Int J Adv Counselling (2014) 36:17–29
DOI 10.1007/s10447-013-9187-7

ORIGINAL ARTICLE

Common Characteristics of Compassionate Counselors: A Qualitative Study

Nikol Bowen · James L. Moore III

Published online: 26 June 2013

Abstract Using a qualitative research methodology involving face-to-face and telephone interviews, the researchers explored the construct of compassion in mental health counseling. The construct of compassion has been empirically studied in many helping professions; however, most studies have focused on counselors working with trauma victims in medical settings and large-scale disasters. The sample comprised 16 mental health counselors (i.e., 13 females and 3 males) who were licensed professionals working in the state of Ohio. Three major themes emerged from the data: (a) client population, (b) work environment, and (c) coping mechanisms. Implications are examined in regard to professional and personal wellbeing for counselors.

Keywords Compassion · Counseling · Fatigue · Satisfaction · Wellbeing

Introduction

The ability to display compassion is essential in mental health counseling. It requires the counselor to empathize with the client (Carroll 2001; Figley 2002a; Rogers 1980). According to Bruhn (2001), forming a relationship with a helper is an emotional experience that requires "a supportive affirmative working alliance between the helper and the [client]" (p. 54). Mental health counselors and other helping professionals are expected to deploy a level of emotional energy that often underpins a therapeutic alliance and supports an empathetic response to client stories (Corey 2009). Figley (2002a) asserted that psychotherapists learn to be impartial and analytical and are trained to put their personal beliefs and feelings aside; however, it is still difficult for them to completely circumvent the personal impact of expressing compassion and empathy.

N. Bowen (✉)
Ohio University, Athens, OH, USA
e-mail: bowenn@ohio.edu

J. L. Moore III
The Ohio State University, Columbus, OH, USA
e-mail: moore.1408@osu.edu

To limit this occurrence, counselors develop tools required for effective work in the area of human service. A major stance often referred to as Humanistic, or Rogerian, provides an environment in which the client does not feel under threat or judged. In 1995, members of the American Counseling Association (ACA) were surveyed, and it was found that "holistic humanistic empowerment for personal development and interpersonal concern" was the predominant value system (Kelly 1995, p. 652). Counselors, who ascribe to these values, are unlikely to avoid experiencing compassion and empathy as they enter the client's worldview to better understand how he/she experiences the world (Figley 2002b; May et al. 1958; Myers and Sweeney 2004: Rogers 1980; Sweeney 2001).

Compassion is defined as a feeling of deep sympathy and sorrow for another person who is stricken by misfortune, accompanied by a strong desire to alleviate the suffering of the individual or community (Merriam-Webster 2002, 2010). Although the term compassion is infrequently used in the counseling literature, it is critical to incorporate this term into the lexicon of counseling to enhance the understanding of the counselor-client dyad and the personal and professional impact of "being" a counselor (Ben-Porat and Itzhaky 2009; Carroll 2001). Aligned with this notion, Carroll stated:

> When human beings [counselors] work they use themselves as the main focus of their work, they infuse themselves into it, they become it; it is them at work, not just work done by them. Their work changes from being a job, or indeed even a career, to becoming an extension of themselves, of who they are. (p. 77)

Therefore, mental health counselors who utilize a humanistic or existential approach may be more susceptible to this phenomenon because of their willingness to be vulnerable with clients (Dollarhide 2010; May et al. 1958; Moodley 2010; Sterling 2001; Yalom 1980).

The concept of compassion is holistic; it is a biological, psychological, and social response to others' experiences (Valent 2002). The willingness to be vulnerable with clients can cause negative (e.g., compassion fatigue) or positive (e.g., compassion satisfaction) effects on the personal and professional functioning of the counselor (Ben-Porat and Itzhaky 2009; Moodley 2010; Stamm 2002; Figley 2002a). Fatigue is recognized as an early indicator of Secondary Traumatic Stress Disorder and is described as a result of bearing the distress of others who are or have been in harmful situations (APA 2000). It is suggested that between a quarter and a half of counselors are at moderate risk for compassion fatigue as a result of working with victims of trauma (Boscarino et al. 2004; Figley 2002a, b).

