attachments (Crowell, Fraley, & Shaver, 2008). Attachment patterns of infants maturing into childhood, and then experiencing adolescence, may not look the same as their initial attachment styles. Thompson (2008) encourages future research to focus on changes in attachment that are developmentally appropriate. Over time, the consistency of a caregiver's parenting style affects whether a child continues to develop secure (or insecure) internal working models of attachment. Main and Hesse (1990) explored disorganized attachment in infants and their caregivers and conducted follow up interviews when the infants turned six. They found that disorganized attachment styles in the infants and children were in part due to unresolved loss, abuse, or trauma that their mothers had experienced. The mothers who had experienced trauma from an attachment figure displayed frightened expressions to their infants, confusing their infants. In their play, the mothers were also more likely to utilize frightening forms of play, which further confused the infants (Main and Hesse, 1990).

Generally, attachment styles and internal working models move towards security over time. Klohnen and John (1998) found that women who initially identified a secure attachment style at the beginning of the study reported remaining secure over time. However, over time, secure internal working models increased for the women who had initially reported anxious or avoidant insecure working models. Significant changes in working models are made throughout the life span. As an individual matures into

adulthood and enters a committed relationship, the need to have a secure base also competes with his or her partner's need for a secure base in times of stress (Gillath et al., 2005). Individuals entering relationships must rely on each other for compassion and reduction of suffering.

Attachment in therapy. From an attachment mentality, the therapist's main role is to function as a secure base from which a client can explore uncomfortable interactions, painful memories, and form new working models in which to view the world (Byng-Hall, 1999; Dozier & Tyrrell, 1998). Some studies have found that both the attachment style of the client and therapist affects whether therapy is effective for the client. Dozier and Tyrrell (1998) found that securely attached therapists were more likely to recognize insecure working models of their clients, and applied appropriate interventions to shift internal working models of their insecure clients. Anxious clients reported failure of their similarly anxious therapists to challenge them during therapy sessions. Anxious therapists applied interventions in session that did not challenge the working models of their anxious clients, in part because they were unable to provide a secure environment for their clients to work from. Conversely, Dozier and Tyrrell (1998) found that avoidant clients need the therapist to intervene more because they are operating with a different internal working model as anxiously attached clients. Securely attached clinicians are more likely to recognize that a client is avoidant and apply interventions that allow him or her to explore and change internal working models (Dozier & Tyrrell, 1998; Gillath et al., 2005).

During sessions, the therapist models a client's primary caregiver and also serves as a secure base the client returns to when painful emotions activate the client's insecure

working models (Byng-Hall, 1999; Gillath et al., 2005). In order for an infant to develop secure attachment, it is necessary for the primary caregiver to show empathy and have compassion for their infant. A therapist who is secure in his or her working models of self and the world is more likely to provide empathy and compassion to clients. Not all clients who come in to therapy are securely attached; a secure therapist gives insecurely attached clients the benefit of experiencing a secure base (Dozier & Tyrrell, 1998).

Attachment and burnout. Attachment styles and frequency of burnout have been studied across a variety of work settings (Malach-Pines, 2004). Individuals with secure attachment styles were found to be less likely to report feeling burned out at work. Conversely, individuals that scored high in avoidant and anxious attachment styles reported higher levels of burnout in their work (Malach-Pines, 2004). Securely attached individuals were more likely to report that they enjoyed working independently, while anxiously attached participants were more likely to report the need for collaboration and community in their working environments. While a therapist has the opportunity to collaborate with other colleagues through professional development, the majority of work completed in therapy is done independently with the client. A securely attached therapist is more likely to appreciate working individually with clients than his or her anxious and avoidant counterparts. Simmons, Gooty, Nelson, and Little (2009) found that employees who were securely attached were more likely to report hope and trust in their supervisors, and less likely to report symptoms of burnout. Burnout served as a third, negative component, and significantly mediated the relationship between individual job performance and attachment styles (Simmons et al., 2009).

Compassion fatigue and attachment. While many people with compassion fatigue also report symptoms of burnout, there are other factors at work when a therapist develops compassion fatigue (Craig & Sprang, 2010; Sprang et al., 2007; Sprang et al., 2011). A loss of empathy is one characteristic unique to compassion fatigue (Figley, 1995). After ending a stressful session, the therapist may not be able to cope by him or herself. The therapists' own attachment systems must be able to provide support after a day spent working through client trauma. A network of social support may also be important to the therapist, no matter his or her attachment style. If the therapist does not receive empathy from a partner on more than one occasion, the therapist risks developing insecure working models (Gillath et al., 2005). In turn, a change in the therapist's internal working model may influence the effectiveness of the work they are able to do. Likewise, if the therapist has an unresolved personal trauma history or has not resolved secondary trauma developed during therapy sessions, they may be at risk of displaying disorganized attachment to their clients and family members, which may further traumatize their clients and confuse their family members (Main and Hesse, 1990).

Self-care and attachment. In many professions, self-care has been hailed as a coping mechanism allowing the professionals to remain fresh and decreasing the likelihood of developing burnout. Attachment styles affect how a person is able to cope and seek support from his or her partner, and may influence whether a therapist participates in communal or individual forms of self-care (Gillath et al., 2005). Terry (1999) observed that "self-care" insinuates to helpers they are required to recover from a traumatic event in isolation, away from the help of their communities. While self-care

may be effectively completed in isolation for some therapists, others may find being in the presence of others to be the most helpful self-care.

Female psychotherapists who participated in more active coping methods of self-care reported fewer PTSD symptoms, less vicarious traumatization, negative affect, and burnout (Schauben & Frazier, 1995). However, some avoidant coping styles in female therapists were found to increased symptoms of PTSD and vicarious traumatization, depending on which styles were utilized (Schauben and Frazier, 1995). Therapists with avoidant or anxious coping styles may be at risk of developing compassion fatigue because their coping mechanisms prevent them from fully recovering after being exposed to client trauma. The present study sought to investigate how secure and insecure attachment styles influenced therapists' utilization of self-care methods to prevent the development of compassion fatigue.

Mindfulness and Attachment Styles

One method of self-care frequently mentioned in the literature is mindfulness. Mindfulness has roots in both Eastern Buddhist spirituality and Christian meditation practices, and is also gaining popularity as a way of maintaining self-care amidst stressful working environments. To be mindful is to maintain an active awareness while remaining a non-anxious presence (Dimidjian & Linehan, 2003). A mindful person non-judgmentally observes and gives attention to new things (Langer & Moldoveanu, 2000). Continuing to remain open to diverse experiences is important, as many helping professions come into contact with differing perspectives through their work. Dimidjian and Linehan (2003) note that mindfulness studies have not been scientifically rigorous enough to promote findings of the benefits for clinicians both in and out of session.

Practitioners may not be correctly utilizing mindfulness because the spiritual component has been removed from the practice; the true impact of mindfulness practice may never be fully realized because of incorrect practice patterns (Dimidjian & Linehan, 2003).

Benefits of mindfulness. Despite differences in conceptualization, mindfulness practices have been linked to decreased worker burnout and increased productivity (Langer & Moldoveanu, 2000). Therapists may not intentionally practice mindfulness during therapy sessions, however, mindfulness may still impact the therapist in a positive way (Dimidjian & Linehan, 2003). Remaining mindful in a therapy setting is important for the effective therapist. A mindful therapist will maintain curiosity when approaching clients in therapy, and will also remain aware of him or herself and judgmental thoughts that might affect the progress of therapy (Langer & Moldoveanu, 2000). May and O'Donovan (2007) found that mindfulness practices were used as a method of self-care for Australian psychologists, and increased the psychologists' ability to empathize with their clients. The more mindful a therapist was, the higher life satisfaction, positive affect, and personal achievement he or she reported. Therapists with higher mindfulness levels had less negative affect, emotional exhaustion, and depersonalization (May & O'Donovan, 2007).

