

How do Counsellors Maintain Compassion Satisfaction: Stories from Those Who Know

By

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B.A., University of Victoria, 2008

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Abstract

Several studies have suggested that compassion satisfaction (CS) promotes counsellor wellness through its mitigating effects on compassion fatigue, burnout, and vicarious traumatization. CS also contributes to career longevity and to a sense of fulfillment, balance, and wellness that extends from counsellors' professional to personal lives. Yet, to date, very little research has been done using counsellor wellness or CS as a primary focus. While the literature on CS is relatively new, even less attention appears to have been paid to what experienced counsellors actively *do* to maintain CS and therefore, their wellness as counsellors. The purpose of this study was to extend the literature on counsellor CS by asking experienced counsellors how they actively maintain CS in their work. Participants ($N = 6$) were counsellors in the Victoria area who had worked in the field for at least 10 years, had a minimum of a Masters degree, and who were experiencing CS at the time of data collection. A social constructivist perspective was used to frame the study, and narrative interviews were used to collect the counsellors' stories of how they had maintained CS throughout their careers. Data were analysed using thematic analysis and 6 themes are reported. Findings suggest that counsellors can actively increase their likelihood of maintaining CS by: (a) maintaining boundaries; (b) practicing self-care; (c) cultivating self-awareness; (d) developing positive, fulfilling relationships; (e) engaging in ongoing learning; and (f) embracing variety. Findings are discussed in terms of their implications for counsellor training programs, the personal and professional lives and retention of counsellors already in the field, directors of counselling agencies, and client care.

AUTHOR'S NOTE. I use the words therapy/counselling and therapist/counsellor interchangeably throughout the manuscript.

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CHAPTER 1

LITERATURE REVIEW

Introduction

Compassion satisfaction (CS) is a relatively new construct in the counsellor wellness literature. CS is defined as the sense of satisfaction and pleasure experienced by counsellors when they are able to “do [their] work well” (Stamm, 2005, p. 5). Counsellor wellness is at the opposite end of the spectrum from counsellor impairment (Kottler, 2007), and is positively correlated with CS (Lawson & Myers, 2011). Counsellor wellness contributes to successful client outcomes (Figley, 1995; Gentry, 2002; Hill, 2004; Witmer & Young, 1996), and several studies suggest that CS mediates counsellor wellness through its mitigating effects on various manifestations of counsellor impairment such as compassion fatigue (CF) (Alkema, Linton & Davies 2008; Collins & Long, 2003; Conrad & Kellar-Guenther, 2006; Killian, 2008; Negash & Sahin, 2011; Radey & Figley, 2007), burnout (Alkema et al., 2008; Collins & Long, 2003; Slocum-Gori et al., 2011), vicarious traumatization (VT) (Killian, 2008), and empathy fatigue (EF) (Stebnicki, 2007). Counsellor impairment “poses the potential for harm to the client” (Lawson & Venart, 2005) by impacting counsellors’ ability to offer their highest level of services to their clients (Figley, 1995; Gentry, 2002; Lawson, 2007; Lawson & Venart, 2005; Wharton, 2009). Counsellor impairment is also problematic for the workplace as it is associated with absenteeism, frequent turnover and attrition, and disruption in services (Conrad & Kellar-Guenther, 2006; Fahy, 2007).

A counsellor’s¹ job is to support the wellbeing of their clients. Counsellors use *themselves* as a primary tool in their work (Lawson, n.d. as cited in Shallcross, 2011). In other

¹ I use the term ‘counsellor’ to include helping professionals such as psychotherapists, social workers, counselling psychologists, pastoral counsellors, and clinical counsellors, among others.

words, in addition to their knowledge of the human psyche and its potential challenges and strengths, counsellors use their own emotional reactions, interpretations, and perceptions to guide their work with clients. This means that counsellors' internal states will impact their ability to work effectively in session with clients. Consequently, it seems intuitive that counsellors' internal state or "wellness" is important to their ability to keep doing their work well. However, given their use of self-as-instrument, and the emotionally taxing nature of their work in an environment with high requirements for caring (Skovholt & Trotter-Mathisen, 2011, p. 149) and empathic engagement, counsellors are at high risk for counsellor impairment (Lawson & Venart, 2005). In fact, in 1996 Kottler and Hazler (1996) found that over 6000 counsellors with some kind of mental or emotional impairment were practicing in the United States at the time of their study (as cited in Sheffield, 1998). While it has been 17 years since Kottler and Hazler's (1996) study, it is apparent that counsellor impairment has remained a concern in North America in the 2000s. For example, in 2003 a Task Force on Impaired Counsellors was established by the American Counselling Association (ACA) to "develop a proposal with options for ACA to address the needs of impaired counsellors and their clients" (Lawson & Venart, 2005). It appears that the prevalence of counsellor impairment was sufficient to motivate such a call.

As I have noted above, several studies suggest that CS promotes counsellor wellness through its mitigating effects on CF (Alkema et al., 2008; Collins & Long, 2003; Conrad & Kellar-Guenther, 2006; Killian, 2008; Negash & Sahin, 2011; Radey & Figley, 2007), burnout (Alkema et al., 2008; Collins & Long, 2003; Slocum-Gori et al., 2011), and VT (Killian, 2008). Further, CS contributes to career longevity and to a sense of fulfillment, balance, and wellness that extends from counsellors' professional to personal lives (Bowles, 2009; Radey & Figley, 2007). If counsellor wellness contributes to successful client outcomes, and if CS promotes

counsellor wellness through its mitigating effects on CF, burnout, and VT, and contributes to career longevity, then CS is an important focus for research and practice.

Yet, to date, the research maintains a strong and primary focus on counsellor impairment (Radey & Figley, 2007). Very little research has been done using counsellor wellness as a primary focus (Coster & Schwebel, 1997; Harrison & Westwood, 2009; Kottler, 2007; Lawson & Myers, 2011; Linley & Joseph, 2007), and little research has examined the role of CS in counsellor wellness. Furthermore, while the literature on CS is, admittedly, relatively new, little attention has been given to what experienced counsellors actively *do* to maintain CS and, therefore, their wellness as counsellors. The purpose of the present research is to extend the literature on counsellor CS by asking experienced counsellors how they maintain CS in their professional practice. In this way, this research will contribute to the body of knowledge on counsellor wellness. My research question is therefore: How do experienced counsellors actively maintain compassion satisfaction in their work? Findings from my research will have implications for theory and knowledge building, future research, counsellor training programs, the personal and professional lives and retention of counsellors already in the field, directors of counselling agencies, and client care.

To securely anchor the development of the construct of CS within the fields of counsellor impairment and wellness, I think it is important to begin by reviewing and by critically discussing, as succinctly as possible, the relatively substantial literature on counsellor impairment. This will serve to outline what we know about counsellor impairment and the more recent shift in focus to counsellor wellness, and to contextually situate and build the case for the greater thesis around CS. In what follows, I first briefly outline the historical development of research on the constructs that fall within the umbrella of counsellor impairment. Next, I define

and describe the constructs of countertransference, burnout, secondary traumatic stress (STS), vicarious trauma (VT), compassion fatigue (CF), and empathy fatigue (EF). I then discuss the differences between and amongst these constructs, and the ongoing inconsistencies in their conceptualization and use. I conclude this section by noting one of the most significant changes in the field of counsellor wellness—the shift from an impairment focus to a wellness focus.

I focus the remainder of the chapter specifically on CS. I do this by first introducing CS, then describing how it differs from other constructs, how I have operationally defined it, and how CS is achieved and maintained according to the current literature. Then, before concluding the chapter, I present my own context and experiences that culminated in my decision to do this study. Finally, I draw the chapter together by laying out the rationale, purpose, and objectives of the present study and conclude with a restatement of the research question.

What Do We Know about Counsellor Impairment?

What is counsellor impairment? According to the ACA, counsellor impairment “occurs when there is a significant negative impact on a counselor’s professional functioning which compromises client care or poses the potential for harm to the client” (Lawson & Venart, 2005, p. 243). According to the existing literature, substance abuse, mental illness, personal crisis, and physical illness or debilitation can cause impairment (Lawson & Venart, 2005); to this, I suggest that all of these can also reflect or develop in response to impairment. While burnout, CF, VT (Emerson & Markos, 1996; Lawson, 2007), and EF (Stebnicki, 2007) are forwarded in the existing literature as constructs of counsellor impairment, these appear to be conceptualized interchangeably as both types and causes of counsellor impairment. The consensus in the literature is that the counselling work of impaired counsellors, unlike stressed or distressed

counsellors, is negatively and significantly impacted, although this does not necessarily imply or include unethical behaviour (Lawson & Venart, 2005).

Historical Development of Constructs

One could argue that the counsellor impairment literature had its beginnings in the stress literature, most particularly through the work of psychologist Herbert Freudenberger who first introduced the term *burnout* in 1974. However, some authors, such as Gentry (2002), for example, argue that the history of counsellor impairment has its origins in Jung's identification of countertransference in 1907. In this section, I will briefly describe the historical development of research on impairment in the counselling profession. I assume interest in counsellor impairment to have begun with Jung's identification of countertransference in 1907 (Gentry 2002), and which has expanded to include constructs of burnout, secondary traumatic stress (STS), VT, CF, and EF. There are several conceptualizations of these constructs, many of which are contradictory or over-lapping. Comprehensively reviewing every definition in the literature is beyond the scope of this thesis given its focus on counsellor wellness generally and on CS specifically. I have therefore chosen to highlight the most common conceptualizations of these constructs using the more recent literature in the helping professions. I begin this brief walkthrough of the history and conceptualization of counsellor impairment and its associated constructs, with an examination of the concept of countertransference.

Countertransference. According to Gentry (2002), one of the earliest references to the deleterious effects of therapy on the therapist (i.e., the costs of caring) in the scientific literature can be traced back to Carl Jung's (1907) mentioning of countertransference in his book, *The Psychology of Dementia Praecox*. There, Jung explains that therapists can have conscious and unconscious reactions to their clients in the therapy setting. It is important to note however, that

Jung described in particular the countertransference reactions that can occur when working with clients experiencing psychosis (Gentry, 2002). Nonetheless, since its conception in the early 1900s, the definition of countertransference has had several permutations (Fauth, 2006), reflecting the same inconsistency seen with the other constructs I discuss in this section (e.g., VT and CF). Some basic definitions of the construct define countertransference as a therapist's short-term (McCann & Pearlman, 1990), conscious or unconscious reactions that surface as a function of traumatic material within the therapist (Fauth, 2006; Figley, 1995; Harrison & Westwood, 2009) to his client (Fauth, 2006; Jung, 1907 as cited in Gentry, 2002) or client's material, and that are confined to the therapy setting (Fauth, 2006; Figley, 1995; Jung, 1907 as cited in Gentry, 2002; McCann & Pearlman, 1990). According to Hayes (2004), research and theory suggest that therapist self-awareness, self-integration, conceptual ability, empathy, and anxiety management facilitate management of countertransference.

In the contemporary literature, countertransference has been compared and contrasted with STS (Figley, 1995), VT (see Fauth, 2006; Figley, 1995; Gentry 2002; Walker, 2004), and CF (see Berzoff & Kita, 2010; Figley, 1995) as forms of counsellor impairment. As I have already said, Gentry (2002) puts the beginnings of the counsellor impairment literature with Jung's identification of countertransference in 1907, but it has been Freudenberger's introduction in 1974 of the term *burnout* in the stress literature, that appears to have sparked most of the recent thinking and research on counsellor impairment.

Burnout. In his article, *Staff Burnout*, Freudenberger (1974) describes burnout as such: The dictionary defines the verb "burn-out" as "to fail, wear out, or become exhausted by making excessive demands on energy, strength, or resources." And this is exactly what

happens when a staff member in an alternative institution burns out for whatever reasons and becomes inoperative to all intents and purposes. (p. 159-160)

Four years later in 1978, Ayala Pines and Christina Maslach were the first to discuss burnout in the context of helping professions, defining burnout as, “a syndrome of physical and emotional exhaustion, involving the development of negative self-concept, negative job attitudes, and loss of concern and feeling for clients” (p. 233). Note that at this time the loss of *concern* (a synonym for *compassion*) for clients was included in their definition. Interestingly, working with Robbins in 1979, Freudenberger described the *loss of compassion* (i.e., what today we would consider as being low on measures of CS or without CS entirely) as a cardinal sign and symptom of burnout, with depression, cynicism, boredom, and discouragement making up the other signs and symptoms of burnout (Freudenberger & Robbins, 1979 cited in McCann & Pearlman, 1990). In 1982, Maslach published a book titled, *Burnout, The Cost of Caring*. In this book, Maslach posited that emotional exhaustion is at the core of burnout, which is the result of working intensely with people over time *especially* when working with those in distress. Later, Figley (1995) suggested that in the context of *helping professions*, burnout is relatively predictable and cumulative, and results when service providers strive to support the wellbeing of their clients while concurrently being disempowered by structures in their workplace that reduce their levels of wellbeing and ability to handle stresses involved in their daily work (Barr, 1984; Karger, 1981; as cited by Figley, 1995, p.16). In sum, since burnout specific to helping professions was introduced in 1978, the term has been associated with emotional and physical exhaustion, and a low sense of personal accomplishment, depersonalization, and discouragement as an employee (Maslach & Jackson, 1981) as a function of unsuccessful striving towards unrealistic internal or external expectations (Fahy, 2007), and the compounding effects of

working a job where one feels powerless, overwhelmed, and unsatisfied (Mathieu, 2009)—often mostly due to external constraints in the workplace such as lack of autonomy (Adebayo & Ezeanya, 2010) or resources. The presence of emotional and physical exhaustion is a common thread that has remained from the first description of burnout to contemporary research (Figley, 1995; Freudenberger, 1974; Killian, 2008; Maslach & Jackson, 1981; Mathieu, 2009; Pines & Maslach, 1978).

Fahy (2007) notes that ‘burnout’ had been used as a catch-all for the symptoms of helping professionals, saying that “[I]n the 90’s, we [still] called it burnout, and wore it like a badge of honor because it meant we were working hard and really cared” (p. 201). However, as early as 1978 Figley began documenting a stress response in war veterans, their loved ones, and helping professionals working with the veterans, which he was sure was not burnout. The identification of what Figley (1978) then conceptualized as a secondary traumatic stress reaction seems to be the first instance of differentiating among stress reactions and describing how these differ from burnout. New conceptualizations of stress-related responses have since been proposed that expand the continuum of the effects of work-related stress for helping professionals. These include secondary traumatic stress (STS), vicarious trauma (VT), compassion fatigue (CF), and empathy fatigue (EF), which I now briefly discuss.

Secondary Traumatic Stress (STS). In 1978, when Charles Figley was studying war veterans and their stress-reactions resulting from combat, he also began to realize the impact that veterans’ stress-reactions were having on loved ones and others around them. So began Figley’s interest in how trauma *secondarily* impacts family members and helpers of trauma survivors. Specifically, Figley suggested that the loved ones of veterans, and the helping professionals working with them, are “susceptible to developing traumatic stress symptoms from being

empathetically engaged with victims of traumatic events” (Figley, 1978, p. 2). Since then, Figley has used several terms to describe this phenomenon; Secondary Victimization (1982), Secondary Traumatic Stress/ Secondary Traumatic Stress Disorder (1983), and later Compassion Stress (1995), and Compassion Fatigue (1995), which he adopted shortly after Joinson (1992) introduced the term *compassion fatigue* to the literature. My reader is likely to appreciate already the fuzziness and interchangeability of terms, and resulting confusion, that besets the literature.

According to Figley (1995) a helper’s degree of empathy and exposure to trauma impacts their risk for STS. Figley (1995) contended that the more empathic and “effective” counsellors are, the greater their vulnerability for STS (p. 1); stating that the simple act of caring for a traumatized individual makes one emotionally susceptible to STS as the negative by-product of caring. This is bad news for counsellors because it implies that the better—or more empathic and “effective” (Figley, 1995, p. 1)—they are in their jobs, the more at risk they are for impairment. However, Harrison and Westwood (2009) had a contrasting, more nuanced approach to understanding the relationship between empathy and impairment, suggesting that when combined with strong boundaries, empathy can actually protect counsellors from work-related stress responses. However, regardless of whether empathy is a protective or a risk factor, Figley (1995) warned that “those who are most vulnerable are those that see themselves as saviours or at least rescuers” (Figley, 1989, pp. 144-145 as cited by Figley, 1995 p. 9).

Vicarious Traumatization. During roughly the same time period that Figley was exploring STS, McCann and Pearlman (1990) coined the term *vicarious traumatization* (VT) to explain the effects that trauma work can have on therapists. In their landmark article, Pearlman and McCann asserted that by listening to clients’ trauma stories, therapists can experience

disruptions in their schemas about self and the world, such as beliefs about trust, safety, power, and intimacy. They described this phenomenon reflected by a change in cognitive schemata and a corresponding transformation in the therapist's inner experience, as VT.

Since the construct first emerged, definitions have remained consistent with the original conceptualization of VT. Current literature suggests that VT reflects a distinct shift in the worldview of helping professionals (Mathieu, 2009; Trippany, Kress, & Wilcoxon, 2004), perhaps impacting or damaging their core beliefs (Mathieu, 2009), memory system, and their sense of identity (Trippany, Kress, & Wilcoxon, 2004) as well. The aforementioned descriptions have influenced the way I have chosen to think about VT, which is: VT is the distinct shift that occurs in worldview and core beliefs about the self and the world, and which can include symptoms such as intrusive images/thoughts, avoidance of stimuli associated with the trauma, and symptoms of hyper-arousal, as a result of working with traumatized clients.

Compassion Fatigue. Only two years after McCann and Pearlman identified VT in 1990, Carla Joinson coined the term *compassion fatigue*. Joinson's (1992) article marked the first time that this nomenclature was used specifically to describe the way helping professionals (in this case, nurses) were impacted by caring for their clients/patients (Figley, 1995). Upon reading Joinson's (1992) paper on CF, I was surprised to note that she did not actually define the construct anywhere in her paper. Rather, Joinson (1992) used a case example describing a nurse with what she conceptualized as CF to illustrate how CF can manifest in helping professionals. In the example, Joinson described a nurse who had stopped allowing herself to have any emotional reactions to her patients' pain. The nurse's level of detachment was so extreme that it had led to the loss of her ability to care for her patients in an effective way.

Joinson (1992) also did not state why she chose to use the word “compassion” when she coined the term CF. The Merriam-Webster online dictionary defines compassion as: “a sympathetic consciousness of others’ distress together with a desire to alleviate it.” Indeed, the word compassion is derived from the latin word, “compati”, which is to sympathize. The definition for sympathy in the Merriam-Webster dictionary is: “an affinity, association, or relationship between persons or things wherein whatever affects one similarly affects the other,” or “the act or capacity of entering into or sharing the feelings or interests of another.” Joinson’s choice of “compassion” as the qualifying word in “compassion fatigue” is therefore interesting given its definitional association with sympathy. The counselling profession has a negative view of sympathy, and tends to emphasize empathy instead. In a text book on counselling skills, Neukrug and Schwitzer (2006) cite Carl Rogers’ (1959) definition of empathy:

The state of empathy, or being empathic, is to perceive the internal frame of reference of another with accuracy and with the emotional components and meanings which pertain thereto as if one were the person, but without ever losing the “as if” condition. (p. 101)

Note the emphasis put on “as if” in the definition of empathy. This speaks to the maintenance of boundaries and a sense of remaining grounded in one’s self that sets empathy apart from the definition of sympathy. In my experience, it has been for this reason that the counselling profession has encouraged counsellors to pursue empathy and avoid sympathy. Using the above definitions of compassion (i.e., a deep sense of sympathetic consciousness with others and the desire to relieve their suffering), it would make sense that fatigue and stress would arise in the helper given that, (a) sympathy is not associated with clear boundaries on behalf of the helper; and (b) it is often is not possible to relieve the suffering of clients. If this is the case, then I think Joinson’s choice of the word “compassion” in CF was astute. Perhaps the repeated engagement

in *sympathy* and not *empathy* is what has a depleting or fatiguing effect on counsellors, and thus it is not the level of empathy that we should be concerned about in counsellors, but instead their level of sympathy.

Since Joinson's (1992) seminal article on CF, several other researchers have attempted to define the construct. One potential definition of CF is that it is a result of being secondarily exposed to trauma through clients, leading to symptoms that mirror post-traumatic stress disorder (PTSD) (Figley, 1995; Figley, 2002; Stamm, 2005). (For a more detailed description of this conceptualization of CF see the section below where I compare and contrast STS and CF). Other common definitions of CF are: mental, physical and emotional exhaustion accompanied by feelings of hopelessness and disconnection from others (Figley, 1993); "a state of exhaustion and dysfunction—biologically, psychologically, and socially—as a result of prolonged exposure to Compassion Stress" (Figley, 1998, p. 23); a form of *languishing*, in which one experiences emotional distress, psychosocial impairment, limitations in daily activities, and loss of work days (Radey & Figley, 2007; emphasis in the original); a combination of burnout and STS (Stamm, 2009, 2010); and a deep physical, emotional, and spiritual exhaustion accompanied by acute emotional pain (Pfifferling & Gilley, 2000). Symptoms of CF include headaches; weight loss; psychosomatic symptoms (Joinson, 1992; Negash & Sahin, 2011); feelings of inequity and irritability; negative feelings towards work, life, and others; depersonalization (Gentry, 2002; Mathieu, 2009; Negash & Sahin, 2011); and disproportionately intense or frequent bouts of anger (Joinson, 1992). CF interferes with counsellor wellness (e.g., sleep, mood; Killian, 2008), and affects both the personal lives of counsellors (e.g., relationships; Wharton, 2009) and their ability to provide effective services to their clients (Figley, 1995; Gentry, 2002; Wharton, 2009).

Drawing on all of the above, for the purposes of the current study, I have chosen to use Mathieu's (2009) definition of CF because I found hers to be the most descriptive and cogent definition in terms of my understanding of the literature, and also because I found her differentiation of CF from the other counsellor impairment constructs to be the most clear. Similar to Joinson (1992), Mathieu (2009) described the common signs of CF to be the loss of enjoyment in one's workplace and increased pessimism. Mathieu (2009) goes on to state that CF points to "the profound emotional and physical erosion that takes place when helpers are unable to refuel and regenerate" (p. 10). Finally, the most distinct and perhaps most devastating characteristic of CF is that it "attacks the very core of what brought us into this work: our empathy and compassion for others" (Mathieu, 2009, p.1). This includes empathy not only for clients, but for loved ones as well.

Empathy Fatigue. In the past decade, new terms for sometimes but not always new constructs have continued to emerge in the field of counsellor impairment and wellness. One of the more notable new terms is *empathy fatigue* (EF). EF was first identified by Mark Stebnicki in 2000 as "a state of psychological, emotional, mental, physical, spiritual, and occupational exhaustion that occurs as the counsellors' own wounds are continually revisited by their clients' life stories of chronic illness, disability, trauma, grief, and loss" (Stebnicki, 1999, 2000, 2001, 2007, 2008 as cited in Marini & Stebnicki 2009). Stebnicki (2007) suggests that counsellors using person-centered and empathy-focused approaches are most vulnerable to EF, and that the onset of EF can be acute, cumulative, and delayed and reflects a depletion in the counsellors' coping and resiliency (Marini & Stebnicki 2009, p. 15).

Interestingly, Stebnicki's definition of EF seems to assume that only counsellors who are "wounded" would be susceptible to EF. Consistent with this notion, studies have indicated that

personal history of unresolved trauma contributes to the development of CF (Figley, 1995; Killian, 2008).

Confusion and Inconsistencies in Current Conceptualizations of Constructs

Clear distinctions between the constructs involved with counsellor impairment have been lacking in the literature thus far, creating confusion and inconsistency for practitioner and researcher alike. For example, in 1995 Figley himself wrote: “Although I now refer to it as Compassion Fatigue, I first called it a form of burnout, a kind of Secondary Victimization” (p. 2), and, in 1997, Stamm wrote that “the great controversy about secondary trauma is not, can it happen, but what shall we call it?” (Steed & Bicknell, 2001, p.1), concluding that there was no consistently used term regarding being exposed to traumatic material as a consequence of being a therapist (Steed & Bicknell, 2001). While referring to countertransference specifically, Fauth articulated why definitional inconsistency is so problematic for the advancement of knowledge, stating: “The lack of conceptual clarity about the term both results from and reinforces the general theoretical fragmentation in the field, thus inhibiting research on the construct” (p. 16). In what follows I will do my best to present a summary of the differences between and among countertransference, burnout, STS, VT, CF, and EF.

Countertransference and vicarious trauma (VT). Countertransference is different than VT because unlike countertransference, the effects of VT are long term, cumulative, and extend beyond the counselling session, impacting various aspects of the therapist’s life including their cognitive schemas about themselves and others (Harrison & Westwood, 2009; McCann & Pearlman, 1990; Trippany, Kress & Wilcoxon, 2004; Walker, 2004). Moreover, with VT the client’s traumatic material is the origin of the VT reaction (Harrison & Westwood, 2009; Trippany, Kress & Wilcoxon, 2004), not the personal experiences or characteristics of the

therapist (Fauth, 2006; Figley, 1995; Harrison & Westwood, 2009) as is the case with countertransference. Also, while countertransference can harm the therapeutic process and client outcomes (Hayes, 2004) VT is more likely to cause damage to the therapist (Harrison & Westwood, 2009). However, it is important to note that although countertransference and VT are separate constructs, there is a relationship between them (Trippany, Kress & Wilcoxon, 2004); the symptoms of VT can increase therapists' susceptibility to having countertransference reactions in session with clients (Pearlman & Saakvitne, 1995).

Countertransference and compassion fatigue (CF). Countertransference and CF are separate and distinct constructs. Countertransference happens in every therapeutic encounter (Berzoff & Kita, 2010) but only in the therapy setting and only as a *negative* result of a client's transference reactions (Figley, 1995). Conversely, CF affects the counsellor beyond the therapy session (Figley, 1995) and is not the result of their own emotional wounds being triggered by an encounter with a client, but rather it is the result of "the cumulative experience of caring for people who are suffering, and the personal experience of the persistent excess of suffering despite one's best efforts at ameliorating it" (Berzoff & Kita, 2010, p. 343).

Compassion fatigue (CF) and secondary traumatic stress (STS). In his early writings, Figley used STS and CF interchangeably, and defined STS/CF as the emotions and behaviours that are the natural result of knowing about a traumatizing event experienced by a significant other and helping or wanting to help that person (1993a as cited by Figley, 1995). Figley (2002) described the symptoms of STS/CF as parallel to the symptoms of PTSD (i.e., recurrent and intrusive images, thoughts, and dreams; persistent avoidance of stimuli associated with the trauma; and persistent symptoms of increased arousal). The only major difference that Figley (1995) cited between STS and PTSD is the source of the trauma (i.e., hearing about the trauma

experienced by someone else becomes the traumatizing event as opposed to direct exposure). Though STS and CF are often used interchangeably (Badger, 2001; Beck, 2011; Figley, 1995; Figley, 2002; Galek, Flannelly, Greene, & Kudler, 2001; Stamm, 2005), I conceptualize these two constructs as separate and distinct because I do not believe that CF has the same PTSD-like symptoms as STS, and as I will describe next, I think that STS and VT are rather the same construct.