In addition, job victimization (e.g., sexual harassment, discrimination, assault) by a client, supervisor, or peer has also been identified as contributing factors to compassion fatigue (Balfour and Neff 1993; Figley 2002a, b). However, these negative experiences can be mitigated by "satisfaction"; a sense of achievement experienced by the counselor related to his/her efforts to help the client, along with the counselor's ability to disengage or distance her/himself from the client's suffering. Due to the detrimental effects of unrecognized and unmanaged compassion fatigue and the benefits of compassion satisfaction, further investigation of the phenomenon among mental health counselors is highly desirable to increase job satisfaction and wellbeing of counselors (Trippany et al. 2004).

For this qualitative study, the two researchers utilized grounded theory to explore the concept of compassion, its historical foundation, and implications for mental health counselors working in diverse backgrounds. More specifically, the researchers explored perceptions and concepts related to compassion in mental health counseling and the impact of "being" a compassionate counselor. They were interested in rendering findings that could both inform and educate mental health counselor educators on the

multiple realities of "being" a compassionate counselor. In essence, the researchers were also interested in how mental health counselors perceived compassion fatigue and compassion satisfaction, and what factors positively and negatively shape their perceptions of these concepts.

Methodology

Participants

The lead researcher, a professional counselor and member of the Ohio Mental Health Counselors Association (OMHCA) in the US collaborated with board members of the organization to initiate the study. Those members of the OMHCA who had opted to be on the Association's electronic listserv (n=277) received an e-mail requesting their participation. Electronic communications included information on the study, a participant data sheet, and a consent form. The majority of interview participants were identified directly through the e-mail listserv, although others were identified by e-mail listserv participants networking with other counselors in the area.

A total of 16 participants agreed to participate in the study. Each participant was a licensed Professional Counselor or Professional Clinical Counselor. Seven of sixteen identified themselves as members of OMHCA. Participants ranged in age from 25 to 68, with a mean age of 45 years old. The mean years of counseling experience was 11 years. Ten of the participants were masters-level mental health counselors, and 6 were doctoral-level.

At the time of data collections, seven worked only in community agencies, three worked in community agencies and also had a private practice, two worked in schools, two worked in colleges and also had a private practice, and two worked in private practice. Just over half (56 %) of the participants self-identified as White and 44 % as African American or other. Thirteen of the participants identified as being female and three male. For more details about the participants, see Table 1.

Following completion of the participation agreement paperwork, appointments were made with each participant for a face-to-face or telephone interview.

Data Collection

This study consisted of three distinct phases and utilized peer debriefing and member checks to maximize the likelihood that the findings and their presentation were credible (Glesne and Peshkin 1992; Lincoln and Guba 1985; Yeager 1999). Phase I consisted of a loosely structured 90-minute interview, designed to facilitate the sharing of information about personal and professional development, compassion within counseling, and common characteristics of "being" a compassionate counselor. The individual interviews began with the specific question: "What have been your experiences with compassion satisfaction and/or compassion fatigue within mental health counseling?" In addition, participants were asked to describe "being" a counselor; how they had learned to process experiences with compassion when working with clients. Participants were not provided with any definitions of compassion satisfaction or fatigue to determine how perceptions differed, changed, or altered over time, space, and context.

