WHITBECK, MEGAN A. Ph.D. The Initial Development and Validation of the Counselor Empathy Fatigue Scale (CEFS). (2023)
Directed by Dr. Carrie A. Wachter Morris. 224 pp.

Since the onset of the global pandemic, rates of anxiety, depression, suicide, and substance use in the United States have risen about 20% (CDC, 2020). As rates of mental health concerns increase, the need for effective counseling services simultaneously grows. This increase in suffering and mental health concerns, coupled with high demand for mental health services, leaves counselors vulnerable to a range of occupational stressors, including empathy fatigue.

Counselors create space for clients to share challenges associated with the pandemic, grief, loss of normal functioning and adjustment, in addition to non-COVID-19 related stressors, all of which can take a toll on a counselor's well-being over time (Joshi & Sharma, 2020; Stebnicki, 2007). This toll, called empathy fatigue, is a state of emotional, mental, physical, spiritual, and occupational exhaustion that occurs as multiple client stories of distress, trauma, grief, loss, and adversity have a cumulative adverse effect on the counselor and compromise their empathic abilities (Stebnicki, 2016). Empathy fatigue is a fatigue syndrome rooted in professional counseling, unlike others such as burnout, vicarious trauma, and compassion fatigue which are discussed broadly across helping professions (Stebnicki, 2007; 2016).

Empathy is a core component of effective counseling practice, a strong therapeutic relationship, and necessary for meaningful client change (Rogers, 1957). Empathy fatigue can arise when practitioners empathically engage with clients in distress, reducing their empathic capabilities, and thus reducing their clinical efficacy (Figley, 1995; Stebnicki, 2016). The purpose of this study was to develop and validate a self-report measure of empathy fatigue in professional counselors. The final CEFS measure included 34-items and four unique factors: 1) Decreased personal wellbeing, 2) Negative attitude toward work, 3) Psychosomatic exhaustion,

and 4) Psychological detachment from the counseling process, explaining 55.04% of the variance. The total scale and all four subscales had high internal consistency and results indicated evidence of convergent validity. Implications for counselor educators, supervisors, and clinicians are offered, including directions for future research on empathy fatigue. The CEFS fills a gap in our knowledge of impairment in clinicians who engage in empathic therapeutic relationships with clients and offers a starting point for the promotion of wellness and prevention of personal and professional impairment in the helping professions.

THE INITIAL DEVELOPMENT AND VALIDATION OF THE COUNSELOR EMPATHY FATIGUE SCALE (CEFS)

by

Megan A. Whitbeck

A Dissertation
Submitted to
the Faculty of The Graduate School at
The University of North Carolina at Greensboro
in Partial Fulfillment
of the Requirements for the Degree
Doctor of Philosophy

Greensboro

2023

Approved by

Dr. Carrie A. Wachter Morris
Committee Chair

DEDICATION

This dissertation is dedicated to all the professional helpers who entered give of themselves for the benefit of others every day. May you find fulfillment, meaning, and contentment in all that you do, and take care of yourself in the same way that you care so naturally care for others.

APPROVAL PAGE

This dissertation written by Megan A. Whitbeck has been approved by the following committee of the Faculty of The Graduate School at The University of North Carolina at Greensboro.

Committee Chair

Dr. Carrie A. Wachter Morris

Committee Members

Dr. Jennifer D. Deaton

Dr. GracieLee Weaver

Dr. Rebecca L. Mathews

February 24, 2023

Date of Acceptance by Committee

February 24, 2023

Date of Final Oral Examination

ACKNOWLEDGEMENTS

The words on this page cannot even begin to describe my sincere gratitude for all those who supported me throughout this entire journey. I could not be more grateful for the immense amounts of support and encouragement I have received from friends, family, faculty, and students at UNCG. First, I would like to thank my dissertation chair, Dr. Carrie A. Wachter Morris, whose genuine compassion, enthusiasm, and expertise was truly a guiding light throughout this dissertation process. Thank you for letting me cry in your office whenever I needed it, and for reminding me that sometimes we just need to watch a bit of Holey Moley and breathe. To my committee members, Dr. Jennifer D. Deaton, Dr. GracieLee Weaver, and Dr. Rebecca L. Mathews, and my honorary committee member, Dr. Jennifer L. Cannon. Your gracious energy, support, and encouragement allowed this study to become something I will be forever proud of. Dr. Cannon, thank you for your unwavering support from near and far, introducing me to mindful moments, and always reminding me to take care of myself. To all the faculty at UNCG: Dr. Wester, Dr. Borders, Dr. Chan, Dr. Young, Dr. Jones, and Dr. Williams, this experience has been a true highlight of my life because of the wisdom you have instilled in me. I could not have asked for a better doctoral experience and getting to learn from you all has been a true gift. Thank you to the faculty in ERM and the Public Health Department for broadening my horizons and expanding my view of what it means to be a helper. Thank you Mitzi, for everything you have done for me throughout this program and for always being up for an office chat, about books, sports, or life. ☺

To my friends, family, and loved ones: There is no way I could name you all. Thank you from the bottom of my heart for cheering me on every step of the way, even when that meant I could not show up for you in the way I wanted to. Mom, thank you for the constant phone calls

and visits filled with nothing but love and support. Dad, thank you for always cheering me on and encouraging me to keep going even when things felt impossible. Macie, thank you for inspiring me every day to grow and achieve things I did not think were possible. Finally, to Sean, who has been my rock and constant source of support through this entire journey. Without you, this program would have been impossible, and I do not have words to express the gratitude for your unwavering love and support. I truly could not have done this without you. You are my best friend and life partner, and I would not have wanted to go through this experience with anyone else. I love you with every fiber of my being and I cannot wait to see where post-doc life takes us!

To my cohort, the #COVIDCohort: we have had our ups and downs, but I have learned so much from each one of you and am grateful to have met you through this process. To Nicole and Luke, thank you for being the best friends a girl could ask for on this journey. We have shared many tears, laughs, and memories I will cherish forever. I don't think anything can bond you like a PhD program.

This program has truly allowed me to achieve a dream, one I will be eternally grateful for. I cannot wait to begin my journey as a Counselor Educator, but UNCG will always be 'home.'

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER I: INTRODUCTION

Recent crises, including the COVID-19 pandemic, effects of climate change, natural disasters, mass shootings/gun violence, and racial violence, to name a few, have heightened trauma and suffering for people in the United States. Rates of anxiety, depression, suicide, and substance use rose approximately 20% since the start of the global COVID-19 pandemic (Centers for Disease Control and Prevention [CDC], 2020). Further, mental health symptoms have intensified for many people from ethnically and racially marginalized groups, particularly given the magnified race-based prejudice and discrimination in the United States (Lund, 2020). Although COVID-19 appears to be receding, mental health concerns continue to rise, tied to pandemic- and event-based stressors (American Psychological Association, 2022).

The need for quality mental health services understandably grows as mental health concerns escalate. In 2019, almost 25% of U.S. adults with a mental illness did not receive needed treatment, highlighting the unmet need prior to the onset of the pandemic (Mental Health America, 2022). In September 2020, 52% of behavioral health organizations reported an increase in the demand for services, according to one national survey (National Council for Mental Wellbeing, 2020). In 2021, the mental health and substance abuse referral line, which is operated by the United States federal government, received 1.02 million calls (Substance Abuse and Mental Health Services Administration [SAMHSA], 2022).

Based on these statistics, it is clear that mental health services are in high demand. During the height of the global pandemic, those seeking professional mental health support encountered difficulty accessing services (Mental Health America, 2022; USA Today, 2021). Mental health counselors have become flooded with large caseloads and long wait lists of individuals seeking treatment, which has intensified job-related stress (Arañez Litam et al., 2020;

Joshi & Sharma, 2020; USA Today, 2021). Not surprisingly, clients report distressing symptoms and trauma due to a myriad of stressors, which may increase counselors' risk of experiencing mental and physical exhaustion, or even impairment (Joshi & Sharma, 2020).

Paradoxically, counselors did not report higher rates of burnout during the COVID-19 pandemic than before its onset (Elder et al., 2022). Counselors surveyed in three studies at different time points during 2021 consistently reported low burnout scores, measured by the Professional Quality of Life Scale (ProQoL; Stamm, 2010; Elder et al., 2022). Results showed that burnout rates in counselors had not increased because of the pandemic. However, the authors argued that counselors *were* experiencing exhaustion, supported by anecdotal evidence. This form of exhaustion may not have been burnout, but 'pandemic fatigue' (Elder et al., 2022). Pandemic fatigue, defined as an exhaustion that is not only isolated to work but "is woven through the tapestry of our lives as a whole" may explain the depletion that counselors are experiencing that permeates all facets of life and functioning, not just work (Elder et al., 2022). Although counselors may not be more burnt out, they may feel greater exhaustion and depletion as stressors rise. At present, we do not have the measurement tools to capture this unique fatigue experience in counselors.

Counselors are also living in the COVID-19 era, navigating similar stressors as their clients while supporting others' mental wellbeing. This constellation of traversing the challenges of providing vital mental health services for individuals and communities while simultaneously caring for their own well-being, may also create an ongoing strain on counselors that threatens their ability to sustain the core counseling conditions that are foundational to effective clinical practice. If counselors are not aware of the distress that can come from consistently listening to

stories of suffering, their ability to provide high quality services to clients may be compromised (Stebnicki, 2007).

Professional Counseling

Professional counselors are trained to provide mental health services for children, individuals, couples, families, and communities (Council for the Accreditation of Counseling and Related Educational Programs [CACREP], 2016). Counseling is "a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals" (Kaplan et al., 2013). Counseling is a unique helping field, characterized by the importance of the professional relationship between the counselor and the client as the primary tool for healing (Kaplan et al., 2014; Rogers, 1957). Researchers have consistently demonstrated the power of the counseling relationship as a key vehicle for client change (Wampold, 2015). A counselor's expression of empathy, authenticity, and unconditional positive regard lays the foundation for a strong therapeutic relationship between the counselor and client (Rogers, 1957). Over time, the counselor and client collaboratively create an authentic relationship that allows the client to vulnerably express their concerns, feel and process emotions and experiences, and improve their overall functioning and quality of life (Kaplan et al., 2014).

Mental health professionals use interpersonal helping skills to communicate a nonjudgmental understanding of their client's experiences (Rogers, 1957). Typically taught early on in a counselor's training program, these skills include active listening, summarizing, paraphrasing, minimal encouragers, and empathy (Stebnicki, 2007). Empathy is an essential helping skill that, if used effectively, can communicate care and concern, allowing a client to feel heard and seen (Clark, 2007). Empathy, "to sense the client's private world as if it were your own, but without ever losing the 'as if' quality," (Rogers, 1957, p. 99), is one of Rogers' core

conditions necessary for client change: meaning that empathy must be present and genuine to help clients reach self-actualization and positive growth. Within the therapeutic environment, "the therapist experiences an empathic understanding of the client's internal frame of reference and endeavors to communicate this experience to the client" (Rogers, 1957, p. 96).

Most researchers define empathy to include affective and cognitive components, where the affective component allows the empathizer to vicariously experience the emotion with the other, and the cognitive component to understand another's feelings (Cuff et al., 2016; Wondra & Ellsworth, 2015). To accurately and effectively express empathy, clinicians must recognize the emotional experience of the client, identify the experience of that emotion within themselves, and respond with care and concern for the client, which involves emotional appraisal and a vicarious experiencing of the emotion that the client is feeling (Wondra & Ellsworth, 2015).