Vicarious trauma (VT) and secondary traumatic stress (STS). When examining the literature, the distinction between VT and STS becomes blurry. In fact, several authors have suggested that VT and STS are the same construct and can be used interchangeably (Killian, 2008; Stamm, 1999). The proposed cause of VT and many of the symptoms associated with VT seem to parallel STS. For example, much like Figley's definition of STS, Pearlman and Saakvitne (1995) described how the symptoms of VT parallel the effects of directly experienced trauma such as acute stress disorder (ASD), post-traumatic stress symptoms (PTSS) and PTSD. Also, like STS, VT is most commonly associated with the effects of empathically engaging with trauma (Collins & Long, 2003; Mathieu, 2009; McCann & Pearlman, 1990; Pearlman, 1999; Pearlman & Saakvitne, 1995; Trippany, Kress, & Wilcoxon, 2004).

However, Pearlman and Saakvitne (1995) contended that although the two constructs are not mutually exclusive, there are distinct differences between STS and VT. The distinction is largely contextual and associated with the basic focus of each term (Pearlman & Saakvitne, 1995). For example, the conceptualization of STS has a greater emphasis on observable symptoms, with less attention given to etiology and context. In contrast, the VT framework takes a more developmental, constructivist approach to explaining counsellor impairment, seeing the individual as a whole, and primarily concerned with the impact on meaning and

relationship. Instead of emphasizing symptoms, they are instead placed “in the larger context of human quest for meaning” (Pearlman & Saakvitne, 1995, p. 153).

For the sake of parsimony and clarity, I subscribe to the former thinking on the relationship between VT and STS; that is, that they are different names describing the same construct. But, given that VT describes the effects of working with trauma from a more holistic, constructivist perspective (Pearlman & Saakvitne, 1995), I have decided to use the term VT instead of STS. From this point forward, I will not refer to STS as a separate construct, I will use the term “VT”.

Compassion fatigue (CF) and vicarious trauma (VT). CF and VT are separate constructs because CF is related to the emotional and physical deterioration caused when helpers are not taking the time to refuel, but VT is additionally associated with the shift in worldview that takes place when a helper hears trauma stories that shatter their values and belief systems (Mathieu, 2009). CF can happen with any helping professional, regardless of whether they work closely with trauma, but VT only happens as a result of exposure to trauma (Mathieu, 2009).

Burnout and compassion fatigue (CF). CF is similar to burnout in that they both create feelings of helplessness, loneliness, anxiety, depression (Conrad & Kellar-Guenther, 2006), loss of enjoyment and satisfaction from work, and increased pessimism (Freudenberger & Robbins, 1979 cited in McCann & Pearlman, 1990; Mathieu, 2009). However, CF and burnout are separate constructs because unlike burnout, CF is specific to helping professionals (Joinson, 1992; Mathieu, 2009), and unlike CF, burnout does not specifically target the helper’s ability to empathize (Mathieu, 2009). In addition, Mathieu (2009) contends that a change in jobs can alleviate burnout, but CF and VT will require more deliberate and specific work to manage and recover from. While burnout “gets under our skin” it appears to do so in a more superficial and

manageable way than does CF. Inasmuch as CF “attacks the very core of what brought us into this [helping] work: our empathy and compassion for others” (Mathieu, 2007, p.1), CF penetrates and permeates our core; unlike burnout, CF is not simply managed by a change in scenery or perspective by taking a break (Figley, 1995; Mathieu, 2009) or changing one’s job (Mathieu, 2009).

Burnout and vicarious trauma (VT). VT is believed to be distinct from burnout in both cause and effect. Burnout is caused by external characteristics of the work environment such as overwhelming expectations (Fahy, 2007), and lack of autonomy (Adebayo & Ezeanya, 2010), and does not include the impact that one’s work can have on core aspects of their self (Pearlman & Saakvitne, 1995). Conversely, VT is caused by interacting empathically with trauma and has a deep impact on an individual’s frame of reference for themselves and the world, namely by interfering with an individual’s sense of worldview, spirituality, and identity (Pearlman, 1999).

Burnout, compassion fatigue, and empathy fatigue (EF). In his writings and delineation of a theoretical framework for EF, Stebnicki (2007) contends that EF is distinct from constructs such as burnout and CF, because: (a) EF “primarily affects counsellors using person-centered and empathy-focused” approaches; (b) EF has cumulative, acute, and delayed onset; (c) these cumulative effects can lead to a depletion of the counsellors’ coping and resiliency; and because (d) the more empathy that a counsellor engages in, the higher his/her risk of EF (Marini & Stebnicki, 2009, p. 15).

Upon reviewing the literature on EF, the distinction between burnout and EF is clear to me, however it appears as if the way that Stebnicki (2007) describes EF parallels the way that Mathieu (2009) conceptualizes CF. For example, both constructs are marked by a depletion in empathy, along with physical and emotional exhaustion; both can occur whether the counsellor

works with trauma or not; and both cumulate over time as counsellors continue to engage empathically (Mathieu, 2009; Stebnicki, 2007). Therefore, I am not convinced that EF and CF are distinct and separate constructs, and so I have chosen to conceptualize EF as the same as CF.

Overall, in my review of the literature I found instances where CF has been described as synonymous with STS (Figley, 1995; Figley, 2002; Stamm, 2005), STS as synonymous with VT (Killian, 2008; Stamm, 1999), or at least highly over-lapping (Deville, Wright & Varker, 2009; Figley, 1995), and instances where CF has been described as synonymous with VT (Gentry, Baranowsky & Dunning, 2002). Yet, it has also been argued that they are all distinct and separate constructs (Pearlman and Saakvitne, 1995). There are also differing conceptualizations of how the constructs relate to each other. For example, Stamm (2009, 2010) posited that CF is made up of two components: burnout and STS. That is, that CF has both the exhaustion, frustration, and depression of burnout combined with the fear and work-related trauma of STS (Stamm, 2010). For the purposes of this research, however, I subscribe to the notion that CF, VT, and burnout are all separate but related constructs (Mathieu, 2009): individuals can suffer from one condition without suffering from the others (Mathieu, 2009), but there is also an interactive relationship between the constructs (Gentry, 2002). Therefore having burnout, for example, makes you more vulnerable for CF and VT (Mathieu, 2009). Lastly, it is worth noting again that due to the strong over-lap with the definitions of VT and STS (Killian, 2008; Stamm, 1999), and the way STS has been sometimes used interchangeably with CF (Figley, 1995), I do not consider STS to be a separate and distinct construct.

Shift in focus from Counsellor Impairment to Counsellor Wellness

The counsellor wellness literature has been a second cousin to the more focal literature on counsellor impairment, and one of the biggest changes to have occurred in the field of counsellor

health is the shift in focus from impairment to wellness (Lawson et al., 2007). This shift has broadened the investigation of counsellors' experiences to include positive experiences in addition to negative experiences. Consistent with the "Positive Psychology" movement (Seligman, 2011), the research community has slowly begun to recognize that the path to health is not only by examining illness, but also by understanding what makes (Campbell, 2011) and keeps us well.

What is counsellor wellness?

The construct of counsellor wellness is broad and may seem unclear, so I will take a moment now to clarify its meaning. Counsellor wellness is both a process and an outcome (Myers & Sweeney, 2007) that involves the deliberate optimization and prioritization of mental, physical, emotional, and spiritual health (counselorwellness.com). Counsellor wellness thus involves counsellors making active decisions to maintain balance in personal and professional domains of their life (counselorwellness.com; Kottler, 2007), and to prioritize their mind/body/spiritual well-being, such that they keep themselves in the best position to provide quality therapy to their clients (Kottler, 2007).

Lawson and Myers (2011) posited three primary components contributing to counsellor wellness; namely wellness, professional quality of life, and *career-sustaining behaviours* (CSBs). Citing Brodie (1982), Lawson and Myers define CSBs as "those personal and professional activities that counsellors participate in which help them to extend, enhance, and more fully enjoy their work experiences" (e.g., spending time with partner/ family, engaging in quiet leisure activities) (as cited in Lawson & Myers, 2011, p. 165). To measure wellness and professional quality of life, Lawson and Myers used the 5F-Wel, and the Professional Quality of Life Scale (ProQOL; the same instrument I used in my study), respectively. Lawson and Myers

purport that CS is one of the three main aspects of professional quality of life (along with burnout and CF), making it a part of the overarching umbrella of counsellor wellness. They reported a statistically significant positive correlation between high wellness scores as measured by the 5F-Wel, and high levels of CS as measured by the ProQOL scale (Lawson & Myers, 2011). Also, not surprisingly, there was a statistically significant negative correlation between scores on the 5F-Wel and both burnout and CF. These findings provide support for the link between wellness and CS. I was happy to come across this study as it is one of the only studies to provide a comprehensive look at wellness and how it specifically fits with CS and CF. I will revisit this study again later in this chapter to describe Lawson and Myers' findings on CSBs in relation to CS.

During my research on counsellor wellness, I came across another related term: counsellor *well-functioning*. Coster and Schwebel (1997) examined well-functioning in experienced psychologists, defining well-functioning as “the enduring quality in one’s professional functioning over time and in the face of professional and personal stressors” (Coster & Schwebel, 1997 p. 5). Coster and Schwebel concluded that well-functioning is the opposite of impairment; this is in keeping with Kottler’s (2007) view of counsellor wellness being the opposite of impairment. Coster and Schwebel also argued that well-functioning is generally the “normal state” (p. 5) for individuals. I will revisit the concepts of counsellor wellness and well-functioning again later in this chapter when I examine CS in more detail.

Why Should we Care About Counsellor Impairment and Wellness?

Kottler and Hazler (1996) reported that there were over 6000 counsellors with some kind of mental or emotional impairment practicing in the US at the time of their study (as cited in Sheffield, 1998). Given the publication date of Kottler and Hazler’s research, the fact that it took

place in the US, and the apparent lack of current research on the prevalence of counsellor impairment in Canada, it is difficult to speculate what the numbers would be now in either the US or Canada. However, Sheffield (1998) indicated that these estimates were likely conservative and I have not found any studies that report a decline in counsellor impairment in the past 20 years. Further, more recently, Mathieu (2009) stated that almost all helpers will experience some kind of CF in their career. Similarly, Figley (2002) stated that counsellors have a high risk of developing CF.

Counsellor impairment is associated with deleterious effects on client care, workplace quality, and of course the counsellors themselves. Firstly, counsellor impairment “poses the potential for harm to the client” (Lawson & Venart, 2005), as it impacts counsellors’ ability to offer their highest level of services to their clients (Figley, 1995; Gentry, 2002; Lawson, 2007; Wharton, 2009). In a study examining the effectiveness of psychologists, almost 60% of participants reported that they had worked when they were too impaired to be effective (Pope, Tabachnick, & Keith-Spiegel, 1987). Consistent with Pope, Tabachnick, and Keith-Spiegel’s finding, Guy, Poelstra, and Stark (1989) reported that 36.7% of psychologists in their study revealed that their own personal distress negatively impacted the quality of services they provided. The interruption of the ability to offer quality service to clients most particularly makes the mitigation of counsellor impairment an ethical issue. Secondly, counsellor impairment leads to disruption in the workplace. Burnout is associated with frequent employee turnover and attrition (Conrad & Kellar-Guenthar, 2006; Fahy, 2007), therefore incurring costs for recruitment and training and increasing disruption in the workplace (Conrad & Kellar-Guenthar, 2006). Thirdly, the effects of counsellor impairment are likely to extend across several domains of a counsellor’s life (e.g., social, emotional, physical, and spiritual) (Lawson,

2007). Figley (2002) stated, “In our effort to view the world from the perspective of the suffering, we suffer” (p. 1434). Different manifestations of impairment have been affiliated with difficulties with mood (Killian, 2008), specifically depression and temporary emotional imbalance/disturbance (Emerson & Markos, 1996; Freudenberger, 1974); difficulty with personal relationships (Mathieu, 2007; Wharton, 2009); sleep disturbance (Killian, 2008); substance abuse, and over-involvement with work (Emerson & Markos, 1996; Freudenberger, 1974). In sum, counsellor impairment appears to be prevalent and laden with risks for counsellors, their workplace, and their clients.

Counsellor wellness, on the other hand, contributes to successful client outcomes (Figley, 1995; Gentry, 2002; Hill, 2004; Witmer & Young, 1996). Taking together the correlates of counsellor impairment and wellness, it is for all these reasons that interest in counsellor wellness continues to grow. This is exemplified by the American Counselling Association’s Task Force on Impaired Counsellors’ emphasis on counsellor wellness as impairment prevention (work was completed in 2007). So what has CS got to do with counsellor impairment and wellness?

First, several studies suggest that CS promotes counsellor wellness through its mitigating effects on variations of counsellor impairment such as CF (Alkema et al., 2008; Collins & Long, 2003; Conrad & Kellar-Guenther, 2006; Killian, 2008; Negash & Sahin, 2011; Radey & Figley, 2007), burnout (Alkema et al., 2008; Collins & Long, 2003; Slocum-Gori et al., 2011), VT (Killian, 2008), and EF (Stebnicki, 2007). Second, counsellor wellness is an umbrella term of which CS is an integral component (Lawson, 2007; Lawson & Myers, 2011).

Compassion Satisfaction

Stamm (2002) was the first to introduce and discuss CS in the helping literature after realizing the significant gap in the discourse on counsellor health. She stated that, “it became

clear that, to understand the negative “costs of caring,” it is necessary to understand the credits, or positive “payments” that come from caring” (p. 109). Though there are some variations in the definitions of CS, they share common themes. Stamm (2005) defined CS as “the pleasure you derive from being able to do your work well” (p. 5), and said that CS is gained through positive connections with colleagues, and the opportunity to help people and contribute to society. Radey and Figley (2007) described CS as the experience of flourishing in the helping professions when one feels a sense of joy, fulfillment, and satisfaction from work, particularly when helping others move from the role of victim to survivor; and agree with Bowles (2009) that CS contributes to career longevity and to a sense of fulfillment, balance, and wellness that extends from counsellors’ professional to personal lives. Though these definitions are a sufficient starting point, for my purposes I found them to be too vague, therefore I have constructed my own operational definition for CS which I will provide later in this chapter.

How does CS Differ from Counsellor Wellness and Counsellor Well-functioning?

As described earlier, CS appears to be an integral component of the over-arching construct of counsellor wellness (Lawson, 2007; Lawson & Myers, 2011). Also, as briefly noted earlier in the chapter, another construct that shares some overlap with CS is counsellor well-functioning, defined by Coster and Schwebel (1997) as “the enduring quality in one’s professional functioning over time and in the face of professional and personal stressors” (p. 5). Like CS therefore, counsellor well-functioning involves the ability to persevere in a professional helping role despite the challenges inherent in the work. The difference between counsellor well-functioning and CS however, is that CS hinges on the experiences of *satisfaction and pleasure* derived from work. Also, like counsellor well-functioning, CS is associated with quality professional performance (Figley, 1995; Gentry, 2002; Hill, 2004; Witmer & Young,

1996), but CS extends beyond quality counselling to a sense of being energized by one's work. Coster and Schwebel (1997) further noted that they used the term "well-functioning" to denote the opposite of impairment, and that they chose to use it over the term *unimpairment* to avoid the double-negative. In contrast, CS is not the opposite of impairment. Counsellors can offer appropriate, effective services to their clients, but that does not mean that they are experiencing pleasure and satisfaction from their work. It is this additional pay-off from work that separates CS from well-functioning. After searching several databases, the article written by Coster and Schwebel is the only one I could find on counsellor well-functioning, so unfortunately I cannot draw from any other sources for this discussion. However, from the information that I have gathered it seems clear that counsellor well-functioning and CS are related but distinctly different constructs. Specifically, counsellor well-functioning appears to be a component of CS.

In sum, it appears reasonable to say CS might be a component of counsellor wellness, and that counsellor well-functioning might either be a component of or necessary for CS, but a clear understanding is beyond the scope of my thesis.

How does CS Differ from Job Satisfaction?

Job Satisfaction is defined as "the pleasurable emotional state resulting from the appraisal of one's job as achieving or facilitating the achievement of one's job values" (Locke, 1969, p. 316). Job satisfaction is therefore similar to CS in that it may result in the pleasurable sense of satisfaction associated with one's job, however it is different because it does not pertain specifically to helping work, as does CS (Radey & Figley, 2007; Stamm, 2005). Stamm (2005) stated that higher levels of CS represent a higher satisfaction in one's ability to *be* an effective *caregiver* in one's job. Conversely, job satisfaction is a function of the relationship one perceives between what one *wants from* one's job and what one believes it is offering (Locke,

1969). So, if what one wants from one's job is to be in a helping role that is fulfilling, and this is perceived as being so, then CS might contribute to overall job satisfaction. However the two constructs can also have no overlap at all. In fact, a study on the relationships between and among job satisfaction, CS (as measured by the ProQOL), and CF in workers who served the homeless found a weak, "rather insignificant" correlation between job satisfaction and CF, and no correlation (chi-squared value of 0.00) between job satisfaction and CS (Howell, 2012, p. 49). Although it is not possible to know without more information, this lack of correlation could be because of the way Howell was defining CS and job satisfaction, but it also appears to be because they are two separate constructs.

After reading articles on job satisfaction (e.g., Howell, 2012; Locke, 1969) I noted that they commonly discuss characteristics of the work place, such as number of hours worked and rate of pay, as being related to job satisfaction. With CS, however, good pay, good hours, and even an enjoyable work setting would not be enough to create CS. For example, a counsellor could have what she might describe as a good job, working for a company or practice that she likes, with good hours and good pay; by definition therefore, this counsellor should have job satisfaction. However, the counsellor may not be feeling fulfilled or satisfied with the helping work she is doing, in fact she might even find it tiring, overwhelming, or disturbing. At the end of the day, she begins to see her work as just a job—a good job but one without compassion satisfaction. Alternatively, a counsellor might have low job satisfaction and yet love the helping work that he is doing. He may be underpaid and over-worked but the energy and fulfillment that he gets from helping a client "transform from the role of victim to survivor" (Radey & Figley, 2007, p. 208), feeds him and brings him satisfaction, if not purpose and meaning. Arguably, this is also why one can experience both burnout and CS at the same time.

Another illustration of the difference between CS and job satisfaction comes from how the two constructs are measured. Seven out of 10 items on the CS sub-scale of the Professional Quality of Life Scale (ProQOL; Stamm, 2005) include the word “help” or “helping”, and of the 3 that do not specifically discuss helping, one talks about making a difference (which could be interpreted as helping). The remaining 2 items, “My work makes me feel satisfied”, and “I am happy I chose to do this work” are more general and could have some overlap with job satisfaction. In contrast, the 30 items on the Job Satisfaction Survey (Wellness Councils of America, 2004) relate to one’s fit and satisfaction with one’s work environment (e.g., “I am aligned with the organizational mission”). There is only one item on the Job Satisfaction Survey that could have some overlap with CS, and that is: “I’m engaged in meaningful work”.

In sum, job satisfaction and CS are independent but not mutually exclusive constructs. I believe that there could be some slight overlap between job satisfaction and CS in that aspects such as positive interactions with colleagues can contribute to both job satisfaction (Howell, 2012) and CS (Stamm, 2005). I also think that CS could theoretically lead to an increase in job satisfaction because if one is feeling that their helping work is fulfilling and meaningful, then one might have an increased sense of job satisfaction. But, I do not think that the two constructs are the same thing, nor do I think that job satisfaction is either sufficient or necessary for CS.

Operationally Defining CS for this Study

By way of reminder, CS is the experience of flourishing, joy, fulfillment, satisfaction (Radey & Figley, 2007) and “pleasure you derive[d] from being able to do your [helping] work well” (Stamm, 2005, p.5)—perhaps most particularly when helping others move from the role of victim to survivor—where being able to do your work well is gained through positive connections with colleagues, and the opportunity to help people and contribute to society (Radey

& Figley, 2007); and contributes to career longevity, and to a sense of fulfillment, balance, and wellness extending from your professional to personal life (Bowles, 2009; Radey & Figley, 2007). The key defining feature of CS across these definitions appears to be positive feelings (e.g., pleasure, joy, satisfaction) associated with one's helping work. As I wrote earlier, however, these definitions felt too vague for my purposes. When attempting to operationalize a definition for CS for my study, I resonated most with Dlugos and Friedlander's (2001) description of *passionately committed psychotherapists* as those who have: (a) a sense of being energized and invigorated by their work instead of drained and exhausted by it; (b) the ability to continue to thrive and love their work despite the personal and environmental obstacles they might face in it; (c) a demonstrable sense of balance and harmony with other aspects of their life; and (d) a sense of energizing and invigorating those with whom they work (p. 298). Note that the first two components of Dlugos and Friedlander's definition parallel definitions of CS, particularly Stamm's (2005) definition that emphasizes gaining pleasure from one's work. To me, these two components therefore conceptually overlap existing definitions of CS. For the purposes of my study, I have broadened the existing definitions of CS to include the last two components of Dlugos and Friedlander's (2001) definition of passionately committed psychotherapists. The working definition of CS I used for my study is thus: Compassion satisfaction is experienced as (a) the sense of being energized and invigorated by one's helping work more often than being drained by it, and (b) one's ability to continue to thrive and to derive pleasure from doing one's helping work well despite the personal and environmental obstacles that one might face.

Important to note is that I dropped Dlugos and Friedlander's fourth criterion from my definition of CS. My operational definition clearly gives way to my own bias that the sense of

“energizing and invigorating those with whom they work” may not necessarily be *what* “doing [one’s] work well” looks like for all counsellors; but rather that the experience of feeling energized and invigorated by one’s helping work is more likely to be a defining aspect of CS. That said, the purpose of my research was to understand what experienced counsellors *actively do* to maintain CS and therefore, exploring the conceptualization and validity of definitional descriptors is for future studies.

Also, note how this definition contrasts with the definition I use for CF. The loss of enjoyment, emotional erosion, and reduced ability to effectively empathize associated with CF (Mathieu, 2009) stands in contrast with the pleasure and sense of invigoration derived from doing one’s compassionate work well. In other words, with CF the individual is depleted by their work, and with CS they are energized by it. So what separates those counsellors experiencing CS from those that end up with CF? Mathieu suggests that the emotional and physical erosion associated with CF take place when counsellors are unable to “refuel and regenerate” (p. 10). Perhaps this is the distinguishing factor between CF and CS, and therefore perhaps these acts of refueling and regenerating are ways that counsellors might be able to avoid CF and increase their chances of experiencing CS. The emphasis on what counsellors are actively doing to maintain CS in this study will hopefully serve to shed more light on what acts of refueling and regenerating might look like for experienced counsellors with CS. Having established what CS is, I now move to discussing the existing literature on how CS is attained or achieved, and maintained.

How is CS Achieved and Maintained?

Given that we know that CS mitigates the effects of burnout, CF, and VT, and creates fulfillment that extends into one’s personal life, perhaps one of the most important questions in

the field of counsellor health is: How is CS achieved and maintained? As I noted earlier, when exploring the CS literature, I came across several studies that discussed professional wellbeing, and some that examined CS specifically (using Stamm's [2002] and Radey and Figley's [2007] definition of CS). In general, some of the most common factors linked with professional wellbeing in counsellors or with CS more specifically, are: social connection/support with both colleagues (Conrad & Kellar-Guenther, 2006; Harrison & Westwood, 2009; Killian, 2008; Stamm, 2002; Wharton, 2009) and loved ones (Harrison & Westwood, 2009; Killian, 2008; Wharton, 2009); the number of hours in contact with clients (Killian, 2008); the therapist's perceived locus of control (Killian, 2008); self-care (Harrison & Westwood, 2009; Negash & Sahin, 2011; Radey & Figley, 2007; Wharton, 2009); a well-developed personal life (Wharton, 2009); witnessing the growth and resilience of clients (Radey & Figley, 2007; Schauben & Frazier, 1995); and feelings of self-efficacy (Stamm, 2002).

There are five articles which I will now describe and discuss in some detail. These five papers most encouraged my thinking about how counsellors might achieve and maintain CS and most influenced my subsequent framework for my study.

Coster and Schwebel (2007). I was taken with Coster and Schwebel's (1997) research on well-functioning in experienced psychologists because I believe that despite their focus on counsellor well-functioning and not CS specifically, they provided relevant information about how CS might be achieved and what might distinguish CS from counsellor well-functioning. As I indicated earlier, using my operational definition for CS it appears that counsellor well-functioning is a component of CS, therefore Coster and Schwebel's exploration of the variables that contribute to well-functioning should shed some light, at least in part, on what contributes to CS.

Coster and Schwebel (1997) interviewed 6 participants who spent 50% or more of their work-related time in direct-client hours, and who had been working in the field for a minimum of 10 years. Participants were 6 psychologists from school, counselling, and clinical settings. Ten themes that contributed to the well-functioning of these participants were reported, namely: peer support; stable personal relationships; supervision; a balanced life; affiliation with a graduate department; personal psychotherapy; continuing education; family of origin (as the source of personal values); awareness of the costs of impairment (e.g., unethical behaviour and deterioration of relationships); and coping mechanisms (e.g., vacations, rest, exercise, spirituality, evenings with friends).

When comparing these themes to other findings from the literature, there was considerable overlap. For example, the themes of peer support, supervision, and affiliation with a graduate department that Coster and Schwebel (1997) described align with findings related to social connection/support from colleagues (see Conrad and Kellar-Guenther, 2006; Harrison & Westwood, 2009; Killian, 2008; Stamm, 2002; and Wharton, 2009). The theme of stable personal relationships and a balanced life is consistent with Wharton's (2009) position on the value of a well-developed personal life, and also parallels the theme of social connection/support from loved ones reflected in several extant studies (see Harrison & Westwood, 2009; Killian, 2008; Wharton, 2009). Next, Coster and Schwebel's findings involving the importance of coping mechanisms fit with themes of self-care (see Harrison & Westwood, 2009; Negash & Sahin, 2011; Radey & Figley, 2007; Wharton, 2009) and creating a well-developed personal life (see Wharton, 2009). While not the same, the theme of continuing education identified by Coster and Schwebel's participants could be linked to self-efficacy, which Stamm (2002) contended is vital to the achievement of CS. In fact, Coster and Schwebel's participants discussed how

continuing education helped them develop new specialties and stay abreast of new developments in the field, which I imagine would impact self-efficacy for many of the psychologists.