All participants were assigned a pseudonym to preserve their confidentiality. Further, each interview was audio taped, transcribed, and analyzed by the lead researcher. During Phase II, feedback from each participant was obtained through e-mail communications with

Table 1 Participant demographic information

Name	Gender	Age	Race	Degree	Credential	Years of practice	Theoretical orientation	Specialization
Athena	F	44	African American	PhD	LPC	5	Varied	Children and families
London	F	44	Latina	PhD	LPC	10	Existential Construction Theory Behavioral	Career counseling
Cara	F	59	Caucasian	MA	PCC-S LICDC	20+	Cognitive behavioral	Substance abuse mood disorders relationships
Leslie	F	56	Caucasian	MEd	PCC CRC	14	Eclectic	Variety
Natalie	F	32	Caucasian	MA	LPCC-S	7	Cognitive behavioral	varies
Maria	F	29	African American	MA	PCC-S	6.5	Cognitive behavioral	Mental health substance abuse
Brian	M	30	African American	MA	PCC	3	Integrative Person-centered, Reality, REBT, & CBT	Individual counseling couples counseling GLBT issues
Cheryl	F	25	African American	Post-Masters	PC	3	Interpersonal process theory Choice theory	Black clients anxiety and depression women's issues body image
Elizabeth	F	60	Caucasian	Ed.D	LPCC-S	33	Eclectic Cognitive behavioral	Adolescents adults couples
Milinda	F	33	African American	MA	PC	3	Eclectic Gestalt	Youth
Lauren	F	42	Caucasian	PhD	PCC-S	19	Play therapy EMDR Person-centered	Children
Jennifer	F	55	Caucasian	MA	LPCC-S	13	CBT Client-centered	Individual/group severe mental illness assessment/ treatment planning
Gina	F	49	Caucasian	MA	LPC RN	3	CBT Holistic	CBT
Tony	M	68	Caucasian	PhD	LPCC-S	15	Psychodynamic Cognitive behavioral	Substance use disorders
Jim	M	50	Caucasian	MS	LPCC	3	Gestalt	Mindfulness mood disorders
Shelly	F	50+	African American	PhD	LPCC-S CRC	20+	Eclectic	Substance abuse mood disorders

participants being asked to submit reactions to or comments on the data bites. The findings from this process were then used, in phase III, to enhance the data analysis and selection of the thick narratives used to represent themes that emerged.

Data Analysis

Naturalistic inquiry does not work with a fixed or predetermined theory design (Erlandson et al. 1993). Therefore, this qualitative research investigation used the concept of emergent design and grounded theory; data analysis was ongoing and emerged throughout the study (Glaser and Strauss 1967; Moore and Flowers 2003; Yeager 1999). The theory that evolved was a result of examining and analyzing "raw units of information" also termed "data bites" to inductively form theory about compassion within counseling. The emergent categories of meaning were coded into "data bites" of information through the application of the "constant comparative method," (Glaser and Strauss 1967). The constant comparative method requires a multi-tiered process, beginning with open coding and progressing to more selective coding as the analysis of the data bites progresses. As each interview was completed, transcribed and reviewed, new data bites were compared with previous data bites, and filed into the category that best fitted the context of the data bite.

Some codes emerged directly from the words of the participants. Other codes that emerged, or core categories, were "sociologically constructed" and assigned by the researcher based on an integration of prior knowledge of the topic with participant data bites (Strauss 1987; Henfield et al. 2008). During Phase II, across case analysis was used and data were examined based on the following: (a) frequency of appearance, (b) relatedness to other categories, and (c) implications posed for the development of themes. In addition, member checking was used to reduce any tendency to lead or guide the research.

Phase III provided participants with an opportunity to react to the reactions of other participants. Core categories that appeared across and throughout the interviews were summarized, and member checking was utilized to evaluate the accuracy of the conceptual interpretations that emerged across participants. Triangulating the data with the use of member checking enhanced the trustworthiness of the study, and the final name for each category emerged after this process (Erlandson et al. 1993; Glesne and Peshkin 1992; & Lather 2004).