Detriments of mindfulness. Being mindful in therapy has the potential to distract the therapist from the client. If a therapist is too self-aware or absorbed in his or her observations, there is a risk of missing opportunities to intervene in session. Being aware of negative self-talk in the therapy room was related to lower client ratings of therapists' effectiveness, as well as therapists' lower perceptions about how effective they were with their clients (Nutt-Williams & Hill, 1996). Therapists reporting a higher self-

awareness before starting a session also reported higher anxiety levels before going into session, and were rated as less effective by their clients after the session ended (Nutt-Williams, 2003). While high self-awareness may hinder therapy, Fauth and Nutt Williams (2005) found that therapists-in-training who rated their in-session self-awareness as higher also rated their self-awareness as more helpful during therapy. The higher the self-awareness of the therapists in session, the more likely clients were to rate them as helpful. Therapists with high self-awareness also reported being more involved during therapy than therapists who did not report high self-awareness.

Forms of Mindfulness Practices. Mindfulness may come more naturally for some people; without receiving any formal training, some individuals may have a more mindful disposition than others (Brown, Ryan, & Creswell, 2007). However, findings have also indicated that mindfulness practices can be effectively learned. Mindfulness Based Cognitive Therapy (MBCT) has been found to improve mindfulness in therapists and other helping professions. Three months after participating in an eight week MBCT training, participants reported significant improvement in awareness and attention, and less psychological distress (Ruths et al., 2012). Likewise, Mindfulness Based Stress Reduction (MBSR) has been found to improve compassion and positive affect. Shapiro, Warren Brown, and Biegel (2007) found that participants who received MBSR training reported significantly lower perceived stress, negative affect, state and trait anxiety, and rumination. MBSR and MBCT training programs have effectively reduced stress and increased mindfulness in several work environments. By participating in the training programs, employees who are not particularly mindful have increased their levels of mindfulness and reduced their stress (Ruths et al., 2012, Shapiro et al., 2007). Yoga,

another form of mindfulness practice gaining popularity, has allowed psychotherapists to increase acceptance of clients while decreasing their levels of stress (Valente & Marotta, 2005).

Attachment and mindfulness. Some authors have commented that the constructs of mindfulness and attachment are related to each other (Brown et al., 2007; Shaver, Lavy, Saron, & Mikulincer, 2007; Snyder et al., 2012). Both attachment styles and mindfulness affect how individuals relate to others. Depending on attachment styles, internal working models affect whether individuals view themselves as desirable, consequently affecting how they interact with the world. Being mindful also impacts the way that individuals relate to each other, through increased awareness of self and others (Snyder et al., 2012). Securely attached individuals have increased self-worth, self-esteem, and are better at regulating their emotions; mindfulness can also lead to increased worth, esteem, and emotion regulation (Shaver et al., 2007). A primary caregiver must have awareness, empathy, and acceptance to provide secure attachment to an infant; the qualities needed to provide secure attachment are also qualities that can lead to caregivers being more mindful (Brown et al., 2007). The therapist also needs to provide a secure attachment to clients who have developed insecure working models. In the process of providing secure attachment, the therapist may be utilizing mindfulness skills unconsciously.

Mindfulness practices may help anxious or avoidant therapists develop skills necessary to become aware of their clients' needs during therapy. Studies have shown mindfulness practice to improve therapist's attention and stress management (Fauth & Nutt Williams, 2005; May & O'Donovan, 2007, Ruths et al., 2012; Shapiro et al., 2007).

Other studies have found that therapist attachment style is a key influence over whether or not the therapist is successful in delivering appropriate therapeutic interventions (Dozier & Tyrrell, 1998; Gillath et al., 2005; Schauben & Frazier, 1995). Whether or not an individual is mindful may be influenced by his or her attachment style. Attachment style may affect whether or not a therapist recognizes the need to intervene in session as well as whether or not a therapist can recognize the attachment style of the client. While attachment styles and the presence or absence of mindfulness both may have an effect on therapy, no therapist (or client) looks the same in the way he or she approaches therapy.

Although insecure attachment hinders therapy sessions, it may be possible for a therapist to modify his or her attachment style with the help of mindfulness practices. Snyder, et al. (2012) found that mothers who were insecurely attached to their caregivers in infancy were able to utilize mindfulness practices in order to modify their attachment style to their infants. Likewise, self-aware mothers were more likely to recognize moments they were irritated with their infant. In some cases, mindfulness practices aided mothers to modify the insecure attachment patterns that they had learned from their original caregivers to secure attachment patterns to their infant. Mindfulness practices that assisted in modification of attachment style with mothers and their infants may have a similar effect for therapists and their clients. Potentially, mindfulness practices may be helpful for therapists who are insecurely attached to develop a secure attachment style, which may make them more effective during therapy.

While secure attachment styles have been partially linked to facets of mindfulness, personality differences complicate the perceived relationship between attachment and mindfulness. Walsh et al. (2009) conducted a study of college students

investigating predictors of mindfulness. They found that anxious attachment was a significant negative predictor of mindfulness, but that trait anxiety was a stronger negative predictor of mindfulness than attachment anxiety. While anxious attachment did significantly predict an absence of mindfulness, whether or not a person was generally anxious had more of an impact on predicting mindfulness. Although Walsh et al.'s (2009) study implied differences in personality traits and mindfulness practices; it also showed that mindfulness and attachment were related.

For a therapist practicing with traumatized populations, the question remains of how compassion fatigue can be prevented. Based on previously reviewed literature, securely attached therapists or therapists practicing mindfulness regularly may be less likely to develop compassion fatigue. Whether or not the development of compassion fatigue can be predicted, and prevented, by identifying the therapists' attachment style and mindfulness practices is a question that has not yet been answered in the literature.

Hypotheses

Mindfulness and attachment have been linked to potential outcomes for the therapist in therapy. The present study hypothesized that there would be a negative relationship between attachment anxiety and mindfulness, and a positive relationship between attachment anxiety and compassion fatigue. It was also hypothesized that a negative relationship between mindfulness practices and compassion fatigue would be found. Finally, a negative relationship between attachment avoidance, mindfulness, and compassion fatigue was hypothesized to exist.

Chapter 3

Methods

Participants

Participants were recruited for the present study through convenience sampling. To obtain a diverse sample, recruitment was focused on surveying therapists as well as those in helping professions related to therapy. The convenience sample was recruited in a number of ways. An invitation to participate in the present study with a link to the online survey was posted on the website of the American Association for Marriage and Family Therapy (AAMFT) and the Kentucky Psychological Association (KPA). Written invitations with a link to the present study were e-mailed to Kentucky Association of Marriage and Family Therapy (KAMFT) approved supervisors, therapists at the University of Kentucky Counseling Center, and therapists living in the state of Kentucky listed at www.therapistlocator.net. In order to make the study more accessible, a presentation was offered to be given at monthly staff meetings at KVC Health Systems and Bluegrass.org, however, due to time constraints and additional IRB requirements at both agencies, neither agency agreed to have their employees participate. The American Red Cross and the Midwestern Region of the American Association of Pastoral Counseling also received written invitations to participate in the study but did not respond with contact information for their regional members.

Using a tailored design method (Dillman, Smyth, & Christian, 2009), participants had several benefits available for their completion of the online survey. The topic of the study may have interested therapists and those in the helping professions who would themselves like to prevent developing compassion fatigue. Potential participants in the

study may also have been interested in increasing the knowledge base to help prevent themselves as well as others from developing compassion fatigue. However, the investment in community involvement may not have been enough of an offered benefit for busy professionals to participate in the upcoming study.

Before beginning the study, it was important to note that some respondents who were invited to participate may have already been experiencing compassion fatigue. A brief mindfulness exercise was included at the end of the survey to help participants in attaining skills to prevent further development of compassion fatigue. Aside from the benefits of contributing to research literature and participating in a brief mindfulness exercise at the end of the survey, a small financial incentive of $10 was given at the end of the survey to include participants who may not be motivated to respond by the previously mentioned benefits.