Empathy can benefit clients in numerous ways. Counselors who use empathy appropriately and accurately can help clients cultivate new ways of thinking that promotes wellness, self-awareness, and motivates personal change (Stebnicki, 2016). A counselor's verbal and nonverbal communication of empathy is essential for their client to feel validated, heard, and understood, fostering empowerment and growth toward treatment goals (Clark, 2007). Higher client ratings of therapist empathy indicate more positive outcomes in psychotherapy (Wampold, 2015). To put it simply, empathy is a core foundation of effective counseling practice.

Empathy is undeniably beneficial to clients, but the consistent use of empathy also has the potential to negatively impact the counselor. Empathy provides a direct pathway for the counselor to fully experience the emotions of their client, and without adequate emotional regulation, this vicarious experiencing could potentially exhaust the counselor over time (Stebnicki, 2016). Simply through their work, counselors are exposed to their clients' stories of

unimaginable trauma, stress, pain, grief, loss, and suffering, using empathy to feel their clients' experiences and resulting emotions with them (Clark, 2007; Rogers, 1957). If a counselor overidentifies with the emotional experience of the client or is unable to differentiate the emotional experience from themselves, personal distress can arise (Stebnicki, 2007). Additionally, counselors' cumulative exposure to multiple client stories of suffering can erode the emotional resources paramount to effective counseling practice (Stebnicki, 2007). Given the need for mental health services at this time, it is essential that we understand and become aware of how this distress manifests, to prevent long-term counselor impairment and implement strategies that maintain wellness and sustainability.

Occupational Hazards in the Helping Professions

Most experts agree that working in a helping field can be stressful (Figley, 1995; Joinson, 1992; Maslach, 2003). Several terms are used to describe various forms of impairment among helping professionals, such as burnout (Maslach, 2003), vicarious trauma (McCann & Pearlman, 1990), and compassion fatigue (Figley, 2002). More recently, scholars have proposed a new term, "empathy distress fatigue," to capture the distinct differences in the phenomena of compassion and empathy (Hofmeyer et al., 2020). Professionals and researchers across fields such as social work, education, medicine, nursing, genetic counseling, psychology, and more, tend to use these terms interchangeably, with little consensus on their distinct etiologies, presentations, and treatments (Klimecki & Singer, 2012). Despite the difference in terminology, these potential negative outcomes of work in the helping field can have profound effects on one's personal and professional development, no matter the definition.

Burnout is one of the most frequently discussed occupational hazards across helping professions. Burnout is as a long-term negative consequence of accumulated work-related stress

characterized by exhaustion, increased cynicism, detachment from the job, a sense of ineffectiveness, and lack of accomplishment related to one's work (Maslach & Jackson, 1981; Maslach, 2003; Thompson et al., 2014). In contrast to the distress that results from hearing stories of trauma and suffering (Figley, 2002), burnout is more strongly associated with conditions of the working environment (e.g., ergonomics, time pressures, lack of flexibility; Cetrano et al., 2017). Burnout results from continuous exposure to stressful occupational-related characteristics, meaning effective treatment may need to come from the organization, rather than the individual (Maslach & Jackson, 1981).

Related more to the work of mental health professionals, vicarious trauma is a term that describes the cognitive shifts in one's worldview after exposure to secondary trauma (McCann & Pearlman, 1990). Secondary trauma refers to the experiencing of trauma from a secondary source, such as hearing details of a traumatic event from their clients (Motta, 2008). Counselors, therapists, and mental health professionals are highly likely to work with trauma survivors during their professional careers (Sommer, 2008). Counselors who help clients heal and process from trauma are indirectly exposed to traumatic events, which increases their risk for experiencing vicarious trauma (Figley, 1995; McCann & Pearlman, 1990). Mental health professionals suffering from vicarious trauma, including trainees, report changes in the way in which they view the world, themselves, and others, and can be negatively impacted by trauma work (McCann & Pearlman, 1990). Mental health professionals working with trauma survivors also poses the risk of compassion fatigue, which is like vicarious trauma, but is characterized by different symptoms (Figley, 1995; 2002).

Compassion fatigue, also called secondary traumatic stress, is an occupational stress resulting from psychotherapists' work with trauma survivors (Figley, 2002). The term

"compassion fatigue" was first introduced in the nursing literature by Joinson (1992), related to deleterious stress that resulted from an overidentification with their caregiving role, where nurses felt they needed to continuously provide care, even at the expense of their own well-being. More recently, Figley (1995, 2002) coined compassion fatigue as the "cost of caring" in helping professionals that resulted from exposure to client suffering (particularly clients with trauma) and the use of empathy. Compassion fatigue manifests as a physical and emotional exhaustion, associated with feelings of helplessness, frustration, confusion, anger, and isolation behaviors related to secondary trauma exposure (i.e., clients sharing stories about traumatic experiences; Figley, 1995; Figley, 2002; Stamm, 2010). Used synonymously with compassion fatigue, secondary traumatic stress manifests as post-traumatic stress disorder (PTSD)-like symptoms, such as re-experiencing of traumatic events, avoidance of reminders, anxiety around the client, and preoccupation with clients (Figley, 1995).

Figley (1995) created a model that outlined how one's empathic ability, coupled with empathic concern and exposure to client can create an empathic response that can lead to compassion stress, and with prolonged exposure over time, create compassion fatigue. Essentially, for the development of compassion fatigue, a helping professional must experience exposure to client suffering and/or trauma and engage in an empathic response (Figley, 1995). If left unaddressed, compassion fatigue could develop into burnout, leaving lasting impacts on personal and professional well-being (Chang & Shin, 2021; Figley, 2002; Stamm, 2010).

Compassion fatigue helps to clarify the harsh reality of working with clients recounting stories of trauma. However, compassion fatigue does not fully capture the holistic nature that working with human suffering can take on an individual- in mind, body, and spirit, nor does it explain how counselors who do not work with trauma survivors experience fatigue. Compassion

fatigue is the distress that can come from working directly with trauma (Figley, 2002), but it's interchangeable use with secondary traumatic stress specifically addresses PTSD-like symptoms that may not need to be present for one to feel emotionally depleted (Stebnicki, 2007). For example, a counselor working with a client considering suicide may not suffer from re-experiencing the event, persistent arousal, or numbing, but feel emotionally drained due to the intensity of their empathic expression toward the client's intense pain.

Further, compassion and empathy are different phenomena (Cuff et al., 2016; Klimecki & Singer, 2012). Compassion is the ability to feel *for* another, versus empathy, which is defined as the ability to feel *with* another (Cuff et al., 2016; Hofmeyer et al., 2020). Defining this form of distress using the word 'empathy' is an important distinction, because this form of exhaustion may decrease one's capacity for empathy, not compassion (Stebnicki, 2016). Some argue that empathy fatigue is different than compassion fatigue, warranting additional consideration for counselors who work with all clients expressing distress and suffering and practice empathy in response to that suffering (Dowling, 2018; Hofmeyer et al., 2020; Stebnicki, 2016). Neuroscience researchers have used functional magnetic resonance imaging (fMRI) studies to validate this claim; empathy and compassion are associated with neurological activation in different areas of the brain (Klimecki et al., 2013; Singer & Klimecki, 2014). The experience of compassion, feeling for another's suffering with a desire to alleviate it, produces positive emotional experiences, even when the other is in distress or suffering (Klimecki et al., 2013).

At present, a more nuanced definition and measurement of counselor distress is needed for greater conceptual clarity, understanding, and creation of effective treatment and prevention strategies unique to counselors. Given that empathy is the cornerstone of the counseling profession, it is important to consider the deleterious effects that unregulated empathy can have

on counselor's well-being so that we can best prepare our counselors to monitor, actively prevent, and reverse professional impairment. Although counselors are called to be compassionate, empathy is at the core of the professional identity of a counselor. A new conceptualization of counselor distress, related to the use of empathy in effective counseling practice, is warranted because: (1) compassion and empathy are different constructs, (2) compassion fatigue is narrowly used to describe psychotherapists work with trauma survivors, (3) compassion fatigue is synonymous with secondary traumatic stress, and (4) compassion fatigue originated and is widely discussed in nursing, a helping field different from counseling. For mental health professionals who engage in empathetic therapeutic relationships, a more accurate term for the effects of consistently hearing client stories of distress and suffering is "empathy fatigue."

Empathy fatigue, "a strong aversive and self-oriented response to the suffering of others, accompanied by the desire to withdraw from a situation in order to protect oneself from excessive negative feelings" (Singer & Klimecki, 2014, p. R875), is one of two possible reactions to expressing empathy, the other being compassion. Helping professionals that experience empathy distress may have a blurred understanding of the self-other distinction and may struggle to cognitively disconnect themselves from the experience of the other's emotion, often described as "emotional contagion" (Singer & Klimecki, 2014). If the counselor acknowledges that their emotional experience not their own, this empathic connection leads to compassion, and a desire to alleviate suffering in the other is present, cultivating positive emotions (Singer & Klimecki, 2014). The differing responses on behalf of the person using them further highlight empathy and compassion as two unique social experiences (Hofmeyer et al., 2020).

Second, Figley expanded on Joinson's discussion of compassion fatigue in nurses as he observed reactions of psychotherapists, who were at risk for developing compassion fatigue by simply "learning about the traumatic event" as their clients' recount trauma experiences in therapy (p. 4, Figley, 1995, 2002). Figley (1995) stated that psychotherapists' working with survivors of violent crime, rape, and natural disasters were at higher risk for experiencing emotional exhaustion. These experiences were described as acute and severely traumatic events, accompanied by vivid details of horror. It appears that Figley (1995, 2002) initially explained that compassion fatigue was an occupational hazard in trauma therapists, who differ slightly from professional counselors in their treatment philosophy and approach and may alter the way mental and emotional exhaustion manifests.

Third, the hallmark symptoms of compassion fatigue are theorized to mirror a PTSD-like response (Figley, 1995). Figley (1995) uses the terms "secondary traumatic stress" and "compassion fatigue" synonymously as secondary traumatic stress may prompt feelings of demoralization because of its stigmatized labeling. "...The terms can be used interchangeably by those who feel uncomfortable with STS [Secondary Traumatic Stress] and STSD [Secondary Traumatic Stress Disorder]. Such discomfort might arise from concern that such labels are derogatory" (p.15, Figley, 1995). Secondary traumatic stress symptoms include re-experiencing of the traumatic event, avoidance/numbing of reminders of the event, and unwanted, persistent arousal, which could escalate to a clinically diagnosable level of a traumatic stress disorder, causing further impairment of the professional (Figley, 1995). Experiencing PTSD-like symptoms because of secondary trauma exposure is arguably qualitatively different than the emotional and mental fatigue that results from undifferentiated empathy. If counselors are experiencing emotional exhaustion that heightens their risk for leaving the field, but do not only

work with trauma survivors or experience secondary traumatic stress symptoms, what is the term for this form of occupational hazard and how is it defined?

Finally, compassion fatigue was first introduced in the nursing field, which primarily heals patients through medical means. Nurses must exercise compassion for their patients to feel called to ease their suffering and treat their pain (Joinson, 1992). Nurses work in stressful, fast-paced environments and interact with a wide variety of health professionals. They are often rewarded by their superiors when their needs are put behind that of their patients, which fosters overworking and increases the risk of burnout (Joinson, 1992). Depending on their credentials, typical duties may include performing health exams, make treatment decisions, administer medications, tend to patient's pain, change bandages and dressings, etc. (American Nurses Association, 2022). Although nurses aim to foster patients' human dignity, their focus is mainly healing through medical practices (American Nurses Association, 2022). Counselors focus primarily on mental health, including emotional and behavioral aspects, which typically involves the mind, more than the body.