Lastly, I would like the reader to note that in Coster and Schwebel's (1997) study the participants did not identify anything related to the pleasure or fulfillment derived from doing their work. As I mentioned earlier, this seems to be the difference between counsellor well-functioning and CS. According to Stamm (2005) the pleasure derived from doing one's work well is a key component of CS. This is exemplified in a study by Schauben and Frazier (1995) and the article by Radey and Figley (2007), both of who discuss the link between CS and the fulfillment that results in witnessing growth and resilience in clients. Coster and Schwebel's findings did not include anything related to how the work itself benefitted the participants.

In conclusion, more research needs to be done on counsellor well-functioning, counsellor wellness, and CS so we can understand how they constellate together and tease apart which components relate to CS specifically. So far what we can take away from these studies, however, is that social connection and support from colleagues, a well-developed personal life, including fulfilling personal relationships and a good work-life balance, coping mechanisms/self-care, and self-efficacy are important factors to focus on for the achievement of either counsellor well-functioning or CS. And, regarding CS specifically, focus will need to be put on how counsellors derive fulfillment and pleasure from their role in their clients' change process.

Lawson and Myers (2011). I highlight this study because it is the only one I know of that brings together measurements and a discussion of the relationships between and among wellness, CS, and what Brodie (1982) identified as career sustaining behaviours (CSBs). Using a sample of 506 professional counsellors, Lawson and Myers investigated wellness on 5 levels: creative self, coping self, social self, physical self, and essential self. Wellness was measured using the

5F-Wel, a quantitative instrument targeting these 5 levels of wellness, and providing a total wellness score. Professional quality of life was measured using the ProQOL scale, which is comprised of CS, CF, and burnout subscales.

Counsellors in private practice scored higher on the 5 indicators of wellness and CS compared to those working in school settings and community agency settings (Lawson & Myers, 2011). Also, counsellors scoring higher in wellness and CS had fewer clients that were considered high risk (i.e., those that were actively or regularly at danger to their self or others). Finally, as a group, there was a strong statistically significant positive correlation between CS and wellness scores. Lawson and Myers stated the reason that private practitioners scored higher on wellness and CS could not be determined from their data. However, I imagine that counsellors in private practice have a greater perceived locus of control and an opportunity to take on fewer direct hours with clients than in other settings, which are both themes that Killian (2008) identified as being integral to CS.

In some ways these findings parallel some of those of other studies I have read, but they are conflicting with some studies as well. For example, Lawson (2007) also found that counsellors in private practice had a significantly higher level of CS compared to those in community agency settings or K-12 school settings. However, when Sprang, Clark, and Whitt-Woosley (2007), and later Craig and Sprang (2010), examined the relationship between work setting and CS, neither group found a statistically significant relationship. Instead, Sprang et al. found that specialized training and increased age were associated with higher CS, and Craig and Sprang found that age (and to a greater extent, number of years of experience), and counsellors' utilization of evidence-based practices were associated with increased CS. These findings make intuitive sense, as specialized training, years of experience, and use of evidence-based practices

could potentially lead to increased self-efficacy, which we know to be strongly linked with CS (Stamm, 2002). Further, private practice work settings tend to have less opportunity for supervision, which is a theme that Coster and Schwebel (1997) named as important for the achievement and maintenance of counsellor well-functioning. Support from colleagues, identified as a contributor to CS by Conrad and Kellar-Guenther (2006), Coster and Schwebel (1997), Harrison and Westwood (2009), Killian (2008), Stamm (2002), and Wharton (2009), is also less accessible when working in private practice. In other words, private practice settings may lack the sense of community and the level of professional support that other work settings provide. Lawson and Myers (2011) did not indicate whether the private practitioners in their sample were using supervision or peer support, however, perhaps the counsellors with high CS in private practices actively seek out supervision and peer support outside of their practice to counter the isolation of their work setting. This would align with Harrison and Westwood's finding that countering isolation through supervision and professional relationships is a key component of protecting oneself from counsellor impairment (specifically VT). In summary, conflicting findings regarding the relationship between work setting and CS are examples of the gaps that still exist in the literature on what factors facilitate CS. These gaps need to be addressed so that we know what conditions best support the development and maintenance of CS for counsellors.

Before moving on to the next study I want to highlight the component of Lawson and Myer's (2011) study that focused on CSBs (career sustaining behaviours). Lawson and Myers asked participants to rate specific CSB strategies on their importance in helping them to function effectively and maintain a positive attitude in their professional role. CSBs were originally defined by Brodie (1982) as "those personal and professional activities that counsellors

participate in which help them to extend, enhance, and more fully enjoy their work experiences” (as cited in Lawson & Myers, 2011, p. 165). Reading this definition it would appear that CSBs are very similar or even equivalent to self-care. However, I like that there is a distinct definition for CSBs, whereas in my experience, self-care has become a catch-all term that is frequently used in the counselling profession and seldom defined. It therefore seems to have lost some of its significance. It might also be apparent that the definition for CSB fits well with how I am defining CS. At the core of my definition of CS is the ability to continue to thrive in one’s career and gain enjoyment from doing one’s work well. Thus, it could be argued that engaging in CSBs could have an effect on CS, making the active, intentional, and effortful utilization of CSBs a contributing factor to CS.

Unfortunately, Lawson and Myers (2011) did not report the highest rated CSBs for counsellors with high CS, however, the 8 top rated CSBs for counsellors with the highest wellness scores were: maintain balance between personal and professional lives, spend time with partner/family, maintain self-awareness, reflect on positive experiences, engage in physical activities, engage in quiet leisure activities, maintain professional identity, and participate in continuing education. In addition, those that scored higher in wellness rated the importance of 19 CSBs significantly higher than those that scored lower on total wellness, indicating that counsellors with higher levels of wellness endorse more CSBs overall than their less-well counterparts. Not surprisingly, counsellors that practiced more CSBs were also less likely to experience counsellor impairment than those that practiced fewer CSBs (Lawson, 2007).

Again, consistencies become evident between this list of CSBs and findings from other studies discussed thus far. Work-life balance, time spent nurturing important relationships, and continuing education are themes that continue to surface. I also think that the CSB referred to as

“reflect on positive experiences” coincides with the theme of witnessing growth and resilience in clients identified by Radey and Figley (2007) and Schauben and Frazier (1995). Implications of findings from this work by Lawson and Myers (2011), are that CSBs, CS, and wellness are all linked; that a private practice work setting and a reduced number of high-risk clients are perhaps conducive to CS and wellness; and that the more counsellors can integrate a variety of CSBs (particularly the ones listed above) into their daily routine, the more likely they are to have increased CS and wellness. To this point, Lawson and Myers (2011) stated that, “an emphasis on all the CSBs could be useful to professionals seeking to maintain satisfaction in their work” (p. 170).

Harrison and Westwood (2009). I considered this study particularly relevant given Harrison and Westwood’s focus on protective practices against VT among a target population of therapists self-identifying as having “managed well” in their work. Participants had to score below average on the burnout and CF scales of the ProQOL to qualify for the study. In many ways I used this study as a model for my study. For example, I used similar inclusion criteria, such as: participants must (a) have been working in the field for a minimum of 10 years (as did Coster & Schwebel, 1997); and (b) have a minimum of a Masters level of education.

Though the focus for Harrison and Westwood’s (2009) research was specific to mitigating VT and not to the maintaining of CS, their overall stated purpose was to examine: individual and organizational practices that contribute to the professional satisfaction and well-being of experienced clinicians who work with traumatized clients ... [given that] very little is known about the success and satisfaction of clinicians who are able to manage in the workplace despite the potentially noxious demands of their work with traumatized clients. (p. 204)

The interest in individual practices, most particularly, that contributed to the professional satisfaction and well-being of experienced clinicians, mirrored the purpose of my study with the exception that I wanted to include experienced clinicians from a variety of fields and caseloads, not just those working mostly with traumatized clients. Given the authors' slightly different research lens, I believed Harrison and Westwood's findings would provide an interesting comparison for my study.

Harrison and Westwood's (2009) findings centered around nine themes: (a) countering isolation in professional, personal, and spiritual domains of life; (b) developing mindful awareness; (c) consciously expanding perspective to embrace complexity; (d) active optimism; (e) holistic self-care; (f) maintaining clear boundaries and honouring limits; (g) exquisite empathy; (h) professional satisfaction; and (i) creating meaning. I will briefly describe each of these themes and work to show how they relate to or can potentially inform current understandings of CS.

Countering isolation in professional, personal and spiritual domains of life was a broad theme that included supervision, professional training/support, diversity of professional roles (e.g., combining therapist role with teaching or administrative work), personal community, and spiritual connection. All of these strategies increased therapists' sense of interconnectedness and decreased feelings of shame and anxiety associated with VT (Harrison & Westwood 2009). The value of nurturing professional and personal relationships was reflected in several studies I reviewed. For example, Conrad and Kellar-Guenther (2006), Coster and Schwebel (1997), Killian (2008), and Stamm (2002), all spoke to the need for social connection/support with colleagues, and Coster and Schwebel (1997) and Killian (2008) included the importance of personal relationships. All of these authors linked professional and/or personal relationships to

CS specifically, with the exception of Coster and Schwebel who examined counsellor well-functioning. Additionally, recall Lawson and Myer's (2011) finding that the second highest rated CSB in counsellors with the best wellness scores was "spend time with partner/ family" (p. 168). What was intriguing to me about this theme was the finding that participants' included spiritual connection as a part of countering isolation. In the extant literature, spirituality is typically broadly discussed and linked with counsellor wellness or CS (see Cashwell, Bentley & Bigbee, 2007; Killian, 2008; Lawson & Myers, 2011). In other words, Harrison and Westwood's finding sheds a new light on the benefits of spirituality by specifically linking it to countering isolation and including it with professional and personal connections.

Developing mindful awareness helped therapists cultivate presence, patience, and compassion. Mindfulness practices allowed therapists to stay calmly focused, grounded, and non-reactive, allowing them to tolerate ambiguity and complexity, and to hold multiple perspectives at one time. These attitudes helped participants remain hopeful even in the face of suffering. Other studies by Christopher, Christopher, Dunnagan, and Schure (2006) and Christopher and Maris (2010) looking at the use of mindfulness practices to support self-care in counsellor training programs, support these findings. Overall, the participants in Christopher et al.'s (2006) study felt "better equipped both emotionally and mentally to deal with daily stress in their lives" (p. 506). Mindfulness increased counselling students' awareness of themselves and their clients, including their awareness of signals from their bodies about their needs (e.g., for rest) and their current psychological state, which allowed students to (a) remain focused, present, calm, and grounded, especially in the face of their own or their clients' distress; and, (b) intervene before they became ill or depleted. Such awareness will surely contribute to CS by creating opportunities for counsellors to regularly tend to their own needs, thereby maintaining

their physical and mental/emotional health and helping them to avoid burnout, VT, or CF. I also think the increased ability to be present and connected to clients would allow counsellors to notice and appreciate the positive moments in therapy that could bring them pleasure.

Participants in the Christopher et al. (2006) and Christopher and Maris (2010) studies also noted increased self-acceptance and self-compassion, which would enable counsellors to be gentle with themselves in the face of the many ups and downs of this work. Lastly, the benefits of mindfulness extended to the effectiveness of the student counsellors' clinical work. Participants in both studies experienced increased competence and confidence in clinical settings, which would likely lead to higher self-efficacy, a factor we know to be integral to CS. Mindfulness of course is often linked to spiritual practices and to grounding/relaxation practices. As such, mindfulness could well be part of the CSBs, self-care, or coping mechanisms that participants have identified in other studies. In fact, the CSBs with the highest and third highest mean differences between the high-wellness and low-wellness groups in Lawson and Myers' (2011) study, were "turn to spiritual beliefs" and "engage in formal relaxation activities" (which could certainly have included mindfulness practices), respectively. In sum, there appears to be a strong link between mindfulness and CS, and the practice of which might be one active strategy to help support and maintain CS in counsellors such that they can continue to thrive and derive pleasure from doing their work well.

Consciously expanding perspective to embrace complexity helped participants in Harrison and Westwood's (2009) study avoid getting caught up in negative emotions. They purposely reminded themselves of other, often more positive ways, of viewing the world by deliberately cuing themselves when they noticed persistent negative thoughts. They did this by using self-talk, seeking interactions with people in other lines of work, using imagery, or taking

time in nature. The ability to embrace complexity helped participants accept the inevitability of both suffering and healing, and to see a “gift side of loss” (p. 210). They believed that their lives were enriched by vicarious experiences of posttraumatic growth. I did not find anything in the extant literature that exactly mirrored this finding of expanding perspective to embrace complexity, but I think that the authors have identified a subtle yet important variable in the achievement of CS here. I absolutely believe that consciously expanding one’s perspective to embrace complexity has implications for CS because doing so: (a) involves attending to negative thoughts and emotions and then immediately caring for oneself as needed (i.e., self-care); and (b) allows one to acknowledge and accept both the positive and negative aspects of counselling work; both of which would make it easier to thrive despite the inherent challenges. Indeed, this finding also involves something I have not seen described in other studies: embracing complexity requires non-dual thinking to accept the positive and negative aspects of therapeutic work. This non-dual thinking will help counsellors, I think, to accept the challenges of their work, and to make space for them to pay attention to the positive aspects of therapy, such as client growth and resilience. Interestingly, the ability to pay attention to the positive aspects of therapy is a factor that Radey & Figley (2007) and Schauben and Frazier (1995) found to contribute to CS.

Active optimism was the fourth theme reported and discussed by Harrison and Westwood (2009). They found that participants shared a positive orientation to self and life, trusting: (a) self as good enough; (b) the therapeutic change process; and (c) the world as a place of beauty despite pain and suffering. There is a reciprocal quality to these beliefs in that the ability to sustain hope is linked to many protective factors that in turn add to a sense of hope and trust (Harrison & Westwood). The optimism discussed here is not ignorant; it is about acceptance of

the realities of life. Even when a problem was big, participants reported an attitude of looking at what small part they could work with. In addition, they actively sought self-care and opportunities for beauty and joy. Embracing complexity and using non-dual thinking to accept the positive and negative aspects of therapeutic work, will help counsellors to “see” and witness the growth and resilience of clients (Harrison & Westwood) which, in turn, would foster, reassure, and perpetuate active optimism; and possibly therefore, CS (given the relationship of noticing positive aspects of therapy and CS [Radey & Figley, 2007; Schauben & Frazier, 1995]). There also seems to be overlap between active optimism and the CSB “reflect on positive experiences” from the study by Lawson and Myers (2011). Most of all, I like that Harrison and Westwood (2009) emphasize that the optimism discussed here is an active process. It requires deliberate, conscious, and ongoing effort and agency and puts the power in counsellors’ hands to cultivate positivity and seek self-care. I think that active optimism has direct implications for CS because it would help one to (a) remain energized and invigorated by one’s work by purposefully seeking and noticing experiences that fuel and inspire, which would then enable one to (b) continue to thrive and to derive pleasure from doing their work well despite the personal and environmental obstacles that one might face.

Holistic self-care described the physical, emotional, mental, spiritual, and aesthetic aspects of self-care identified by participants. Though self-care is a common theme in the literature on CS (see Negash & Sahin, 2011; Radey & Figley, 2007; Wharton, 2009), this is the first time I have come across the term ‘aesthetic self-care’, and I find the construct intriguing. It involves purposely seeking beauty and bringing it into one’s life, for example by spending time in nature. Again, the theme of actively searching out positive, renewing experiences is noted. Further, aesthetic self-care also likely has an element of mindfulness involved with it, because a

person must exercise a certain amount of present-moment awareness and stillness to notice the beauty around them. More generally, participants in Harrison and Westwood's (2009) study considered self-care practices as helping to provide balance, closure, renewal, and the ability to be present in personal and professional relationships.

Maintaining clear boundaries and honouring limits included participants' awareness and acknowledgment that (a) they could not carry the responsibility of change for their clients; (b) they knew where they ended and their clients began; (c) change comes in small steps and is slow; and (d) large scale change is a community responsibility. While the importance of maintaining clear boundaries and honouring limits is not a new or surprising finding to the counselling literature, it does emphasize the importance of the finding and one that I think, has strong implications for CS. By holding and not transgressing one's boundaries or limitations, counsellors can remove unrealistic expectations that tend to weigh heavily on them and which set them up for disappointment. In lightening the burden of their work in this way, counsellors will also decrease the risk of impairment, and make room for positive experiences that could lead to CS. A variety of helpful strategies were identified for maintaining boundaries, such as supervision/consultation, personal therapy, before and after-work rituals, mindful awareness of unresolved issues, and vacations.

Returning to the second theme identified by Harrison and Westwood (2009), namely, the development of mindfulness, I want to briefly expand on how these two themes (*mindfulness*, and *maintaining clear boundaries and honouring limits*) are reciprocal. A taken-for-granted understanding in the professional field is for counsellors to be highly self-aware. Therefore, at least theoretically, the more *self*-awareness mindfully practiced by a counsellor, the more accepting and honouring of boundaries and limitations a counsellor should be. Because

mindfulness facilitates and supports self-knowledge and self-awareness, the importance of mindfulness in helping therapists to identify, acknowledge, and accept boundaries and limits in their relationships and work with clients, becomes clear. The ability to be mindfully and, thus, truly present in the moment will also protect counsellors from intrusive thoughts about work when they are at home, thus strengthening their boundaries between work and home. In addition, mindfulness increases overall personal awareness, helping counsellors identify when their resources are becoming depleted and when they are becoming triggered.

Lastly, honouring boundaries distinguishes empathy from sympathy. As I discussed earlier in this chapter, I believe the engagement of sympathy is a cause of CF and that empathy can contribute to CS as long as it is accompanied with appropriate awareness of one's boundaries and limits. Harrison and Westwood's (2009) finding of "exquisite empathy" as a theme, is an interesting finding. *Exquisite empathy* is described by Harrison and Westwood as the ability to be fully present and attuned with one's client, while still maintaining firm boundaries and discerning where the client ends and the self begins. I understand Harrison and Westwood's characterization of exquisite empathy to be the most sophisticated and refined level of empathy possible. This understanding might explain why this finding of empathy as a protective factor for Harrison and Westwood's participants does not support much of the research where authors suggest that empathy has a deleterious effect on helpers (see Conrad & Kellar-Guenther, 2006; Figley, 1995; Figley, 2002; Figley & Radey, 2007; Marini & Stebnicki, 2009) and where in some cases, it manifest as EF (Marini & Stebnicki, 2009) as described earlier. This type of empathy is energizing rather than draining because therapists using exquisite empathy do not fuse with their clients' stories or emotions. Instead, therapists benefit from this type of connection because they recognize that their relationship is benefitting the client, thus contributing to a sense of CS.

I believe that Harrison and Westwood's (2009) study makes an important contribution to the research as it illustrates how one can still hold clear boundaries while being empathic. The presence or absence of healthy boundaries may be the pivotal factor that determines whether empathic engagement leads to satisfaction or to depletion.

Professional satisfaction was experienced when participants felt efficacious and skilled at what they are doing, and if they sensed their work as meaningful. This finding has implications for CS because it is very similar to deriving pleasure from doing one's work well, which is a component of my working definition for CS. When therapists experience professional satisfaction, they see their work as more than just a job; it is enriching their lives. In this study the therapists viewed their work as a privilege instead of a burden (Harrison & Westwood, 2009). This sense of honour and pleasure sustained the therapists (Harrison & Westwood, 2009) and while certainly protecting them against VT, it is likely that it may have also contributed to a sense of CS. I say this because it is in keeping with Negash and Sahin's (2011) hypothesis that perception of work affects CS, and with Stamm's (2002) hypothesis that efficacy is a key component of CS. Also, professional satisfaction encompasses concepts similar to Grawitch et al.'s (2010) conceptualization of what they call *job embeddedness*, which explains how work becomes more intrinsically motivating when one's job is appraised as a calling or is linked to meaningful personal interests.

The last theme presented by Harrison and Westwood (2009) was that of *creating meaning*. It seems that regardless of what therapists use to make meaning of their experiences, the process of drawing meaning from their work is a protective and sustaining factor. This is a broader theme that is reflected in several of the ingredients for CS that I have discussed so far. For example, some participants discussed their use of spirituality to make meaning of their work,

while others drew meaning from making human connections. Both of these examples have appeared in the extant literature. We can also create meaning by reflecting on positive experiences and honouring the growth and resilience that we witness in clients, and by attending personal counselling. This finding is relevant to CS because creating meaning helps one to process the difficult stories that one is exposed to as a helper and therefore weather the challenges of this work. Through this process new perspectives can be found and it becomes possible to find the gifts and lessons in struggle (whether it is ours or our clients’).

Dlugos and Friedlander (2001). A fourth study that informed my research framework was by Dlugos and Friedlander (2001) on *passionately committed* counsellors. As noted in the beginning of this chapter, I incorporated and adapted Dlugos and Friedlander’s definition of passionate commitment for the operational definition of CS I have used in my research. To remind the reader, passionately committed therapists are those who have: (a) a sense of being energized and invigorated by their work instead of feeling drained and exhausted by it; (b) the ability to continue to thrive and love their work despite the personal and environmental obstacles they might face in it; (c) a demonstrable sense of balance and harmony with other aspects of their life; and (d) a sense of energizing and invigorating those with whom they work.

For their study, Dlugos and Friedlander (2001) interviewed 12 experienced therapists to gain a richer understanding of how they were able to maintain a strong level of work commitment throughout their careers. Peer nomination was used for recruitment and semi-structured interviews were used to collect data. Four themes were salient across all 12 narratives. These 4 themes were balance, adaptiveness/openness, transcendence/humility, and intentional learning. Within the 4 themes specific categories were developed.

The first theme, *balance*, had four categories: (a) maintaining physical and psychological boundaries between work and personal life; (b) passionate engagement in at least one non-work activity; (c) deliberately seeking variation in work activities to maintain freshness; and (d) recognition of the power of monetary motivation to reduce passion for work. Several authors speak to the importance of balance for counsellor wellness. For example, Coster and Schwebel (1997) and Bowles (2009) also contended that balance between personal and professional life is an essential ingredient in counsellor well-functioning and counsellor wellness respectively, and Lawson and Myers (2011) indicated that “balance between personal and professional lives” (p. 168) was the highest rated CSB for counsellors with the best wellness scores. I like that Dlugos and Friedlander (2001) further developed the concept of balance between time spent at work and home by noting that their participants were *passionately* engaged in at least one non-work activity. The implications for this finding suggest that balancing one’s time at work and home might not be sufficient. Instead, this finding suggests that therapists should look for other activities that inspire them outside of work.

The second theme, *adaptiveness/openness*, has two categories. The first is meeting obstacles as challenges to be faced with creativity and persistence, and the second is hunger for feedback through supervision. This first category shares similarities with the “active optimism” theme from Harrison and Westwood’s (2009) study because in both instances, counsellors intentionally reframed challenges that they faced to find more flexible, optimistic ways to move forward. The second category of hunger for feedback through supervision supports Coster and Schwebel’s (1997) earlier finding that supervision was vital for counsellor well-functioning. Several other studies similarly highlight the importance of peer support for counsellor wellness

or CS specifically (see Conrad & Kellar-Guenther, 2006; Harrison & Westwood, 2009; Killian, 2008; Stamm, 2002; Wharton, 2009).

The third theme, *transcendence/humility*, also has two categories: acknowledgement of the spiritual nature of therapy, and locating the significance of therapy within community/social responsibility. This theme is comparable to the “creating meaning” theme from Harrison and Westwood’s (2009) study, however it is unique because it describes the actual process of therapy as spiritual. I find this to be an interesting way of framing therapy, and though many would debate it, there is a part of me that resonates with it. Locating the significance of therapy within community/social responsibility is also reflected in part in Harrison and Westwood’s (2009) theme of maintaining clear boundaries and honouring limits. When describing this finding, Harrison and Westwood stated that their participants recognized that “larger scale change is a community rather than an individual responsibility”.

Finally, the fourth theme is *intentional learning*. This theme has three categories, namely the recognition of the complementary relationship between personal and professional development, the understanding that work as a therapist allows for congruent self-expression, and the continual fascination with the human condition and with human development and change. None of the studies that I read through the course of reviewing the literature used the term “intentional learning,” however some identified the connection between continuing education and counsellor well-functioning or wellness (see Coster & Schwebel, 1997; Lawson & Myers, 2011). Dlugos and Friedlander are taking this aspect of continuing education/professional development in the life of a counsellor even further, however, by suggesting that steps actively taken towards developing oneself as a counsellor through intentional learning will enrich and benefit oneself as a whole.

As I said earlier, I resonated strongly with Dlugos and Friedlander's conceptualization and characterization of passionate commitment and believe that there is a strong overlap between passionate commitment and CS. In fact, I suspect that passionate commitment and CS are two names for the same construct; however more research will have to be done to compare the two before any conclusions can be made. For now, counsellors and psychotherapists who wish to achieve CS would be well advised to paying attention to creating balance in their lives, focusing their efforts on cultivating adaptiveness/openness and transcendence/ humility, and intentionally maintaining their learning.

Radey and Figley (2007). I highlight this study because Radey and Figley specifically discussed CS and provided a comprehensive exploration of the mechanisms involved in CS. Radey and Figley (2007) proposed a model for creating CS that involves three key, interrelated components: increasing positive affect, increasing resources to manage stress, and increasing self-care. The researchers hold that by focusing on these three components, counsellors can increase their positivity-negativity ratio, thereby increasing their opportunity for CS to take root and hold.

The first component mediating CS in Radey and Figley's (2007) model, *increasing positive affect*, involves maintaining optimism towards one's clients and work. To maintain optimism, Radey and Figley (2007) recommend caseload variety, sufficient time off, creating distance from client issues, and opportunities to discuss client challenges and successes. The authors also assert that regardless of personality traits, helpers can learn to be more optimistic by actively looking for positive meaning in challenging circumstances. I appreciate this agentic component of Radey and Figley's model suggesting that even those who do not identify as naturally optimistic can take deliberate and active steps to increase their positive affect. This

theme clearly parallels two of Harrison and Westwood's (2009) findings: that active optimism and consciously expanding perspectives to embrace complexity protected those working with trauma caseloads against VT. Intentionally choosing to take positive instead of negative perspectives and to bring optimism to one's work, are active strategies serving and supporting counsellors' internal resources and perhaps therefore, their levels of CS.