Measures

Pro-Quality of Life Questionnaire Version 5 (Pro-QOL-5): Developed by Stamm (2009), this measure is a 30-item instrument that asks participants to respond based on how they have been feeling over the last 30 days on a 5-point Likert scale (1 *being never*, 5 *being very often*). It has been widely used in studies of compassion fatigue (Bride, Radley, & Figley, 2007; Craig & Sprang, 2010), and is a revision of the Compassion Fatigue Self Test originally developed by Figley (1995). Figley's (1995) original measure contained subscales of burnout and compassion fatigue. The Pro-QOL-5 measures a third facet: compassion satisfaction. The instrument does not have an overall score; rather, participants are given a score for each of the subscales. Internal reliability for each of the separate subscales has been found to be very high, ranging from .72-.87

(Bride et al., 2007). Validity has of the measure has been reported as very high (Stamm, 2010); however, validity scores have not been published for the Pro-QOL 5 (Bride et al., 2007).

Experiences in Close Relationships-Revised (ECR-R): Participants will also complete the ECR-R (Fraley, Waller, & Brennan, 2000). The ECR-R contains 36 items, 7-point Likert scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). The measure is widely used and focuses on two aspects related to attachment and the way people function in close relationships: anxiety and avoidance. Both anxiety and avoidance are measured in 18-item subscales. The ECR-R has been found to have high temporal stability, internal reliability, and construct and discriminant validity (Sibley & Liu, 2004; Sibley, Fischer, & Liu, 2005). Before revising the scale, Fraley et al. (2000) noted that alpha coefficients for both the anxiety and avoidance subscales were .81 for each.

Five Facet Mindfulness Questionnaire (FFMQ): The FFMQ (Baer et al., 2006) will be used to measure mindfulness practices. The FFMQ contains 39 items and has five separate subscales that all measure facets of mindfulness: observing, describing, acting with awareness, non reactivity to inner experience, and non judging of inner experience. Participants respond to the FFMQ on a 5-point Likert scale, 1 *being never or rarely true* to 5 *very often or always true*. The FFMQ is a subset of 112 original items that were compiled by Baer et al. (2006) in their evaluation of mindfulness measures. From the 112 items, 39 emerged that measured five unique facets of mindfulness. In a second study, Baer et al. (2008) identified nonmeditators and experienced meditators and gave

them the FFMQ. Findings suggested that there were significant differences between both groups, revealing that the FFMQ has excellent construct validity.

Work Environment and Demographics Questionnaire: The final measure included in the survey was a brief questionnaire developed for the study. The questionnaire asked participants their age, gender, as well as information regarding their current work setting, how many clients they see daily that are dealing with trauma, and the percentage of their caseload that consists of trauma clients. The questionnaire has been developed based on findings of previous studies of compassion fatigue and burnout in the helping professions. The questionnaire and explanation for the inclusion of items in the questionnaire can be found in Appendix H and I. The questionnaire asks personal information about the participants' income level, trauma practices, and personal trauma history. In order to minimize participant discomfort, each item sensitive to personal experience on the questionnaire had a response choice labeled "Not Applicable."

Procedure

The quantitative study was conducted with tailored design survey methodology (Dillman et al., 2009). Participants were recruited through web or e-mail invitation to complete a survey regarding their experiences in the helping professions (Appendix A). Two weeks before the survey becomes open online, an email was sent to the participants who were being recruited through e-mail (Appendix B). The email briefly introduced the study, informed participants of the incentive available to them, and were provided with the link in case they wanted to complete the survey early. Two weeks from the time the initial email was sent to participants, a second email was distributed with a link to the Qualtrics survey informing participants that the survey was open (Appendix C). Four to

six weeks after the survey was open on the Qualtrics website, an e-mail was sent to participants thanking them for their participation as well as informing them that they would receive a brief update on the study after the results were analyzed, if they desired to be informed of the results (Appendix D).

The survey was available to participants online through Qualtrics. In order for participants to acknowledge their consent to participate in the study as well as to inform them of the study's findings upon completion of the study, minimal personal contact information was obtained from participants. Participants read the first page of the survey, which informed them that their personal information would be kept confidential from the rest of their responses. By responding by giving their names and e-mail addresses, participants consented to participate in the study. Addresses of the participants were also used to send the $10 incentive. Personal information of the survey respondents was kept separate from their responses on the additional instruments.

In their study comparing the tailored design method (TDM) amongst two samples, Huang, Hubbard, and Mulvey (2003) found that TDM did not necessarily indicate that a high response rate would be achieved. Huang et al. (2003) caution researchers against using mailing lists put out by organizations, as well as the importance of knowing what incentives will motivate the population to respond. The present study recruited participants with diverse means via written invitation through e-mail and posted invitations on professional websites. The present study offered a financial incentive, as well as a direct benefit in the form of mindfulness exercises, in order to heighten participants' motivation to respond to the survey.

Chapter 4

Results

All data were imported from Qualtrics into SPSS and analyzed in SPSS 21. Several items in the Pro-QOL-5, ECR-R, and FFMQ were reverse coded. Seventy-four therapists aged 24-75 (M = 36.87, SD = 12.14) participated in the survey. A description of further demographic information is included in Table 4.1. *Percentage of trauma clients, current* includes the percentage of trauma clients currently on the therapist's caseload. *Percentage of trauma clients, career* includes the total percentage of trauma cases a therapist has conducted therapy with throughout the course of his or her career. The current work setting of the therapist is also included in the table; a majority of participants entered other (N = 30), most likely because they fill more than one role and could only select one option in the questionnaire.

Table 4.1 *Selected Demographics*

		M	SD
Age		36.87	12.14
Percentage Trauma Clients, Current		48.82	31.65
Percentage Trauma Clients, Career		50.16	28.05
		N	%
Gender			
	Male	23	32.9
	Female	47	67.1
Received Specific Trauma training			
	Yes	42	60
	No	28	40
Experienced Trauma as a Child			
	Yes	21	30
	No	48	68.6
	Declined	1	1.4
Current Work Setting			
	Inpatient MHC	2	2.9
	Community MHC	18	26.1
	Emergency Response	2	2.9
	Church or Parish	1	1.4
	Private Practice	16	23.2
	Other	30	43.5

Reliability Analyses

Separate subscales of compassion satisfaction, burnout, and secondary traumatic stress (compassion fatigue) for the Pro-QOL-5 were computed by adding together items that belonged to each category. Initial reliability analysis for each subscale of the Pro-QOL-5 was conducted using Cronbach's alpha. The compassion satisfaction (α = .91), burnout (α = .83), and secondary traumatic stress (α = .83) subscales were found to be highly reliable. As compassion fatigue has been also termed secondary traumatic stress, in the results and discussion section the secondary traumatic stress score on the Pro-QOL-5 will be utilized to identify levels of compassion fatigue in therapists (Figley, 1995; Stamm, 2010). To compare Pro-QOL-5 scores with normative cut off scores from previous versions of the Pro-QOL-5, the subscales were converted into Z scores and then into t scores. Details of how the data were converted can be found in the Pro-QOL-5 manual (Stamm, 2010). Anxiety and avoidance subscales for the ECR-R were computed by taking the mean of items that pertained to each anxiety and avoidance subscale. Both anxiety (α = .95) and avoidance (α = .96) were also found to be reliable. Finally, FFMQ subscales of observe, describe, acting aware, nonjudgment, and nonreact were computed by taking the sum of each item assigned to separate subscales (Baer, 2006). Observe (α = .83), describe (α = .89), acting aware (α = .9), nonjudgment (α = .95), and nonreact (α = .83) subscales were found to be reliable.