Trustworthiness of Data

Methodological triangulation was used throughout the study to ensure adequate trustworthiness of the data; relating to the degree to which the findings of the study were accepted by the participants of the study, and the larger community represented by the study (Glesne and Peshkin 1992; Lincoln and Guba 1985; Mason 1996). This approach provided improved likelihood of credible interpretations of the data as they were collected, entered, and analyzed. As themes emerged from the study, member checking was also used to ensure that the themes were grounded in the perspectives of the participants, allowing the findings to be generalized to other contexts.

Research that includes multiple phases lends itself to a broader understanding of the use of language; in this case relating compassion in the counseling field and how definitions of compassion differ, change, or alter over time, space and context (Erlandson et al. 1993; Glesne and Peshkin 1992; Lather 2004). One criterion for persons selected through networking for Phase I of the study was diversity related to personal demographics, work setting, and theoretical orientation. The lead researcher used bracketing and a reflexive journal to help minimize the distortion of the data and minimize the impact of expectations and biases held by the researchers (Senge et al. 2004).

Research Findings

Data analysis yielded three major themes or categories: (a) client population, (b) work environment, and (c) coping mechanisms. Each category is illustrated, using direct quotes from the mental health counseling participants.

Theme One: Client Population

Within the category of client populations served, the following were identified as contributing to both compassion fatigue and satisfaction (not in any particular order): (a) Borderline Personality Disorder, (b) abuse victims, (c) substance abusers, (d) chronically mentally ill, (e) children, (f) disabled/low IQ, and (f) low socioeconomic status/impoverished. When discussing the various client populations with the mental health counseling participants, two major points emerged: (a) sources of compassion and (b) affective experiences for counselors.

Within this broad theme, all of the participants used the active voice (i.e., draining and rewarding), when describing their affective responses to experiences with compassion fatigue or satisfaction. For example, Athena [African American, female, 5 years experience] stated: "*Working with clients who have hit rock bottom and are ready for change is satisfying when they accomplish their goals*."

In addition, most indicated that their ability to cope with feelings of helplessness and hopelessness (e.g., suicidal ideation) was impacted by their level of self-care and ability to create emotional distance from their clients' actions or decisions to end their life. Brian [African American, male, 3 years experience] stated: "*Although I allow myself to experience compassion fatigue momentarily, I reframe the experience. When time is up* [break between clients], *that is where it stops; it is my job not my life*." Similarly, Gina [Caucasian, female, 3 years experience] asserted:

> Obviously you [I] care about people, you [I] want them to survive, you [I] want them to get it, you [I] want them to see their worth…but they could go out there and choose not to survive. So you've got these heavy issues weighing on your mind, kind of all the time [compassion fatigue]. They can't help but to want you to feel some of their pain [countertransference]. So there's an antenna out there, a sticky antenna reaching out to you [me]…To cope I tell myself it is what it is, and I've done my best [compassion satisfaction]. I don't want them to harm themselves or anyone else. You know, if they do, I guess I will just have to deal with that, but it's hard to do because you [I] still have thoughts, so it's [coping is] a challenge.

Another mental health counselor noted progress in her ability to work with suicidal clients as she gained more experience. For example, Lauren [Caucasian, female, 19 years experience] stated: "*Crisis pre-screen when the client is not hospitalized, but has suicidal ideation, used to create a lot of worry* [compassion fatigue]; *but now I recognize I did what I thought was best*."

Despite expressions of frustration when working with suicidal clients, many of the participants indicated experiences with compassion satisfaction when working with clients who experience "dark stuff" and behave in ways that have been termed as "unnatural" to some. London [Latina, female, 10 years experience] agreed with themes related to sources of satisfaction (e.g., instillation of hope, client self-acceptance, and helping client feel heard) and stated: "*I agree that my major sources of compassion fatigue and satisfaction relate to suicidal clients. Being able to connect with a human being and save a life are probably one*

of the most anxious yet deepest experiences I have had." She went on to express her experiences with this phenomenon in relationship to her diversity. For example, she asserted: "*As a person of color and international, nothing compares to connecting emotionally with a human being. We all experience pain, regardless of how we express it and/or how we seek help*." Another participant, Brian [African American, male, 3 years experience] explained something similar:

> I got her to open up and really divulge what was bothering her. Helping her feel a sense of safety within my office just building that trust [being compassionate] and helping her realize that there is something she needs to say. I worked with her for over a year and helping her find her voice and the ability to say, 'My life isn't over…I don't deserve to be here.' Seeing that change in her made me feel good.