Taken together, these reasons offer insight into the conundrum that exists regarding the term "compassion fatigue" being used to discuss counselor distress and exhaustion. The lack of conceptual clarity around this phenomenon provides an opportunity for researchers in the counseling field to consider emotional depletion within the unique context of being a professional counselor and measure it more precisely.

Given the fact that empathy is a core component of effective counseling practice, it is important to acknowledge the downsides of using empathy as counselors. Current terms defining impairment and distress experiences in the helping fields do not adequately capture the negative effects of cumulative exposure to client distress outside of trauma. The importance of accurately

defining this kind of empathic counselor distress is rooted in the preventative strategies that follow, to allow for the most efficient strategies that could prevent further impairment.

Statement of the Problem

Counselors are at risk for experiencing exhaustion due to the nature of their empathic work, that could escalate to significant impairment if not recognized and managed. Empathy without self-other differentiation (i.e., taking on the client's intense emotional experience of anxiety, depression, grief, loss, suffering, etc. as their own) can lead to empathic distress, which may negatively impact counselors' personal and professional well-being (Hofmeyer et al., 2020; Stebnicki, 2007). Professional counselors work in a multitude of settings and may still be at risk for empathic distress fatigue even if they do not work solely with trauma, warranting further distinction of this phenomenon from existing impairment constructs (i.e., compassion fatigue, vicarious traumatization, secondary traumatic stress).

Counselors exposed to client distress can cause them considerable personal stress and over time, can erode empathy, which is a vital aspect of effective counseling services (Stebnicki, 2016). Being that empathy is a core component of the work of counselors, understanding and measuring this phenomenon in an accessible way is essential to preserve the health, well-being, and longevity of professional counselors, so that they can continue to provide high quality services to their clients in need of services. At this time, the only measure of empathy fatigue that exists calls for multiple observer-ratings (Stebnicki, 2016), which may be an unrealistic assessment option given the decreased resources and increased work demands on counselors during this time. A self-report measure would benefit practitioners as they can quickly and easily self-assess their levels of empathy fatigue, to intervene appropriately.

Need for Study

At the core of counseling practice are Roger's (1957) person-centered qualities of empathy, congruence, and unconditional positive regard. Counselors use their personal mental and emotional resources to help clients heal and move toward positive functioning. This unique healing modality is different than helping fields such as nursing (where the concept of compassion fatigue originated) as nurses heal patients' physical ailments with external medical treatments, versus themselves (American Nurses Association, 2022). Therefore, the counseling field can benefit from a specific definition of this kind of fatigue to strengthen wellness strategies and interventions that promotes healthy regulation of empathy. With a definition and way to measure empathy distress that aligns with the counseling field, counselors and counseling organizations can implement targeted prevention and treatment strategies to improve counselors' overall wellness and emotional longevity. Ultimately, the goal is to increase counselor awareness of empathy distress before it escalates to a more damaging, deeply ingrained exhaustion. With an accurate way of measuring empathy fatigue, counselors can proactively prevent or mitigate impairment with intentional self-care and personal resource-restoration activities.

Fatigue syndrome definitions (e.g., compassion fatigue, secondary traumatic stress, vicarious traumatization, burnout etc.) do not adequately capture the symptoms of empathy distress in counselors. Empathy fatigue captures the practitioners who work with clients that may not present with trauma concerns, although they may be trauma survivors, their work in counseling may focus on other stressors and concerns. Although scholars have contributed to the discourse on distinguishing compassion fatigue from empathy distress (Dowling, 2018; Hofmeyer et al., 2020; Stebnicki, 2016), to the author's knowledge, no self-report measures exist that capture the experience of empathic distress for counselors. The only existing measure of

empathy fatigue, called The Global Assessment of Empathy Fatigue (GAEF), created by Stebnicki (2007), is a lengthy observer-rated measure that includes seven distinct categories that holistically capture empathy fatigue across five levels of impairment, ranging from Level I (least impaired) to Level V (most impaired). The seven categories include cognitive, behavioral, spiritual, process, emotional, physical, and occupational symptoms. The instrument is intended for multiple observers to rate a counselor's functioning across domains to objectively capture the degree to which the professional is impaired (Stebnicki, 2007). Its intended use is for counselors who work with clients with a diverse range of issues, from daily stressors to severe traumatic events (Stebnicki, 2007).

Although an observer-rated measure of empathy fatigue is beneficial, organizations, colleagues, and/or supervisors may not have the time or resources to conduct an observational assessment by several objective sources. A self-report measure can easily be used by counselors wanting to take inventory of their emotional resources as it is brief and potentially faster to score. Additionally, the GAEF measure does not account for a counselor's baseline prior to the development of empathy fatigue; it begins at Level I, assuming a mild level of impairment (Stebnicki, 2007). Counselors may have more awareness than observers about their functioning prior to experiencing empathic distress, which could serve as a baseline comparison for a more accurate assessment of empathic distress levels.

Purpose of Study

The purpose of this study is to develop and validate a self-report measure of empathy fatigue for mental health professionals who engage in empathic, therapeutic relationships. Overall, the researcher aims to offer conceptual clarity on this form of counselor distress by creating a psychometrically sound self-report instrument that assesses empathy fatigue.

Research Questions

Research Question 1: What is the factor structure of the Counselor Empathy Fatigue Scale (CEFS)?

Research Question 2: What is the internal consistency of the CEFS and identified subscales (if applicable)?

Research Question 3: What is the evidence for convergent validity of the CEFS using scores from the Counselor Burnout Inventory (CBI; Lee et al., 2007)?

Research Question 4: What is the evidence for discriminant validity of the CEFS using the scores of the compassion satisfaction subscale of the Professional Quality of Life Scale (ProQoL; Stamm, 2010)?

Research Question 5: Are participants responding to items on the CEFS in a socially desirable way based on scores from the BIDR-16 (Hart et al., 2015)?

Significance of Study

This study will significantly contribute to the counseling field in several ways. Current conceptualizations of professional impairment in the helping fields exist outside of counseling (e.g., burnout, compassion fatigue, vicarious trauma). Counselors could benefit from a reliable and valid measure of this form of emotional resource depletion as it relates to the unique context of the counseling field. This study aims to contribute a conceptualization of empathy fatigue to increase shared understanding of the emotional toll that being a professional counselor can have, while increasing counselor awareness about the potential negative effects of undifferentiated empathic connection. With increased awareness and understanding, counseling organizations, workplaces, and professionals can help generate effective solutions and prevention strategies to sustain empathic functioning. With greater understanding and awareness, counselors may be

positioned to equip themselves with emotion regulation practices that reduce empathy distress and increase the fulfillment and longevity of their career. Counselors' wellbeing is vital to provide high quality services clients and feel fulfilled in their work as a counselor, and the demand is high for mental health services.

This study will build on the definition of empathy fatigue, further supporting or refuting the theory of empathy fatigue (Stebnicki, 2007). A measurement tool will be developed to help professional counselors better understand their own empathy fatigue. By further defining and explaining empathy fatigue through measurement, more counselors may recognize the need for focused self-care strategies and wellness practices. Being that counseling focuses on empathic connection with clients, strategies that reduce emotional suffering for the counselor can increase sustainability of their counseling practice and overall wellness.

Definition of Terms

For the purposes of this study, *empathy* will be defined as a cognitive and affective process of recognizing and feeling the actual or inferred emotional experience of another person (Cuff et al., 2016; Decety & Jackson, 2004; Stebnicki, 2007). *Empathy fatigue* will be defined as a state of emotional, mental, physical, spiritual, and occupational exhaustion that occurs as multiple client stories of distress, trauma, grief, loss, adversity, etc. have a cumulative adverse effect on the counselor and compromise their empathic abilities (Stebnicki, 2007). *Burnout* will be referred to as "a syndrome of emotional exhaustion and cynicism that occurs frequently among individuals who do 'people-work' of some kind" (Maslach & Jackson, 1981, p. 99). *Vicarious trauma* is defined as "the transformation that occurs within the therapist (or trauma worker) as a result of empathic engagement with clients' trauma experiences and their sequalae" (Pearlman & Mac Ian, 1995, p. 558). *Compassion fatigue* will be defined as an emotional

exhaustion in helping professionals that results from exposure to trauma, that includes secondary traumatic stress symptoms including but not limited to reexperiencing the traumatic event, avoiding, or numbing of reminders of event, and persistent arousal (Figley, 1995).

Chapter Summary

This chapter provided an overview of the current study, including a brief literature review, research questions, hypotheses, purpose, and need of the study. The next chapter, the literature review, will analyze the extant literature base supporting the theoretical and conceptual framework for the study, as well as identify the gap that this study seeks to fill. Chapter three will detail the methodology used to answer the proposed research questions. After data collection, chapter four will be used to describe the study results, and chapter five will discuss the meaning of the results, within the context of the counseling field.

CHAPTER II: LITERATURE REVIEW

Brief Overview

Chapter One laid the foundation for the current chapter by providing an overview of the current study. The researcher presented a brief introduction of the theoretical grounding needed to support the development of a self-report instrument to assess empathy fatigue in professional counselors. In this chapter, the supporting literature will be reviewed in depth, highlighting the need for a self-report instrument measuring empathy fatigue and the purpose of the study. A quantitative scale may enhance counselors' self-awareness of symptoms of empathy fatigue. The empirical research on professional counselors' empathy fatigue is limited. Given this limitation of limited research, the researcher will discuss empirical research on fatigue syndromes related to empathy fatigue, including burnout, vicarious trauma, and compassion fatigue. The purpose of the study will be provided in this chapter, highlighting the need for a reliable and valid quantitative scale measuring empathy fatigue. This chapter will provide an explanation of the theoretical framework used to develop the CEFS, based on Stebnicki (2008, 2016).

Prevalence of Mental Health Concerns

In the United States, mental health concerns and experiences of trauma have increased due to recent crises including the COVID-19 pandemic, effects of climate change, natural disasters, mass shootings/gun violence, and racial violence, to name a few. The trauma and loss associated with enduring the ongoing global COVID-19 pandemic has taken a profound toll on the mental health of the general population (Smith et al., 2022). According to the World Health Organization (WHO), mental health issues and substance use disorders have increased 13% around the world (WHO, 2022). Since the onset of the global pandemic, rates of anxiety, depression, suicide, and substance use in the United States have risen about 20% (Centers for

Disease Control and Prevention [CDC], 2020). Suicide is the leading cause of death among 15–29-year-olds, and about 20% of adolescents currently live with a mental health condition (WHO, 2022). The American Psychological Association (APA) recently surveyed its members and found that referrals for anxiety, depression, and trauma-related disorders had increased (APA, 2021). Citing these statistics, it is no surprise that experts believe the United States is facing a mental health crisis (Auerbach & Miller, 2020; Holland et al., 2021).

With this rise of mental health concerns and trauma in the general population, the need for mental health services understandably grows. According to one national survey conducted in September of 2020, 52% of behavioral health organizations reported a rise in the demand for mental health services (National Council for Mental Wellbeing, 2020). More people are seeking behavioral health services than ever before, increasing the workload of many counselors and mental health professionals (Arañez Litam et al., 2021; APA, 2021). During the height of the pandemic, 45% of psychologists reported not being able to meet client demand (APA, 2021). In an effort to increase accessibility of mental health services, telementalhealth sessions helped counselors provide services to those who may not have otherwise had access, particularly during COVID-19 when social distancing and isolation measures were enacted to reduce the spread of the virus (Auerbach & Miller, 2020; Smith et al., 2022). Telementalhealth provided clinicians a way to continue seeing clients—or even increase their caseloads—during the pandemic, continuing to strain their already minimal emotional and occupational resources (Sampaio et al., 2021). As a result of increased need and expanded accessibility, counselors have become inundated with more requests for services and may have long wait lists, which have intensified job-related stress (APA, 2021; Arañez Litam et al., 2021; Joshi & Sharma, 2020; USA Today, 2021).