Initial Analyses

Initial analyses included correlations of subscales of the ECR-R and FFMQ with compassion satisfaction, burnout, and secondary traumatic stress. A significant positive relationship between secondary traumatic stress and anxiety (r = .41,

$p < .001$) as well as secondary traumatic stress and avoidance ($r = .35$, $p = .003$) was found. A significant positive relationship between burnout and anxiety ($r = .62$, $p < .001$) and burnout and avoidance ($r = .55$, $p < .001$) was also found. A significant negative relationship between compassion satisfaction and anxiety ($r = -.41$, $p < .001$) and avoidance ($r = -.44$, $p < .001$) was found.

Although there were significant relationships between all subscales of the ECR-R and Pro-QOL-5, not all subscales of the FFMQ had significant relationships with Pro-QOL5 subscales. A significant negative relationship was found between burnout and all FFMQ scales except for the observe subscale. The same finding was true for the relationship between secondary trauma and all FFMQ subscales; there was a significant negative relationship between secondary trauma and all FFMQ subscales except for observe. Interestingly, there was a positive relationship between all five subscales of the FFMQ and the compassion satisfaction subscale, but only the relationship between nonjudge and compassion satisfaction was found to be significant ($r = .23$, $p = .05$). A complete table of correlations between Pro-QOL-5, ECR-R, and FFMQ subscales is included in table 4.2.

Table 4.2 *Pro-QOL-5, ECR-R, and FFMQ Subscale Correlations*

	Secondary Traumatic Stress	Burnout	Compassion Satisfaction	Anxiety	Avoidance	Observe	Describe	ActAware	Nonjudge	Nonreact
Secondary Traumatic Stress	1									
Burnout	.592**	1								
Compassion Satisfaction	-.255*	-.649**	1							
Anxiety	.405**	.619**	-.412**	1						
Avoidance	.347**	.546**	-.436**	.737**	1					
Observe	0.001	-0.119	0.149	0.051	-0.145	1				
Describe	-.290*	-.266*	0.205	-.270*	-.376**	.500**	1			
ActAware	-.336**	-.350**	0.225	-0.178	-0.228	.389**	.470**	1		
Nonjudge	-.436**	-.390**	.233*	-.349**	-0.207	.343**	.604**	.599**	1	
Nonreact	-.254*	-.254*	0.13	-.265*	-.232*	.401**	.609**	.620**	.641**	1

** Significant at the 0.01 level (2-tailed).

* Significant at the 0.05 level (2-tailed).

An independent samples t-test was conducted to test for differences in gender in Pro-QOL-5, ECR-R, and FFMQ subscale scores. No significant differences were found between gender on the compassion satisfaction and burnout subscales of the Pro-QOL-5. However, a significant gender difference was found in secondary trauma subscale scores $t(68) = -3.44$, $p = .001$, $\eta^2 = .15$. Females ($M = 52.59$, $SD = 10.36$) scored significantly higher on the secondary trauma subscale scores than males ($M = 44.47$, $SD = 6.45$). No significant gender differences were found in the anxiety and avoidance subscales of the ECR-R. Only two significant gender differences were found in the subscales of the FFMQ. There was a significant difference in gender in responses on observe $t(68) = -2.12$, $p < .05$, $\eta^2 = .06$ and nonreact $t(68) = 2.38$, $p < .05$, $\eta^2 = .08$ subscales. Females scored higher ($M = 27.91$, $SD = 4.71$) on the observe subscale of the FFMQ than males ($M = 25.39$, $SD = 4.62$). Males scored higher ($M = 25.78$, $SD = 4.20$) than females ($M = 23.45$, $SD = 3.69$) on the nonreact subscale of the FFMQ. Table 4.3 depicts the independent samples t-test exploring for gender differences on the Pro-QOL-5, ECR-R, and FFMQ.

Multiple Regression Analyses

To further explore relationships between gender, attachment and mindfulness, a Multiple Regression equation was conducted combining data from both genders. Secondary trauma was treated as the outcome variable, while the Anxiety and Avoidance subscales of the ECR-R and the Observe, Describe, ActAware, Nonjudge, and Nonreact subscales of the FFMQ were used as the predictor variables. While none of the ECR-R and FFMQ subscales significantly predicted the variance in secondary traumatic stress scores, the Nonjudge subscale approached significance $b = -.276$, $t(70) = -1.81$, $p = .08$.

Although the model did not reach significance, initial a priori power tests indicated that to achieve a Cohen's f^2 of .15 and a power of 80%, a sample of 55 participants would be needed. The observed effect size of the initial model was moderate (f^2= .321), with an observed power of 99.7%. Table 4.4 depicts the initial findings of the Multiple Regression equation.

Previous literature has identified higher percentages of clients with PTSD in the therapists' caseload as a significant predictor of whether the therapist would experience compassion fatigue (Brady, et al., 1999; Craig & Sprang, 2010; Figley, 2002; Sprang et al., 2007). On average, the sample reported that nearly half of their current caseloads as working with PTSD or trauma clients (M = 48.82, SD = 31.65). Throughout the course of their careers, therapists reported that PTSD clients had comprised half of their caseloads over the course of their careers (M = 50.16, SD = 28.05). Due to the smaller sample size and large standard deviations among the sample, amount of trauma in the therapists' caseloads was not utilized as a predictor in the Multiple Regression model.

Table 4.3 *Independent Samples T-Test Comparing Gender Differences*

Variable	Gender	N	Mean	Std. Deviation	*t*
Compassion Satisfaction	Males	23	50.47	7.91	0.41
	Females	47	49.46	10.46	
Burnout	Males	23	49.68	10.35	-0.42
	Females	47	50.75	9.96	
Secondary Traumatic Stress	Males	23	44.47	6.45	-3.44**
	Females	47	52.59	10.36	
Anxiety	Males	23	2.47	1.30	0.59
	Females	47	2.29	1.15	
Avoidance	Males	23	2.33	1.09	0.83
	Females	47	2.11	1.01	
Observe	Males	23	25.39	4.62	-2.12*
	Females	47	27.91	4.71	
Describe	Males	23	31.43	5.92	0.02
	Females	47	31.40	4.46	
ActAware	Males	23	28.74	5.19	0.70
	Females	47	27.83	5.04	
Nonjudge	Males	23	30.91	6.36	0.43
	Females	47	30.17	6.94	
Nonreact	Males	23	25.78	4.20	2.74*
	Females	47	23.45	3.69	

** Significant at the 0.01 level (2-tailed).
* Significant at the 0.05 level (2-tailed).

Next, a Multiple Regression was conducted using the same outcome and predictor variables using female gender as a selection variable. For females, the anxiety subscale of the ECR-R reached significance in the model $b = .43$, $t(46) = 2.1$, $p < .05$. Gender also accounted for a large amount of the variance in secondary traumatic stress scores in females $R^2 = .40$, $F(7, 39) = 5.40$, $p < .001$. Only one mindfulness subscale reached significance in the female model; ActAware was significant in the model $b =$ -.34, $t(46)$

= -2.19, $p < .05$. Effect sizes for the female model were large ($f^2 = .669$), with a high overall observed power (99.9%). The same analyses were run using male gender as the selection criteria. While none of the ECR-R subscales reached significance in the model, the Nonjudge subscale of the FFMQ did reach significance in the model $b = -.81$, $t(22) = -2.29$, $p < .05$. While ActAware was the only significant subscale in the regression with females and Nonjudge was the only significant subscale in the regression with males, Nonreact approached significance in the model $b = .65$, $t(22) = 1.96$, $p = .08$. Effect sizes for the male model were smaller than the female model ($f^2 = .274$) with a moderate overall observed power of 65.5%. The smaller effect sizes and lower observed power in the male model may also reflect that there fewer males than females who participated in the survey. Tables 4.5 and 4.6 show the Multiple Regression models for females and males, respectively.