During phase II, all participants provided reactions to the phenomenon that all populations identified can create experiences of compassion satisfaction and fatigue. Natalie [Caucasian, female, 7 years experience] stated: "*I'm surprised to see that the same areas that fatigue some* [people] *experience provide satisfaction for others. However, I guess that makes sense as I figure that the fatigue is created when the counselor is struggling and not seeing progress with these clients, whereas the satisfaction comes from when success with these clients does occur*."

When reflecting on themes related to suicidal/homicidal ideation, most participants expressed strong reactions to clients diagnosed with borderline personality disorder and expressed difficulties when working with clients with Axis II disorders; personality disorders (APA 2000). For example, Jim [Caucasian, male, 3 years experience] stated: "*Most of these* [client populations] *are not much more challenging to me except for Axis II. They require me to be vigilant of my own boundaries, and this is work*." He further stated: "*My fatigue will be higher for crisis* [suicidal ideation]. *I have to get it right in terms of asking the right questions*."

Maria [African American, female, 6.5 years experience] mentioned client resistance; she stated, "*the people who usually tax me are those that are resistant, who* [long pause] *sometimes you have those personality clashes, you know, like were fighting for control basically* [long pause] *that is taxing, annoying, and stressful*." Three other participants also mentioned that they were embarrassed about their affective responses to client stories (i.e., countertransference, hopelessness, etc.) and felt isolated, when contemplating about how to cope with difficult clients.

Theme Two: Work Environment

Within the category of work environment, the following subthemes were identified as impacting compassion fatigue and satisfaction for mental health counselors: (a) work setting (e.g., private practice, agency, school), (b) caseload/workload, (c) supervisor, and (d) theoretical approach. When discussing work environment and compassion, 11 participants were reluctant to disclose their experiences and were concerned about the confidentiality of their stories. However, Leslie [Caucasian, female, 14 years experience] described the additional burden of private practice that counselors working in agencies do not experience. More specifically, she posited: "*Each setting is unique to its own stressors* [whether] *school, agency,* [or] *private* [practice]. *All have their own unique issues. In private practice, 75 % of time* [is] *devoted to billing and office management, while 25 % of time* [is] *spent with clients*."

The mental health counselors working in agencies expressed the most fatigue based on (a) productivity demands, (b) managed care requirements, (c) lack of supervisor support, and

(d) client resistance to treatment method. Seven stated that interactions with supervisors impacted them personally and professionally. For example, Jennifer [Caucasian, female, 13 years experience] asserted: "*People leave and positions are not filled…caseloads increase and people are overworked…and that is bad for clients and staff*."

When discussing supervisor support, Maria [African American, female, 6.5 years experience] stated

> I think the leadership has a large part in it, whether or not you're satisfied or not. Um.. If the leadership is, at the very least, if the leader is doing what he or she is supposed to be doing then you do feel a little bit better about the situation. Also if the leader is healthy. I once had a boss, who was mentally ill, and I didn't know she was mentally ill initially, and the interactions were kind of weird, made me feel bad. In hindsight it was, oh, she had something going on, it really wasn't about me.

However, all of the participants working in agency settings reported that they derived satisfaction from their work environment and mentioned that (a) discussing clients with colleagues, (b) having an empathetic and supportive relationship with a supervisor, and (c) teaching clients coping strategies within the theoretical approach used by the agency was rewarding, fun, and validating.