Increasing resources to manage stress was the second component mediating CS; according to Radey and Figley (2007): "intellectual, social, and physical resources are critical in maximizing compassion satisfaction" (p. 212). During formal education, intellectual resources can be maximized when educators highlight how course concepts can be applied to future careers. After formal education is complete, one can further cultivate intellectual resources through continued education and professional development. This is what Dlugos and Friedlander (2001) referred to as "intentional learning" (p. 301). Lawson and Myers (2011) and Coster and Schwebel (1997) also refer to continuing education as a constituent of counsellor wellness (and thereby CS) and counsellor well-functioning respectively. To increase social resources, Radey and Figley (2007) emphasize the importance of reaching out to loved ones, colleagues, and supervisors. As I have mentioned, positive professional (see Conrad & Kellar-Guenther, 2006; Harrison & Westwood, 2009; Killian, 2008; Stamm, 2002; Wharton, 2009) and personal (see Harrison & Westwood, 2009; Killian, 2008; Lawson & Myers, 2011; Wharton, 2009) relationships are highlighted in several other studies related to CS as well. Finally, physical resources (e.g., proper exercise and nutrition) are also identified in the common place as essential for the health of the practitioner and the optimization of client care. Taken together, what we can learn from this component of Radey and Figley's (2007) model for CS is that by

building resources intellectually, socially, and physically, counsellors can bolster themselves against deleterious effects of their work and increase their chances for CS.

Self-care is the third mediating component in Radey and Figley's (2007) theoretical model of CS. This is in keeping with other researchers (e.g. Harrison & Westwood, 2009; Negash & Sahin, 2011; Wharton, 2009) contending that self-care is crucial for the maintenance of wellness in helpers. In the Radey and Figley model of CS, self-care has some conceptual and operational overlap with the first two components (i.e., increasing positive affect, and increasing resources to manage stress) inasmuch as Radey and Figley have included in self-care such things as taking time off, exercising, re-energizing hobbies/ activities, and debriefing with colleagues; all of which would facilitate either or both increasing positive affect and stress-management resources. The three components of CS that Radey and Figley propose are so intertwined that I found the distinction between them confusing, particularly with regards to the difference between increasing resources to manage stress and self-care. Radey and Figley do acknowledge, however, that increasing positive affect, increasing resources to manage stress, and self-care influence each other and have a reciprocal relationship. Further, though they underscore the need for programs and workplaces that emphasize self-care for the mitigation of burnout and achievement of CS, the only definition that they offer for self-care is that it is "a potential mechanism to increase clinicians' positive affect and physical, intellectual, and social resources" (p. 210). Radey and Figley provide examples of self-care (e.g., taking time off), but I could not find a concrete operational definition of self-care anywhere in the article. This is an example of the lack of clarity around the definition of self-care that I have mentioned earlier in this chapter.

With respect to my research question (i.e., how do experienced counsellors actively maintain CS in their work), Radey and Figley (2007) have an answer. If a counsellor wants to

achieve CS, they need to increase their positive affect by taking actions that maintain their optimism, increase the number and variety of their personal resources to manage their stress, and regularly engage in self-care.

Taken together, these five studies offer many great points for consideration. I have noticed that increasing positive affect and experiences is a meta-theme across most of the studies I have encountered. Whether it's through self-care, acknowledging the growth and resilience of clients, cultivating relationships (both personal and professional) that are nurturing, finding a passion outside of work, or actively seeking beauty in the world, these themes all result in increased positive affect and have all been associated with counsellor wellness or CS specifically. Therefore, it appears central for CS that counsellors actively pursue positive feelings and experiences, and conversely, to monitor their negative affect so that they are aware when the ratio of positive and negative affect becomes unbalanced.

Support both at work from colleagues and in personal relationships also appears to be a meta-theme that comes up consistently in the studies I have read. It makes intuitive sense that those who provide support to others for a living would benefit from a strong support network that they can lean on when they need to recuperate or re-energize. As their "cup continues to be filled", they too can then continue giving. This analogy also works for the next meta-theme I have noticed, healthy coping behaviours. I am using the term "coping" but some authors have called it self-care or career sustaining behaviours (CSBs). Regardless of nomenclature, over and over studies show that counsellors need routine practices that help them refuel and minimize or tolerate stress. Lastly, the final meta-theme that stood out to me as I read the literature, was balance. I would hazard to guess that balance is closely tied to support and healthy coping because having a good balance between work-life and home-life allows one time for the things

that boost their energy and, as Radey and Figley (2007) would say, increase their positivity ratio (e.g., receiving support from loved ones and engaging in healthy coping behaviours).

The studies outlined above provided a valuable starting point for me to structure my research. It will be evident to my reader in the following chapter on methodology that I borrowed from each of these studies when deciding on my inclusion criteria, sample size, recruitment methods, and conceptualization of CS. The findings from these five studies described above will also provide interesting comparisons and discussion points for my findings.

Researcher Location

As a counsellor-in-training, this study has plenty of personal relevance for me. I have been one of the many helping professionals plagued by counsellor impairment. Five years ago, I began working at a children's hospital in their autism unit as an Autism Interventionist. My work entailed doing intensive three hour shifts of work back-to-back with children between the ages of two to six. As I worked one-on-one with the children, tantrums, self-injurious behaviour, and physical aggression were common. It was normal for me to be hit, kicked, pinched, spat on, and screamed at daily. The learning curve was steep with these kids and there was not a lot of room for error.

As the youngest on the team I was eager to please and not as savvy as my colleagues at saying no. For the first three years I worked there, I was not eligible for benefits, sick days, or vacation time. I was also financially broke from my undergraduate degree so I would cover other people's vacations whenever I could. Also, looking back now, I realize I lacked self-awareness and had no self-care plan. I did not have any grounding practices I could consciously employ throughout the day if I felt overwhelmed. I had no deliberate way to actively replenish myself and it did not take long before I became completely depleted. I remember driving home

after work, parking, and sitting in my car for twenty minutes, unable to muster the energy to get out and walk to my front door. When I finally did get inside, I would completely shut down in front of the TV for hours. I had no energy left for the physical activities I enjoyed before.

The worst part for me was the impact my burnout had on my mood. I began feeling quite depressed, Sundays were the worst. All day on Sunday I would carry feelings of hopelessness, sadness, and resentment as I thought about starting another work week. I cried most nights on Sundays because I was dreading work the next morning. Overall my moods became unpredictable and difficult to control; I cried a lot, angered easily, and felt anxious often.

Of course, all of this had a toll on my relationships. For example, I found myself snapping at my partner over little things, I had little patience with my family, and became bitter towards friends that seemed content. I am embarrassed to admit that I also became resentful of my little clients. Behaviours that were once cute became annoying. I began to dread seeing certain clients and would spend my shifts full of frustration. This experience wore me down bit by bit until I left to return to school. It was an immensely challenging, exhausting experience but looking back now, I am grateful that I have had a taste of what can happen if I do not take care of myself.

Now I know the consequences of impairment, and I know that the risk for impairment lies ahead of me again as I enter the counselling field. I carried this awareness with me into my master's program in counselling. Throughout the program I have felt many moments of exhaustion and depletion. These experiences have been like little sign posts along the way, reminding me of how easy it can be to let go of self-care or compromise my boundaries. In this program I have struggled to learn my own definition of what is good enough. I found (and continue to find) this difficult because I have a lot of pride in my work and passion about what I

am doing, and there is still SO much for me to learn, so it has been easy to keep pressuring myself to do more and more. By doing this I have lost the balance between my work life and home life many times. I have taken these experiences as more fuel for my interest in the maintenance of CS and mitigation of counsellor impairment. What has made an even greater impact on my passion about this research topic, however, has been my experiences of CS itself. In both of my practicums overall I felt fulfilled, energized, and excited about my counselling work. More often than not I left my practicum site at the end of the day still buzzing from the “high” of working with clients one-on-one in such a meaningful way. In these moments I would find myself thinking, how can I make sure that my career is full of experiences like this?

When I was working at the children’s hospital, no one talked to me about burnout. No one asked me about my self-care, or warned me of the price I would pay for neglecting my boundaries. At the very least, I would be happy if this study acts as another reminder of the costs of impairment in the counselling field if one does not care for themselves. However, my hope is that this study will bring awareness to the things that helping professionals can do to achieve CS. I want to contribute to the body of knowledge on how we can stay well and sustain long careers as helping professionals. If this study can increase the chance of one person going to bed on Sunday excited for the week ahead, I will be delighted.

When I typed “counsellor impairment” into an academic search engine, I found 40,937 articles. When I typed in “compassion fatigue,” I found a total of 121, 816 articles. However, when I typed in “counsellor wellness” I found 20,252 articles; around half as many as for counsellor impairment. And, when I typed in “compassion satisfaction,” I found 241 articles. Further yet, when I ran my eyes over these 241 titles, the majority seemed not to have CS as the

primary focus but as a way to mitigate risks of impairment, and less than a handful speak to the *maintenance* of CS over a career-span.

After reviewing the literature, the most significant impression I was left with, was the need for a shift in the way that we approach and understand not only what keeps counsellors going in their work, but also what keeps them able to *continue to derive pleasure from doing their work well*. In other words, shifting the balance to a focus on CS in the face of the undeniable and very real costs of impairment, or of what Figley (1995) referred to, as the “occupational hazards” of helping work. It became clear to me that in the pursuit of long, healthy careers, our time might be best spent looking to those “master counsellors” that have achieved what we hope for—satisfying sustainable careers, instead of spending our energy studying the ways that we might become depleted or impaired. Also, because of my experiences I think it is imperative that training programs and workplaces take more responsibility to teach students and workers about the risks and costs of helping work and how they can avoid them.

Now that I have shared what drew me to do this study, I want to acknowledge that my experiences undoubtedly impacted the lens through which I approached my research. Going into this research I was already primed only to the one-sided thinking that difficult case-loads and lack of exercise, holidays, and self-care lead to burnout. I did my best not to allow these assumptions to unduly diminish my ability to be open to my data by being aware of these assumptions, engaging in reflexivity, expanding my perspective to embrace complexity, seeking support and consultation with my thesis supervisor and peers, remembering to actively incorporate regular self-care and self-nurturing activities into my weekly life, and by keeping a field journal regularly.

Research Rationale, Purpose, and Question

Research Rationale

Due to the emotional nature of their work and essential requirements for caring (Skovholt & Trotter-Mathisen, 2011, p. 149) and empathic engagement, counsellors are at high risk for CF (Figley, 2002; Mathieu, 2009). CF interferes with counsellor wellness (e.g., sleep, mood; reference) and affects both the personal lives of counsellors (e.g., relationships; Wharton, 2009) and their ability to provide effective services to their clients (Figley, 1995; Gentry, 2002; Wharton, 2009). Conversely, counsellor wellness contributes to successful client outcomes (Figley, 1995; Gentry, 2002; Hill, 2004; Witmer & Young, 1996) and counsellor impairment “poses the potential for harm to the client” (Lawson & Venart, 2005). Additionally, the workplace benefits from healthy counsellors, as they are less likely to experience frequent turnover and attrition, therefore saving costs for recruitment and training and reducing disruption in services (Conrad & Kellar-Guenther, 2006; Fahy, 2007).

Several studies suggest that CS promotes counsellor wellness through its mitigating effects on CF (Alkema et al., 2008; Collins & Long, 2003; Conrad & Kellar-Guenther, 2006; Killian, 2008; Negash & Sahin, 2011; Radey & Figley, 2007), burnout (Alkema et al., 2008; Collins & Long, 2003; Slocum-Gori et al., 2011), and vicarious traumatization (Killian, 2008). Further, CS contributes to career longevity and to a sense of fulfillment, balance, and wellness that extends from counsellors’ professional to personal lives (Bowles, 2009; Radey & Figley, 2007). If counsellor wellness contributes to successful client outcomes and CS promotes counsellor wellness through its mitigating effects on CF, burnout, and vicarious traumatization, then CS is an important focus both for theory and knowledge building through research and for the promotion and maintenance of ethical practice.

Yet, to date, the research maintains a strong focus on counsellor impairment (Radey & Figley, 2007) and not counsellor wellness. Very little research has been done using counsellor wellness as a primary focus (Coster & Schwebel, 1997; Harrison & Westwood, 2009; Kottler, 2007; Lawson & Myers, 2011; Linley & Joseph, 2007), and even less has examined the role of CS in counsellor wellness. Furthermore, while the literature on CS is a relatively new, little attention appears to have been paid to what experienced counsellors actively *do* to maintain CS and therefore, their wellness as counsellors.

Research Purpose

Given that the exploration and understanding of what counsellors actively do to maintain CS is valuable for ethical client care, effective maintenance of workplaces that employ counsellors, and the wellbeing of counsellors themselves; the purpose of the present research is to extend the literature on counsellor CS by asking how experienced counsellors actively maintain CS in their work. In this way, this research will contribute to the body of knowledge on counsellor wellness. Findings from my research will have implications for counsellor training programs, the personal and professional lives and retention of counsellors already in the field, directors of counselling agencies, and client care.

Research Question

Given the rationale and purpose for this study, my research question is: How do experienced counsellors actively maintain compassion satisfaction in their work?

Chapter Summary

Within the overarching context of counsellor impairment and counsellor wellness, I have defined countertransference, burnout, STS, VT, CF, EF, and CS. I have discussed the relationship between and among these constructs and the way that they have emerged throughout

the history of the counselling wellness literature. I have highlighted some constructs that are related to CS, and I have also reviewed the extant literature on how CS is achieved and maintained.

Almost two decades ago, Figley (1995) summed it up well when he said, “traumatic events will continue to occur and traumatized people will continue to require the services of professionals therefore we need to keep these caring professionals at work and satisfied” (p. 4). We now know that the way to help counsellors avoid impairment and keep them effective and satisfied at work, is to help them achieve and maintain CS. Yet, there is significantly less research on counsellor wellness generally and on CS specifically, than there is on counsellor impairment. My study attends to this gap in the literature. Unique to many studies in the extant literature, I focus on how experienced counsellors actively maintain CS through their careers. In a profession that stresses prevention and resilience in clients, it is time for us to explore how to promote strength and resilience in ourselves.

CHAPTER 2 METHODOLOGY

Introduction

First, to refresh the reader my research question is: How do experienced counsellors actively maintain CS in counselling practice? I deemed a qualitative design as the most suitable approach to bring to my research question. I wanted to explore and understand experienced counsellors' constructions and explanations of how they maintain CS in their work. After careful consideration, I chose to do *narrative interviews* to collect, and *thematic analysis* to analyze, my data. In this chapter, I first work to provide a rationale for my decision to use a qualitative research design, and then describe the particulars of the social constructivist perspective I bring to bear on this study. Thereafter, I describe the narrative positioning for this study and why I thought it was the best fit. Then, I explain my decision to use thematic analysis as my data analytic strategy. After outlining the rationale for my research choices, I shift to describing the steps I took in the research process, beginning with sample recruitment, the interview procedure, transcription, and then the analysis procedure. Following this, I transition to methodological credibility, how it is defined in qualitative research, and how I assessed credibility in my study. Finally, I discuss the ethical implications of my study, before concluding this chapter.

Qualitative Research Positioning

Before outlining why a qualitative approach is best suited for my research, I will begin by defining qualitative research. Qualitative research can be defined as a means for investigating and gaining understanding of contextually situated human experiences (Elliott, Fischer, & Rennie, 1999 as cited in Haverkamp & Young, 2007) and insight into the meanings ascribed to them by index individuals or groups (Creswell, 2007; 2009). That is, qualitative approaches to

inquiry are particularly focused on individual meaning, and exploring the complexity of a given situation or phenomenon (Creswell, 2007; 2009). Qualitative research is unique compared to quantitative research because in qualitative approaches the researcher typically plays a more essential, active role in both the gathering (Creswell, 2009) and interpreting (Creswell, 2009; Haverkamp & Young, 2007) of data than one would typically see in quantitative approaches.

Though the acceptance and popularity of qualitative research has vastly increased (Haverkamp & Young, 2007; Lincoln, Lynham & Guba, 2011), and the validity of postpositivist (the belief that objective reality cannot be obtained or captured and can only be approximated; Guba & Lincoln, 2005) and postmodern (the recognition that the notions of reality are embedded in the language used to describe the perceptions of reality; Wilber, 1998) paradigms have been well established in the past several years (Lincoln et al., 2011), the qualitative/ quantitative debate continues. Black (2008) argued, however, that the debate itself is inconsequential because they are different ways of representing data and that one research approach is not superior to the other. He contended that in the study of internal experiences, whether numbers (e.g., statistics) or words (e.g., narratives) are used, both forms of (reduced) data are representations of the data collected. Neither approach use the actual data in their analyses. Black went on to argue that people are confounding the issues in the qualitative/quantitative debate when they mistakenly regard the numbers in quantitative research as the actual data. Similarly, Creswell (2009) stated that quantitative and qualitative approaches are not dichotomous, just different perspectives that exist on a continuum, with differing philosophical assumptions, research strategies, and research methods. Furthermore, said Black (2008), the assumption that quantitative research allows the researcher to get closer to the truth compared to qualitative research (or vice versa) is based on an “inadequate or partial definition of the term

“empiricism”, a misreading of the word “paradigm”, and the ways in which “validation” of knowledge have been perhaps inappropriately limited in the social sciences” (p. 2). Here, Black described two types of empiricism originally identified by Wilber (1998): narrow empiricism, and broad empiricism. Narrow empiricism requires experiential evidence that is gathered through the “eye of the flesh” (i.e., only information that can be measured or observed with the five physical senses) (p. 2). This is the commonly accepted concept of empiricism, particularly in the hard sciences. With broad empiricism, however, one can gather evidence through any of the three ways of knowing that Wilber (1998) discusses: the eye of the flesh (sensory experience gathered from any of the five senses), the eye of the mind (information gathered using mental experience, mathematics, logic, reason), and the eye of the spirit (spiritual experience, satori, oneness with Spirit, etc.).

Narrow empiricism is a logical fit for the physical sciences because the objects of study are things that have a simple location in the physical world. Given that they can be perceived with the physical senses, they can be measured using the physical senses. However, Black (2008) proposed that “regarding the study of subjective human experience, any attempt to employ a narrow empiricism is doomed to failure” (p. 3). This is because the subjective human experience is “invisible to the hard sciences” (Wilber, 2000, as cited by Black, 2008, p. 3). When studying the internal experiences of individuals, the physical senses alone offer a limited source of information, therefore the researcher must draw from the other “eyes” of knowing to create a more complete and accurate picture of the phenomena under study. As Polkinghorne (1988) stated, “although the material realm might be best studied by the use of quantifying procedures and statistical estimates, the realm of meaning is best captured through the qualitative nuances of its expression in ordinary language” (p. 10).

While some quantitative studies have attempted to address the prevalence of CS and the components of CS through questionnaires and surveys, I wished to explore the experiential aspects of CS by drawing from experienced counsellors' "eyes" of knowing. The concept of CS is complex, and after reviewing the literature, I was curious about the personal practices and unique philosophies that counsellors have developed throughout their careers to maintain CS. I wanted to hear about the everyday details that make the big difference overall for these practitioners. These everyday details and the meaning behind them could not be captured by questionnaires, or any test that I could administer. My participants are the experts on their own experience. Therefore, to get a more complete, rich understanding of how the complex experiences, choices, and personal philosophies of my participants connected to their experience of CS, I needed to hear their stories, in their own words. Given that these stories do not have a physical location in the world, they cannot be measured using the traditional methods of the hard sciences (Black, 2008; Polkinghorne, 1988). As Polkinghorne (1988) asserted: "narrative meaning is not an "object" available for direct observation," and consequently cannot be counted or quantified by an impersonal instrument (p. 1). Therefore, the approach that best suited my research question was qualitative inquiry because it allowed me to gather my participants' narratives and analyze them using a broad definition of empiricism. Finally, an additional reason that I chose qualitative inquiry for this study is that it fits with my personal epistemological and ontological paradigm. The paradigm that I ascribe to and that therefore provides the philosophical foundations of this study is *social constructivism*.

Paradigmatic Framework: Social Constructivist

Before outlining how I will collect and analyze my data, I must first delineate my beliefs about knowledge and reality, as these beliefs set the framework for how I will go about

conducting and analyzing my research. First, the paradigmatic lens through which I approach my research is social constructivist. Within the constructivist paradigm, my ontology, or my belief about the nature of reality (Creswell, 2007), is relativist. That is, I believe that there are multiple social realities that are equally valid (Haverkamp & Young, 2007). I also believe that it is not possible to ever objectively know the experiences of others. Therefore, as a researcher I believe it is my role to participate in the research process to ensure my interpretations are as reflective of my participants' constructions of their realities as possible. My epistemology, or understanding of the nature of knowledge (Creswell, 2009), is based on the notion that that knowledge is obtained through interaction with others (Creswell, 2009; Haverkamp & Young, 2007). It is through dialogue and other forms of social transmission that knowledge is shared and co-constructed.

It is the case, that the data for this study were co-constructed as I interacted with my participants (Guba & Lincoln, 2005). When describing constructivism, Haverkamp and Young (2007) assert that knowledge and meaning cannot be observed directly and must be interpreted. As part of the research process, my subjectivity will have influenced the data that I collected and the findings I am presenting here, and therefore I acknowledge that the findings that I report are interpretations. It is impossible to separate an individual from their lived experiences, and therefore any knowledge that is co-constructed between two people will be influenced by each person's subjective and largely private and personal, realities. However, it was my responsibility as a researcher to be aware of my own context, values, and beliefs and to have remained aware of these when I was listening to, transcribing, and coding the narrative interview data. I will describe how I went about this later in this chapter.

Narrative Positioning

I have chosen to use a narrative approach as the method and frame of reference for my study because it corresponds well with my constructivist perspective, and the question that I am asking in my study. “Narrative approach” is a broad term that can include a myriad of things depending on who one is speaking to. As Moen (2006) says, “the narrative approach is a frame of reference, a way of reflecting during the entire enquiry process, a research method, and a mode for representing the research study” (p. 2). For this study, I used narrative interviews as a method of data collection consistent with the philosophical approach I took to understanding the researcher and participant roles. I will explain this process in more detail below in a segment subtitled “Data Collection Procedure: Narrative Interview”. The present section will focus on describing the narrative research approach and why I chose it as my method of inquiry.

Narrative inquiry is a diverse sub-type of qualitative research that is part of the overarching epistemological category of social constructivism (Moen, 2006; Patsiopoulou & Buchanan, 2011), and is based on a curiosity about life experiences as told by those that live them (Chase, 2011). A narrative is the main way that humans make meaning of their experiences (Chase, 1995; 2011; Polkinghorne, 1988) and communicate meaning to others (Chase, 1995). Meaning making is achieved through the telling of stories that organize a series of events that are important to the narrator or their audience (Chase, 2011; Moen, 2006), and help one make sense of one’s own actions or the actions of others, or to help make clear connections between patterns of actions and consequences (Chase, 2011).

Storytelling is a universal way of sharing experiences (Barthes & Duisit, 1975) that people utilize throughout their lives, beginning in childhood (Moen, 2006; Polkinghorne, 1988). To illustrate the centrality and universality of narratives, Barthes and Duisit (1975) stated, “indeed narrative starts with the very history of mankind; there is not, there has never been

anywhere, any people without narrative” (p. 237). Given that my aim was to elicit the personal experiences of my participants of how they actively maintain compassion satisfaction in their work and the meaning of these experiences, asking for their stories was a logical fit. In addition, in narrative research (and social constructivism) it is understood that the stories people tell reflect both the individual and their context, as these two things cannot be separated (Moen, 2006). Therefore, by asking for participants’ stories, I was able to access a level of depth and richness in my data that would not have been possible with questionnaires or surveys. Having chosen to use my participants’ stories as my data, and knowing that research designed to elicit stories of life experiences and how they develop over time is most suited to narrative research (Creswell, 2007), I concluded that narrative inquiry using narrative interviewing was ideal for me.

Further, I chose to use a narrative approach because it is well suited to my positive psychology-based research goals and clinical perspective. Chase (2011) purports that it is common for narrative researchers to focus on the relationship between the life stories of individuals and their personal *wellbeing* (italics added for emphasis). This was precisely my aim for my study. In support of positive-psychology based research, Chase (2011) also stated, “I suggest that we have as much to learn from narrative inquiry into environments where something is working as we do from inquiry into environments where injustice reigns” (p. 430).

Thematic Analysis as Data Analytic Strategy

There are several qualitative analytic methods, each with their own advantages and disadvantages (Braun & Clark, 2006). One should choose their qualitative analytic method depending on the type of questions they are asking (Marshall & Rossman, 2011) and the kind of data they seek (Burnard, 1991). For the purposes of my study, I chose to use thematic analysis as my data analytic method.

Thematic Analysis is a widely used foundational qualitative research method (Braun & Clarke, 2006). However, thematic analysis does not always get the same recognition that other methods might because it is rarely acknowledged in research reports (Boyatzis, 1998; Braun & Clarke, 2006), it's steps are seldom described in the literature (Boyatzis, 1998; Braun & Clarke, 2006), and at times it is called different names (Boyatzis, 1998). Adding to the confusion surrounding thematic analysis, some authors, such as Boyatzis (1998), do not describe it as a separate, stand-alone method. However, like Braun and Clarke (2006), I disagree. Braun and Clarke (2006) argue that thematic analysis is a robust and important research method that should be acknowledged as a method in its own right. Though I have consulted other sources, I have used both the steps and conceptualizations of thematic analysis that Braun and Clarke (2006) propose as a framework throughout my analysis.

What is Thematic Analysis?

Braun and Clarke (2006) suggested that there was no clear consensus on the definition of thematic analysis thus far. Extant definitions suggest that thematic analysis is a method for identifying and analysing patterns (or themes) across a data set (Boyatzis, 1998; Braun & Clarke, 2006), then encoding (Boyatzis, 1998), and reporting these themes systematically using a “reasonably exhaustive category system” (Burnard, 1991, p. 426) with the goal of organizing and describing the data in rich detail (Boyatzis, 1998; Braun & Clarke, 2006). Additionally, thematic analysis frequently goes beyond identifying and reporting themes, interpreting aspects of the research (Boyatzis, 1998). As the central goal of thematic analysis is to construct themes from one's data, it is worthwhile at this point to define what constitutes a theme. Boyatzis (1998) defined a theme as a pattern in the data that “at minimum describes and organizes the possible observations and at maximum interprets aspects of the phenomenon” (p.4). A theme can be

identified directly from observable data (i.e., manifest theme), or identified from an underlying phenomenon (i.e., latent theme) (Boyatzis, 1998; Braun & Clarke, 2006). Thematic analysis can do both types of content analysis at the same time (Boyatzis, 1998), though it usually focuses on one (Braun & Clarke, 2006). The different ways to develop and verify themes will be discussed in a later section.

Why Thematic Analysis?