Table 4.4 *Multiple Regression of all Subscales, Both Genders* (N = 70)

Predictor Variable	B	St. Error	β	*t*	AR^2	*F*
Anxiety	1.319	1.473	.159	.896		
Avoidance	1.620	1.681	.168	.964		
Observe	.419	.243	.207	1.728		
Describe	-.056	.263	-.030	-.214		
ActAware	-.483	.291	-.260	-1.659		
Nonjudge	-.398	.220	-.276	-1.814		
Nonreact	.335	.331	.144	1.011	0.243	4.22 **

** Significant at the 0.01 level (2-tailed).

Table 4.5 *Multiple Regression of Predictors of Secondary Traumatic Stress, Females* (N =47)

Predictor Variable	B	St. Error	β	*t*	AR^2	F
Anxiety	3.90	1.88	0.43	2.07*		
Avoidance	0.50	2.04	0.05	0.25		
Observe	0.39	0.29	0.18	1.37		
Describe	-0.27	0.34	-0.12	-0.79		
ActAware	-0.70	0.32	-0.34	-2.19*		
Nonjudge	-0.26	0.24	-0.17	-1.09		
Nonreact	0.57	0.40	0.20	1.43	0.401	5.40**

** Significant at the 0.01 level (2-tailed).

* Significant at the 0.05 level (2-tailed).

Table 4.6 *Multiple Regression of Predictors of Secondary Traumatic Stress, Males* (N = 23)

Predictor Variable	B	St. Error	β	*t*	AR^2	F
Anxiety	.549	1.898	.111	.290		
Avoidance	1.039	2.371	.175	.438		
Observe	-.371	.370	-.265	-1.002		
Describe	.076	.389	.070	.195		
ActAware	-.086	.519	-.069	-.165		
Nonjudge	-.825	.360	-.813	-2.291*		
Nonreact	.999	.537	.650	1.860	0.22	1.86

* Significant at the 0.05 level (2-tailed).

Chapter 5

Discussion

While men and women are both at risk for the development of compassion fatigue, women have a higher risk. The present study identified gender as a significant predictor of the development of compassion fatigue. Women reported higher levels of compassion fatigue; this finding is consistent with previous literature (Craig & Sprang, 2010; Kassam-Adams, 1999; Leiter & Harvie, 1996; Negash & Sahin, 2011). Women who reported high levels of compassion fatigue were also more likely to report high levels of attachment anxiety. The same finding was not true for males; neither attachment anxiety nor attachment avoidance subscales on the ECR-R were predictors of compassion fatigue in men.

Stamm (2010) created a database of Pro-QOL-5 scores from a number of different studies. Average secondary trauma subscale scores for females (M = 50.18, SD = 10.15) were lower than secondary trauma subscale scores for females in the present sample (M = 52.59, SD = 10.36). Average secondary trauma subscales for males (M = 49.05, SD = 9.95) were higher than secondary trauma subscale scores for males in the present sample (M = 44.47, SD = 6.45). It may be that males who were more distressed chose not to participate in the present study, while females who were more distressed chose to participate.

Attachment anxiety in close relationships predicted a significant amount of the variance of secondary trauma scores in women, but not men. Clinicians and researchers who are developing interventions for therapists with compassion fatigue should consider including interventions focused on increasing secure attachment styles of female

therapists with higher levels of attachment anxiety. Anxiety-reducing techniques may also be beneficial for female therapists, although these techniques may be focused solely on reducing general anxiety and not necessarily attachment anxiety. Mindfulness-based practices such as Mindfulness Based Stress Reduction (MBSR) and Mindfulness Based Cognitive Therapy (MBCT) have been found to reduce anxiety and may play a helpful role for female therapists in reducing general anxiety (Ruths et al., 2012; Shapiro, Warren Brown, & Biegel, 2007).

The present study measured attachment anxiety; however, other forms of anxiety may have interacted with facets of mindfulness that led to the result of anxiety being a significant predictor of compassion fatigue in females. Walsh et al. (2009) found that trait anxiety was a better predictor of an individual's mindfulness levels than attachment anxiety. In the present study, male and female therapists with high trait anxiety may have responded to the FFMQ differently than therapists with high attachment anxiety. In turn, high trait anxiety might affect reported levels of secondary traumatic stress. The present discussion is limited to reported levels of attachment anxiety.

The findings suggest that mindfulness is a factor assisting in reducing levels of secondary trauma in therapists. In general, mindfulness subscales were negatively related to burnout and secondary trauma subscales of the Pro-QOL-5, however, the observe subscale was not significant for any of the subscales on the Pro-QOL-5. This finding may be due to the fact that Observe is not as reliable a predictor of mindfulness as the four alternative subscales of the FFMQ. In a study of reliability of the FFMQ, Baer et al. (2006) noted that the observe subscale may not play a significant role in the construct of mindfulness.

Depending on gender, mindfulness may have a positive or negative impact on the development of compassion fatigue. For women, the ActAware subscale was associated negatively with secondary trauma scores. Being aware of surroundings in work environments may play a role in decreasing women's anxiety levels, which could contribute to their prevention of compassion fatigue. While ActAware also negatively predicted secondary trauma scores in men, the relationship was not significant. Instead, the Nonjudge subscale was a significant negative predictor of secondary trauma scores for male therapists. Men's ability to maintain a nonjudgmental attitude toward the clients or environment they work in may help in preventing the development of compassion fatigue.

The Nonreact subscale was positively related to secondary trauma levels in males and females, although the relationship approached significance for male participants only. . It may be that as therapists hear traumatic experiences their clients have undergone, they attempt not to react so their clients are not alarmed by their reactions. However, not reacting to the client's trauma may increase the therapist's levels of secondary trauma. Because the Nonreact subscale was not a significant predictor, therapists may use other facets of mindfulness to cope with the trauma they experience as they listen to their clients. While the Nonreact subscale approached significance in the model of male participants, these findings should be interpreted with caution because of the lower power in the male multiple regression model.

Current literature has not identified gender differences in effectiveness of mindfulness based training approaches (Shapiro et al., 2007; Shapiro et al., 2006). In the present study, levels of reported mindfulness subscales differed based on gender,

although the predictions of mindfulness subscales related to secondary trauma had the same direction for both genders. Men and women may differ in how they respond to mindfulness-based training approaches; more research is needed to identify gender differences and whether training programs should differ based on gender. Likewise, more information is needed on whether different types of mindfulness practices are beneficial for male and female therapists.

Presently, anxiety has been found to be a significant predictor of secondary trauma. Avoidance did not predict secondary trauma levels in male or female therapists, however, Walsh et al. (2009) proposed that there may be different facets of attachment avoidance that play a role in levels of mindfulness. Mindfulness, or lack of mindfulness, may interact differently with therapists' secondary trauma levels in the presence of attachment avoidance. Thus, more work is also needed that identifies different facets of attachment avoidance that may lead to the development of compassion fatigue.

Therapists provide a secure relationship for clients who may not have had the ability to create secure attachments in their lives. Clients are able to utilize secure attachment to therapists to explore previous insecure relationships or traumatic experiences. Therapists without a secure attachment to clients may be affected negatively when clients share their trauma, which may affect the therapists' development of compassion fatigue. Although the present study found that attachment anxiety was a positive predictor of compassion fatigue for females only, attachment anxiety and avoidance may be present for males in different ways that were not measured. Whether a therapists are male or female, is important for the therapists to remain aware of how their clients are attaching to them. If a relationship between a therapist and client is not a

secure attachment, the therapist may need to seek out supervision in order to prevent the development of compassion fatigue. However, the therapist may not be mindful of how his or her attachment style is affecting the client. Figley (1995) pointed to the importance of educating trainees in a supervision and practicum setting about how to observe and respond to stress, compassion fatigue and burnout. If a therapist is already licensed and no longer utilizes supervision, he or she may not be aware of how his or her attachment style is affecting the therapeutic relationship, as well as the potential to develop compassion fatigue from being insecurely attached to the client. One method that may be helpful in preventing compassion fatigue is to diversify caseloads. Having a caseload with a variety of clients may ensure that the therapist has fewer trauma cases; this may lead to the therapist being able to devote better clinical attention to all clients involved.