Regardless of setting, all of the participants expressed internal feelings of isolation, even when peers, colleagues, or supervisors were accessible, and when they were unsure of their decisions related to client treatments and outcomes. They all also described their hesitation to reach out for support, due to their fear of being judged as unprofessional or unethical. In particular, Cheryl [African American, female, 3 years experience] emphasized: "*Confidentiality is tough. I work with children. Deciding what to share with parents* [or administrators] *is difficult to cope with*."

Overall, all of the participants working in agencies or schools described a hierarchy and expressed frustration with the constant struggle to balance having compassion for themselves, their clients, and their employer. As an example of this, Milinda [African American, female, 3 years experience] discussed her passion for working with impoverished children and her frustration with the system: "*A lot of people write them* [students] *off because of where they come from. They don't value them because they don't come from money*." Milinda was not the only participant to find satisfaction working with those who have limited or no resources. Tony [Caucasian, male, 15 years experience] also stated: "*I treat people who have been fired* [terminated] *from other public agencies due to no money, no Medicaid, no SSDI, no SSI, and do not have access to entitlement programs*." He went on to say "*Working in the free clinic has brought me the most satisfaction experienced in my life*." When asked how he was able to remain compassionate, despite frustration with the systemic health care crisis, Tony further explained: "*If you have the gift of healing you find another way to earn your living*." While this practice of counseling may seem idealistic, numerous participants expressed finding compassion satisfaction through pro bono work of some kind, either through direct client care or through advocacy.

Theme Three: Coping with Compassion

When discussing coping mechanisms, all of the participants were aware of the necessity for self-care; however, 10 out of 16 admitted that they had experienced moments when they did not implement the skills that they knew were effective in coping with compassion fatigue. Within the category of coping mechanisms, the following subthemes emerged from this broader theme: (a) experience, (b) self-care, (c) spirituality/religion, and (d) humor.

When discussing the counseling influence experience (e.g., amount of time practicing as a professional counselor) had on her ability to cope with compassion fatigue, Cara [Caucasian, female, 20+ years experience] asserted: "*As I spend more time in the field, I have found more ways to cope…things that used to bother me don't bother me anymore*." Other mental health participants illustrated their ability to reframe interactions with clients, colleagues, and supervisors as a healthy coping skill. As an example of this, Gina [Caucasian, female, 3 years experience] posed: "*How much are we willing to apply what we teach* [e.g., Cognitive Behavioral Therapy]?" All of the participants highlighted the struggle to resist getting "caught up" in client stories and stressed the need for self-care physically and emotionally. When discussing self-care, most also highlighted that engaging in physical exercise and eating healthy were common coping mechanisms. One participant, in particular, admitted that eating healthy and exercising were areas of self-care that are often neglected by counselors. Maria [African American, female, 6.5 years experience] stated: "*I could see myself eating unhealthy foods when annoyed by stressful clients*." However, the topic of eating habits did not arise for the 2 male counselors.

As for coping emotionally, numerous participants discussed the impact compassion fatigue had on their family dynamics and acknowledged the dangers of bringing home "baggage" (e.g., compassion fatigue). Elizabeth [Caucasian, female, 33 years experience] described feeling lucky because her spouse was also a therapist. She specifically stated: "*Bringing home baggage isn't a problem…my husband understands what it is like, and he is willing to listen to me and helps me process my experiences with clients*."

Most of the mental health counselors expressed the use of spirituality/religion as a source of satisfaction, when engaging with clients and a coping strategy to deal with compassion fatigue. As an example of this, Gina [White, female, 3 years experience] explained:

> For me, it [spirituality/religion] impacts it [experiences with compassion] a lot, and it's always in the form of satisfaction…Like I said before, we're holistic, body, mind, spirit; and just being mindful and paying attention to all of the above. And you know for me, prayer takes it off me and puts it onto God; that may not sound like coping but it's good to be able to let go.