In addition to the strained capacity of providers within the mental health care system to meet rising demands, counselors are creating space for clients sharing challenges associated with the pandemic, trauma, grief, fear, isolation, loss of normal functioning and adjustment, all of which can take a toll on a counselor's well-being over time (Joshi & Sharma, 2020; Stebnicki, 2007). This negative 'toll' that comes from being exposed to stories of pain and suffering while providing counseling can take many forms, depending on the clinician's symptoms. Often referred to as occupational hazards in the helping fields, the potential adverse consequences include burnout, compassion fatigue, secondary traumatic stress, vicarious trauma, and empathy fatigue.

Sampaio et al. (2021) found that 37% of therapists reported experiencing greater burnout during COVID-19 than before the pandemic, and 46% of psychologists surveyed by the APA in October 2020 said they felt burnt out (APA, 2021). Although these statistics indicate a large portion of therapists and psychologists were experiencing burnout during the pandemic, reported rates of burnout in counselors did not seem to have increased compared to pre-pandemic burnout rates (Elder et al., 2022). In a series of three studies conducted over the course of 2021, counselors consistently reported low burnout scores, as measured by the Professional Quality of Life Scale (ProQoL; Stamm, 2010; Elder et al., 2022). Maladaptive coping styles, negative perceptions of working conditions, decreased compassion satisfaction, low levels of resilience, and high numbers of clients with trauma-related concerns predicted burnout (Elder et al., 2022), many of which appear to be conditions counselors are facing within the context of COVID-19. The question remains—if burnout has increased in other helping professionals, why not counselors?

Burnout is a fatigue syndrome empirically associated with organizational factors, such as inadequate working conditions, long work hours, and lack of flexibility in scheduling (Cetrano et al., 2015; Maslach, 2003). Burnout refers to the experience of depletion and exhaustion one might encounter from working in a stressful environment (Maslach, 2003). Although caseloads are increasing due to demand, counselors heightened stress during this time may not be due to environmental or job-related factors, but rather the nature of topics clients are sharing during session. The emotional depletion that comes from expressing high amounts of empathy with clients who are experiencing high distress, suffering, and pain is called empathy fatigue (Stebnicki, 2007). Empathy fatigue is associated with counselors consistently hearing stories of suffering, grief, and loss, including daily stressors (Stebnicki, 2007), rather than logistical work-related factors associated with burnout. One plausible explanation for what we are seeing in the counseling field may be empathy fatigue may be higher but is not being measured. Given the increase in mental health issues and number of clients seeking counseling, it is not a far reach to suggest that these circumstances are taking a toll on professional counselors. The unique characteristics of the field of counseling and closely related sister helping professions (e.g., social work and psychology) make empathy fatigue more plausible than other fatigue syndromes (e.g., burnout, compassion fatigue, vicarious trauma). A rationale for why empathy fatigue in counselors and related mental health professionals who engage in empathic therapeutic relationships with clients warrants further exploration. Occupational hazards of working in the helping professions and empirical studies associated with fatigue syndromes will be explored throughout this chapter, to address the need for examining this critical gap in the counseling literature.

Further, counselors and mental health professionals are navigating societal and sociopolitical stressors and traumas at the same time as their clients, all while providing vital mental health care services (Holmes et al., 2021). This unique context could be considered an experience of shared trauma among providers and clients (Holmes et al., 2021). Given these circumstances— a rise in mental health concerns, increased demands for services, clients' stories of suffering, grief, and loss, and improved accessibility—counselors must be aware of the potential impacts of these conditions on their personal and professional well-being. Counselors providing mental health services during the pandemic may experience higher stress levels, which can significantly impact professional quality of life (Arañez Litam et al., 2021). Now more than ever, understanding how empathy fatigue may impact professional counselors' personal and professional well-being is crucial to support the longevity of clinicians in the mental health care profession.

Nature of Professional Helping

Counseling is a unique helping field. Its philosophical underpinnings differ from other helping professions (such as nursing, social work, psychology, and medicine) as counseling is focused on using a therapeutic relationship to connect genuinely, authentically, and empathically with clients to support healing and change (Kottler & Balkin, 2017; Parsons & Zhang, 2014; Rogers, 1957). The national governing body in counseling, the American Counseling Association (ACA), proposes that counseling "is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals" (Kaplan et al., 2013). This definition was agreed upon by 29 out of 31 major counseling associations (Kaplan et al., 2013). Counselors use a strengths-based, holistic approach when working with clients that considers all aspects of their functioning, not just

mental health symptoms (Fuenfhausen et al., 2017). Rather than considering what is wrong with clients based on a disease or deficit model, counselors use the wellness model of mental health which helps clients focus on using strengths to move forward into optimal functioning, not just reducing symptoms (Fuenfhausen et al., 2017). Counselors take physical, emotional, mental, spiritual, social, occupational, financial, and sexual facets into account to help clients live a fulfilling life of well-being (Fuenfhausen et al., 2017).

While there are different modalities of counseling such as individual, family, couple, and group, as the definition states, counseling is defined by the professional relationship (ACA, 2022). A trusting, collaborative, working relationship between the client and counselor that helps clients achieve desired outcomes is essential to counseling (Kottler & Balkin, 2017; Parsons & Zhang, 2014). In fact, the factor that explains the most client change in counseling can be attributed to the quality of this relationship between the counselor and client (Bordin, 1979; Castonguay et al., 2006; Kottler & Balkin, 2017; Rogers, 1957; Wampold, 2015).

In addition to counseling, related mental health professions such as social work and psychology use similar principles of empathy in their mental health care practice (Hall & Schwartz, 2019; Gabbert et al., 2020). Expressing empathy is a foundational tool for building a strong therapeutic relationship across mental health fields (Gabbert et al., 2020; Moudatsou et al., 2020). Social workers use empathy to display care and concern for their clients, using empathy to create a safe, trusting relationship (Howe, 2019). Howe (2019) states, “The socially empathic worker needs the client to know that they are trying to see and understand things as the client sees and understands them” (p. 113). This sets the stage for a relationship that allows the client to make positive changes in their life- knowing that their social worker has their best interest at heart (Howe, 2019).

In psychology, several theories including psychoanalysis and person-centered therapy view empathy as an integral component to effective therapeutic outcomes (Kaluzeviciute, 2020). Even Sigmund Freud (1912) noted that empathy was a crucial part of understanding patients' worldview and experiences. Further, contemporary psychology highlights the importance of empathy in helping patients experience validation of their feelings (Abramson, 2021). Empathy is a core skill that builds effective therapeutic relationships and moves people toward change through feeling understood, across helping disciplines. The practice of empathy towards clients is a common thread, stitching the fields of counseling, psychology, and social work together.

Common factors theory suggests that there are several components that contribute to success in therapy or counseling, including a strong therapeutic relationship (Laska et al., 2014). Common factors refer to the underlying principles that govern the effectiveness of counseling, regardless of the specific treatment intervention. It includes things like empathy, mutual connection, and support (Leibert, 2011). Essentially, they are "ways of being" that allow a client to feel accepted, valued, and safe, within the counseling setting. Lambert (1992) hypothesized that common factors account for 30% of counseling outcomes, more than any other factor. The other factors that attribute to outcomes are client expectations that treatment will be helpful (15%), client characteristics and extra therapeutic conditions (40%), and specific treatment interventions/approaches (15%).

These common factors most notably include the therapeutic relationship. The therapeutic relationship forms the working alliance, a goal-oriented collaborative relationship that aims to help clients achieve treatment goals (Parsons & Zhang, 2014). Together, through mutual trust, vulnerability, and exploration, the therapeutic relationship provides a vehicle for client change (Norcross & Lambert, 2011). The quality of the therapeutic relationship significantly contributes

to positive client outcomes (Laska et al., 2014). Rogers (1957), often regarded as the "father of modern counseling" theorized that "...significant positive personality change does not occur except in a relationship" (p.96). Going further, he stated that simply having a relationship is not sufficient for personality change, but the client must experience the counselor's expression of empathy in order to strengthen the relationship (Rogers, 1957). Therefore, a significant component to creating a strong therapeutic relationship is the expression of empathy (Rogers, 1957). Roger's (1957) necessary and sufficient conditions of personality change include two persons in psychological contact; the client is in a state of anxiety or incongruence; the therapist is congruent and integrated into the relationship; the therapist experiences unconditional positive regard for the client; the therapist experiences empathy and attempts to communicate that to the client, and the client can experience the therapist's communication of empathy and unconditional positive regard. If these core conditions exist and are sustained over time, Rogers (1957) argued that client change will follow.

Unconditional positive regard communicates a nonjudgmental attitude toward the client, without conditions tied to their acceptance (Rogers, 1957). In addition to unconditional positive regard, the quality of the therapeutic relationship hinges on the therapist's genuineness and authenticity. Within the relationship, a therapist must (to an appropriate degree), be "freely and deeply himself" (Rogers, 1957, p. 97), suggesting the relevance of a counselor's personal characteristics and behaviors affecting the relationship. Finally, empathy is a key aspect of Rogers six core conditions for client change. Essentially, for a client to experience successful change in therapy, their counselor must genuinely feel and express empathy in a way that the client can experience it (Rogers, 1957).

Empathy, defined by Rogers (1957), is the experience of knowing another's inner world as if it was your own, without losing the understanding that the experience is the client's. It is the ability, and willingness, of a person to understand another's inner world, from their unique point of view, potentially uncovering things that the client may not be aware of themselves (Rogers, 1980). Empathy consists of a recognition and understanding of another's emotional state, but also a successful communication of empathy. In other words, the client must be able to receive and feel the therapist's expression of empathy toward them to make positive change (Rogers, 1957). Empathy is the glue that binds all counseling approaches into what we consider to be counseling; it is the heart of the counseling profession. (Kottler & Balkin, 2017).

With the exception of the physical environment and other external factors (e.g., client factors), much of the necessary building blocks of an effective therapeutic relationship come from the counselor's own resources. The labor used to build and strengthen the therapeutic relationship is in large part due to the counselor's expression of empathy, counseling skills, and emotional responsiveness (Kottler, 2003; Leibert 2011). In other words, the counselor uses their own personal resources as part of the mechanism of change within the counseling space (Parsons & Zhang, 2014). Just as those who work in construction or trades use their bodies for physical labor to create infrastructure, counselors use their mental and emotional resources throughout the therapeutic process to help clients achieve greater levels of self-awareness and healing. Of the many factors that contribute to a strong therapeutic relationship and positive outcomes in counseling, counselor expression of empathy is a powerful tool that can help clients feel safe exploring the deepest parts of themselves and their experiences (Rogers, 1957).

Empathy

Empathy is a multifaceted construct that has been subject to considerable debate among researchers in psychology, counseling, social work, and neuroscience (Cuff et al., 2016; Wiseman, 1996; Zurek & Scheithauer, 2017). At a basic level, empathy is the ability to feel what another person is feeling (Wondra & Ellsworth, 2015). For the purposes of this study, the person experiencing empathy for another will be referred to as the observer or empathizer, and the person being empathized with will be referred to as the target. Empathy is considered a vicarious emotional response, as the observer is attempting to understand and feel the emotions of the target (Decety & Jackson, 2004).

Empathy is considered a unique trait that separates humans from other non-human species and has ties to evolutionary emotional and altruistic behaviors (Decety & Jackson, 2004; Decety et al., 2014). Within the social neuroscience perspective, empathy is considered to be an innate human response that arises out of a concern to help someone in need or suffering (Decety et al., 2014). When someone is perceived to be in pain, it is a natural human response to increase attention to the subject and engage in prosocial behaviors (Decety et al, 2014). Although an evolutionary and social neuroscience perspective exists in the process of empathy, several theories exist to explain empathy. Citing its complex and nuanced nature, researchers have proposed a variety of definitions for empathy (Cuff et al., 2016).