Therapy also requires therapists to continually terminate sessions with clients finishing therapy and form new attachments with clients who are starting therapy. Valente and Marotta (2005) utilized the term caring burnout as when the therapist is unable to attach to new clients because the therapist has had to sever attachments with so many other clients. Developing compassion fatigue or being insecurely attached to clients may have an effect similar to caring burnout; if therapists struggling with either issue are unable to seek out supervision, their ability to deliver services to the client may be impacted.

Limitations and Implications for Future Research

The present study is limited to quantitative self-report measures completed by therapists. While the Pro-QOL-5, ECR-R, and FFMQ have been utilized in many studies and demonstrated good validity and reliability, the therapist completing the instruments

may not be aware of his or her burnout or compassion fatigue levels. Completing mixed methods studies utilizing qualitative interviews of therapists about their work experiences and stress may be one way of capturing more meaning behind their individual Pro-QOL-5 scores. Qualitative interviews would also allow the therapist to describe methods of self-care that may be unrelated to mindfulness but still allow the therapist to prevent the development of compassion fatigue.

While gender differences in mindfulness, attachment styles, and compassion fatigue were found in the present study, these results should be replicated with a larger sample of male therapists. Twice as many females responded to the survey than did males. Because previous literature has not found concrete differences in effects of mindfulness training between genders, it will be important to determine whether the differences found in the present sample were due to sample size. If gender differences in mindfulness are found in future studies, it will be helpful to develop different approaches to mindfulness training and interventions for each gender.

The demographic questionnaire asked therapists about their current working environment; however, there were not enough respondents to compare therapists working in community mental health centers with those who were practicing privately. Findings from previous studies have indicated that therapists working in community mental health and outpatient facilities have the highest risk of developing compassion fatigue. However, therapists practicing privately may have just as much risk in the development of compassion fatigue if they do not seek supervision for difficult cases. Further studies are needed to investigate differences of the development of compassion fatigue in

therapists working in community mental health settings versus those who are practicing privately.

Current literature has focused mainly on the effects the development of compassion fatigue has for therapists. Future studies should widen the scope of those interviewed to include family members of the therapist. A therapist with compassion fatigue may interact differently with his or her family, which will in turn affect family members and could lead to a more stressful home environment. Future models should consider if high levels of compassion fatigue may cause the therapist to be more anxiously or avoidantly attached to clients, family members, and friends. Likewise, it will be important to continue studying differences in the quality of support delivered to clients in therapists with compassion fatigue as well as burnout. Involving clients of therapists with compassion fatigue and comparing their experiences to non-distressed therapists as well as burned out therapists will allow for continued clarity about how compassion fatigue and burnout symptoms in therapists affect clients the therapist is seeing.

Finally, the therapist must be creative when challenges arise in the therapeutic process. As one therapeutic model or approach does not work for every client, therapists must feel empowered to seek out supervision and other forms of self-care that will allow them to take care of themselves while maintaining clinical excellence. Mindfulness practices and stress reduction techniques may be one method of remaining aware of how certain clients are affecting therapists' personal and professional efficacy. However, these practices may not be the only way to reduce symptoms of compassion fatigue. Valente and Marotta (2005) found that therapists who had a regular yoga practice were

more patient with themselves as therapists, and more accepting of their clients. Some therapists may appreciate practicing yoga over participating in structured mindfulness training programs. Some therapists may find that meaningful self-care practices may not involve mindfulness; they may already participate in a spiritual practice, which was found to be related to lower levels of compassion fatigue and burnout (Sprang, Craig, & Clark, 2011).

In moving forward with compassion fatigue research, it will be important to include instruments that measure other practices therapists may participate in to reduce their symptoms of secondary trauma as well as increase their mindfulness. Continuing work is needed, with diverse research methodology, to explore whether there are other ways to predict and prevent compassion fatigue in therapists.

Appendix A

Sample invitation posted on professional counseling association websites

Participants are needed for an upcoming study through the Department of Family Sciences at the University of Kentucky. The purpose of the study is to identify factors that predict and/or prevent the development of compassion fatigue in the helping professions. Your responses will aid in further understanding how compassion fatigue can be further prevented. If you desire, the results of the study will be shared with you at the completion of the study. Participants who respond to the online survey will have the opportunity to learn more about mindfulness practices that can be incorporated into daily practice, intended to reduce stress. The first 100 respondents of the survey will also be awarded a $10 check. Those interested in participating can follow this link to complete the survey: www.linktoqualtricssurvey.com, or contact stephanie.armes@uky.edu.

Appendix B

Sample invitation to participate in the study via e-mail

The following e-mail was sent to participants two weeks in advance of the survey being opened online at the Qualtrics website.

Dear Sir or Ma'am,

You are invited to participate in a research study through the Department of Family Sciences at the University of Kentucky. The purpose of the study is to identify factors that predict and/or prevent the development of compassion fatigue in the helping professions. During this season of heightened communication, your response is greatly appreciated, as it will aid in further understanding how compassion fatigue can be further prevented. The results of the study will be available to you at the completion of the study.

Participants who respond to the online survey will have the opportunity to learn more about mindfulness practices and stress reduction exercises that can be incorporated into daily practice. The first 100 respondents to the survey will also be awarded a $10 check. In two weeks, a link to the survey that will be available through Qualtrics will be sent to you at this e-mail address. Thank you in advance for your participation in the upcoming survey.

Appreciatively,

Stephanie Armes
Intern Therapist and Research Assistant
Department of Family Sciences
University of Kentucky
315 Funkhouser Building
Lexington, KY 40517
Stephanie.Armes@uky.edu

Appendix C

Sample invitation to take the survey online

The following e-mail was sent to participants two weeks after the introductory e-mail in Appendix B, and contained a link for participants to follow to complete the survey.

Dear Sir or Ma'am,

Two weeks ago, an e-mail was sent inviting you to participate in a research study through the Department of Family Sciences at the University of Kentucky. The purpose of the study is to identify factors that predict and/or prevent the development of compassion fatigue in the helping professions. Attached to this e-mail you will find a link to complete the survey. As you follow the link, the first page of the survey will ask you for your name and contact information. This information will be separated from the rest of the survey, and will not be linked to your survey responses. By filling in your name and e-mail, you are acknowledging your consent to participate in the study. To complete the survey, follow this link: www.linktoqualtricssurvey.com

At the end of the survey, you will have the opportunity to complete a mindfulness and stress reduction exercise that can be incorporated into your daily practices. The first 100 respondents to the survey will also be awarded a $10 check. Thank you in advance for participating in the upcoming survey. Please feel free to contact me at stephanie.armes@uky.edu if you have any questions.

Appreciatively,

Stephanie Armes
Intern Therapist and Research Assistant
Department of Family Sciences
University of Kentucky
315 Funkhouser Building
Lexington, KY 40517

Appendix D

Reminder e-mail thanking participants for their time

The following message was sent to participants four to six weeks after the survey was open online.

Dear Sir or Ma'am,

Thank you for your participation in the survey on compassion fatigue, which was sent in a link to you six weeks ago. We value your response and will be informing you of the study's findings as soon as all responses have been collected and analyzed. Your response is greatly appreciated, as it will aid in further understanding how compassion fatigue can be further prevented amongst the helping professions. If you missed the e-mail containing the survey link and are interested in completing a survey, please feel free to follow the link here: www.linktoqualtricssurvey.com.

Again, thank you for adding to the literature that will increase our understanding of predictors and preventers of compassion fatigue.

Sincerely,

Stephanie Armes
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Appendix E

Professional Quality of Life Scale (ProQOL) Version 5 (2009)

When you [help] people you have direct contact with their lives. As you may have found, your compassion for those you [help] can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a [helper]. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last 30 days.