Thematic analysis is a good fit for my explorative study for several reasons. Thematic analysis is not theoretically or epistemologically bound (Boyatzis, 1998; Braun & Clarke, 2006), so it can be used across paradigms. Also, the strengths of thematic analysis are its flexibility (Boyatzis, 1998; Braun & Clarke, 2006) and suitability for inductively accessing—and therefore, “discovering”—themes within the data. Flexibility is allowed for in the way one determines themes and prevalence within their data (Braun & Clarke, 2006). For example, the researcher can decide to pursue “a rich description of the data set, or a detailed account of one particular aspect” (Braun & Clarke, 2006, p. 83).

Secondly, I chose thematic analysis because it is more structured and less ambiguous than other qualitative analytic methods (Braun & Clarke, 2006). For example, the clear guidelines that Braun and Clarke (2006) suggested provide a road map that aids in the navigation of the often unclear process of qualitative analysis. These guidelines offer a framework that makes qualitative research and its subsequent findings accessible to novice researchers (Braun & Clarke, 2006), along with a broad audience of scholars and researchers from various fields, including those on the other side of the qualitative-quantitative debate (Boyatzis, 1998). Indeed, Braun and Clarke (2006) suggested that thematic analysis is advantageous because it does not require the “theoretical and technical knowledge” of many other approaches (e.g., thematic

discourse analysis and grounded theory; p. 81), and added that it should be seen as a “foundational method for qualitative analysis” because it provides core skills that can be applied to a myriad of methodologies (p.78). As such, it is well suited for a researcher early in their career that wishes to develop skills in qualitative research. Further, the guidelines create an opportunity for more consistency within and across studies, instead of the “anything goes” mentality that qualitative research is often critiqued for (Braun & Clarke, 2006, p. 78). Together, the structure and consistency that thematic analysis offers makes it more accessible and communicable to a more diverse audience, therefore allowing for a comprehensive understanding of the phenomenon under study, bridging the gap between the qualitative and quantitative worlds, and contributing to the acceptance of qualitative research (Boyatzis, 1998).

In sum, thematic analysis is a way of “seeing” and systematically analyzing qualitative data that has been deemed as an effective method for understanding information about people, events, or organizations (Boyatzis, 1998, p. 1), and creates a rich, yet complex representation of the data (Braun & Clarke, 2006) that is widely accessible (Boyatzis, 1998).

Sample Recruitment and Study Participants

Ethical approval for my study was obtained from the University of Victoria’s Human Research Ethics Board (HREB). My inclusion criteria required that prospective participants: (a) devoted a minimum of 50% of their work-related time to psychotherapy (group, individual, or family therapy); (b) had been working in the field for a minimum of 10 years, the past 5 of which had been consecutive years of direct counselling work; (c) had a minimum of a Masters level of education; (d) were registered with a regulatory body for counsellors/therapists (e.g., RCC, CCC,

AAMFT, R. Psych, RSW); (e) self-identified as being high in CS (as defined for this study)²; and (f) were proficient in spoken and written English.

Participants were recruited by letters of invitation, with 28 sent out in total via email and post. I found contact information for the counsellors that I invited either from doing an online search for “counsellors in Victoria” or from recommendations by others that knew about my study. Specifically, I used counsellingbc.com and theravive.com to obtain contact information for local counsellors. I also emailed all of the students in my cohort and asked if they had worked with anyone that they thought would be a good fit for my study. In response to my email to my fellow classmates, I received three recommendations. I also stated in the letter of invitation that people were welcome to suggest another counsellor that they thought would fit the study’s inclusion criteria. The other 6 recommendations were either from faculty in the counselling psychology department, or from counsellors who had received an invitation letter. Of the 28 invitees, 9 (32.1%) indicated interest in the study, 7 (77.8%) of who met the inclusion criteria. Two people did not meet the inclusion criteria because they spent less than 50% of their work-related time doing psychotherapy. The 7th person responded to the invitation after I had completed data collection and had already begun data analysis. Given time constraints of the thesis program, my supervisor and I decided to thank her for her interest but to gracefully decline her willingness to participate. In sum, the final number of participants was 6.

My study sample comprises 6 counsellors (3 male, 3 female) over the age of 18 ($M = 53$, range = 44-66 years). Two were married, two were separated, and two were living with common law partners. Four participants identified their joint family income as falling into the “middle income group,” one participant indicated “high income group,” and one participant said they

² For the purposes of this study CS is defined as: (a) the sense of being energized and invigorated by one’s helping work more often than being drained by it, and (b) one’s ability to continue to thrive and to derive pleasure from doing one’s helping work well despite the personal and environmental obstacles that one might face.

were not sure. One participant indicated that their highest level of education was a Doctoral degree (PhD.), and the remaining five participants reported that their highest level of education was a Masters degree; however, one of them had two Masters degrees. Three participants worked in private practice, two in an out-patient treatment setting (one of whom also maintained a private practice 1 day/week), and one participant checked “other” on the demographic questionnaire and wrote in the name of the specific clinic where she worked. In terms of specializations, two participants identified themselves as Trauma Counsellors; one described herself as a specialist in both Grief/Bereavement Counselling and “Cancer;” one as a Marriage and Family Counsellor, and a Spiritual Counsellor, who worked with a “wide range of other issues;” one as an Addictions Counsellor; and the 6th participant stated that he practiced as a general practitioner (no specialization). One participant had been practicing as a counsellor for 10 to 15 years, two had been practicing for 16 to 20 years, two for 21 to 25 years, and one participant had been practicing for 30 or more years. All participants indicated that they were employed full time and that English was their first language.

Data Collection Procedure: Narrative Interview

Qualitative data were co-constructed using one-on-one narrative interviews with participants in their place of work. Conducting interviews is one of the most common and most recommended methods of data collection in qualitative research (Creswell, 2007). In general, interviews are advantageous because they give the researcher the opportunity to determine the line of questioning, yet they still allow the flexibility for participants to elaborate and provide historical information where it is helpful (Creswell, 2009). In particular, narrative interviews, unlike structured or even semi-structured interviews, allow for participants to tell their stories unencumbered by the structure of pre-formulated questions other than the opening question—or

invitation—to “please tell me your story about ...,” and by clarifying questions such as “are you saying that ...?” or encouragers such as “please tell me more about that.” Prompts are used judiciously in narrative interviews when the researcher is confident that the participant is straying from the question and needs to be gently brought back on-topic (e.g., can you go back to what you were saying about ...). Doing one-on-one (in vivo) interviews also enabled me to meet with each of my participants in their place of work, giving me additional context that added richness to the stories I collected. For example, every participant I met voluntarily showed me around their office and almost all of them subsequently offered information on how their physical work space impacted their CS. It was also important to me that I had a chance to connect with every participant in my study so that I could understand them and their context to the best of my ability, and offer each of them the freedom and time necessary for their stories to unfold as they deemed best. Both of these conditions allowed me to gain a more detailed and accurate picture of each individual's story than would have been possible if I were doing a focus group or questionnaire. I also did not want my participants to censor their stories or be worried about seeming boastful in front of a group of fellow counsellors as would have potentially been the case if I had done a focus group.

Every interview was between 1 to 1.75 hours long and took place in the participants' office. After reviewing the consent form with the participant, I started each interview with my research question phrased as an invitation: *Please tell me your story of how you have maintained an overall level of compassion satisfaction in your work as a counsellor.* I expected participants would describe a variety of things that they do that contribute to their CS, such as personal practices, as well as belief systems and attitudes. I also expected that participants would answer my question by telling stories if I created and allowed the space for them to do so. After asking

my initial research question, my task was to engage fully and listen carefully while simultaneously asking myself, “is this topic pertinent to my research question?” Aamodt (1982) described this dual role of the qualitative researcher as not only an observer, but a “participant” (p. 210) as well, and Marshall and Rossman (2011) described the role in terms of degrees of “participantness” (p. 113). I also used Marshall and Rossman’s (2011) suggestions on the ethical considerations of dual roles as a guide to ensure that I preserved the qualities of a research interview instead of slipping into a counselling interview.

As I said above, I asked only one and the same question at the beginning of the interview to all my participants: *Please tell me your story of how you have maintained an overall level of compassion satisfaction in your work as a counsellor.* I told participants to start their story at whatever point they deemed best, and to answer my question in whichever way they thought was true for them. The rest of the interview was dictated by how my participants told their stories of CS. There were times during the interview when, for example, I wanted to verify that I was following the narrative as precisely as possible, when I wanted the participant to elaborate further, or when it seemed to me that the discussion was no longer relevant to the research question (e.g., the participant was talking about their colleague that had become burnt out). During these times I asked clarifying questions and provided prompts. Examples of such clarifying questions and prompts are as follows:

1. I am hearing ____, am I following you properly?
2. Just to clarify, when you said ____, do you mean that ____?
3. Can you tell me more about ____?
4. When you mentioned ____, how do you think it contributes to your CS, if at all?

5. Bringing us back to *how* you maintain CS, do you think that what you are talking about is part of it, or is it something different?

6. You mentioned _____, is that part of how you maintain CS?

Lastly, to ensure that my participants had completely addressed my research question in the way they intended, I finished every interview by asking, “With what you have told me, would you say that you have told me your story?”

The interviews and my explanation of informed consent were audio-recorded using a hand-held recorder. Additionally, I kept a notebook on me during the interview to note any important information that may not have been captured on the tape. For example, I noted the time and a few of the participants’ spoken words if a participant teared up or paused with a distinct look on their face. These notes were later incorporated into the transcription. I also made field notes after the interviews. The field notes consisted primarily of my own emotional, cognitive, and sometimes physical reactions to the interviews, along with any questions that came up for me. I referred back to these field notes both during and following transcription and data analysis. I kept the original audio tapes in a locked filing cabinet along with my field notes, and audio copies and transcripts on a password-protected computer.

Professional Quality of Life Scale

Though I used only narrative interviews to answer my research question, I did use an additional measure, the Professional Quality of Life Scale, Version 5 (ProQOL) (Stamm, 2009) as an extra source of information on the level of CS, CF, and burnout that participants were experiencing at the time of their interview. I chose the ProQOL over other measures because it is the most widely used (it has been translated into 17 languages) standardized measure of the negative and positive effects of helping others (Stamm, 2009), namely burnout, CF, and CS in

contemporary research (Bride, Radey & Figley, 2007; Stamm, 2009), and supported in the literature as a reliable and valid tool (Bride, Radey & Figley, 2007; Stamm, 2005, 2009). I chose to use the ProQOL because I was interested, albeit only out of anecdotal curiosity, to see how participants' self-report data on the level of CS, CF, and burnout aligned with their self-identification of being high in CS. I also wanted to see if the way I was operationally defining CS would align with the more general definition that is used for the ProQOL Version 5. I considered this would be evidenced by whether participants who self-identified as high in CS in terms of the operational definition I provided on the invitation to participate, would also rate as high in CS according to the ProQOL. In Chapter 3, I briefly report the participants' ProQOL scores and compare them with their self-report of CS.

Information on the ProQOL was provided in the letter of invitation to participants and I spoke about it in the telephone calls prior to interviews. Participants were told that they could opt out of taking the ProQOL at any time and could still carry on with the interview if they chose not to complete the ProQOL for whatever reason (e.g., time pressure). Every participant chose to fill it out but none of them expressed interest in knowing their ProQOL scores. The ProQOL takes approximately 5 minutes or less to fill out and was administered after the interview so that the test would not influence our conversation in any way. However, it is possible that the interview impacted my participants' responses on the ProQOL by priming them to focus on their experiences of CS, and perhaps influencing them to over-estimate their level of CS while completing the scale. I scored the ProQOLs on my own after I had left the interviews.

Interview Data Transcription

With the help of a research assistant, we transcribed all interviews following each interview. Of the six interviews, I transcribed the first and the last. Due to time pressures, I was

unable to transcribe all of the interviews, so a research assistant transcribed the 2nd, 3rd, 4th, and 5th interviews. It is therefore important to acknowledge that the research assistant, by virtue of her involvement in the transcription of the interviews, is therefore a contributor to the co-construction of the data.

Transcriptions cannot directly “capture” the exact essence of the interview as it was experienced in the moment because the transcription process itself is a theory-laden, interpretive act (Lapadat & Lindsay, 1999). That is, transcription is part of the analytic process because while transcribing, researchers perceive the data via their own unique contextual framework through which they view the world. Furthermore, dialogue is a co-construction that occurs between two people in that particular moment in time. That is, dialogue cannot be captured and measured as one might a butterfly or a kilogram of soil. Lapadat and Lindsay (1999) argued that by failing to acknowledge the constructive nature of transcription, researchers in the past have misrepresented it as a more objective process than it is. As transcription is an active part of my research methodology (Lapadat & Lindsay, 1999), it warrants acknowledgement and further explanation.

Multiple suggestions and protocols exist for transcription, but because there is no standard set of guidelines for transcription (Lapadat & Lindsay, 1999) my research assistant and I created our own system drawing on what we had learned in academic courses requiring us to complete “verbatim” transcriptions of practice-counselling sessions. We met together before she began transcribing to clarify how she was going to annotate nonverbal utterances, pauses, emphasis in speech, and changes in tone of voice so that we were both using a consistent transcription format. Interviews were transcribed verbatim inasmuch as every spoken utterance from both me and the participant were transcribed; no words or sections of dialogue however seemingly irrelevant or off-topic (e.g., a comment about the weather outside), were left out. My

research assistant also reviewed the transcription I completed for the first interview so that she had a “reminder” reference of the format we were using. In addition, whenever the research assistant had any questions about how to present parts of the interview, she contacted me so that we could discuss it and decide together. Lastly, after all six of the transcriptions were complete, I listened back through each of the tapes simultaneously reviewing the transcriptions, and made final edits and corrections. Though precautions were taken to maintain consistency across the transcriptions, I acknowledge that because my research assistant and I are different individuals, we have different lenses through which we see the world. As such, we are likely to have interpreted the recorded interviews slightly differently. In the end, however, having a research assistant was an asset to this study because her involvement created an opportunity for triangulation of investigators (among other things). I will discuss this concept and others related to methodological credibility later in the chapter.

Analysis Procedure: Thematic Analysis

According to Braun and Clarke (2006), there are several important decisions that must be made leading up to and during the initial phase of data analysis. The questions they pose are as follows:

1. What counts as a theme, and how big does a theme need to be?
2. Are you are going to provide a rich description of your entire data set, or a more detailed account of one particular aspect?
3. Are you going to use inductive (bottom-up) or deductive (theoretical/top-down) thematic analysis?
4. Are you looking for semantic (explicit) or latent (interpretive) themes?
5. Are you prescribing to an essentialist/realist, or constructivist research epistemology?

To address the first of Braun and Clarke's (2006) questions, I determined both prevalence and "themeness" by counting the number of different participants represented by an articulated theme across the data set as opposed to each individual occurrence of textual data reflecting the theme in the data set as a whole. To be counted as a theme, the pattern must have been present in at least 60% of my participants' data. Therefore, given that I had 6 participants, the theme had to be present in a minimum of 4 of the 6 different interviews. In terms of the "keyness" (Braun & Clarke, 2006, p. 82) of a theme, this was determined not by quantifiable measures such as prevalence, but rather by the significance of the particular theme to my research question (Braun & Clarke, 2006).

Braun and Clarke's (2006) second question asks researchers to decide if they will focus on a description of their entire data set, or a more nuanced account of one particular aspect of their data. My research question pertains to *how* CS has specifically and actively been *maintained over time* by counsellors. My goal was not to gather just any information on CS, such as why it occurs or how prevalent it is. Rather, there was a more finely tuned focus to my investigation. For this reason, I focused my analysis on a more detailed description of particular aspects of my data that pertained to my research question of *how* participants actively maintained CS over time.

Braun and Clarke's (2006) third question addresses the issue of coding. According to Boyatzis (1998), there are three ways to develop a code: a theory-driven deductive approach, from prior data/prior research, or by taking an inductive approach. Braun and Clarke (2006) discuss only two types of analysis as they combine theory driven and prior data/prior research driven analysis into one category, which they term deductive or theoretical analysis. Because I have used the social constructivist perspective to frame my study, I took an inductive approach to

thematic analysis. In inductive, or bottom-up coding, the themes are constructed from the raw data and therefore are directly linked to the data themselves (Boyatzis, 1998; Braun & Clarke, 2006). The codes stay as close to the data as possible, using the words and syntax of the raw information. This process is also called data-driven, because the codes and higher-order themes are not created with a pre-existing theory or framework in mind, they are driven only by the data that were collected for that particular purpose (Boyatzis, 1998; Braun & Clarke, 2006). In theoretical, or top-down (or theory driven and prior data/prior research driven) analysis however, the coding is driven by a pre-existing framework that the researcher has developed through a theoretical interest in the topic or existing knowledge on the topic (Boyatzis, 1998; Braun & Clarke, 2006). In this instance, researchers aim to understand how the data fit in relation to their preconceived notions.

Further to the social constructivist perspective informing my decision to analyze my data inductively, was of course that my research question was novel and I was bringing an exploratory design to my study. On this matter, Boyatzis (1998) stated that when using inductive analysis, “previously silenced voices or perspectives inherent in the information can be brought forward and recognized” (p. 30). Much of the extant research and literature focus on CF with CS as a secondary consideration, and of the few studies that do focus on CS, none focus on *how* CS is maintained *over time*. I did not want my existing knowledge about CF and CS to unduly color any new findings I could make with my unique research question. Additionally, I chose to do an inductive analysis because it allowed me to engage more fully and openly with my data. Boyatzis (1998) contended that working directly with and from the data in this way, the researcher is better able to appreciate the intricate parts of the data and the larger data set as a whole. Also, this approach helps to remove intermediaries that could otherwise impact my

ability to see the uniqueness in my participants' stories (Boyatzis, 1998). It is important to acknowledge that the literature I had read in the past and the ideas I had already formulated, inevitably informed my understanding of CS and the factors that contribute to it. My literature review gave me a solid generalized orientation to counsellor impairment and CS, but as I proceeded with my coding I was mindful of my existing knowledge base and the ample literature I had reviewed for my thesis, and how these might influence what I saw in my data. I was therefore cautious to not allow it to unduly influence how I approached the coding of my data. For example, I engaged in reflexivity (which I will describe in more detail later in this chapter) and checked in with my supervisor frequently to talk about my own assumptions and how they might influence my interpretation of the data.

I also acknowledge that with inductive analysis, coding can become more arbitrary and less consistent in comparison to theoretical analysis. To account for this, Boyatzis (1998) suggested that researchers keep their codes as close to the raw data as possible. With this in mind, I did just that, using my participants' exact words in the codes whenever possible. For the same reason, I also made sure to keep returning to my data throughout the data analysis process, and again after tentatively writing up my findings.

The fourth question posed by Braun and Clarke (2006) relates to semantic versus latent themes. Semantic themes are those that can be identified directly from the data. With this type of analysis, the researcher does not extrapolate beyond what has been explicitly stated by the participants (Braun & Clarke, 2006). In contrast, when identifying latent themes, one takes the analysis a step further, moving from a description of the data to an interpretation of it. For example, when identifying latent themes, a researcher would tune into the underlying ideas that are not explicitly stated and yet are informing what is said (Braun & Clarke, 2006). As

mentioned previously, this method involves considerably more nuance and interpretation, which can become problematic. The issue with this is that by inferring meaning beyond the words of their participants, the researcher is making an assumption that they know what their participants meant without having any proof of this. Braun and Clarke (2006) suggest that thematic analysis usually focuses on one level or the other, and to avoid being too inferential with my data, I have chosen to use semantic analysis when identifying themes. Additionally, to ensure that my interpretations did not misrepresent the data, I later gave my participants a chance to either validate or disagree with the themes and quotes (data extracts) I chose in the member checking process.

The fifth and final decision that Braun and Clarke (2006) described is regarding research epistemology. Research epistemology dictates how you conceptualize truth and knowledge, and what you can say about your data (Braun & Clarke, 2006; Denzin & Lincoln, 2011; Sanders & Wilkins, 2010). As I mentioned previously in this chapter, my research epistemology is social constructivist. As such, I believe that there are multiple social realities that are equally valid (Haverkamp & Young, 2007) and therefore, I did not aim to capture an objective truth or reality in my research because I do not believe that is possible. However, I was diligent in attempting to remain cognizant of and open to fitting my reality—in terms of my understanding and analyzing of participants' narratives—with those of my participants.

The six decisions that Braun and Clarke (2006) described are helpful to understanding the framework that a researcher uses to approach their study. For me, it helped to consider each decision carefully as I approached my analysis, knowing that the decisions I made impacted the meaning that my findings would have. Once I had clearly identified each choice, I was ready for the arduous, yet exciting task of coding and developing themes. Again, for this process, I used

Braun and Clarke's guidelines as a model. After outlining the six choices that researchers must consider, they described six phases of thematic analysis. The phases are:

1. Familiarization with the data (transcriptions, repeated readings).
2. Generation of initial codes (looking through all data, and coding as much as possible).
3. Develop themes (essentially looking for connections between the codes, and grouping them).
4. Develop themes (two levels – check for themes creating a coherent pattern, and then check if the coherent pattern accurately reflects data set).
5. Define and name themes (refine themes into their essences and do analyses on each theme).
6. Produce the report.

Once all of my interviews had been transcribed and checked for relative completeness and accuracy, I re-read each transcription again. I had recently done the interviews and had been immersed in the transcription process, so I had already been noticing patterns in my data. However, I refrained from writing down any codes at this point as my focus was simply to re-read the transcripts in their entirety; with the aim of immersing myself in the data and staying open to different perspectives or nuances I had not yet noticed. After this read-through, I wrote down questions I had about the data and patterns that I was beginning to notice.

Next, I read the transcripts again, this time writing brief codes in the margins of the documents and writing a star beside potential quotes that could be used in the report. I only coded the part of the transcriptions that pertained to my research question. Also, I kept the codes as close to the data as possible by incorporating as much of the participants' words as I could. At this stage I began to notice the relationship between the different codes and how they might organize into themes. In my notebook, I drew concept maps to represent these relationships and I began a list of broader themes that I was consistently identifying across the data set. I reviewed

the codes with my thesis supervisor and a fellow researcher, ultimately editing them so that they succinctly represented the most fundamental, meaningful aspects of my data.

After all of the transcripts were coded and I subjected to the recursive peer consultation process, I wrote the refined and agreed-upon codes on large post-it notes and cut out the data extracts that corresponded to each code. I grouped extracts together according to their codes. I then shifted focus again to the relationship between and among codes, grouping them into “candidate themes” by rearranging the post-it notes into broader or higher-order categories (Braun & Clarke, 2006, p. 90). Again, I drew out concept maps and met with a fellow researcher and my thesis supervisor to discuss my candidate themes. I revised my themes, collapsing some together and creating sub-themes where necessary. Once my revisions were made and I was confident that they represented my data in an accurate, meaningful way, I defined and wrote a short narrative description for each theme. I then presented these themes and their definitions, descriptions, and exemplar quotes to a group of three fellow graduate students and my thesis supervisor, using the peer-consultation process. Following this process, I refined the themes again, and consulted one further time with my thesis supervisor. The final step before the report writing phase was member checking to ensure that the themes and quotes I had chosen accurately represented the participants’ stories.

Ensuring and Assessing Rigour and Trustworthiness

Haverkamp and Young (2007) state that, “an investigation’s paradigmatic base determines the appropriate standards for evaluating its rigor and trustworthiness” (p. 268). This notion is commonly accepted in contemporary social science research. It then follows that, because qualitative and quantitative research differ in their fundamental goals, they would have different models for evaluation (Guba, 1981; Haverkamp & Young, 2007; Krefting, 1990).

The terms “reliability” and “validity” that we hear so often in discussions of research rigour are positivist terms that do not fit with the paradigmatic framework of qualitative research (Krefting, 1990). In 1981, Guba wrote a paper outlining a model for evaluating qualitative research that was later endorsed by Krefting (1990). The model is based on four criteria for trustworthiness that are relevant to both quantitative and qualitative research: *truth value*, *applicability*, *consistency*, and *neutrality*. I referred to Guba’s framework and Krefting’s article throughout my research process to guide my conceptualization of rigour and trustworthiness.

Truth Value

Truth value in qualitative research is assessed by a study’s *credibility* (Krefting, 1990; Lincoln & Guba, 1985) and aligns with the quantitative idea of internal validity. Credibility pertains to researchers’ confidence that their findings are representative of the truth according to the participants in the context in which the study was done (Krefting, 1990). Internal validity on the other hand, is based on the positivist belief that there is only one, tangible reality (Lincoln & Guba, 1985). As I operated from the assumption that there are multiple realities, applying terms like internal validity to my study would have been misguided. Instead, my responsibility was to represent the multiple realities of each participant as truthfully and as adequately as possible (Krefting, 1990).

In qualitative research, credibility is achieved if the researcher is able to sufficiently investigate, and then communicate the unique personal experiences of each participant. Given that only the individual has direct access to his own experiences, truth value can only be distinguished by the participants, not the researcher (Krefting, 1990). Thus, one of the most valuable ways to determine truth value is to confirm with participants if the findings are representative of their truth (Krefting, 1990). I did this in the member checking stage of my study. During member

checking, I emailed each participant a list of my themes, their definitions and a brief description, together with the data extracts I was using to support each theme. Participants were asked to review the findings and say whether they accurately represented their experience or whether they would like some changes to be made.

Reviewing the literature on strategies for increasing truth value/credibility, Krefling (1990) offers several suggestions, many of which I used. For example, I engaged in *reflexivity* throughout the research process. Reflexivity is the assessment of the degree to which the researcher's own background, assumptions, and values are influencing the research process (Krefling, 1990; Sanders & Wilkins, 2010). In qualitative research it is accepted that "the researcher is part of the research, not separate from it" (Aamodt, 1982 as cited by Krefling, 1990, p. 218), so it is not expected that researchers will be completely neutral or removed. However, precautions can still be taken to increase the accuracy and authenticity of findings. One of the tools I used for reflexivity was a field journal. I started it in my qualitative research course, before I had even applied for ethical approval, as a way of recording any thoughts, fears, and questions about my study. As I began the interview process I noted any expectations I had and the information that surprised me or invoked emotions in me. Using my journal I monitored biases that were coming forward in me. The more aware I was of them, the more I was able to determine if they were unduly influencing my interpretations of the data. I also spent a lot of time reflecting with my supervisor and my peers about my own process as I engaged in this research.

Another strategy from Krefling's (1990) suggestions that I employed was *triangulation*. Triangulation is founded on "the idea of convergence of multiple perspectives for mutual confirmation of data to ensure that all aspects of a phenomenon have been investigated" (Knafl

& Breitmayer, 1989 as cited by Krefting, 1990, p. 219). I used two forms of triangulation: triangulation of data methods, and triangulation of investigators. For example, I used the ProQOL assessment as an additional source of data to corroborate the participants' self-identification (Marshall & Rossman, 2011) of being high in CS.