Empathy is often described as a multidimensional phenomenon, including affective, social, and/or cognitive components (Cuff et al., 2016). One of the most common debates within empathy research is whether empathy is a cognitive or affective process (Cuff et al., 2016). For example, some scholars define empathy as an “emotional response to the emotions of another person” (Zurek & Scheithauer, 2017). Others believe that empathy is an inherently cognitive

process, as it includes a conscious awareness and understanding of another's emotional experience (Decety et al., 2014; Zurek & Scheithauer, 2017). Some authors argue that empathy cannot be either one or the other, but rather, it is a relating process that uses both affective and cognitive components (Cuff et al., 2016; Wondra & Ellsworth, 2015; Zurek & Scheithauer, 2017). Decety & Jackson (2004) also note that empathic responses can be unconscious (e.g., emotional connection) or require intentional awareness (e.g., cognitive processing, perspective taking). Understandably, most researchers believe that cognitive, affective, and interpersonal components play a role in empathy as it is a multifaceted, complex interpersonal process (Baston, 2009; Clark, 2015; Cuff et al., 2016; Decety et al., 2014; Zurek & Scheithauer, 2017). Attuning to another human's emotion takes a concert of cognitive, affective, and social processes.

In a review of the literature on the definition of empathy, Cuff et al. (2016) identified 43 unique definitions proposed by various researchers. In an attempt to develop an integrated and consistent definition of empathy given the breadth of literature, Cuff and colleagues (2016) ultimately proposed the following:

> Empathy is an emotional response (affective) dependent upon the interaction between trait capacities and state influences. Empathic processes are automatically elicited but are shaped by top-down control processes. The resulting emotion is similar to one's perception (directly experienced or imagined) and understanding (cognitive empathy) of the stimulus emotion, with recognition that the source of the emotion is not one's own (p.150).

Empathy is a highly individualized response, based on personal and contextual factors. For example, some easily vicariously feel with the target (i.e., person being empathized with)

and can become emotionally stimulated (Baston, 2009; Stebnicki, 2007; Wondra & Ellsworth, 2015). Some can see another person in distress and may not have an emotional response, based on several factors such as novelty or lack of information, as a facet of empathy consists of emotional appraisal (Decety & Jackson, 2004; Wondra & Ellsworth, 2015). If the observer simply does not attend to the target or receive information about their emotional state, no appraisal will be made (Wondra & Ellsworth, 2015). Therefore, exposure to another must occur in order for an empathic response to happen (Wondra & Ellsworth, 2015).

Moreover, if an observer is exposed to another's situation or experience, an observer must appraise the target's situation as novel to their experience for an emotional response to take place as observers become desensitized to novelty over time (Wondra & Ellsworth, 2015). This phenomenon appears to be empirically supported, as more experienced mental health professionals tend to have lower levels of burnout, compassion fatigue, and empathy fatigue and less experienced mental health professionals report higher rates of the same fatigue syndromes (Browning et al., 2019; Craig & Sprang, 2010; Elder, 2021; Sprang et al., 2007; Thompson et al., 2014). This may explain why counselor trainees and newer career professionals are hypothesized to be more susceptible to work-related fatigue because of their work with clients in distress (Browning et al., 2019; Fye et al., 2021; Stebnicki, 2007), as they may not have yet encountered the particular type of concern their client is sharing. Fye et al. (2021) found that younger prelicensed counselors reported elevated affective distress compared to those who were older.

Empathy can be seen as a double-edged sword for counselors. Empathy is a key ingredient in effective counseling practice but can also take a toll on the emotional resources of the practitioner (Stebnicki, 2016). In his popular book, *On Being a Therapist,* Jeffery Kottler (2003) states:

> To be genuine, to truly accompany a client during his journey of self-exploration, requires selfless devotion during forty-five-minute intervals. We eventually feel the wear and tear of such devotion, or alternatively, we experience complete detachment from the world and from the feelings behind our professional stance (p.24).

The realities of working in the helping professions have long been a matter of grave concern, drawing attention from scholars, educators, and leaders in the helping fields. Nearly 20 years ago, the ACA created The Task Force on Impaired Counselors to address the needs of impaired counselors and their clients, as well as promote resilience in professional counselors (Lawson & Venart, 2005). Counselor impairment is not a new issue, however, there continue to be calls for more education on fatigue syndromes and burnout prevention in counselor training programs (Can & Watson, 2019; Merriman, 2015; Newell & MacNeil, 2010; Sprang et al., 2007).

Counselors with higher levels of empathy may be susceptible to more emotional exhaustion (Lai et al., 2021). Higher empathy is also related to higher rates of burnout in counselors (Elder, 2021). Elder (2021) examined whether empathy was predictive of counselor burnout or resilience in a sample of counselors that had been counseling anywhere from one to 41 years, working mostly in private practice. Results of multiple regression analyses indicated that empathy significantly predicted burnout in counselors, and compassion, particularly self-compassion, significantly predicted resilience (Elder, 2021). As empathy is rooted in the fabric of the counseling profession, the toll that empathizing with the suffering, including burnout, compassion fatigue, and empathy fatigue takes can be considered an occupational hazard because of the potential for impairment (Figley, 1995; Stebnicki, 2007). Counseling is often regarded as a rewarding, fulfilling, and meaningful career, but counselors in a “high touch” field

must be aware of how their work as a counselor impacts their functioning, so that steps can be taken to protect their overall well-being and longevity in the field (Arañez Litam et al., 2021; Rothschild & Rand 2006; Skovholt, 2001; Stebnicki, 2016).

Occupational Hazards of Helping Fields

"The capacity for compassion and empathy seems to be at the core of our ability to be wounded by the work." - B. H. Stamm (1995, p.ix).

Occupational Stress

Work in the helping professions brings a unique stress that involves caring for and healing others. Broadly, occupational (or job) stress is defined as "the harmful physical and emotional responses that occur when job requirements do not match the capabilities, resources, or needs of the worker" (Sauter et al., 1999, p. 6). Although it has been subject to debate, some researchers believe that individual worker characteristics play a role, whereas others view working conditions as the primary stressor (Sauter et al., 1999). Consequently, occupational stress can have lasting impacts on workers' mental and physical health, including anxiety and depression, burnout, cardiovascular disease, and mood impairments (Maslach, 2003; O'Keefe et al., 2014). Individual risk and protective factors of occupational stress vary by worker, in addition to characteristics of the work environment (Quick & Henderson, 2016; Sauter et al., 1999). Factors such as socioeconomic status, competitiveness, and social isolation may increase the ill effects of work stress, whereas characteristics such as having secure relationships and hardiness may act as protective factors against the negative effects of occupational stress (Quick & Henderson, 2016). Health and human service professionals have reported increased occupational stress within the last few years, including alarming rates of compassion fatigue and burnout (Arañez Litam et al., Cavanagh et al., 2020; Prasad et al., 2021).

Occupational stress has increased within the last few years, particularly in the helping professions, as COVID-19 took a dramatic toll on physical and mental health (Auerbach & Miller, 2020). Social isolation, fear of illness, caregiving responsibilities, among other disruptions in daily life, wreaked havoc on individuals' mental health (Rettie & Daniels, 2020). Counselors faced a surge in caseloads and waitlists as the need for mental health services rose (USA Today, 2021). In September 2020, 52% of behavioral health organizations reported an increase in the demand for services according to one national survey (National Council for Mental Wellbeing, 2020). Coupled with a need for services, 65% of behavioral health agencies reported having to reschedule or turn away clients due to a diminished capacity to offer services (National Council for Mental Wellbeing, 2020). A greater need for services and a reduced ability to provide them strained the mental health care system, imposing significant stress on the helping professionals working within it (APA, 2022). This contextualized accumulation of work stress highlights the need for a better understanding of how to prevent and reduce fatigue syndromes within the helping professions, such as burnout, vicarious trauma, compassion fatigue, secondary traumatic stress, and empathy fatigue.

Burnout

One of the most discussed consequences of accumulated job stress is burnout. Coined by Christina Maslach (1981), burnout has been widely studied in relation to occupational environments. Burnout is defined as "a syndrome of emotional exhaustion and cynicism that occurs frequently among individuals who do 'people-work' of some kind" (Maslach & Jackson, 1981, p. 99). Burnout results from the experience of chronic stress over time and typically takes longer to develop (Maslach & Jackson, 1981). In 2003, Maslach expanded the definition of burnout to include interpersonal and systemic considerations of the work environment, including

the worker's response to the job (i.e., cynicism) and themselves (i.e., feelings of inefficacy; Maslach, 2003). Workers experiencing burnout find less enjoyment and satisfaction from their work and are at risk for leaving their field (Maslach, 2003), which indicates that this problem impacts human services professions as a system if its employees are not continuing to work.

In the counseling field, novice professional counselors (i.e., post-graduate counselors under supervision for licensure) noted that symptoms of burnout included negative emotional experiences, fatigue/tiredness, feeling unfulfilled by counseling work, physical symptoms, less interest in practicing self-care, perceived ineffectiveness, cognitive impairment, negative impact on personal relationships, negative coping strategies, questioning career choice, and psychological distress (Cook et al., 2021). Burnout has also been associated with depression in pre-licensed counselors (Fye et al., 2021). Many of these symptoms overlap with symptoms of empathy fatigue. Considering the vital importance of healthcare and human service workers at this time, burnout poses a serious threat to the stability of healthcare and human service professions.

Several risk and protective factors may exacerbate or prevent burnout. These factors can be categorized in domains related to the person (i.e., helper), organization, or client. In one study in healthcare settings, the odds of experiencing burnout were about 40% lower in employees who felt valued by their organization (Prasad et al., 2021). Reducing job-related stressors, workloads, and creating a healthy work environment may be crucial protective factors of burnout in healthcare settings, as burnout is tied closely to factors of the work environment (Maslach, 2003; Sharifi et al., 2020). Counselors who experience higher stress may be more susceptible to burnout, particularly within the context of COVID-19 (Arañez Litam et al., 2021).

Perceived organizational support has also been related to less burnout in the counseling field, as higher levels of perceived emotional support are related to greater retention (Eby & Rothrauff-Laschober, 2012). In a path model of factors that lead to burnout in community mental health professionals, Chang and Shin (2021) identified that occupational stress, maladaptive emotion regulation strategies, aggressive client behavior, and compassion fatigue were positively associated with burnout and cognitive emotion regulation strategies and compassion satisfaction were significantly inversely associated (Chang & Shin, 2021). Counselors with higher resilience levels also may be less susceptible to burnout (Arañez Litam et al., 2021). While the literature on burnout is comprised of both person- and work-related factors, other fatigue syndromes in the helping professions relate more directly to client-related factors, such as working with client trauma.

Vicarious Trauma

Counselors, therapists, and mental health professionals are highly likely to work with trauma survivors during their professional careers (Sommer, 2008). Clients seeking treatment for trauma share intimate details of their traumatic experiences with mental health professionals in order to process and heal from the trauma. Listening to stories of traumatic experiences can take a toll on those absorbing and holding space for processing (Figley, 1995; McCann & Pearlman, 1990). Secondary trauma results when one is exposed to someone who endured a traumatic event (Motta, 2008). Although not all counselors exposed to secondary trauma will experience secondary traumatic stress reactions, counselors and mental health professionals are at high risk for secondary traumatic stress, as they support their clients through processing stories of traumatic events (Figley, 2002).