Generally speaking, more than half of the mental health participants identified a relationship among spirituality, compassion satisfaction, and coping when working with clients. These same participants also expressed experiencing meaning and purpose in their life, when able to connect with a client on a spiritual level. Cara [Caucasian, female, 20+ years experience] stated: "*I meditate, I breathe,* [and] *I put it* [compassion fatigue] *onto a higher power*." As further evidence of this point, Elizabeth [White, female, 33 years experience] illustrated this point with the following conversation with the lead researcher.

> Elizabeth: I believe in God, I'm a Christian. That doesn't mean that there's only one way.
> Interviewer: So you're a Christian and you believe in God. Do you think your beliefs assist with your coping with compassion fatigue or help you derive satisfaction when working with certain populations?
> Elizabeth: It's support for me and that's how I look at it…does it help me work with clients?, that one I don't know. Does it keep me grounded?, I have no idea…It's just something I choose to do.

Shelly [African American, female, 20+ years of service] not only discussed her use of spirituality to cope with compassion fatigue, she also described how she helped clients explore the interaction between their beliefs and lack of coping skills. Specifically, in regard to working with substance abusers, she stated, "[When counseling] *people with substance*

abuse issues, we talk about their higher power [spirituality/religion] *whatever it might be, and I urge them to find* [their] *higher power, and* [I] *openly share with them my beliefs. But I'm not saying that has to be* [their] *power, but* [they] *need a power;* [they] *need something* [spirituality/religion] *to help* [them] *face turbulent times*." She also stated: "*When I listen to some of the things they've gone through I could see myself* [If I did not have my beliefs] *having compassion fatigue, just listening and dealing with some of the situations*."

Most of the participants indicated that clients who were willing to engage in the counseling process and were motivated to make changes in life were satisfying. "*I've met clients who have worked* [engaged in counseling] *and have gone on, and I think that knowing them and being in their life for the time I've been in their lives has been absolutely wonderful*," stated Tony [Caucasian, male, 15 years experience].

During phase II, participants were asked, "Do you feel that the data represented in your context aligns with what we have learned from other contexts?" Most of the participants indicated, "Yes, for the most part." In other words, none of the participants stated, "No" or indicated that the findings did not capture their experiences with compassion fatigue or satisfaction. When asked if there were any additional comments they would like to make regarding the study, most participants reflected on the importance of the topic and what they learned from engaging in the process. For example, one counselor commented how the process of engaging in the interview and reacting to the themes provided an opportunity to reflect on "being" a counselor. Jennifer [Caucasian, female, 13 years experience] stated: "*Participating in the interview allowed time for re-evaluating what/why I do this type of work, helped to affirm the meaning and purpose,* [and] *also all of the stressors involved*." She went on to say, "[it] *seems like the better counselors are able to use self-care and manage stress, the better able* [they are] *to do the work*".

Discussion

Based on the findings, studying compassion satisfaction may add more insight into counselors' source of resiliency and provide increased understanding on their affective development. Additionally, by reflecting on the voices articulated in this study, the counseling profession may recognize the importance of finding strategies to reduce the stigma related to counselors seeking mental health treatment themselves. Further, the profession may recognize the role intensive supervision has in addressing issues of compassion fatigue and systemic issues within mental health settings that often impair counselor functioning.

In 2003, ACA established a task force on counselor wellbeing. This group worked to create awareness of impairment risks and to promote wellness. The theoretical foundation of this task force was informed by research on burnout, compassion fatigue, vicarious traumatization, and secondary traumatic stress disorder (Figley 1995; Lawson and Venart 2006). Further, the task force conducted a survey of members and inquired about their beliefs on counselor impairment. Based on the findings, three goals related to counselor vulnerability, wellness, and resilience were implemented: (a) focusing on strengths-based prevention and resiliency education to identify areas of vulnerability and provide strategies for wellness; (b) increasing access to resources for intervention and providing best-practice criteria for counselor educators and supervisors; and (c) advocating on a state and national level to address the stigma related to counselors seeking mental health treatment (Lawson and Venart 2006).