For triangulation of investigators, as noted previously, I worked with a research assistant during transcription. Having her review my transcriptions for textual completeness and accuracy, and then subsequently reviewing her transcriptions, increased the likelihood that my data were as close to the interview as possible. In addition, I worked closely with my supervisor during thematic analysis, asking for her input regarding the manner in which I was coding and constructing themes to ensure that I had not become too enmeshed with my participants or data. For example, there were times when I became stuck in my analysis because it seemed that some of the data extracts could be interpreted multiple ways. I thought I knew what my participants were trying to say, but when I discussed this with my supervisor she re-directed me back to focusing on my participants words (i.e. semantic themes) instead of getting caught in meanings I was trying to extrapolate beyond their words (i.e., latent themes).

Another strategy that Krefting (1990) highlighted is *peer examination* or, what Marshall and Rossman (2011) call, *peer debriefing*. This strategy requires the researcher to discuss the research process and their findings with peers who are impartial, yet knowledgeable about qualitative research (Krefting, 1990; Marshall & Rossman, 2011). I was lucky enough to have regular meetings with a colleague who has a strong understanding of qualitative research and yet has no ties to this study. I discussed everything from interview protocol, to transcription, to thematic analysis with him. By talking through my analysis, I was able to get his perspective and become clear about why I was making the choices I was. As I also noted above, I also used a

peer-consultation group for the penultimate refining process of the themes before subjecting these to member checking.

Lastly, Krefting (1990) stated that credibility can be improved during the interview process. I followed Krefting's suggestions by repeating, reframing, and expanding on questions to make sure that participants understood what I was asking, and that I understood what they were trying to say. Also, by performing the interviews in each participant's office, my hope was that the familiar environment would increase their level of comfort and therefore encourage authenticity in their interview responses.

Applicability

The next criterion for trustworthiness that Krefting (1990) highlighted from Guba's (1981) list, is applicability. Applicability refers to the *transferability* of a study's findings (Guba, 1981). In other words, the relevance findings would have for other groups, contexts, or settings (Krefting, 1990). Quantitative research describes transferability of findings to indicate the "generalizability" of findings from a study. Some qualitative researchers contend that the issue of transferability is not relevant to their research (Krefting, 1990). However for me, it was important that my study had practical relevance because my driving purpose for doing this study was to research something that my colleagues and I could apply to better our chances of enjoying long, fulfilling careers. Citing Guba (1981), Krefting (1990) purported that transferability is possible when there is enough similarity between the context to which one is trying to apply the findings, and the context in which the study took place.

To increase the applicability (or transferability) of my study, I did two things. First, I invited counsellors from several settings and a variety of specializations to take part in my study. My goal was to collect data that reflected the experiences of several different types of

counsellors, thus making the findings more applicable and hopefully relevant to more than just a select group of practitioners. I believe I achieved this at least partially by interviewing both male and female counsellors who have a variety of specializations, such as trauma, grief, marriage and family counselling, addiction, spiritual counselling, and general counselling. However, I also acknowledge that the notion of transferability is a tricky one from a social constructivist perspective because the stories in this study are unique co-creations that resulted from my interactions with the participants and therefore are not representative or generalizable to the greater population of counsellors. However, as Krefting (1990) suggested, in this report I provide considerable information about my participants' background and work setting, and the general research context so that others can assess how transferable my findings are for them. After all, it is the researcher's responsibility to provide adequate information, but the burden of determining transferability lies in the hands of whomever is trying to transfer the findings (Lincoln & Guba, 1985; Marshall & Rossman, 2011).

Consistency

The third criterion for trustworthiness is consistency (Guba, 1981 as cited by Krefting, 1990). Consistency, or the dependability of a study, refers to whether the replication of a study would yield similar findings if the context was similar and the participants were the same (Krefting, 1990). Quantitative research uses "reliability" as a yardstick to describe the consistency of results. As the qualitative approach aims to investigate complex human experiences using natural settings for data collection, variation in the research process is expected. As such, researchers are typically not concerned with, nor capable of, creating controlled environments that could be easily replicated (Krefting, 1990). However, citing Guba (1981, p. 216), Krefting (1990) proposed that qualitative researchers can instead aim for

dependability through “trackable variability,” or variability that can be accounted for by sources acknowledged by the researcher (e.g., increasing insight on the researcher’s part, informant fatigue, changes in participants’ life situation, etc.).

To increase dependability, Guba (1981) (as cited in Krefting, 1990) recommended that researchers leave an “audit” trail by documenting their decision process and providing detailed information about their data collection and analysis (p. 221). I followed this suggestion by carefully outlining the methods that I used and the steps that I took for data collection, transcription, and analysis in this document. As described previously, I used peer examination in my study, which is also recommended to increase dependability (Krefting, 1990).

Neutrality

The final criterion for trustworthiness first described by Guba (1981), and later cited by Krefting (1990) is neutrality. Neutrality is defined as “the degree to which the findings are a function solely of the informants and conditions of the research and not of other biases, motivations, and perspectives” (Guba, 1981 as cited in Krefting, 1990, p. 216). The concept of neutrality initially caused me some confusion as I associated it with objectivity, a term strongly linked to quantitative research, but not commonly used in the qualitative approach. However, in the case of qualitative research, Lincoln and Guba (1985) suggest shifting the focus from neutrality of the researcher to neutrality of the data.

Lincoln and Guba (1985) introduced the term *confirmability* as the criterion for neutrality, stating that neutrality is achieved when applicability and truth value are present. Further, Gasson (2004) proposes that to achieve confirmability, a study’s findings should accurately represent the situation being researched as much as possible, and not “the beliefs, pet theories, or biases of the researcher” (p. 93). Several suggestions are made for increasing

confirmability, many of which I engaged in throughout my research process. For example, Guba (1981) recommends the audit strategy, triangulation, and reflexivity. Please see above for my description of how I applied these strategies in my research. Lastly, Guba (1981) also contended that researchers should support every interpretation that they make with at least two sources from their data. I also did this, using at least two data extracts to illustrate each theme that I identified.

Ethical Implications

Given that my research did not include anyone from a vulnerable population, that there was no physical risk to participants, no challenging tests or deception involved, and that it focused on positive aspects of participants' professional lives, my research had very minimal risk. Therefore, the potential for harm in my study was no greater than would be expected in the participants' everyday lives.

Though the focus of my study was on positive aspects, there was a possibility that while filling out the ProQOL or during the interview participants may be reminded of their experiences in the past with burnout, CF, or VT. Even though all three experiences are common among counsellors, I was cognizant that individuals who have experienced one or more of burnout, CF, or VT at some point in their career may believe that they have failed in some way, and may therefore feel embarrassed. To minimize and prevent the risk of this, I included some information on the high prevalence of burnout, CF, and VT in my recruitment letter and telephone script. My hope was that this information would normalize any past experiences of burnout, CF, or VT for participants. I also verbally reminded participants before they completed the ProQOL that experiencing some indicators of CF is unavoidable in helping professions (Mathieu, 2009); and does not necessarily indicate that they are experiencing CF. It is also

important to note that as part of my graduate program, I received training in the sensitive, empathic, and ethical administration of self-report instruments and facilitation of interviews. In addition, during the interviews I drew upon my experience as a professional counsellor-in-training. I provided appropriate empathy, containment, and support when needed. I also made every effort to be sensitive and attentive to participants as they answered the interview questions and came prepared to support participants if they found any part of our interview challenging. For example, if I noticed that a participant was becoming triggered or very emotional, I planned to ask them if they needed to stop and take a break. However, none of the participants needed to take a break, nor did anyone become emotional to the point of concern.

There was also a small possibility that participants would experience emotional or psychological discomfort if they discovered that their ProQOL scores did not align with their perceived level of CS. To minimize this risk, I decided to give participants the choice to be told their ProQOL scores or not. I also had additional information available on the ProQOL scale for participants that were interested. As I noted earlier, no participants requested to be informed of their ProQOL score, and therefore the risk of any emotional discomfort pertaining to their scores was avoided. I thought it was interesting that none of my participants requested to know their ProQOL scores. I think this could have been because the participants were confident in their level of CS and they trusted their own gauge of their CS, and therefore did not need a scale to validate this for them.

In addition to the low level of risk in my study, I would like to briefly highlight some of the benefits of participation, as I believe there are many. Firstly, participants may have benefitted from their involvement in this study by having an opportunity to tell their stories of success and resilience in their careers. The positive focus of the interview gave participants a chance to

reflect on what has been going well in their professional life. It appeared to me that this acknowledgement of their successes was reaffirming and bolstered a sense of positivity and hope within the participants. After the interview, several participants expressed their appreciation for the opportunity to acknowledge aloud the resilience they have had over the course of their career. Participants also expressed how important they thought conversations such as ours were, and that they were happy to be a part of research that may help other counsellors thrive in their careers. I conclude this chapter by way of simply reaffirming my confidence in my decision to bring a qualitative research design, informed by a social constructivist perspective, to my research question and research planning decisions.

CHAPTER 3

FINDINGS

Introduction

In this chapter I briefly describe the findings from the Professional Quality of Life scale (ProQOL) that each participant filled out. I then use the remainder of the chapter to describe my thematic findings, including supporting quotes for each theme.

Professional Quality of Life Scale

After each interview I asked participants to complete the Professional Quality of Life Scale, Version 5 (ProQOL) (Stamm, 2009). Again, I did not use the ProQOL as a measure to answer my research question. As I described in Chapter 2, I used it as an extra source of information on the level of CS, CF, and burnout that participants were experiencing at the time of their interview, and to see if the way I was operationally defining CS would align with the more general definition that is used for the ProQOL (as would be evidenced by whether participants who self-identified as high in CS would also rate as high in CS according to the ProQOL). Results of the ProQOL corroborated the participants' self-report of CS. Five out of the 6 participants scored in the range of "high" (≥ 42), and the remaining participant scored 35, which is in the "average" (23-41) range on the CS subscale of ProQOL 5. Also, all of the participants had low levels of burnout (< 22 on the Burnout subscale) and Secondary Traumatic Stress (what I call CF) (< 22 on the Secondary Traumatic Stress subscale) on the ProQOL.

Themes

The following are the titles and descriptions of the 6 themes I developed, as well as representative supporting, verbatim quotes in response to the research question: How do

counsellors actively maintain compassion satisfaction in their work? Please note that all names that appear in the participant quotes have been changed.

Theme 1: Maintaining Boundaries

All participants spoke consistently to the importance of creating and maintaining various types of boundaries inside and outside of their workplace. For example, participants described how they maintain boundaries between work life and home life, in how they empathize, and even in potentially draining or overwhelming environments outside of work.

When I go home my time is MINE. And....not that I ever really thought about patients before [at home], um, but I put a lot of pressure on myself before, I don't pressure myself as much. I won't survive this work if I allow it to come into my off time. And feeling okay about that because it allows me to give it the level I really want to, I go full out when I'm here. (Participant 2)

Researcher: You've mentioned boundaries. Would you say then that boundaries is something that's really important to you in maintaining your sense of compassion satisfaction?

Participant: Absolutely. Ya. For sure, I mean I love the work that I do and I love it in the context of, it's a part of my life but it's not all my life. And I think um, a clear boundary that I've put around...that's important for me, is to have a really clear boundary between you know when I'm doing work related things when I'm at work, and when I'm not at work and, and really kind of not mixing those...um another good example is, when I walk out of here at 4:30, I don't think about work. I make a conscious effort not to. (Participant 4)

I hold space for people and um... I do empathize but I don't, I don't experience their feelings in me. Like- it's not that, it doesn't, maybe I have too strong of boundaries but for me it works. Like, it makes me be able to do it day in and day out. (Participant 5)

So, you know, um I recognize that I have a sensitive nervous system so I have to be pretty careful about my boundaries, um, if I go into a place where it's going to be overwhelming, um that's ok but I can't stay there, I have to look after myself. And you know over the years I've been particularly mindful about what's overwhelming and what's not and how much I can sustain and therefore where my boundaries are.

(Participant 1)

Theme 2: Practicing Self-care

All participants referred to the need for self-care. Activities used to meet the need for self-care included regular exercise, time in nature, time off of work, treatments such as acupuncture and massage therapy, and rituals that helped the participants to let go of deceased clients or remain grounded after difficult sessions. All of these activities serve to nurture, ground, centre, and re-energize the participants practicing them, so that they can continue to gain pleasure from their work despite the challenges they face.

In terms of the- how I've maintained [compassion satisfaction], a big piece of that has been around self-care. ...Um, you know I see my own counsellor, and it depends on whether I'm struggling or whether I'm not. Um, when I'm not struggling, it's every couple of months um, ...when I am struggling it might be as frequent as every two or three weeks. I have acupuncture, I have massage, those are monthly... time off, that's a piece for me... I need time off from this place because the work is predominantly trauma and adjustment related...it's high... there's a high intensity often. ... I exercise, three

times a week. Um, ...you know and it doesn't really matter what the exercise is but its, its jazzercise, there's a lot of cardio. There's a bunch of pop music, I go with my friends and family...so what I get is a burn off of the stress hormones...um, I get connection with people I really like, I get this light upbeat music, and I've tired myself in a really positive way. So the addition of that has made a big difference. And I like that it is very much about surface oriented. It's a nice offset. It's a nice balance. (Participant 2)

And clearly one of them you know in terms of maintaining compassion satisfaction is, for me it's all about self-care... I get...uh, acupuncture, I go for massage therapy, I ride my bike to work, I often walk at lunch-time or, or get out on my bike for a ride...um. And um, doing my own personal therapy over the years, really important. (Participant 3)

Regular physical activity has probably been the most beneficial thing um, that I've found to, to just kind of cope with the stresses of working um with people... And um, I'm not a hugely spiritual guy in a traditional sense but having some connection with the natural world has always been a part of me, even like long before ever since I was a kid it was something I was taught, I learned as I was growing up in a family that was very outdoor oriented, um, that's been, that's been huge for me too. It help, helps maintain that humanistic perspective in terms of our place in the universe or you know, um, you know it may seem like you know, life is pretty shitty sometimes but actually when you see this gorgeous sunset, that kind of puts things into perspective. (Participant 4)

I have come up with some sort of formula for myself that says that when I'm off duty I need nurturing kinds of things, so that would include... lots of alone, down time, um where I'm in a place where I want to be, um sometimes that could be just driving up and down the island, it could be exercising, it could be going for a walk it could be even

having a nap for that matter, but it's about bringing my nervous system to a place of neutrality if you will, so I pay a lot of attention to that. Um, and part of the attention I pay, um pay, is in the word fun I suppose, that as long as things are fun, I'm going to be there. (Participant 1)

There are days when I come home and I light a candle and I'll send a vision to one or more clients and for two or three minutes and then when I blow the candle out, I'm done. ... I have to be careful that energetically I don't pick up [on clients]. I do all the little things. I use lavender spray, and I, sometimes after some people leave I shake them off-- literally. Yup, I spray myself with lavender sometimes. There's two clients that I have now that if I'm having a session with them I won't book anybody else right away and I'll go out for a walk. I actually literally have to go out and walk. (Participant 5)

And another way that the satisfaction- because about half my people die, um... I will look at their files and then do a bit of a closure ritual. Um, not when they die, like I've got a bunch of people who've died in the last few months, so when I'm ready, which is basically when my...when my drawer gets so full I can't fit another person in, I will go through, I will look at the files, I'll remember them, I'll think about what I cared about and loved and what we did, and sometimes even ask the questions about what didn't go well...you know that stuff. ... And I may do stuff like simply just speak out loud, and people can frame this in whatever way they want, but I feel like I'm speaking to their essence or their spirits saying, you know, thank you. You touched me. (Participant 2)

Theme 3: Cultivating Self-awareness

Self-awareness was an ongoing practice and way-of-being for participants. Participants practiced mindfulness, for example, as a way to develop and retain an ongoing self-awareness

inside and outside of work. They spoke about self-consciously checking in and monitoring internal states (bodily, emotions, thoughts) so they can identify present-moment needs and then attend to them.

How I gauge myself, and this is, something that I work with clients around, is, um the only way I can be absolutely present, this comes with mindfulness, um is to keep a witness going on for myself. You know, um and so there's this, this kind of witness observer if you will, this capacity to not be so highly subjective in everything that's going on that I lose myself, um or I become that moment... so it's, it's the um (pause) the times that I'm not with clients, I'm kind of practicing having this awareness, this witness observer. ... because if I can't witness myself then I can't witness you any longer.

(Participant 1)

Researcher: and so, how do you do that though? How do you find that you're able to, to listen to patients like that without becoming annoyed or drained by it?

Participant: Mhmm, um, so, so then that comes into in my own ability to be self-aware. So one of the things that being a body oriented therapist has always made sense to me, is that if I'm not really present and really in my body with you in that moment that there's all kind of ways I might react. ...I remember kind of being aware of that shock sensation rising in me and going "ok, well that's good information isn't it?" This woman is in a complete state of shock in a different way than anyone else because she's never really considered that she might die... So I can then sit with that because I can track that sensation of shock internally and then ground that and then use that as a place to come um, from a place of curiosity and explore what that shock is like for *her* internally. To be really present in your body and know what that feels like as a therapist and to be able to

then use that information, to me that's the scaffolding of that you know, deep connection with your client, that, and that is essentially um, uh, transformative... And then that's what, you know, that's, that's the joy in what I do. (Participant 3)

[Describing her strengths and weaknesses using the 5 elements as an analogy]: So in some ways if you're a good therapist, your ability to know yourself well, I would say actually that's probably the strongest thing that will keep you in compassion and avoid burnout. When you're ahead of your own shadow and you're consistently looking at "ok, I know I have a lot of earth, I know I could sink into- I'm going to need to develop more air"... So having that awareness, I'm always on guard that I don't go into earth too much. Right? (Participant 5)

I don't have an "always" ritual. I think my always stuff is building in the self-care and then I do the other stuff as needed... and that's more about being aware of what's happening in my body and in my mind and then I'll do something about it.... (Participant 2)

Theme 4: Developing Positive, Fulfilling Relationships

Several participants mentioned the importance of positive, fulfilling relationships at work with colleagues and mentors, and outside of work with family and friends. Participants were careful to specify that these relationships are reciprocal and emotionally nourishing. Even though they likely still require work, the relationships described in this theme involved a give-and-take of some form. Additionally, some of the participants described how they have become more and more careful over the years about deliberately choosing to surround themselves with people who are positive in energy.

I'm also fairly relationship oriented. So um, you know I've got like that peer supervision group that allows me to talk about when I'm struggling, but with people that I was in grad school with so we've been working together for seven, eight years. There's a level of we're all in the same place. Um, and we have each other's backs, its safe, we can pretty much not have to sensor in any way. So that's been really important... The debriefing helps me to maintain more satisfaction because I'm, it allows me to get out something that didn't work well which then allows me to show up fully for the next patient and then the next patient and then the next. It allows me to keep moving. (Participant 2)

I keep in my life relationships which are, um, sustaining- uh they're positive, they're sustaining... I have come up with some sort of formula for myself that says that when I'm off duty I need nurturing kinds of things, so that would include special relationships um with coherent people... In my relationship with my clients, and my colleagues and my students, you know I know what we're doing is incredibly serious and earnest at a certain level but I want to retain a playfulness with it, and so, and so that keeps me buoyant, you know. ... I thrive on the relationships I guess. (Participant 1)

I have two grandchildren but, and as much as they sometimes wear me out they're clearly, they fill my cup. You know? (Participant 5)

Researcher: Are there any other things that kind of help you to maintain your compassion satisfaction?

Participant: Ya, so um.. right now I've got a newborn child and that really helps me to you know, that's very grounding and beautiful. (Participant 6)

This theme of *maintaining positive, rich relationships* had a 100% endorsement rate during interviews and again in member checking.

Theme 5: Engaging in Ongoing Learning

Several participants were adamant about the importance of continued training throughout their career. They explained how training keeps them fresh, engaged with, and inspired by their work. Participants also stated that ongoing learning provides them with opportunities to gain new perspectives and suggestions to try with clients.

The other part is training, right? It's like getting your Masters degree is really a license to learn. ... You know, do the extra training um, ya, and that I think helps with confidence, helps to create structure. So that would be I guess the other piece for me that's keeping me satisfied is that I've, you know... I have always been interested in personality disorders, and I've tried to find a way to find out more about that, and you know a couple years ago I stumbled upon a training program for that, which was kind of exciting, and that's sort of like the direction that I'm going to be going in and training in. (Participant 6)

Another thing that compassion um...is when I do training. Training that makes it uh, affects how I think, it sometimes its new information, sometimes its release, uh pieces around new interventions. I love learning new ways of working, I'm excited about the idea of there may be different ways of thinking, approaching and actual specific interventions that may allow a person to have more control, more sense of mastery and be able to impact and lessen the pain. That really excites me. (Participant 2)

Researcher: And so, ok, so to name few things we've touched on um, that has led to some of your compassion satisfaction: self-care, your framework for working which is somatic therapy, uh variety, we touched on, oh...what else?

Participant: Ya, ya, uh, supervision... um and something along those lines too was uh, ya on-going training. I have on-going training and education for myself absolutely. Reading, I do a lot of reading, writing. (Participant 3)

Researcher: I'm trying to imagine the kind of developmental cycle of becoming a compassion satisfied counselor and um, I'm wondering how one might go from being someone like me who is very-- right now I have a lot of satisfaction because I'm excited about the work and everything is new and novel and I'm passionate about it and loving it um...so how someone goes from that, to then you know, I'm going to get used to things and things aren't going to be as exciting and novel anymore and dah, dah, dah, dah, and yet still to be 22 years later and be like "ya, I still really like my work and I'm still feeling satisfied".

Participant: Ya, for sure, um... I think a lot of the evolution [of becoming a counsellor with CS] comes from um, learning more skills and tools and all, you know, formal training and finding out niches or ways of, of helping that um, that I was kind of drawn to. Um, and also you know being, being able to um, kind of have ongoing kind of professional challenges. Like um, I did my masters when I was 35 so that was after about ten years of working in the field with a bachelor's degree so that kind of ongoingly, um, kind of kept the process of being, challenging myself professionally and taking things to the next level um with the aim of being more effective and supportive and helpful with clients. (Participant 4)

This theme of *engaging in ongoing learning* was initially validated by 5 participants, but during member checking it had a 100% endorsement rate.

Theme 6: Embracing Variety

Variety—the idea of ‘mixing things up’— appeared as a theme throughout the interviews in several different ways. This theme includes actively seeking out variety in clientele, variety in work roles, and even taking time away from one’s typical job to do something different for work.

There’s variety in my work. So, I do individual, couples, family and group work. I also [educate clients on community resources and options for financial support], so that’s you know, 10-20% of my work, that adds variety. I work with people with all [name of illness] types. I work with people from all stages...from just brand new diagnosed to doing bereavement work, and everything in between... So that variety is helpful. The variety helps me to stay a bit lighter. (Participant 2)

So another key thing for me to kind of um avoid burn out and compassion fatigue is to move around, is to kind of change and I’ve been really fortunate that way. And I know once I, once I stick in a job for around three or four years um, I start to get a little um... it’s, it’s harder to maintain that compassion satisfaction... and then I need to move around. Um, or you know stay within a job but just having different, different um tasks within it.” (Participant 4)

Researcher: I wanted to check this out with you because this is my word, you haven’t said it yet.. but that variety has been something that has come up.

Participant: (laughing) Yes, yes very good, ya. I even change the way I cycle to work everyday because I can’t stand doing the same old, same old ya, ya. So that’s a big part of it, in fact um, uh, that’s probably one of the big pieces that has allowed me to be here for 20 years because I, I have been involved in program development, and I have um, been involved in a lot of development of how we do what we do here as counselors and ya, so the variety is huge because I see individuals, I see couples, um, um, do groups, um,

supervise the [name of program] clinic, um I get involved more provincial level committees, um, you know doing um, planning for conferences, giving presentations, ya.
(Participant 3)

You need breaks, you need to change things up every once in a while and take 6 months, do something different and connect with yourself again. And I think when people don't have those opportunities to do that, it's uh, it can you know, I mean it can kill you, you know? (Participant 6)

This theme of *embracing variety* was validated by 4 participants in the narrative interviews, and by 5 participants during member checking.

Auxiliary Findings

The following findings were prevalent across the interview transcripts but are not considered to be direct responses to my research question, and therefore do not meet the criteria as themes derived from this study. However, the prevalence of these findings suggests that these points are important, or at least worthy of consideration when conceptualizing the achievement and maintenance of CS. Additionally, I suggest that the following findings represent potential topics for further study (which will be discussed further in Chapter 4).

Accepting the Scope and Limitations of my Role

All participants held a clear conceptualization of their role as a counsellor, and within that they held realistic and self-compassionate expectations for what they could accomplish, and what fell outside of the limits of their role:

You're not going to alleviate grief, you just aren't. If it's a significant loss it's going to be there at least over a year. That's just milestones, right? We can accompany, we can

help find clarity, meaning, we can help them shift, grow, evolve, all that stuff...but you're not taking away grief, and you're not taking away the cancer." (Participant 2)

I'm certainly not responsible for peoples' success or their failures and that's kind of a really clear belief that I have and I'll always have in the counselling realm. (Participant 4)

I just stay with "how can I support in any way? Is the support holding compassionate space in listening?" It's no small thing, when it's really there. Sometimes that's all you can deal. And it has to be enough, and you have to know that it's enough. (Participant 5)

Valuing the Meaningfulness of my Work

Five of the six participants expressed how they value the meaningfulness of their work, and how this contributes to their sense of CS. They described how satisfied, honoured and inspired they feel by doing this work and being able to play a part in client change. For example Participant 3 said the following:

And then that's what, you know, that's, that's the joy in what I do because then there's the satisfaction of seeing the transformation of this high distress into, I can cope, into a sense of resiliency... When you reach that place of you know, um, really being a part of helping somebody move forward on their journey, I mean that's so rich, right?

Participants stated that they engage in reflection on the meaningfulness of their work, and remind themselves of positive past experiences when they need a boost in positivity. For example, Participant 2 said this:

One of the patients that I just wrapped up with... she sent me an email that said, you know I went home...thought about what we've been talking about, I feel like you're really in the right profession, you are where you need to be, and you made a difference for me. I'm keeping the e-mail, and I will look at it again.

Finally, Participant 1 described an experience he had running into a past client that he had not seen in 25 years:

...so she [the past client] re-introduced me, and she introduced me as “this is Brian, from [name of youth program], he’s the man who saved my life” (tears up)... I felt really honoured, you know. And it’s so motivating, it’s so motivating, to think that ya, maybe a smile here, or a touch here, or a conversation there might make a difference.

Conclusion

In this chapter I have presented the findings from the ProQOL scales that each participant completed, described the 6 themes that I identified during thematic analysis and provided supporting participant quotes for each theme, and noted the auxiliary findings from this study. In the following chapter, I will offer an in-depth examination of these findings in comparison to the existing literature as well as suggesting what I think my findings mean for theory, research, counsellor training, and practice.