During this retelling of traumatic events, a counselor uses empathy and compassion, which leaves them vulnerable to vicariously experiencing the emotions and pain that comes with trauma. The counselor themselves does not need to experience the traumatic event directly for traumatic reactions to take place. Trauma experts refer to this phenomenon as vicarious trauma (McCann & Pearlman, 1990). By definition, vicarious trauma refers to "the transformation that occurs within the therapist (or trauma worker) as a result of empathic engagement with clients' trauma experiences and their sequalae" (Pearlman & Mac Ian, 1995, p. 558). Specifically, the worldview of the counselor or helping professional is profoundly impacted by stories of trauma survivors that they serve throughout their career. A hallmark symptom of vicarious trauma is a change in the counselor or helping professionals' cognitive schemas as a result of exposure to secondary trauma (McCann & Pearlman, 1990).

The phenomenon of vicarious traumatization is rooted in constructivist self-development theory, which posits that humans construct their known realities based on interpretation of their life experiences (McCann & Pearlman, 1990). This constructed knowledge about the world was coined as a cognitive schema (Piaget, 1971). Cognitive schemas include assumptions, expectations, and beliefs about self, others, and the world (McCann & Pearlman, 1990). Due to the disruptive nature of secondary trauma exposure, a therapist's schemas may change subtly or drastically, depending on the nature of their life experiences prior to their work healing trauma (McCann & Pearlman, 1990). They may feel more cynical, distrusting of others, and question others' intentions as the traumatic material conflicts with their previously constructed knowledge (McCann & Pearlman, 1990). These changes in knowledge about the world have the potential to impact personal and professional functioning, as counselors try to make sense of such horrific

events (Dayal et al., 2021; Figley, 2002; McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995).

Other factors in addition to secondary trauma exposure may also contribute to vicarious trauma. These factors include particular kinds of traumatic experiences (e.g., sexual abuse survivors, domestic violence survivors, etc.), the kind of details shared in counseling, client behaviors, work environment, and socio-cultural context (Adam & Riggs, 2008; Lanier & Carney, 2019; Pearlman & Mac Ian, 1995). Personal experiences of trauma may be triggered by counseling work with clients which can impact a counselor in a variety of ways, one of them being vicarious trauma (Adams & Riggs, 2008; Dayal et al., 2021; Jimenez et al., 2021). Earlier career professionals may also be at higher risk for vicarious trauma as they have less exposure to client trauma and experience coping with the after effects of hearing their stories (Adams & Riggs, 2008; Jimenez et al., 2021; Pearlman & Mac Ian, 1995).

Counselor trainees and newer professionals may not have an awareness or understanding of what vicarious trauma is, what signs to look out for, and how to treat it, making them vulnerable to developing vicarious trauma (Dayal et al., 2021). It is highly likely that counselors will encounter exposure to trauma early on in their careers, highlighting the importance of education, training, and supervision around recognizing and mitigating vicarious trauma for early career counselors (Adams & Riggs, 2008; Jimenez et al., 2021; Merriman, 2015; Lanier & Carney, 2019; Sommer, 2008). In one study that sampled mental health care providers in a hospital setting, Jimenez et al. (2021) found that regardless of their professional role, providers were exposed to themes of trauma. Trippany and Colleagues (2004) stress the reality that counselors will certainly work with trauma survivors throughout their careers, and call on supervisors, agencies, and counselor training programs to support and prepare counselors for this

occupational reality. One study conducted by Lanier and Carney (2019) found that 85% of a sample of practicing counselors thought about their clients and their work outside of work time and 100% of their sample (N = 220) reported having repeated, distressing, and unwanted memories of the stressful client experience. This statistic alone highlights the need for attention to preparing and educating counselors about vicarious trauma early on in their careers (Sommer, 2008; Trippany et al., 2004).

Intentional self-care and wellness practices can aid in preventing and mitigating vicarious trauma. Establishing a solid support network, employing healthy coping mechanisms, and engaging in meaningful spiritual practices are self-care strategies that may offer protection against vicarious trauma (Trippany et al., 2004). Agencies and counseling workplaces can help mitigate experiences of vicarious trauma by limiting the number of trauma cases on a counselor's caseload and providing a supportive environment for peer supervision (Trippany et al., 2004). A multifaceted network of support within and outside of the counselor's workplace and healthy coping mechanisms are critical to fostering counselor well-being, given their inevitable work-related exposure to trauma (Jimenez et al., 2021; Lanier & Carney, 2019; Sommer, 2008).

Vicarious trauma is accompanied by a profound shift in cognitive schema that is a potential outcome of working with trauma survivors (Pearlman & Mac Ian, 1995). Counselors employed in a wide variety of clinical settings will be exposed to or provide treatment for trauma and trauma-related disorders (Sommer, 2008). Each counselor will be affected by their work differently, depending on their own experiences of trauma, coping history, resilience levels, etc. (Leung et al., 2022; Stebnicki, 2007). Reactions to secondary trauma exposure are individualized and nuanced. While some may experience profound shifts in the way they view the world, others may exhibit secondary traumatic stress symptoms as a result of exposure to others' trauma that

could severely impact personal and professional wellbeing (Figley, 1995, 2002). This form of occupational stress in helping professionals is referred to as compassion fatigue, or secondary traumatic stress.

Compassion Fatigue/Secondary Traumatic Stress

Compassion fatigue was first introduced in the nursing literature by Joinson (1992), where she described it as a unique form of caregiver stress, where nurses tended to neglect their own mental, physical, and emotional needs at work. In nursing, individual level (e.g., awareness, coping resources, self-image) and job-related characteristics (staffing shortages, nursing assignments, hurried coworkers) interact to produce an exhaustion that is all-consuming and difficult to manage, ultimately impacting nursing professionals. People are often drawn to become nurses because of their compassionate nature as people (Joinson, 1992). Being that caring and nurturing is simply part of their personality, it can be easy for them to override their needs and continue caring for their patients (Joinson, 1992). Ignoring stress responses and continuing to power through when resources are low can lead to impairment and long-term depletion of compassion toward their work and patients (Joinson, 1992). To mitigate their own suffering, an emotionally wounded professional may disconnect or disengage from their client as a means of self-protection, resulting in the potential for professional missteps and mistakes (Coetzee & Laschinger, 2018). These disastrous effects can impair professional well-being, and erode nurses' desire to compassionately care for their patients (Cavanagh et al., 2020; Coetzee & Laschinger, 2018).

In 1995, Charles Figley continued the discussion on compassion fatigue, calling it a secondary traumatic stress disorder occurring in trauma therapists that is characterized by symptoms that resemble Post-Traumatic Stress Disorder (PTSD). The terms secondary traumatic

stress and compassion fatigue are often used interchangeably when discussing the adverse consequences of working with trauma survivors (e.g., Figley 1995, 2002; Ludick & Figley, 2017), as fatigue comes from secondary trauma exposure. As trauma therapists help their clients heal deep wounds, they empathically connect with traumatic material and experiences of suffering, feeling the pain along with them (Figley, 2002). This empathic connection increases the therapist's risk of absorbing the information shared by their clients, often ladened with stories of grief, loss, and suffering (Figley, 1995). Essentially, hearing stories of trauma causes a secondary, or vicarious, traumatic response on behalf of the therapist, or helper.

Compassion fatigue symptoms can vary among each individual helper, but Figley (1995) proposes the following categories of symptoms, mirroring PTSD: re-experiencing of the traumatic events, avoidance or numbing of reminders of event, and persistent arousal. Regarding re-experiencing, the therapist may encounter reminders or have recollections of the event discussed by the trauma survivor (Figley, 1995). They may avoid thoughts and feelings related to the event or experience, avoid activities or situations that remind them of the trauma material, and/or experience a detachment from others and activities they once enjoyed (Figley, 1995; Sprang et al., 2018). Persistent arousal could look like difficulties with sleep, feeling irritable, having difficulty concentrating, or an exaggerated startle response (Figley, 1995). Although this is not an exhaustive list of symptomatology, compassion fatigue symptoms can greatly impact the personal and professional functioning of the therapist, reducing their effectiveness and capacity to empathize with clients (Figley, 1995, 2002; Sprang et al., 2018; Stamm, 2010). In addition to therapists, other helping professionals can experience compassion fatigue, such as nurses, social workers, counselors, and genetic counselors (Ludick & Figley, 2017).

Secondary traumatic stress appears to affect many helpers working in 'high-touch' service professions, like counseling (Sprang et al., 2018). In a study conducted in licensed mental health professionals working in a social service agency in New York City, 22.7% of the sample were experiencing secondary traumatic stress at the time of the study (Ivicic & Motta, 2017). A study of mental health professionals working with military populations reported a prevalence of secondary traumatic stress at 19.2% (Cieslak et al., 2013). Unfortunately, rates of secondary traumatic stress in mental health professionals are likely to continue to rise due to exposure to trauma because of the COVID-19 pandemic (Joshi & Sharma, 2020).

In terms of its measurement, Figley created the 40-item Compassion Fatigue Self-Test (CFST; Figley, 1995) which measured compassion fatigue and burnout. Later, Figley and Stamm (1996) added a compassion satisfaction component to measure the positive aspects of helping, and the original CFST evolved into the Compassion Satisfaction and Fatigue Test (CSFT) consisting of 66 items. The CSFT had adequate reliability and internal consistency as measured by alpha coefficients on each of the three subscales: burnout (.90), compassion satisfaction (.87), compassion fatigue (.87; Figley & Stamm, 1996). Through continuous development, the CFST eventually evolved into what is more commonly known as the Professional Quality of Life Scale (ProQoL; Stamm 2002).

Professional Quality of Life

Stamm (2010) nested compassion fatigue within a concept called professional quality of life. Based on research about the quality of life for those who care for others, Stamm (2010) offered a conceptual framework for considering factors that relate to one's professional quality of life. Compassion satisfaction and compassion fatigue contribute to one's professional quality of life, or "the quality one feels in relation to their work as a helper" (Stamm, 2010, p. 8).

Compassion satisfaction refers to the positive aspects of working as a helper, such as feeling fulfilled by having a meaningful career and finding satisfaction in helping others (Stamm, 2010). Compassion fatigue is a combination of burnout and secondary traumatic stress, where burnout is "associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively (Stamm, 2010, p. 13), and secondary traumatic stress refers to the PTSD-like symptoms from exposure to trauma survivors (Stamm, 2010).

Following this conceptual framework, the ProQoL consists of 30-items divided into three subscales with 10 items each, which are compassion satisfaction, secondary traumatic stress, and burnout (Stamm, 2010). Stamm (2010) notes that secondary traumatic stress and burnout comprise the measure of compassion fatigue, but each subscale is calculated and interpreted separately (i.e., there is no total scale score). Internal consistency measures for each subscale are adequate (burnout = 0.75, secondary traumatic stress = 0.81, compassion satisfaction = 0.88) and good construct validity (Stamm, 2010). Stamm (2010) offers further explanation depending on high, medium, and low levels of each construct (burnout, compassion satisfaction, and secondary traumatic stress). For example, in the *Concise Manual for the Professional Quality of Life Scale*, Stamm (2010) notes that the most distressing combination might be if someone scores high on secondary traumatic stress, high on burnout and low on compassion satisfaction. It may be best to assess this helper for PTSD and depression, and may need some time away from their work setting to recover (Stamm, 2010).

Stamm (2010) offered a theoretical model of professional quality of life called *The Theoretical Model of Compassion Satisfaction and Compassion Fatigue*, to explain factors that influence the experience of either compassion satisfaction or compassion fatigue. Aspects of a

helping professional's work environment, client environment, and person environment can create positive or negative experiences at work, or even direct trauma (Stamm, 2010).