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

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

Appendix F

The Experiences in Close Relationships-Revised (ECR-R) Questionnaire

Scale:
The statements below concern how you feel in emotionally intimate relationships. We are interested in how you generally experience relationships, not just in what is happening in a current relationship. Respond to each statement by circling a number to indicate how much you agree or disagree with the statement.

QUESTION 1=Strongly Disagree……7=Strong Agree

1. I'm afraid that I will lose my partner's love. 1 2 3 4 5 6 7
2. I often worry that my partner will not want to stay with me. 1 2 3 4 5 6 7
3. I often worry that my partner doesn't really love me. 1 2 3 4 5 6 7
4. I worry that romantic partners won't care about me as much as I care about them. 1 2 3 4 5 6 7
5. I often wish that my partner's feelings for me were as strong as my feelings for him or her. 1 2 3 4 5 6 7
6. I worry a lot about my relationships. 1 2 3 4 5 6 7
7. When my partner is out of sight, I worry that he or she might become interested in someone else. 1 2 3 4 5 6 7
8. When I show my feelings for romantic partners, I'm afraid they will not feel the same about me. 1 2 3 4 5 6 7
9. I rarely worry about my partner leaving me. 1 2 3 4 5 6 7
10. My romantic partner makes me doubt myself. 1 2 3 4 5 6 7
11. I do not often worry about being abandoned. 1 2 3 4 5 6 7
12. I find that my partner(s) don't want to get as close as I would like.1 2 3 4 5 6 7
13. Sometimes romantic partners change their feelings about me for no apparent reason. 1 2 3 4 5 6 7
14. My desire to be very close sometimes scares people away. 1 2 3 4 5 6 7
15. I'm afraid that once a romantic partner gets to know me, he or she won't like who I really am. 1 2 3 4 5 6 7
16. It makes me mad that I don't get the affection and support I need from my partner. 1 2 3 4 5 6 7

17. I worry that I won't measure up to other people. 1 2 3 4 5 6 7

18. My partner only seems to notice me when I'm angry. 1 2 3 4 5 6 7

19. I prefer not to show a partner how I feel deep down. 1 2 3 4 5 6 7

20. I feel comfortable sharing my private thoughts and feelings with my partner. 1 2 3 4 5 6 7

21. I find it difficult to allow myself to depend on romantic partners. 1 2 3 4 5 6 7

22. I am very comfortable being close to romantic partners. 1 2 3 4 5 6 7

23. I don't feel comfortable opening up to romantic partners. 1 2 3 4 5 6 7

24. I prefer not to be too close to romantic partners. 1 2 3 4 5 6 7

25. I get uncomfortable when a romantic partner wants to be very close. 1 2 3 4 5 6 7

26. I find it relatively easy to get close to my partner. 1 2 3 4 5 6 7

27. It's not difficult for me to get close to my partner. 1 2 3 4 5 6 7

28. I usually discuss my problems and concerns with my partner. 1 2 3 4 5 6 7

29. It helps to turn to my romantic partner in times of need. 1 2 3 4 5 6 7

30. I tell my partner just about everything. 1 2 3 4 5 6 7

31. I talk things over with my partner. 1 2 3 4 5 6 7

32. I am nervous when partners get too close to me. 1 2 3 4 5 6 7

33. I feel comfortable depending on romantic partners. 1 2 3 4 5 6 7

34. I find it easy to depend on romantic partners. 1 2 3 4 5 6 7

35. It's easy for me to be affectionate with my partner. 1 2 3 4 5 6 7

36. My partner really understands me and my needs. 1 2 3 4 5 6 7

Appendix G

Five Facet Mindfulness Questionnaire

Description:
This instrument is based on a factor analytic study of five independently developed mindfulness questionnaires. The analysis yielded five factors that appear to represent elements of mindfulness as it is currently conceptualized. The five facets are observing, describing, acting with awareness, non-judging of inner experience, and non-reactivity to inner experience.

Please rate each of the following statements using the scale provided. Write the number in the blank that best describes your own opinion of what is generally true for you.

1	2	3	4	5
never or rarely true	very rarely true	sometimes true	often true	very often or always true

_____ 1. When I'm walking, I deliberately notice the sensations of my body moving.
_____ 2. I'm good at finding words to describe my feelings.
_____ 3. I criticize myself for having irrational or inappropriate emotions.
_____ 4. I perceive my feelings and emotions without having to react to them.
_____ 5. When I do things, my mind wanders off and I'm easily distracted.
_____ 6. When I take a shower or bath, I stay alert to the sensations of water on my body.
_____ 7. I can easily put my beliefs, opinions, and expectations into words.
_____ 8. I don't pay attention to what I'm doing because I'm daydreaming, worrying, or otherwise distracted.
_____ 9. I watch my feelings without getting lost in them.
_____ 10. I tell myself I shouldn't be feeling the way I'm feeling.
_____ 11. I notice how foods and drinks affect my thoughts, bodily sensations, and emotions.
_____ 12. It's hard for me to find the words to describe what I'm thinking.
_____ 13. I am easily distracted.
_____ 14. I believe some of my thoughts are abnormal or bad and I shouldn't think that way.
_____ 15. I pay attention to sensations, such as the wind in my hair or sun on my face.
_____ 16. I have trouble thinking of the right words to express how I feel about things.
_____ 17. I make judgments about whether my thoughts are good or bad.
_____ 18. I find it difficult to stay focused on what's happening in the present.
_____ 19. When I have distressing thoughts or images, I "step back" and am aware of the thought or image without getting taken over by it.
_____ 20. I pay attention to sounds, such as clocks ticking, birds chirping, or cars passing.
_____ 21. In difficult situations, I can pause without immediately reacting.
_____ 22. When I have a sensation in my body, it's difficult for me to describe it because

I can't find the right words.

_____ 23. It seems I am "running on automatic" without much awareness of what I'm doing.

_____24. When I have distressing thoughts or images, I feel calm soon after.

_____ 25. I tell myself that I shouldn't be thinking the way I'm thinking.

_____ 26. I notice the smells and aromas of things.

_____ 27. Even when I'm feeling terribly upset, I can find a way to put it into words.

_____ 28. I rush through activities without being really attentive to them.

_____ 29. When I have distressing thoughts or images I am able just to notice them without reacting.

_____ 30. I think some of my emotions are bad or inappropriate and I shouldn't feel them.

_____ 31. I notice visual elements in art or nature, such as colors, shapes, textures, or patterns of light and shadow.

_____ 32. My natural tendency is to put my experiences into words.

_____ 33. When I have distressing thoughts or images, I just notice them and let them go.

_____ 34. I do jobs or tasks automatically without being aware of what I'm doing.

_____ 35. When I have distressing thoughts or images, I judge myself as good or bad, depending what the thought/image is about.