CHAPTER 4

DISCUSSION AND CONCLUSION

Introduction

To my knowledge, this study is the first to focus solely on the exploration of what counsellors actively do to maintain CS in their careers. The research question for my study was simply: How do experienced counsellors actively maintain compassion satisfaction in their work?

Study Purpose and Research Summary

Several studies have suggested that CS promotes counsellor wellness through its mitigating effects on CF (Alkema et al., 2008; Collins & Long, 2003; Conrad & Kellar-Guenther, 2006; Killian, 2008; Negash & Sahin, 2011; Radey & Figley, 2007), burnout (Alkema et al., 2008; Collins & Long, 2003; Slocum-Gori et al., 2011), and VT (Killian, 2008); and that CS contributes to career longevity and to a sense of fulfillment, balance, and wellness that extends from counsellors' professional to personal lives (Bowles, 2009; Radey & Figley, 2007). To date, very little research has been done using counsellor wellness as a primary focus (Coster & Schwebel, 1997; Harrison & Westwood, 2009; Kottler, 2007; Lawson & Myers, 2011; Linley & Joseph, 2007) let alone the role of CS in counsellor wellness. While the literature on CS is relatively new, not much attention has been paid to what experienced counsellors actively *do* to maintain CS and therefore, their wellness as counsellors. The purpose of this study was to extend the literature on counsellor CS by asking experienced counsellors how they maintain CS in their professional practice. In this way, this research will contribute to the bodies of knowledge on counsellor wellness and CS. Findings from this study will have implications for counsellor

training programs, the personal and professional lives and retention of counsellors already in the field, directors of counselling agencies, and client care.

The participants were counsellors in the Victoria area who have worked in the field for at least 10 years and consecutively for the past 5, have a minimum of a Masters degree, devote a minimum of 50% of their work-related time to psychotherapy, are registered with a regulatory body for counsellors, and who self-reported experiencing CS in their work. Narrative interviews were used to collect the counsellors' stories of how they have managed to maintain CS across their careers.

Summary and Discussion of Findings

Ultimately, I distilled 6 themes from within and across the data set, namely: Maintaining Boundaries, Practicing Self-care, Cultivating Self-awareness, Developing Positive, Fulfilling Relationships, Engaging in Ongoing Learning, and Embracing Variety. I also noted 2 auxiliary findings: Accepting the Scope and Limitations of My Role, and Valuing the Meaningfulness of My Work. All of these findings are supported by the existing literature. I will describe each finding and discuss how they compare to the extant literature.

Maintaining Boundaries

The maintenance of clear boundaries was a theme that I identified consistently across my interviews. These boundaries included the distinction and balance between work life and home life, and the personal boundaries between self and others both outside of work and with clients. Firstly, several participants stated that they make an effort not to think of clients when they are at home. They do not check work-related emails, and they made sure to have friendships that are separate from work. One participant mentioned that when he spends time with friends from work outside of work, they purposely avoid talking about work. Participants described their

lives outside of work as rich, indicating that it is important that they “have a life” outside of work. Further, one participant underlined the importance of having a passion that is separate from his counselling work. Consistent with my findings, Wharton (2009) contended that creating a well-developed personal life helps mitigate CF. Dlugos and Friedlander (2001) also reported similar findings. Dlugos and Friedlander’s first theme, *balance*, had two categories that are relevant to my finding of the need to establish boundaries between home life and work life: (a) maintaining physical and psychological boundaries between work and personal life; and (b) passionate engagement in at least one non-work activity. Comparatively, Coster and Schwebel (1997) found that a balanced life was vital for counsellor well-functioning, and Lawson and Myers (2011) found that maintaining balance between personal and professional lives was one of the top 8 CSBs for counsellors with the highest wellness scores. In conclusion, clear boundaries between work and home, balance between work and home, and passionate interests outside of work have all been linked to the maintenance of CS, both in my study and in the current literature.

Secondly, 4 of the 6 participants in my study spoke about either maintaining strong boundaries while they empathize with other others (in particular clients), or cultivating boundaries around *when* and *how deeply* they engage in empathy. This is an interesting and noteworthy finding because it contributes to the discourse on the role of empathy in CS. While being empathic is part of the role and responsibility of a counsellor, participants were explicit in also noting the importance of defining and delimiting empathy itself. For example, one participant used the term “compassionate detachment,” describing this as not being overly (i.e., unhealthily) invested in their clients’ change processes. Another participant reported that she is careful not to lose herself while empathizing with clients, stating, “I do empathize but I don’t, I

don't experience their feelings in me... It is not my experience to experience actually”

(Participant 5). This finding is akin to a theme identified by Harrison and Westwood (2009), which they called *exquisite empathy*. In their paper on protective factors against VT in trauma therapists, Harrison and Westwood described exquisite empathy as the ability to be fully present and attuned with one's client, while still maintaining firm boundaries and discerning where the client ends and the self begins. Harrison and Westwood contended that as long as this type of exquisite empathy is used, empathy can *prevent* counsellor impairment (specifically VT) instead of causing it. My findings suggest that not only does strong boundaries in empathy prevent impairment, it promotes CS. Two participants also spoke about the importance of deciphering when and how much to empathize. For example, one of my participants described how, outside of sessions with clients, he has learned to “turn down the amplifier” on his “counsellor antennas” to adjust his level of empathy according to whether he is working with clients, or outside of work and “off duty”. Taken together, maintaining strong boundaries around empathy is an important finding not only because it corroborates the notion that empathy is best used with strong, clear boundaries (Harrison & Westwood, 2009), but because it points out the need to go even further than establishing the boundaries between where the client ends and the self begins, to the ability to intentionally adjust one's degree of empathy based on the given environment. Given that the counsellor's “tool” is their self, it can be difficult to know how and when to set aside one's empathic skills (or tools), especially as they are often so well-developed and ingrained. However, it makes sense that honing the ability to intentionally shift in and out of what Harrison and Westwood (2009) called “exquisite empathy” would be very adaptive for a counsellor hoping for a long, healthy career.

In sum, given the strong endorsement of this theme in my study and the current literature, it would appear that the maintenance of boundaries on several levels is an important component of maintaining CS. According to my participants, boundaries and balance between work life and home life, boundaries between self and others, and boundaries in how and when one engages in empathy are all applicable considerations for the maintenance of CS.

Practicing Self-Care

Every participant described specific activities that they do to nurture, ground, centre, and re-energize themselves. These activities are included in what many participants referred to as “self-care” (e.g., regular exercise, time alone, meditation, time in nature, personal therapy). In many of the studies I have reviewed, self-care is regarded as a cornerstone for counsellor wellness (see Harrison & Westwood, 2009; Negash & Sahin, 2011; Radey & Figley, 2007; Wharton, 2009). In Harrison and Westwood’s (2009) paper, their theme called *holistic self-care* described the physical, emotional, mental, spiritual, and aesthetic aspects of self-care identified by their participants. My participants also spoke about physical (e.g., exercise), emotional (e.g., seeking support through personal therapy), and spiritual (e.g., meditation) self-care. They spoke about continual training as well, which Harrison and Westwood classified as mental self-care, however I have included ongoing learning and training as a separate theme because my participants spoke of training separately from their discussion of self-care. As I mentioned in Chapter 1, I was initially intrigued by aesthetic self-care, as I had not come across this concept previously. According to Harrison and Westwood (2009), aesthetic self-care involves purposely seeking beauty and bringing it into one’s life, for example, by spending time in nature. I was interested to find that one of my participants described something very similar when he stated:

I was growing up in a family that was very outdoor oriented, um, that's been, that's been huge for me too. It help, helps maintain that humanistic perspective in terms of our place in the universe or you know, um, you know it may seem like you know, life is pretty shitty sometimes but actually when you see this gorgeous sunset, that kind of puts things into perspective. (Participant 4)

I would like to see more research on the concept of aesthetic self-care because it seems to have an impact on CS, and it relates to actively seeking beauty and positivity, which has also been linked with CS, and which I will discuss again later.

Though they were not discussing CS specifically, it is also worth noting that personal psychotherapy and “coping mechanisms” were two themes that Coster and Schwebel (1997) found in their study examining factors that contribute to counsellor well-functioning. In my study several participants stated that engagement in their own personal therapy was a part of their regular self-care practices. Also, though my participants did not use the term “coping mechanism,” the examples of coping mechanisms in the Coster and Schwebel study (e.g., vacations, rest, exercise, spirituality) are practices that my participants described as well, most often referring to them as “self-care.” Also, in the Lawson and Myers’ (2011) paper, 2 of the 8 top rated CSBs (a construct similar to self-care) for counsellors with the highest wellness scores were “engage in physical activities,” and “engage in quiet leisure activities.” Engaging in physical activities and quiet leisure activities appeared in my study as well.

Lastly, Gentry (2002) stated that good nutrition, creative expression, meditation/mindfulness, spending time outdoors, and spirituality are all common examples of self-care activities that they have found in their work with caregivers. Each of these examples also appeared in my data. Even more interesting, however, was that Gentry found that regular

exercise was the most important aspect of self-care. Similarly, in my study, regular exercise was the most prevalent self-care practice.

Given its prevalence in my study and in the current literature, self-care appears to be a very important aspect of maintaining CS. What I am taking away from these findings is that developing a regular regimen of self-care activities should be a top priority for me as a novice counsellor looking to have a long, fulfilling career. It seems to me that self-care has become a buzz-word in the helping professions, but when it is spoken about it is often not defined well, or at all. When I have sought definitions for self-care, what I have been able to find has been very vague and broad. For example, Gentry (2002) defines self-care as “the ability to refill and refuel oneself in healthy ways” (p. 17). I was hesitant to use the term self-care in my themes because of its ambiguity; I was worried my readers would not be able to take any practical implications away from a suggestion such as “practice self-care.” I know that when I have heard similar advice, I have often wondered, “what exactly does that mean?” So, for the sake of clarity I want to specify what I mean by “self-care” in relation to this theme. I have taken my definition from my participants’ descriptions. I noticed that my participants used the term self-care to refer to any nurturing, grounding, centering, and re-energizing practices that they were deliberately doing for themselves to combat the negative, heavy, or draining aspects of their work. Therefore, that is how I am defining self-care. Sometimes these activities were proactive (e.g. a weekly exercise class to maintain high energy) and some were reactive (e.g. going for a walk after a difficult session). The specific activities varied depending on each participants’ individual needs and preferences, but they were all done intentionally with the awareness of how these activities can reduce impairment and/or increase satisfaction. In brief then, my conceptualization of self-care reads as: any practices that are done to deliberately nurture, ground, center, and/or re-energize

oneself. I acknowledge that this definition is still not perfect, but it was the most that I could surmise from my data as they were. If I were to do this study again, I would like to ask each participant how they personally define self-care.

Cultivating Self-Awareness

Participants' acute level of self-awareness allows them to track their internal states continuously, in any given situation. Participants stated that consciously attending to this information helps them notice and monitor their own needs so that they can care for themselves on moment-to-moment (e.g., during sessions) and more general, ongoing bases. Additionally, they use this information to better empathize and connect to clients, but they also use their awareness to stay grounded in themselves. Participants spoke about monitoring their thoughts, but most commonly talked about using their body-based experiences as information on their internal states and emotions. Lawson and Myers (2011) described a comparable finding in their study on wellness, CS, and CSBs. In their study, Lawson and Myers reported that "maintain self-awareness" was one of the 8 top rated CSBs for counsellors with the highest wellness scores. In other words, counsellors with high levels of wellness (which is strongly and positively correlated with CS) endorsed maintaining self-awareness as one of the most important behaviors for sustaining and enjoying their careers (Lawson & Myers, 2011). What remains unknown, however, is if an endorsement of a CSB on a pencil-and-paper questionnaire indicated actual effortful and active *engagement* in that CSB.

In my study, some participants used mindfulness as a way to "witness" (Participant 1) their inner experiences and thus maintain self-awareness. Correspondingly, in Harrison and Westwood's (2009) study on protective factors against VT in trauma therapists, they identified a theme called, *Developing mindful awareness*. Their participants described how mindfulness

helped them cultivate presence, patience, and compassion; allowing them to stay calmly focused, grounded, and non-reactive; and to hold multiple perspectives at one time.

There are several by-products of mindfulness that could increase one's opportunities for CS, including, increasing one's ability to maintain a high level of self-awareness while also being present and grounded enough to effectively attune to one's client. As Christopher, Christopher, Dunnagan, and Schure (2006) and Christopher and Maris (2010) indicated, this level of self-awareness can increase counsellors' ability to notice and then attend to their own needs so that they can sustain their level of well-being and avoid becoming depleted. As such, mindfulness practices can have applications for facilitating, maintaining, or increasing CS by cultivating self-awareness.

Developing Positive, Fulfilling Relationships

Every participant in this study spoke about the positive relationships in their lives, and how important they are to their overall wellbeing and level of CS. This theme includes both work relationships and relationships with friends and family. Most importantly, the relationships described in this theme are more emotionally fulfilling than they are draining. This theme appears to be integral to CS, as it emerges several times in the current literature, and it is even present in the description that Stamm (2005) used to define CS. Specifically, Stamm stated that CS is partially achieved and maintained through positive connections with colleagues. Additionally, social connection/support with colleagues is described as a contributor to counsellor wellness (Harrison & Westwood, 2009; Wharton 2009) and CS (Conrad & Kellar-Guenther, 2006; Killian, 2008; Stamm, 2002). Further, current literature also supports the notion that positive relationships with loved ones are an integral ingredient for counsellor wellness (Harrison & Westwood, 2009; Wharton, 2009) and CS (Killian, 2008). Similarly, Coster and

Schwebel (1997) indicated that peer support (i.e., supportive work relationships) and stable personal relationships were both factors that contributed to counsellor well-functioning; a construct which, as I have said, appears to be a component of CS. Also, “spend time with partner/family” was one of the 8 top rated CSBs for counsellors with the highest levels of wellness in Lawson and Myer’s (2011) study.

It is not surprising that this theme appears again and again in the literature, and now again in my study. The important take home message, however, is that it is not simply any relationship that will contribute to CS. To achieve and maintain CS, it appears important for one to focus on cultivating positive and fulfilling relationships inside and outside of work where the rewards outweigh the effort required to maintain them.

Engaging in Ongoing Learning

Five participants spoke about the way that continual professional development keeps them inspired, confident, and interested in their work. Many of the participants in my study also described training in their theoretical framework of choice as a turning point in their career as it gave them a framework for understanding their clients and a sense of confidence and competence. In addition, they spoke about the importance of ongoing training and learning that continues throughout their career. Continual professional development allows them to follow new areas of interest, gives them new things to try with clients, and keeps them connected to the counselling community.

Similarly, Coster and Schwebel (1997) found that supervision and continuing education were significant ingredients for counsellor well-functioning; Sprang, Clark, and Whitt-Woosley (2007) found that specialized training was associated with higher CS; and 2 of the top 8 rated CSBs for counsellors with the highest wellness scores in Lawson and Myers’ (2011) study were

“maintain professional identity,” and “participate in continuing education.” Lawson and Myers do not describe what maintaining professional identity looks like, and maintaining professional identity was not specifically identified in my study. Nonetheless, I think it is reasonable to suggest the ongoing pursuit of one’s professional development could result in the maintenance of one’s professional identity. Lastly, Harrison and Westwood’s (2009) theme, *Countering isolation in professional, personal and spiritual domains of life* was a broad theme that included professional training/support, and therefore directly mirrors my finding. In conclusion, ongoing training appears consistently across the literature as being an important contributor to counsellor well-functioning, counsellor wellbeing and CS. Not only do these practices offer new skills to apply with clients, they offer opportunities for counsellors to stay fresh and interested in their work, and to feel competent in their work, leading to increased levels of CS.

Embracing Variety

This theme includes variety in clientele, variety in work roles, and variety in schedule. Participants reported that they seeking out work with different types of clients with an array of presenting concerns, becoming involved in a variety of roles and activities at work, and changing up their schedule (e.g., taking 6 months away from work to do something different), keeps them fresh, interested, and satisfied in their work as counsellors.

Similarly, Harrison and Westwood (2009) reported a broad theme called *Countering isolation in professional, personal and spiritual domains of life* which included diversity of professional roles (e.g., combining therapist role with teaching or administrative work) as a component. Dlugos and Friedlander (2001) also had some noteworthy similarities in their findings. Their first theme, *balance*, had four categories, one of which was: deliberately seeking variation in work activities to maintain freshness. This theme makes intuitive sense to me

because variety combats boredom and stagnation. If one is looking for longevity and fulfillment in their career, it is important that they find ways to keep themselves engaged in what they are doing. That is exactly what my participants have done, by keeping their minds working, seeking new challenges, and pursuing inspiration.

Auxiliary Findings

Accepting the scope and limitations of my role. All 6 participants spoke about how they define their role as a counsellor and what they believe falls outside the limits of their role. They accept what they cannot change, are aware that change is ultimately their clients' responsibility, and they remain conscious about not trying to fix people. This helps my participants to maintain their CS because they do not set themselves up for disappointment and frustration by holding unrealistic expectations for themselves as counsellors. When unrealistic expectations do arise, they do their best to identify them and replace them with more realistic expectations. This finding is related to my theme of *maintaining boundaries*, however this finding does not speak to what my participants are *actively doing* to maintain CS in the same way that the *maintaining boundaries* theme does. Rather, *accepting the scope and limitations of my role* is an awareness or notion that my participants hold about their role as counsellors. Therefore I have included this finding as a separate auxiliary finding, because although it does not meet the criteria to be considered a theme, it is an important pattern in my data that I identified across every interview.

Harrison and Westwood (2009) reported a theme that aligns partially with this finding of *accepting the scope and limitations of my role* and partially with my theme of *maintaining boundaries*. Harrison and Westwood's theme of *maintaining clear boundaries and honouring limits* included participants' awareness and acknowledgment that (a) they could not carry the

responsibility of change for their clients; (b) they knew where they ended and their clients began; (c) change comes in small steps and is slow; and (d) large scale change is a community responsibility. The awareness of the boundaries between one's self and one's clients supports my theme of maintaining boundaries, however, the acknowledgement that one is not responsible for client change, and that change is a slow process is reflected in what my participants spoke about in terms of accepting the scope and limitations of their role. Harrison and Westwood identified a variety of helpful strategies for maintaining boundaries, such as supervision/consultation, personal therapy, before and after-work rituals, mindful awareness of unresolved issues, and vacations. All of these strategies were also mentioned in my study, however not always in relation to maintaining boundaries or accepting the scope and limitations of one's role. Given the complete endorsement of this finding of *accepting the scope and limitations of my role* in my study, and the fact that it is substantiated by the literature, it appears that having a clear understanding of where one's responsibilities as a counsellor begin and end is an important component in the maintenance of CS.

Valuing the meaningfulness of my work. *Valuing the meaningfulness of my work* is represented here as an auxiliary finding because it does not speak clearly enough to what counsellors are *actively doing* to maintain CS, however it was endorsed by 5 out of the 6 participants. The meaningful experiences reported by my participants were typically the result of them "doing well" (Stamm, 2002) at their job, however, the essence of the supporting quotes used to create this finding boiled down to how positive experiences such as hearing about the long-lasting impact of their work on a past client, made the participants *feel*. The focus of their narratives was on their sense of gratitude, honour, inspiration, and meaningfulness that they feel in relation to the relationships that they build and the roles that they play as counsellors.

Participants described how inspiring it was to witness their clients' growth and change and also discussed how meaningful their role as a counsellor is to them in explicit terms. They are honoured to play a special role in their clients' lives, and in doing so they experience satisfaction and fulfillment. One participant described it this way: "If I'm being candid, I see myself as a healer, um which is kind of a universal, if you will. Um, and so I think that that, kind of, that gives me life in and of itself - that capacity to be involved in somebody's healing" (Participant 1).

This finding of valuing the meaningfulness of one's counselling work is reflected in several studies and appears to be an essential component of CS. In fact, it is at the core of how Radey and Figley (2007) and Stamm (2002; 2005) define CS. As I noted in Chapter 1, Radey and Figley define CS as the experience of flourishing in the helping professions when one feels a sense of joy, fulfillment, and satisfaction from work, particularly when helping others move from the role of victim to survivor. This is precisely the essence of what I found in my participants. They were inspired to witness their clients' resilience and felt a great amount of fulfillment and honour in being able to accompany their clients on their personal journey. Comparatively, Stamm (2005) defines CS as "the *pleasure* you derive from being able to do your work well" (p. 5) (italics added for emphasis). Again, as I mentioned earlier, this idea of valuing the meaningfulness of my work revolves around the experiences of gratitude, meaningfulness, or put more broadly, pleasure, that is ultimately the result (at least in part) of the counsellor doing their work well, and of holding onto the belief that the work they do with clients is valuable, meaningful, and important work.

There also seems to be overlap between and among my finding of *valuing the meaningfulness of my work*, with the CSB "reflect on positive experiences" (Lawson & Myers,

2011), and 2 themes identified by Harrison and Westwood (2009): *Active Optimism*, and *Professional Satisfaction*. Firstly, in my study, 3 participants described instances when they had received positive, validating feedback from past clients about the impact that their work together had. The participants stated that they reflect back on these positive experiences when they need to bolster their positivity. Lawson and Myers do not describe what the CSB “reflect on positive experiences” entails, but I imagine it is exactly what it sounds like, and exactly what my participants identified as something that they did to boost their positivity and satisfaction with their work (e.g., one of my participants described how she purposely kept an email from a client so that she could look at it later when she needed to be reminded of some of the positive impacts and experiences she has had with her clients). Next, when describing their theme of Active Optimism, Harrison and Westwood stated that the clinicians in their study on VT viewed “the therapeutic enterprise as meaningful” and, as the name of the theme would suggest, actively sought positive experiences to increase their optimism (p. 211). Also, in their theme of Professional Satisfaction, Harrison and Westwood’s participants indicated that they derived satisfaction from knowing that they made a “meaningful contribution through their professional efforts” and that their role as counsellors was an honour. As noted above, my participants also described their work as highly meaningful, and when they pause to remind themselves of the positive feedback they have received from clients, in essence, I think they are also actively seeking optimism. The reader will note that my participants also felt a sense of satisfaction and pleasure from their role as counsellors.

Valuing the meaningfulness of my work was a resounding finding in my data. It was one of the patterns in my data that I noticed immediately because it was so prominent in my interviews. This is especially interesting given that it is reflected in the definition of CS at its

core, and it appears several times in the literature on CS. To me, this means two things. First, that my participants were truly experiencing CS as it was first described by Stamm (2002), and second, that counsellors wishing to achieve CS would be well advised to reflect on the positive, meaningful aspects of their work on an ongoing basis.

Limitations of the Study

My study has much notable strength, which I detail in the next section, but is not without its limitations. Given that I used qualitative research methods, there are certain claims I cannot make about this study. Namely, my sample size was much smaller than would be expected in a quantitative study to be considered “representative,” and my findings are therefore not “generalizable.” However, generalizability was not the aim of this study (nor is it the aim of qualitative research methods, generally). Due to the lack of research on how CS is maintained and to the fact that my research aim was to collect first-hand descriptions (or narratives) of how CS is maintained, an exploratory design was appropriate. More so, rather than relying on a large survey or even structured interviews to collect my data, I used a method that could elicit the narratives of exemplary counsellors. Now complete, this research can inform future research questions with larger populations and greater generalizability. Also, the findings from my exploratory study provide a thematic description and not a theory of how participants maintain CS. The goal of the study, which was to explore experienced counsellors’ stories of how they actively maintain CS in their work, was practical rather than theoretical; I sought to generate insight and questions for counselling training and practice.

The purposive sampling methods I used for participant recruitment also introduce some limitations to this study. Though I sent out 28 letters of invitation for my study to randomly selected counsellors that I found online and in the phone book, all of the counsellors that I ended

up recruiting were first nominated by one of their peers. In other words, I did not receive any response from the invitations that I mailed out. Rather, as my friends and fellow counsellors learned of my study, they recommended counsellors that they thought would meet the inclusion criteria. I then asked the nominators to get permission from the nominees for me to contact them before emailing them a letter of invitation. As I will explain shortly, I believe that for the most part, this peer nomination process added strength to my study. However, those who nominated participants for this study were all people who, (a) knew me; (b) knew about my study; and (c) knew local practitioners that they thought would meet the criteria for CS. Consequently, the people that nominated my participants came from a relatively small pool of counsellors. Therefore, the pool of counsellors that my participants were drawn from was correspondingly small. Also, because participants were nominated by other practitioners, they may have agreed to participate because they felt a sense of obligation to the peer who nominated them. Further to having been nominated, participants may have wanted to live up to the favorable way their peer had initially represented them. Therefore, it is possible that my participants embellished or over-emphasized their degree of CS and their stories of how they maintain it. However I would like the reader to note that several times throughout all of the interviews I was struck by the humility and authenticity of each of the participants. They were open about weaknesses and humble about their accomplishments. Ultimately, the inclusion of participants relied on their self-report of CS, meaning that I relied on participants to represent themselves as accurately as possible. However, to corroborate each participants' self-report of CS, I used the Professional Quality of Life scale (ProQOL); and indeed each participant scored in the high range for CS, with the exception of one participant who scored in the average range. As I described in Chapter 2, the ProQOL is empirically validated, and it is the most commonly used measurement of CS. Also,

in my informed consent it was explicitly stated that participation was completely voluntary and confidential, so the participants knew that there was no obligation for them to take part in the study and that the person who recommended them for the study would never know if they ended up agreeing to participate.

Regardless of the way that peer-nomination might have affected participants' responses (and thus my findings), as a social constructivist I believe that there is no absolute truth that is out there to be captured. There are only subjective "truths" that change with every new context. The best I can do is to strive to accurately represent the narrative participants shared with me, and I believe I did that to the best of my ability.

Lastly, as a relatively inexperienced researcher, I may also have had an unintentional impact on this study. For example, knowing that I was a relatively new researcher and novice counsellor, my participants may have identified with me and wanted to help or encourage me by agreeing with my perception checks or endorsing my themes during member checking, when in fact I was not correct. Also, the fact that this was my first time doing qualitative research, including narrative interviews, coding, and theme development, is a limitation as well. To mitigate this limitation, I completed two graduate-level courses on research methods, one of which was specifically on qualitative research. Also, my research process was closely supervised by an experienced researcher, and I also engaged in peer examination with my committee-member, as well as with several fellow grad-students involved in qualitative research.

Strengths of the Study

There are many strengths of this study that make me proud to share it with you, the reader. Doing narrative interviews enabled me to listen to participants tell me their stories unencumbered by scripted questions. In this way, participants' stories were allowed to unfold

without being hindered by an imposed structure. I was able to hear my participants' stories in their own words, and yet if I was ever unsure of their meaning, I had the flexibility to ask for clarification or elaboration. This approach allowed me to get as clear of an understanding of my participants' experiences as possible in the time allowed, and resulted in data that were rich and deep.