Work-Environment Factors

Characteristics of the work environment include organizational climate, culture, and specific tasks of the work. These factors can interplay to create positive or negative work-related outcomes (Stamm, 2010). For example, organizations that acknowledge vicarious trauma and secondary traumatic stress in their workers often have more positive outcomes and improved employee well-being (Sprang et al., 2021; Sutton et al., 2021). In a study examining how organizational-level factors influence employee well-being, Sprang et al. (2021) implemented a secondary traumatic stress-informed intervention, where organizations received training, consultation, and technical assistance from experts to reach specific organizational goals around becoming more secondary traumatic stress-informed. Sprang and colleagues (2021) found that employees who worked for organizations that completed the intervention had significantly reduced burnout and secondary traumatic stress levels, a result that continued post-intervention. In a sample of law enforcement officers, greater perceived organizational support was associated with more compassion satisfaction and lower burnout and secondary traumatic stress (Miller et al., 2017).

Several work-related factors can exacerbate occupational distress or fatigue syndromes (Kreitzer et al., 2020; Sinclair et al., 2017; Sutton et al., 2021; Turgoose & Maddox, 2017). Larger caseloads, greater workload, income, lack of scheduling flexibility, and amount of trauma cases may increase vicarious trauma in mental health professionals (Sutton et al., 2021; Thompson et al., 2014; Turgoose & Maddox, 2017). Social workers experiencing compassion fatigue reported lack of relationship building, poor managerial communication, unrealistic

productivity standards, reduction in services, highly political climates and climates of fear as organizational factors that exacerbate occupational distress (Kreitzer et al., 2020).

Person-Environment Factors

Person-related characteristics are another facet of professional quality of life (Stamm, 2010). Person-environment refers to the unique attributes of the counselor that can serve as risk or protective factors (Stamm, 2010). Examples of such personal factors that have been studied in relation to compassion fatigue are one's own trauma history, coping style, years of experience in the field, level of self-judgment, mindfulness, gender, and empathic ability (Beaumont et al., 2016; Craig & Sprang, 2010; Figley, 2002; Rossi et al., 2012; Thompson et al., 2014).

Client-Environment Factors

Client-environment refer to factors about the client that create positive or negative experiences for the helper (Stamm, 2010). For example, more direct client-contact is negatively associated with professional quality of life (Stamm, 2010). Currently, researchers have identified the client population and type of presenting concern (e.g., child-welfare clients, clients with trauma, cancer patients, clients with severe mental illness) may be contributing factors to CF (Figley, 2002; Pehlivan & Güner, 2020; Stamm, 2010), but little research exists on this specific component of the model.

Researchers across helping and service disciplines such as social work, psychologists, psychiatrists, medicine, and education, have discussed the dangerous consequences of compassion fatigue on the helping professional and the clients receiving their services (Cavanagh et al., 2020; Holmes et al., 2021; Smart et al., 2014). For example, in a sample of 297 oncology nurses, 37.4% reported high levels of secondary traumatic stress, which was associated with a desire to leave the unit they worked on (Arimon-Pagès et al., 2019). Social workers in one study

conducted during the COVID-19 pandemic, reported rates of PTSD at five times the national averages, affecting their capacity to serve their clients (Holmes et al., 2021). Compassion fatigue can take a toll on a diverse range of professionals, which tends to degrade their capacity to care for clients and patients (Cavanagh et al., 2020).

Unfortunately, the empirical research on compassion fatigue in the counseling profession is sparse. This is likely because the concept of compassion fatigue emerged from the nursing field (Joinson, 1992) and was further elaborated on within the field of psychology (Figley, 1995). Current researchers have discussed predictors and risk factors of compassion fatigue, particularly in counselor trainees, and advocated for the need for further training to prevent compassion fatigue (Can & Watson, 2019). Research on more strengths-based perspectives appear to be more common in the counseling literature (Browning et al., 2019), which appears logical as the counseling philosophy is grounded in holistic wellness and optimal functioning. Browning and colleagues (2019) focused on positive counselor characteristics that buffer compassion fatigue, including gratitude, hope, and spiritual practices. They found that gratitude and engaging in daily spiritual practices significantly predicted less burnout in practicing counselors (Browning et al., 2019). Similarly, Fye et al. (2021) found a strong, significant, negative relationship between compassion satisfaction and depression in pre-licensed counselors, suggesting that counselors who experience greater fulfillment from their work may have higher protection against the ill effects of helping.

Although further empirical research is needed on how compassion fatigue impacts professional counselors' ability to empathize, build rapport, and provide nonjudgmental spaces for clients, it may be helpful to identify a more clearly aligned occupational stress syndrome, rooted in the theory and philosophy of the counseling field (Stebnicki, 2016). An emerging

narrative in the occupational stress literature is that the term ‘compassion fatigue’ may be misleading, or simply an inaccurate interpretation of what is happening. Recent neuroscience researchers have demonstrated that compassion is not the cause of fatigue, but rather is a restorative, protective emotional experience (Dowling, 2018; Elder, 2021; Hofmeyer et al., 2020).

Differentiating Empathy Fatigue from Other Fatigue Syndromes

The terms vicarious trauma, secondary traumatic stress, compassion fatigue and burnout may not accurately represent the fatigue that is felt in the counseling field. For one, vicarious trauma, secondary traumatic stress, compassion fatigue, and burnout are potential consequences of helping that are broadly discussed across diverse helping fields and applied to the counseling context. None of their definitions were born out of the counseling field, which operates from a different philosophical basis than other helping fields. Second, not all counselors are trained to provide trauma services, or work with clients that are processing traumatic experiences. Although it is important for counselors to be aware of vicarious trauma and secondary traumatic stress (i.e., compassion fatigue), they may not experience the profound changes in worldview and PTSD-like symptoms that accompany it.

The theoretical basis for empathy fatigue is rooted in the field of professional counseling (Stebnicki, 2016). Empathy fatigue accounts for the broad experience of spiritual woundedness; a sense of questioning the meaning of tragic events in the way of our clients’ suffering (Stebnicki, 2007). Counselors hear stories of tragedy and trauma, but also daily stressors in their client’s lives, that over time, take a toll on the soul of the person that sits in the counselor’s chair. Given the unique characteristics of counseling that include exercising empathy and exposure to

stories of distress, grief, loss, and suffering, beyond traumatic events, a tailored conceptualization of occupational hazards is warranted.

Empathy Fatigue

In 1998, Stebnicki coined the term empathy fatigue to differentiate the effects of working as a professional counselor from other helping professionals and previous fatigue syndrome definitions (i.e., burnout, vicarious trauma, compassion fatigue, etc.). Stebnicki noticed a gap in professional helping fatigue syndromes that failed to capture the spiritual component of emotional exhaustion for professional counselors working with all clients, not just with trauma survivors (Stebnicki, personal communication, 2022). The theoretical basis of empathy fatigue is grounded in professional counseling, a unique helping field, as previously discussed. This is one of the only helping professional fatigue syndromes that is specifically geared toward professional counselors. Stebnicki's (2007) theory of empathy fatigue has been supported by recent neuroscience literature, pointing to the toll that empathic engagement can take on personal and professional functioning (Dowling, 2018; Hofmeyer et al., 2020).

Stebnicki defines empathy fatigue as a syndrome that "...results from a state of psychological, emotional, mental, physical, spiritual, and occupational exhaustion that occurs as the counselors' own wounds are continually revisited by their clients' life stories of chronic illness, disability, trauma, grief, and loss" (Stebnicki, 2007, p.16). Helping professionals, including counselors, who approach their work with clients in a wholeheartedly empathetic way, are at risk for experiencing this form of exhaustion (Stebnicki, 2007). Put simply, listening to stories of suffering and pain take a toll on the holistic being of a counselor (Stebnicki, 2007).

Symptoms of Empathy Fatigue

Empathy fatigue impacts counselors holistically, not unidimensionally. Counselors suffering from empathy fatigue may notice changes in several areas of their personal and professional lives, including physical, mental, spiritual, emotional, occupational, and professional functioning. Chronic activation of the stress response system can take a devastating toll on one's mind, body, and spirit. Essentially, professional counselors experience activation of their stress response system when listening to details of stress, pain, and suffering of their clients (Stebnicki, 2007). People who observe others experiencing or recovering from stress leads to noticeable increases in heart rate, suggesting that witnessing someone in stress can create a contagion effect in the observer, even if they are not under stress themselves (Dimitrioff, 2017). This increased heart rate takes the same toll on the body as directly experiencing stress first-hand, further highlighting the need for resilience and coping strategies that activate the parasympathetic nervous system (Dimitrioff, 2017).

Each symptom of empathy fatigue discussed in this chapter can be considered on a mild to severe continuum, with functioning being significantly impacted as empathy fatigue becomes more severe. Stebnicki's (2016) GAEF has five levels, level one being the mildest form of empathy fatigue, to level five being the most severe. In its mild form, an individual may notice small deviations from functioning, such as tiredness, slight difficulties in concentration, awareness of needing to refocus on spiritual beliefs and meaning, or a slightly down mood, and is mostly able to manage them with their current coping practices. In the most severe stage, spiritual meaning and purpose may be nonexistent, a counselor may be missing work, expressing cynicism, having significant difficulties concentrating, and disconnecting from their therapeutic working alliance with clients (Stebnicki, 2007). More drastic measures may need to be taken to

improve functioning at this stage, such as removal from their occupational environment or treatment from a mental health provider. Taking time away from work may be necessary as empathy fatigue can impact counseling skills, which increases the potential for causing harm to clients (Stebnicki, 2007). Ethical considerations must be made to protect empathy fatigue from harming the clients that counselors serve.

Cognitive Symptoms. Cognitively, empathy fatigue can manifest as difficulty concentrating, mental preoccupation, disorganized thoughts, attending to client in a disconnected way, irrational thoughts, or difficulty focusing on therapeutic process. Counselors may notice physical signs as well, including shallow breathing, sweating, fatigue, discomfort when sitting, dizziness, nausea, muscle tremors or twitches, severe headaches, disturbances in visual acuity. Severe emotional impacts include a diminished emotional state, moodiness, clear high and lows, increased feelings of sadness, tearfulness, feeling emotionally depleted/exhausted, and feeling generally more negative and pessimistic. The emotional toll of empathy fatigue in its mild form can appear as a slightly down mood and some emotional tiredness, but can become increasingly disruptive to functioning and observable by others as severity increases.

Behavioral Symptoms. Behaviorally, a counselor might exhibit a wide range of behaviors atypical to their normal. For example, on the mild end, a counselor might have some display of restlessness but feel in control enough to manage it, can maintain good eye contact with clients, and vocal quality/speech may be occasionally strained. At the highest severity, the individual may exhibit impatience, irritability, aggression, and hypervigilance. Their vocal tone and eye contact in session are poor, impacting the quality of the counseling relationship and environment. A counselor may even behave cynically toward their clients.

Spiritual Symptoms. Although emotional, cognitive, physical and behavioral impacts of empathy fatigue can severely impact a counselor's personal and professional life, spiritual implications may take a pronounced toll on the meaning one makes from their spirituality and purpose (Stebnicki, 2007). Other fatigue syndromes like burnout, compassion fatigue, and vicarious trauma, discuss profound impacts on behavior, emotional functioning, and occupational functioning (Figley, 1995; Maslach, 2003; McCann & Pearlman, 1990), but do not capture the toll that empathy fatigue takes on one's soul. Stebnicki (Personal communication, 2022) noted that a major component of empathy fatigue is the spiritual changes; whether that be in a counselor's spiritual practices, or the meaning they make from their work, and the way they view the world. By sitting with those who have suffered great traumas and experience great stressors, our beliefs about the ways of the world and the meaning we make of these events, shifts (Stebnicki, 2007). Thus, counselors experiencing empathy fatigue may experience disconnection with their typical spiritual practices and/or supports (Stebnicki, 2007). They may find themselves questioning their meaning and purpose in the face of hearing such tragic details of suffering, grief, and loss (Stebnicki, 2007).