_____ 36. I pay attention to how my emotions affect my thoughts and behavior.

_____ 37. I can usually describe how I feel at the moment in considerable detail.

_____ 38. I find myself doing things without paying attention.

_____ 39. I disapprove of myself when I have irrational ideas.

Appendix H

Work Environment Demographic Questionnaire

1. What is your age? _____ years

2. Gender: _____ Male _____ Female

3. What is your annual income before taxes?
    a. $0-9,999
    b. $10,000- 19,999
    c. $20,000-29,999
    d. $30,000-39,999
    e. $40,000-49,999
    f. $50,000-59,999
    g. $60,000-69,999
    h. $70,000-79,999
    i. $80,000-80,999
    j. $90,000 or above

4. What is the highest degree you have earned?
    a. High School
    b. Some College
    c. College
    d. Graduate School, masters level
    e. Graduate School, Doctoral Level
    f. Postdoctoral residency
    g. Other: _____

5. What best describes your current position?
    a. Emergency Medical Technician
    b. Emergency/Disaster Responder
    c. Mental Health Worker
    d. Case Manager
    e. Clergy
    f. Registered Nurse (RN)
    g. Licensed Clinical Social Worker (LCSW)
    h. Licensed Marriage and Family Therapist (LMFT)
    i. Licensed Professional Clinical Counselor (LPCC)
    j. Clinical Psychologist (PhD, PsyD)
    k. Counseling Psychologist
    l. Psychiatrist
    m. Doctor
    n. Other _____

6. Have you received specific trauma treatment training? _____ Yes _____ No

a. If yes, please specify _____

7. How many years have you spent working in the field?
    a. 0-3 years
    b. 4-6 years
    c. 7-10 years
    d. 11-14 years
    e. 15-17 years
    f. 18-20 years
    g. 21- 24 years
    h. 25+ years

8. What percentage of clients in your current caseload have experienced personal trauma?
    a. 0-5%
    b. 6-10%
    c. 11-15%
    d. 16-20%
    e. 21-25%
    f. 26-30%
    g. 31-35%
    h. 36-40%
    i. 41-45%
    j. 46-50%
    k. 51-55%
    l. 56-60%
    m. 61-65%
    n. 66-70%
    o. 71-75%
    p. 76-80%
    q. 81-85%
    r. 86-90%
    s. 91-95%
    t. 96-100%
    u. Not Applicable

9. Over the course of your career, what percentage of your caseload has been dealing with personal trauma?
    a. 0-5%
    b. 6-10%
    c. 11-15%
    d. 16-20%
    e. 21-25%
    f. 26-30%
    g. 31-35%
    h. 36-40%

i. 41-45%
j. 46-50%
k. 51-55%
l. 56-60%
m. 61-65%
n. 66-70%
o. 71-75%
p. 76-80%
q. 81-85%
r. 86-90%
s. 91-95%
t. 96-100%
u. Not Applicable

10. Did you experience personal trauma as a child? _____ Yes _____ No _____ N/A

11. What is your current work setting?
    a. Inpatient Mental Health Center
    b. Community Mental Health Center
    c. Emergency Response
    d. Church or Parish
    e. Private Practice
    f. Other _____

12. What best describes the setting of your place of work?
    a. Very rural
    b. Rural
    c. Somewhat rural
    d. Neither rural nor urban
    e. Somewhat urban
    f. Urban
    g. Very urban

Appendix I

Explanation for the Inclusion of Items in Work Environment Demographic Questionnaire

Much of the rationale for choosing each item in the questionnaire has been covered in the literature review. Each item included in the questionnaire has been utilized as a variable in previous studies concerning compassion fatigue or PTSD amongst therapists or the helping professions.

Item	Article(s) Informing Decision	Rationale
Age	Craig, & Sprang(2010), Eriksson, Bjorck, Larson, Walling, Trice… Foy, (2009).	The younger the individual, the more likely that they will report symptoms of compassion fatigue.
Gender	Craig, & Sprang (2010), Kassam-Adams (1999), Leiter & Harvie (1996), Negash & Sahin (2011).	Younger females newest to the field were more likely to report compassion fatigue than older therapists.
Income	Chrestman (1999).	Making less income was related to higher reported levels of burnout.
Degree(s) Earned and Degree Type	Data collected for purposes of the diverse convenience sample.	Not focused on in literature review, but related to training background of therapist/helping professional.
Training	Chrestman (1999); Craig & Sprang (2010).	Whether or not an individual had received specific trauma training affected how highly he or she scored on measures of compassion fatigue/burnout.
Years Experience/Years spent in the field	Chrestman (1999), Craig, & Sprang(2010), Eriksson, Bjorck, Larson, Walling, Trice… Foy, (2009), McCann and Pearlman (1995).	Therapists with less experience scored higher in measures of burnout/compassion fatigue.

Current amount of trauma clients in caseload	Kassam-Adams (1999), Pearlman (1990), Negash & Sahin (2011).	Higher the amount of trauma clients in caseload, the more likely person develops compassion fatigue.
Percentage of trauma clients in caseload throughout career (accumulative trauma clients)	Kassam-Adams (1999), Pearlman (1990), Schauben, & Frazier (1995).	Higher number of trauma clients throughout career has led to increased reports of compassion fatigue.
Personal trauma history as child and adult	Kassam-Adams (1999), Pearlman (1990), McCann and Pearlman (1995).	Therapists with personal trauma history, but who had remained in the field for a longer amount of time, showed less
Work Setting	Figley (2002), Kassam-Adams (1999), Meldrum, King, & Spooner (2002), Negash & Sahin (2011).	Working in an inpatient facility or mental health center has been found to yield the highest level of burnout, working in administration yields the least amount of burnout.
Population Density of current place living/practicing	Sprang, Craig, & Clark (2008), Meldrum, King, & Spooner (2002).	Therapists living in more rural areas were more likely to report symptoms of burnout and compassion fatigue.

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Vita

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Education

Bachelor of Arts in Psychology
Minor in Spanish
Seattle Pacific University
June 2007, Magna Cum Laude

Research and Teaching Experience

University of Kentucky
Lexington, Kentucky
08/2012-present
Graduate Research Assistant, Family Interaction Research Lab

Seattle Pacific University
Seattle, WA
03/2007-06/2007
Undergraduate Research Assistant, Early Educational Enrichment Program

Seattle Pacific University
Seattle, WA
09/2006-06-2007
Teaching Assistant, General Psychology

Seattle Children's Hospital
Seattle, WA
06/2006-09/2006
Undergraduate Research Assistant, Eating Disorders Yoga Intervention Study

University of Washington
Seattle, WA
08/2005-06/2006
Undergraduate Research Assistant, Behavioral Research and Therapy Clinic

Clinical Experience

University of Kentucky Family Center
Lexington, KY
01/2013-05/2014
Intern Therapist

People Assisting the Homeless (PATH)
Los Angeles, CA
Regional Manager, 05/2011-07/2012
Community Outreach Coordinator, 05/2009-05/2011
Street Outreach Case Manager, 09/2008-05/2009
Outreach Intern, 08/2007-08/2008

Seattle Children's Hospital
Seattle, WA
06/2006-09/2007
Inpatient Psychiatric Unit Intern

Presentations

Armes, S. (2014 April). Ethical Implications of the Homeless Vulnerability Index. Poster presented at the University of Kentucky Human Environmental Sciences Research Day, Lexington, KY.

Armes, S., Frey, L. M., Smith, L., Werner-Wilson, R., & Ashurst, K. (2013 October). Promoting Communication between Adolescents and Their Deployed Parents. Poster presented at the American Association of Marriage and Family Therapy National Conference, Portland, OR.

Armes, S., Frey, L. M., Werner-Wilson, R., & Ashurst, K. (2013 April). Effects of a Military Adventure Camp on Adolescent and Family Functioning. Poster presented at the University of Kentucky Children at Risk Conference, Lexington, KY.

Moe, A., Walrath, E., **Pashby, S**., & Ward, R. (2006 May). Parental and Peer Influence on Religiosity in College Age Students. Paper presented at the Stanford Undergraduate Psychology Research Conference, Palo Alto, CA.

Conferences and Workshops Attended

American Association of Marriage and Family Therapy National Conference, Portland, OR 2013

National Research Summit on Research Component Military Families, presented by Military Support Programs and Networks, Ann Arbor, MI 2013

Kentucky Association of Marriage and Family Therapy Conference, Louisville, KY 2013

Professional Affiliations

American Association of Marriage and Family Therapy (AAMFT)
Kentucky Association of Marriage and Family Therapy (KAMFT)
University of Kentucky Student Association of Marriage and Family Therapy

Awards Received

Recipient of Alice P. Killpatrick Fellowship, Fall 2013 and Spring 2014

Recipient of the School of Human Environmental Sciences Graduate Student of Excellence Award, May 2014