Participants consisted of 3 males and 3 females ranging in age from 44 to 66 with diverse workplace settings and specializations. Also, the participants in this study were nominated by their peers as having CS, the participants themselves self-reported as having CS, and their ProQOL scores corroborated this. Taken together, I feel confident that I found a sample of participants that could speak credibly to the achievement and maintenance of CS. Further, the fact that 5 of the 6 themes received a 100% endorsement rate on member checking, with the other theme getting one vote shy of 100% endorsement, suggests that the themes presented in this study accurately represent the participants' experiences.

Lastly, the findings from this study add to the current body of knowledge on counsellor wellness, and on CS specifically. These findings are valuable because to my knowledge this is one of very few studies that shifts focus from counsellor impairment (i.e., burnout, CF, and VT) to CS, and it is one of the first studies I know of to narrow in on *how* CS is maintained. The 6 themes and 2 auxiliary findings in this study largely mirror findings from the existing literature, thus underscoring the trustworthiness and relevance of these findings. Finally, I believe that my study's focus on how compassionately-satisfied counsellors actively maintain CS in their work, has wide-reaching implications for the field of counselling psychology, which is what I will discuss next.

Insights and Implications for the Field of Counselling Psychology

I originally elected to do this study because I wanted to focus my research on something that would have relevance to me as a counsellor. I wanted to come away from this experience able to apply what I learned in a way that would help me to have a long, healthy, and fulfilling career as a counsellor. This study has offered me just that, but the implications extend far beyond just me. This study's findings generate practical suggestions for how to maintain CS despite the challenges inherent in the counselling profession, and bring insight into how threats or challenges to CS can be protected against in the first place. My findings have implications for theory, knowledge building, and research in the field of counselling generally; and for the wellbeing of individual counsellors at any stage in their career, counselling training programs, workplaces that employ counsellors, and for client care. Though the focus of this section is on implications for counselling psychology, this study also has implications for any helping professional (e.g., nurses, paramedics, doctors, etc.).

Overall, the findings from my study suggest that counsellors who are compassionately satisfied in their work actively and consciously focus on maintaining clear boundaries, practicing self-care and self-awareness, cultivating fulfilling relationships, pursuing ongoing learning opportunities, and embracing variety in their work. Counsellors who are interested in maintaining CS would be advised to consider incorporating any or all of these practices into their life. Also, counsellors would do well to iteratively take stock of what they are currently doing to actively maintain their CS, and to continue or adjust course, so to speak, accordingly. Instead of focusing on counsellor impairment, counsellor training programs and workplaces that employ counsellors can open up dialogues with their counsellors about CS, what they might already be doing to support it, and how they can create a realistic, manageable plan to include more strategies (such as the ones suggested by my study) to promote and maintain CS.

Woven throughout my participants' narratives there seemed to be a common thread relating to attending to one's inner needs. Whether they were talking about self-care, boundaries, or healthy relationships, my participants described how these aspects contributed to their CS and spoke about them as being non-negotiable and essential. To me, these appeared to represent some of my participants' inner needs. It also struck me that my participants were all skilled at noticing (through their keen self-awareness) and then attending to these alluded-to personal needs. Not all of the participants used the word "needs" to describe the maintenance of their CS, so I acknowledge that this is my interpretation of the data. However, this conceptualization stood out to me quite strongly when I took a step back and looked at the "big picture" of my data, and it left me wondering if perhaps one of the most important contributors to the maintenance of CS is the ability to know, notice, and actively attend to one's inner needs. If this is the case, this is a potentially meaningful conceptualization of what my participants said they did overall to maintain CS in their work. Particularly given that counsellors are known for being proficient at noticing and attending to the needs of others, and not always as good at making sure they are getting what they need for themselves. The corresponding implications for this conceptualization of how CS is maintained, is that counsellors seeking CS should be clear on what they need, fine-tune their awareness of their inner needs, practice noticing them moment-to-moment, and learn how best to meet those needs. They would need to be willing to make their own needs a priority and take the necessary steps to meet them.

These findings are all encouraging because they suggest that there are practical strategies that can be used to increase one's chances for maintaining CS. In other words, if one is willing to put the work in, one will have the power to impact one's level of CS. What needs to be acknowledged, however, is that living and working in this way is a mindset that requires

deliberate and consistent choice and action on the part of the counsellor. Maintaining CS takes attention and continual work, as “resiliency in counsellors is not an accident. Rather it is the cumulative effect of counselors’ healthy decision making” (Meyer & Ponton, 2006, p. 200). However, given that we know that CS reduces the risk for counsellor impairment *in addition* to offering benefits to counsellors that extend from their work to the rest of their life, I would certainly argue that CS is worth the work required to maintain it.

Future Areas of Research

While doing this study, I became aware of some potential areas for future research. Firstly, I think that future research needs to continue to use a positive psychology lens by focusing on what counsellors are doing—and *can* do—well to maintain healthy, fulfilling careers (i.e., CS) instead of on pathology and the “occupational hazards” of CF and VT (e.g., Mathieu, 2012, p. 139). As I mentioned earlier, it would be wonderful to see studies on CS with larger samples. It would be interesting to replicate the study and include an additional group of participants that are currently experiencing CF as a comparison. I am also curious about how counsellors who have CS and have never experienced burnout, CF, or VT would compare in terms of CS strategies and their overall approach to work, to counsellors who have CS but who have experienced counsellor impairment at some time in their lives. In addition, it would be interesting to explore the relationship between CS and the honouring of inner needs to see if my speculation of this connection is substantiated by further research.

In the future I would like to see more consistency in the definitions and use of constructs associated with counsellor wellness and impairment. Describing, for example, the lack of clarity around the definition of countertransference, Fauth (2006) articulated why such conceptual inconsistencies (which appear so prevalently in the counsellor wellness and impairment

literature) are problematic, stating: “The lack of conceptual clarity about the term both results from and reinforces the general theoretical fragmentation in the field, thus inhibiting research on the construct” (p. 16). I believe that one of the best ways to increase the consensus on the definitions of the constructs in the areas of counsellor wellness and impairment, would be to highlight their inconsistencies in the literature and turn attention to them in research. For example, if I could do this study again, I would ask each participant how they defined self-care, compassion, burnout, job satisfaction, and empathy. This information would add depth to my findings and would help not only to identify the similarities or inconsistencies in how counsellors and the literature are defining and using these popular terms, but also to get clearer on their relation to CS.

Conclusion

More than six decades ago, Victor Frankl said, “That which is to give light must endure burning” (Frankl, 1963, as cited in Gentry, 2002, p. 5). Years later, we know that counsellors are at high risk for counsellor impairment (Figley, 2002; Lawson & Venart, n.d.; Mathieu, 2009), and that the costs of caring take their toll on client care (Figley, 1995; Gentry, 2002; Lawson, 2007; Wharton, 2009), the workplace (Conrad & Kellar-Guenther, 2006; Fahy, 2007), and counsellors’ personal lives (Lawson, 2007; Mathieu, 2007; Wharton, 2009).

In recent years we have also begun to understand that CS promotes counsellor wellness through its mitigating effects on CF (Alkema et al., 2008; Collins & Long, 2003; Conrad & Kellar-Guenther, 2006; Killian, 2008; Negash & Sahin, 2011; Radey & Figley, 2007), burnout (Alkema et al., 2008; Collins & Long, 2003; Slocum-Gori et al., 2011), and VT (Killian, 2008); and that CS contributes to career longevity and to a sense of fulfillment, balance, and wellness that extends from counsellors’ professional to personal lives (Bowles, 2009; Radey & Figley,

2007). However, very little research has been done with counsellor wellness as the primary focus (Coster & Schwebel, 1997; Harrison & Westwood, 2009; Kottler, 2007; Lawson & Myers, 2011; Linley & Joseph, 2007) and even less has been done on CS specifically, or how CS is maintained.

Thus, the aim of this study was to address this gap in knowledge by asking experienced counsellors how they actively maintained CS in their careers. I found the existing definitions of CS too vague, so I combined and fine-tuned several definitions to come up with an operational definition of CS, which is: (a) the sense of being energized and invigorated by one's helping work more often than being drained by it, and (b) one's ability to continue to thrive and to derive pleasure from doing one's helping work well despite the personal and environmental obstacles that one might face. In retrospect this definition describes my participants precisely.

My study has implications for theory, knowledge building, research, and practice in the helping professions; individual counsellors at any stage in their career; counselling training programs; workplaces that employ counsellors; and ultimately, for client care. For example, counsellor training programs might look to include a required course on counsellor wellness that includes learning about CF and CS, with a focus on strategies associated with the maintenance of CS over the span of a helping career. My findings suggest that counsellors can actively increase their likelihood of maintaining CS by: (a) maintaining boundaries; (b) practicing self-care; (c) cultivating self-awareness; (d) developing positive, fulfilling relationships; (e) engaging in ongoing learning; and (f) embracing variety. My hope is that now complete, this study will be a foundation for further research and continued dialogue about CS.

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Appendix A

Recruitment Letter



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Recruitment Letter

Working Study Title: How do Counsellors Maintain Compassion Satisfaction? Stories from Those Who Know

My name is Alex Sterling and I am a MA student in the Counselling Psychology program in the department of Educational Psychology and Leadership studies at the University of Victoria. I am working with my supervisor Dr. Susan Tasker (stasker@uvic.ca or 250-721-7827), who is a faculty member in the Department of Educational Psychology.

I am currently recruiting participants for a study on how experienced counsellors actively maintain compassion satisfaction. For the purposes of this study I am defining compassion satisfaction as: a) a sense of being energized and invigorated by one's work more often than being drained by it, and b) the ability to continue to thrive and love one's work despite the personal and environmental obstacles that one might face (adapted from Dlugos & Friedlander, 2001). I am looking for counsellors to self-nominate for the study if they meet the following criteria:

- a) Devote a minimum of 50% of their work-related time to psychotherapy (group, individual, or family therapy)
- b) Have been working in the field for a minimum of 10 years, the past 5 of which have been consecutive years of direct counselling work
- c) Have a minimum of a Masters level of education
- d) Are registered with a regulatory body for counsellors/ therapists (e.g., RCC, CCC, AAMFT, R. Psych, RSW)
- e) Self identify as being high in compassion satisfaction
- f) Are proficient in spoken and written English

I am interested in learning more about how compassion satisfaction is maintained in the counselling profession. Experiences of compassion fatigue, burnout, and vicarious trauma are common in helping professions, yet there are also many stories of resilience and satisfaction from the work of counselling. Through this study I hope to generate insight into the skills, knowledge, practices, and attitudes that allow some counsellors to thrive in their career despite the challenges of their work. This research is important because it will contribute to the limited body of knowledge on what counsellors do to maintain longevity and health in their careers. The information that participants provide will have implications for counsellor training programs, the personal and professional lives and retention of counsellors already in the field, directors of counselling agencies, and client care.

Your participation would consist of one 1-1.5 hour audio-taped interview reflecting on how you actively maintain compassion satisfaction in your counselling practice. After the

interview you will also be asked to complete a brief demographic questionnaire and a measure of professional quality of life. The questionnaires together should take approximately ten minutes. The interviews will take place at a location of your choice and at a time that is convenient for you. A few weeks later, you will be contacted by email or phone to verify that the data analysis has accurately captured your story. This member checking process will vary in length depending on whether there are changes you would like to make. All information that you share will be kept confidential and no names will be given in the final research report.

If you are interested in participating in this study, please contact me. After you contact me I will give you a chance to ask any questions, and we can set up our interview if you are still interested. Please note that this study has received approval from the Human Research Ethics Office (250-472-4545 or ethics@uvic.ca).

If you have any questions feel free to contact me. Thank you so much for your interest in this study.

Sincerely,

Alex Sterling, Masters in Counselling Psychology Student
Educational Psychology & Leadership Studies
University of Victoria

Contact- phone: 250-818-5539 email: alexsterling7@gmail.com

Appendix B

Telephone Script

The following is an example of the script to be used when participants (P) initiate contact with the primary investigator, Alex Sterling (AS); exact wording and order may change slightly depending on participants' responses:

AS: "Thank you for taking the time to call. We will need 10 to 15 minutes to talk about the study. Do you have the time to talk right now or should I call you back at a different time?"

P: "Yes, we can talk now." ("No, I don't have 15 minutes right now.")

AS: "First, would it be alright if I ask you a few questions?" ("When would be a good time for me to call you back?")

P: "Yes." ("Can you call me in 30 minutes?")

AS: "Do you devote a minimum of fifty percent of your work-related time to psychotherapy, for example group, individual, or family therapy?"

P: "Yes." ("No.")

→ If YES, continue as follows. If NO, thank participant for their interest and explain that this is an important part of the selection criteria.

AS: "Have you been working in the helping field for a minimum of ten years?"

P: "Yes." ("No.")

→ If YES, continue as follows. If NO, thank participant for their interest and explain that this is an important part of the selection criteria.

AS: "Have you been doing direct counselling work for the past five years consecutively?"

P: "Yes." ("No.")

→ If YES, continue as follows. If NO, thank participant for their interest and explain that this is an important part of the selection criteria.

AS: "Do you have a minimum of a Masters level of education?"

P: "Yes." ("No.")

→ If YES, continue as follows. If NO, thank participant for their interest and explain that this is an important part of the selection criteria.

AS: "Are you registered with a regulatory body for counsellors or therapists, for example CCC, RCC, RSW, R. Psych, or AAMFT?"

P: "Yes." ("No.")

→ If YES, continue as follows. If NO, thank participant for their interest and explain that this is an important part of the selection criteria.

AS: “For the purposes of this study I am defining compassion satisfaction as a) a sense of being energized and invigorated by one’s work more often than being drained by it, and b) the ability to continue to thrive and love one’s work despite the personal and environmental obstacles that one might face. Would you say that you fit this description?”

P: “Yes.” (“No.”)

→ If YES, continue as follows. If NO, thank participant for their interest and explain that this is an important part of the selection criteria.

AS: “Are you proficient in spoken and written English?”

P: “Yes.” (“No.”)

→ If YES, continue as follows. If NO, thank participant for their interest and explain that this is an important part of the selection criteria.

AS: “Thanks for sharing with me. I would be happy for you to participate in this study if you are still interested.” P: “Yes, I’m still interested.” (“Actually, no thanks.”)

→ If YES, continue as follows. If NO, thank participant for their interest and wish them well in their continued work.

AS: “Can I tell you a bit more about the study? (OK, that is not a problem. I appreciate you taking the time to phone me. Best wishes for continued success in your career.)”

P: “Yes.”

AS: “The objective of this study is to gain a better understanding of how experienced counsellors actively maintain compassion satisfaction. In other words, I want to explore the ways that counsellors maintain balance, wellness, and fulfillment in their professional lives. We know from past research that counsellors experience compassion fatigue, burnout and vicarious trauma as a result of their work and that these experiences come at a cost both professionally and personally to counsellors. We also know that unfortunately the experience of one or more of compassion fatigue, burnout and vicarious trauma is common among helping professionals. What I find really interesting though is that recent studies report that compassion satisfaction reduces the risk of compassion fatigue, burnout and vicarious trauma, along with other benefits to counsellors’ levels of wellbeing. There have been very few studies, however, that focus on exploring how compassion satisfaction is maintained. Therefore, instead of focusing on what is not working for us in our profession, I want to look closer at what is working and how people are thriving in their counselling

careers. As you might imagine, this information will have implications for counsellor training programs, the personal and professional lives and retention of counsellors already in the field, directors of counselling agencies, and client care.

As the recruitment letter mentioned, your participation would include 1-1.5 hour interview, during which I would ask for your story of how you have maintained compassion satisfaction overall across your years of clinical practice. I will send you a copy of the interview questions AND THE CONSENT FORM before the interview so you can have a look at them in advance. After the interview is complete I will ask you to complete a demographic questionnaire and a professional quality of life measure. They should take 5-10 minutes in total to complete both. This information is used to provide a richer description of each participant's individual context. Scores on the Professional Quality of Life scale will only be reported as group data in the final report, using descriptive statistics only.

Lastly, I will be contacting you via email or phone a few weeks after your interview to verify that the data analysis has accurately captured your story. This may vary in length depending on if you would like to make some changes. The interviews will be audio-recorded for data analysis purposes but your participation will be completely confidential and there will be no names included in the final report. You are also free to withdraw from the study at any time without consequence and your data will be removed if you wish.

How does all this sound to you?"

P: "That sounds alright to me." ("I think that's going to be too much for me to be able to do right now.")

AS: "Great! I am hoping to do interviews between (date) to (date), is there a time during then that would work for you?" ("Thanks for letting me know that. I really appreciate the time you took to contact me.")

P: "Yes. I could meet on (date) at (time)." ("No.")

AS: "Perfect. Do you have a location that you would prefer to conduct the interview? There is space available for us to use on campus but I am happy to meet you somewhere that is convenient for you. I suggest we choose somewhere that we will be uninterrupted and that is private." ("Is there another time that would work better?")

P: "We could meet at my office." ("Let's meet at the university.")

AS: "May I write your name and contact details on my list of interested participants?"

P: "Yes." ("No.")

AS: Would it be ok if I phone you two days before the interview to confirm?

P: "Yes." ("No.")

AS: "Could you please give me your phone number?"

P: "Yes. My number is 250-250-2502 "

AS: Do you have any other questions for me at all?"

P: "Yes." ("No, I think I'm fine for now.")

AS: "If anything comes up between now and when we meet, please feel free to give me a call. My cell phone number is 250-818-5539 (it's a local Victoria number) and my email is alexsterling7@gmail.com. Thank you for taking the time to call and talk with me. I'm looking forward to meeting with you in person. Good-bye for now."

Appendix C

Script for Unstructured Interview

Preamble:

During this interview I'm going to be asking you to tell me your story about how you have maintained compassion satisfaction overall across your years of clinical practice. Feel free to start your story at whatever point in your life that you think your story of this experience begins. During the interview I will be asking clarification and prompting questions to make sure that I am following and understanding you accurately, that you have said all you want to, and to support you if you need help in telling your story. Before we finish up today I will check with you to make sure you have told me everything you want to or feel comfortable telling me, and if your story seems complete to you.

Questions:

- 1) Tell me your story of how you have maintained an overall level of compassion satisfaction in your work as a counsellor?
- 2) With what you have told me, would you say that you have told me your story?

Potential prompts and clarifiers:

Do you mind telling me a bit more about...
How was it for you when...
Is this what you meant by ...
What did you do then ...
Do you mind repeating...

Appendix D
Professional Quality of Life Scale (ProQOL)
 Compassion Satisfaction and Compassion Fatigue
 (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.

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Version 5 (ProQOL). /www.isu.edu/~bhstamm or www.proqol.org. This test may be freely copied as
long as (a) author is credited, (b) no changes are made, and (c) it is not sold.

Appendix E

Demographic Questionnaire

STUDY IDENTITY #: _____

DEMOGRAPHIC & BACKGROUND INFORMATION

*The following questions are required to describe the participants taking part in this study as a **group**. For example, the average age of the participants will be calculated by summing the ages of all the participants and dividing that number by the number of participants. No individual will be identified in any report of this study. If you are not comfortable giving an answer, simply skip that question and move on to the next question.*

1. Your age: _____

2. Gender: _____

3. What language do you speak at home?

1. English as first language 2. Other:

4. Current relationship status:

1. Single 2. Serious dating relationship 3. Married 4. Common-

Law/Cohabiting 5. Separated 6. Divorced 7. Widowed

5. Do you have any children? 1. NO 2. YES

If YES:

Number of children: _____

Ages of children: _____

6. My family's income level (social economic status) currently*:

**If not in a relationship with a joint income, please indicate your personal income level*

- 1. High income group
- 2. Middle income group
- 3. Low income group
- 4. Poverty group

7. What is the highest level of education that you have completed?

- 1. Bachelors degree
- 2. Masters degree (e.g. MA)
- 3. Doctoral degree (e.g. PhD.)

8. My occupational setting is:

- 1. Private Practice
- 2. Government setting (e.g. MCFD)
- 3. In-patient treatment setting
- 4. Out-patient treatment setting
- 5. Non-profit organization
- 6. School setting (elementary/ high school)
- 7. Post-secondary school setting
- 9. For-profit counselling agency
- 10. Other _____

9. My specialization is:

- 1. Marriage and Family Counsellor
- 2. Addictions Counsellor
- 3. School Counsellor (elementary and high school)
- 4. Post-Secondary School Counsellor
- 5. Grief/ Bereavement Counsellor
- 6. Pastoral Counsellor
- 7. Social Worker
- 8. Child/ Adolescent Counsellor
- 9. Trauma Counsellor
- 10. No Specialization (general practitioner)
- 11. Other _____

10. I have been practicing as a counsellor for:

- 1. 10-15 years
- 2. 16-20 years
- 3. 21-25 years
- 4. 26-30 years
- 5. Over 30 years

11. Currently, I am:

- 1. Employed fulltime
- 2. Employed part-time
- 3. None of the above

12. Please provide the professional/regulatory body you are currently registered with:

Appendix F

Informed Consent Form



*Department of Educational Psychology
and Leadership Studies
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Working Study Title: How do Counsellors Maintain Compassion Satisfaction? Stories from Those Who Know

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Purpose and Objectives of the Research

- The purpose of this research is to explore counsellors' stories of how they have maintained compassion satisfaction overall across their years of clinical practice. Specifically, I am interested in counsellors/ therapists who:
 - a) Devote a minimum of 50% of their work-related time to psychotherapy (group, individual, or family therapy)
 - b) Have been working in the field for a minimum of 10 years, the past 5 of which have been consecutive years of direct counselling work
 - c) Have a minimum of a Masters level of education
 - d) Are registered with a regulatory body for counsellors/ therapists (e.g., RCC, CCC, AAMFT, R. Psych, RSW)
 - e) Self-identify as being high in compassion satisfaction
 - f) Are proficient in spoken and written English
 - g) Agree that the following working definition fits for them: As counsellors, they have (a) a sense of being energized and invigorated by one's work more often than being drained by it, and (b) the ability to continue to thrive and love one's work despite the personal and environmental obstacles that one might face (adapted from Dlugos & Friedlander, 2001).
- With this information I hope to contribute to the understanding of how counsellors maintain compassion satisfaction and associated wellness in their professional lives.

This Research is Important Because

- Due to the nature of their work, counsellors are prone to emotional and physical exhaustion and distress. This has an impact on counsellors' personal and professional health, on their ability to provide effective, ethical services to their clients, and on their likelihood to remain in the field. Despite the considerable research on the negative impacts of this work on counsellors and the effects thereof, there is much less research on what counsellors are doing to stay well. It appears however that compassion satisfaction plays a central role in counsellor wellness. Instead of focusing on what is not working, this research aims to identify the qualities, attributes, and practices of counsellors who self-report compassion satisfaction from their work.
- This information will contribute to the greater body of knowledge on compassion satisfaction specifically and on counsellor health and wellness generally, with direct implications for counsellor training programs, counselling departments or agencies, individual counsellors themselves, and counselling clients.

Participation

- You are being invited to participate in this study because you are a counsellor that has self-identified as being high in compassion satisfaction and you meet the criteria as laid out on page 1.
- Your participation in this research is completely voluntary and your choice.

What is Involved in Participation

- Your participation will consist of one 1-1.5 hour audiotaped interview with myself, the researcher. Following the interview you will be asked to complete a demographic questionnaire and a measure of professional quality of life, taking 5-10 min in total. The location will be a place of your choice and together we will decide on a time that is convenient for you.
- You will also be contacted a few weeks after your interview to confirm that the data analysis accurately represents your story. The time commitment for this process will depend on whether you wish to make changes.

Inconvenience

- Involvement in this research will not involve any substantial inconvenience for you other than the time to participate in the interview, the time to travel, and the time to validate findings.

Benefits

- The experiences and information that you share will contribute to the body of knowledge on how counsellors maintain compassion satisfaction in their professional work. What you share may help other counsellors to shape their careers in a healthier, more effective way.

- You may benefit from the positive-focus of the interview. By sharing your stories of success and resilience in your professional life you may reaffirm strengths and bolster your sense of confidence.

Risks

- There is a possibility that while filling out the Professional Quality of Life scale (ProQOL) or during the interview you may be reminded of past experiences with burnout or compassion fatigue. Though both burnout and compassion fatigue are *common* among counsellors, individuals that have experienced either of them may believe that they have failed in some way, and may therefore have a negative reaction.
- There is also a small possibility you will experience emotional or psychological discomfort if you discover that your ProQOL score does not align with your identified level of compassion satisfaction. You can choose not to know your ProQOL score.

Researcher's Relationship with Participants

- I, the Principal Investigator (Alex Sterling), have no knowledge of, or relationship to you or to other participants that I am aware of.

Withdrawal of Participation

- You may withdraw at any time without any obligation, explanation or consequence. You may also choose not to answer certain questions in the interview or on either of the questionnaires. You also have the right to not participate when I call or email you after your interview to verify the accuracy of the data analysis.
- If you choose to withdraw, you will be asked if you want the data you have contributed to be part of analysis. If you agree, your data will remain in the study. If not, your audio-taped interview will be erased and all data associated with you will be destroyed.

Anonymity and Confidentiality

- The information you share with the researchers will be kept private and confidential. Your identity will only be known to the researchers (Alex Sterling and Dr. Susan Tasker).
- No names will be given in the final research report.
- The audio recording will only be used to write down your responses to my interview questions. This will help me to accurately record and remember your responses. The audio recordings will not be shared with the results of the study.
- All information collected will be stored in a locked cabinet in Dr. Tasker's research office in MacLaurin Building at UVic.
- All information will be kept for 5 years maximum and will be destroyed when all data analyses have been completed.

Exceptions to Confidentiality

- Alex Sterling, and Dr. Susan Tasker may have access to your data and will adhere to ethical standards required by their governing professional body, the Counselling Psychology program, and University of Victoria to maintain confidentiality.
- Confidentiality will be broken, however, if I have good reason to believe that a child or vulnerable adult is being abused or neglected. Should you reveal information to suggest this is the case, it is my obligation to report this. In BC, a child is anyone under the age of 19.

Research Results will be Used/Disseminated in the Following Ways

- It may be shared in professional reports, publications, and conference meetings.
- The report will be presented in a Master's thesis presentation.
- This report may also be provided directly to participants if they so wish.

Questions or Concerns

- Contact the researcher(s) using the information at the top of Page 1.
- Contact the Human Research Ethics Office, University of Victoria, 250 472-4545 or ethics@uvic.ca

Consent

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researchers, and that you agree to participate in this research project.

Name of Participant

Signature

Date

A copy of this consent will be left with you, and a copy will be taken by the researcher.