According to the findings of this present study, it is may be advantageous for ACA to revisit counselor vulnerability, wellness, and resilience. As a way to assist in this, the

researchers offer a number of recommendations to major counseling stakeholders, such as counselors, counselor supervisors, and counselor educators.

Recommendations for Counselors

In a timely manner, counselors should seek out support from peers, supervisors, and/or colleagues, when experiencing compassion fatigue. Self-care is an ongoing task that should be attended to throughout their professional career. Therefore, counselors should be encouraged to develop a personal model for resiliency to combat compassion fatigue and enhance compassion satisfaction when working in mental health settings (Myers and Sweeney 2004; Sweeney 2001).

As evidenced by the findings of this study, the counselors' perspective on interactions with clients and his/her ability to cope with those experiences can impact their state of "being" and ability to remain emotionally present and compassionate with clients (Witmer, and Young 1996; Ronnestad, and Skovholt 2003).

Recommendations for Supervisors

Individuals providing supervision to counselor trainees or newly licensed counselors should normalize compassion fatigue and satisfaction when discussing cases. In addition, supervisors need to be cognizant of distress and burnout signs for counselor supervisees. If the warning signs are noticed and discussed in a timely manner, it is likely that counselor supervisors can better assist counselor supervisees with developing a plan of action to decrease fatigue, while enhancing supervisees' satisfaction for helping and counseling. Addressing the affective development of supervisees is a normative, restorative, and supportive process (Henderson 2001).

In order to enhance this process of affective development for counselor supervisees, supervisors should attend to the "swings in supervisees' self-confidence, optimism and locus of control, and the impact of these on the quality and quantity of the work they do" (Henderson 2001, p. 93). This suggestion is aligned with the ACES (1977) recommendations for training programs to address the personal development of counselors, as well as the ACA recommendations for personal development of counselors to enhance counselor competency, especially when working in cross cultural counseling dyads (Dollarhide 2010; McNeill et al. 1995).

Recommendations for Counselor Educators

Counselor educators are encouraged to incorporate curriculum and experiential activities that address the affective development of counselors (Dollarhide 2010). Terms, such as "compassion", can be explored and discussed to enhance counselors' ability to understand themselves to better connect with clients (Bradley and Fiorini 1999; Busacca and Wester 2006). Additionally, counselor educators should discuss wellness within counselor education and encourage counselor trainees to process difficult client situations to enhance their development of "personal process."

Further, concurrent research should be conducted to develop evidence-based ethics training that addresses counselor trainees' emotional development (Holcomb-McCoy, and Bradley 2003; McAdams, and Keener 2008; Welfel 2005). For example, the Accelerated Recovery Program (ARP) for distressed students (Gentry et al. 2002) is an excellent model for achieving this objective. Research has consistently demonstrated a relationship between counselor competence and professional and personal development (Baldo et al. 1997).

Conclusion

All counselors should be encouraged to develop a personal model for resiliency to combat compassion fatigue and enhance compassion satisfaction when working in mental health settings (Myers and Sweeney 2004; Sweeney 2001). As evidenced by the findings of this study, counselors' interactions and their ability to cope with those experiences can impact the counselor's state of "being" and their ability to remain emotionally present and compassionate with clients (Witmer and Young 1996; Ronnestad and Skovholt 2003). Continued investigation into counselor experiences with compassion fatigue and satisfaction within mental health care is recommended.

Conducting qualitative studies to better understand this phenomenon may reveal the realities of "being" a mental health counselor in today's society. As work environments become more diverse and holistic, mental health professionals will be expected to work with clients with different values and from different cultures, collaborate more with other professionals, as well as support others associated with clients (e.g., guardians, extended family) and other individuals or organizations with vested interest in the client's welfare (Casto 1994; McDonald 2010; McNeill et al. 1995).

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