Spirituality is a facet of wellness that is important to the personal and professional functioning of counselors. "For counselors, taking care of the soul or being conscious of spiritual health is critical to survival and personal and professional growth" (Stebnicki, 2007, p.51). The spiritual impacts of empathy fatigue are dually important, as spiritual practices and support are connected to resilience and well-being (Browning et al., 2019). If spirituality, a source of resilience and coping, is adversely affected by empathy fatigue, recovery may be more challenging. Considering that professional counselors are often tasked with helping their clients

process and make meaning of life events, counselors must be acutely aware of how their spirituality and connection to meaning may be impacted by empathy fatigue (Stebnicki, 2007).

Physical Symptoms. A clinician may experience a range of physical symptoms, depending on the severity of empathy fatigue. Some physical ailments may include changes in eating habits, muscle tension, headaches, or general discomfort (Stebnicki, 2016). These physical changes are indicative of the activated stress response when exposed to client details of suffering, pain, and trauma, without proper self-care (Stebnicki, 2016). See Stebnicki (2016) for a thorough list of physical symptoms based on the Global Assessment of Empathy Fatigue Rating Scale.

Emotional Symptoms. Counseling, by nature, is an emotionally-ladened process. It is no surprise that hearing painful stories evokes emotional changes in the practitioner. Emotional symptoms of empathy fatigue include increased moodiness, irritability, pessimism, emotional exhaustion, and a diminished affective state (Stebnicki, 2016). Depending on the severity of the empathy fatigue, the emotional distress increases with heightened empathy fatigue. Most of all, depleted emotional resources reduces the clinician's capacity to provide empathic care to their clients, compromising their clinical effectiveness and potentially causing harm to clients (Stebnicki, 2016).

Process Skills. In addition to the impacts previously mentioned, empathy fatigue also affects occupational and professional functioning (Stebnicki, 2007; 2008). As empathy fatigue sets in, professional counselors' ability to actively listen and engage empathetically with clients diminishes (Stebnicki, 2007). Counselors' process skills negatively shift, as the therapeutic working alliance is strained (Stebnicki, 2007). At the most severe stage, a counselor may not attend to the client in an empathetic manner, gather details of the client's story versus

recognizing themes and patterns in a client's presentation, resist challenging clients or miss opportunities to use immediacy, and may not use open questions as often as they typically would (Stebnicki, 2007).

Occupational Symptoms. As a clinician's therapeutic effectiveness suffers, coworkers and supervisors may notice behaviors impacting their work as well. For example, if a counselor is suffering from high levels of empathy fatigue, they may miss work almost once per week, leave work early, cancel or no show for counseling sessions, avoid meetings or interactions with coworkers, act cynical with coworkers, and/or display a dark sense of humor (Stebnicki, 2007). Taken together, the counselor is holistically impacted, intrapersonally, interpersonally, and occupationally in ways that may be overt or covert to the counselor or others around them. Given the complexity of empathy fatigue symptoms, it is critical to assess risk and protective factors, as well as context, to understand a path forward to recovery (Stebnicki, 2007).

Empathy fatigue symptoms examined in isolation could be easily confused for other mental health concerns, such as mood or trauma-related disorders. Because of this, it is important to consider the counselor's context in relation to empathy fatigue symptoms. Gathering additional information about personal, environmental, and client factors may help paint a clearer picture as to whether the counselor is experiencing empathy fatigue. Ideally, observers who know the counselor personally and professionally may be able to provide insight that the counselor cannot, which may help determine necessary interventions. The GAEF (Stebnicki, 2007) is an observer-rated assessment that can be used by supervisors, co-workers, clients, family members, friends, and the counselor, to create a converging picture of the counselor's empathy fatigue status. However, a self-report tool to improve the counselor's self-awareness may benefit the resilience and recovery process (Posluns & Gall, 2020; Young, 2013).

Empathy Fatigue Risk Factors

Empathy fatigue is a multifaceted, highly individualized, dynamic, and complex phenomenon in professional counselors (Stebnicki, 2007). A myriad of risk and protective factors interact to influence the degree of empathy fatigue felt by the counselor, and must be taken into consideration when assessing for empathy fatigue. Similar to how different clients will exhibit different symptoms of depression depending on their environment, life circumstances, genetics, etc., empathy fatigue experiences will differ from counselor to counselor (Stebnicki, 2016).

Stebnicki (2007) offers ten risk factor domains to consider when addressing empathy fatigue. They include current and preexisting personality traits or states, history of emotional/psychiatric problems, maladaptive coping behaviors, age- and experience-related factors, organizational and system dynamics at the counselor's place of work, specific job duties of the counselor, unique sociocultural attributes, response to past critical or stressful life events, level of support and resources, and spirituality. These can be categorized into personal and work-related risk factors.

Person-Related Risk Factors. Aspects of personality, spirituality, and personal mental health issues are either risk or protective factors for empathy fatigue. A counselor's personality trait and state, including factors such as being "type A," having unrealistic or high expectations for client change, need for recognition, and attitudes of cynicism may elevate their risk for empathy fatigue. Personal characteristics of the professional play a role in the experience of different fatigue syndromes. For example, one's own trauma history (Rossi et al., 2012), coping styles (Thompson et al., 2014), years of experience in the field (Craig & Sprang, 2010), self-

judgment (Beaumont et al., 2016), gender (Thompson et al., 2014) and empathic ability (Figley, 2002) have been connected to compassion fatigue in helping professionals.

Changes in personal spiritual practices are considered a risk factor of empathy fatigue. Spiritual questioning, such as wondering about the purpose and meaning of life or losing faith in spiritual beliefs or feeling angry toward God or a higher power may heighten one's risk for empathy fatigue (Stebnicki, 2007). In addition, having a personal history of emotional or mental health problems, using maladaptive coping strategies, and factors related to age and experience of the counselor (e.g, younger vs. older professionals, experiences working with different kinds of clients, crisis response experience, etc.) are all important pieces of information to gather when it comes to assessing empathy fatigue.

Counselors with personal trauma histories are at higher risk for fatigue syndromes (Leung et al., 2022; Thompson et al., 2014; Ray et al., 2013; Rossi et al., 2012; Stebnicki, 2007). There seems to be a strong connection between experiencing secondary traumatic stress and vicarious trauma and having a personal trauma history, but not necessarily burnout (Leung et al., 2022). However, Rossi and colleagues (2012) found a relationship between lifetime traumatic events and burnout, that staff working in community mental health with more than one lifetime traumatic event had a higher burnout score than those without a trauma history. They also found that those who had suffered a negative life event within the last 12 months reported higher compassion fatigue compared to those who reported no negative life events in the same time period (Rossi et al., 2012). Having a history of trauma is one of the most studied and supported factors that increase the risk of professional helpers experiencing negative effects from their work (Hensel et al., 2015; Martin-Cuellar et al., 2018; Newell & MacNeil, 2010; Ray et al.,

2013). Therefore, a counselor's self-awareness of how their own trauma history may be triggered by their work is crucial to understanding personal experiences of empathy fatigue.

Separate from personal trauma history, a counselor's history of resilience and methods of responding to difficult life situations may connect to patterns of managing stress related to empathy fatigue (Stebnicki, 2007). Maladaptive coping behaviors are related to compassion fatigue in mental health counselors (Thompson et al., 2014). Thompson and colleagues (2014) used multiple regression to investigate how coping strategies, among other variables such as gender, mindfulness, and years of experience, predict compassion fatigue. They examined whether problem-based coping, emotion-focused coping, and maladaptive coping strategies related to compassion fatigue and burnout. Researchers found that maladaptive coping mechanisms significantly predicted compassion fatigue, but both and emotion- focused and maladaptive coping were significant predictors of burnout (Thompson et al., 2014). Considering that compassion fatigue and burnout are similar in nature to empathy fatigue, counselor's previous patterns of coping with difficult life events may be particularly relevant to empathy fatigue. However, more empirical research is needed to understand this relationship.

Work-Related Risk Factors. Like the way that work environment factors influence compassion fatigue and compassion satisfaction in The Theoretical Model of Compassion Satisfaction and Compassion Fatigue (Stamm, 2010), work-related factors can impact empathy fatigue as well (Stebnicki, 2007). Dynamics of the organization including minimal support or acknowledgement of counselors' emotional needs, lack of flexibility to new operation methods in the workplace may exacerbate empathy fatigue (Stebnicki, 2007). Relatedly, organizational factors such as flexibility in scheduling, lack of organizational support, and the type of therapeutic setting can worsen compassion fatigue, a condition like empathy fatigue (Singh et al.,

2020). Counselors that work within an organization that is unsupportive of their emotional needs, wellness, and overall functioning, may be at higher risk for empathy fatigue (Stebnicki, 2000). Further empirical research is needed on how these specific organizational factors relate to empathy fatigue, as the condition arises from working with clients, but is affected by external factors outside of the counseling relationship (Stebnicki, 2007). The instrument being developed in the current study would support empirical research in this area, as the measure could be used to quantify empathy fatigue.

Empathy fatigue may be influenced based on the specific setting or duties of the counselor (Stebnicki, 2007). For example, whether the individual is providing direct service to clients or has a more supervisory role could dictate their level of interaction providing counseling services. Caseload size, demanding workloads, and unrealistic time pressures are theorized to exacerbate empathy fatigue (Stebnicki, 2007). It is well established in the literature that aspects of the occupational environment can influence an employee's wellbeing (e.g., Cavanagh et al., 2020; Jirek, 2020; Kulkarni et al., 2013; Sprang et al., 2021; Thompson et al., 2014). For example, burnout is closely related to the structure and conditions of the work environment (Eby & Rothrauff-Laschober, 2012; Maslach, 2003). Counselors who perceive their work environment more favorably are less likely to leave their job than those who have less favorable perceptions of their work environment (Eby & Rothrauff-Laschober, 2012). Moreover, a counselor's sociocultural attributes, such as values, beliefs, and cultural identities that are different or not valued by the employer, may lead the counselor to feel ostracized or undervalued, making it more difficult to navigate the emotional stressors at work (Stebnicki, 2007).

Protective Factors. A strong social support network can protect against the destructive consequences of empathy fatigue (Stebnicki, 2007). Counselors should consider the quality of

support at individual, group, personal, and occupational levels (Stebnicki, 2007). Supervisory, coworker, and organizational support serve as protective factors, mitigating therapeutic job demands related to compassion fatigue (Singh et al., 2020). A counselor's ability to seek out assistance may support their recovery from empathy fatigue, therefore, having knowledge of one's propensity to reach out for support when facing difficulty is relevant to empathy fatigue resilience (Stebnicki, 2007).

Having a clear picture of risk factors for empathy fatigue is essential to understanding the toll it may take on an individual, given their context and circumstances. Current and preexisting personality traits or states, a history of emotional/psychiatric problems, maladaptive coping mechanisms, age- and experience-related factors, organizational and system dynamics, job duties of the counselor, sociocultural attributes, responses to past critical or stressful life events, level of support and resources, and spirituality are all factors to consider in assessing for empathy fatigue. While these risk factors are difficult to measure and cannot be included in a self-report measure of empathy fatigue, counselors can use this information to consider their risk level and necessary precautions to take to manage their wellness.

Importance of Measuring Empathy Fatigue

Long-term consequences of empathy fatigue can be prevented, mitigated, and treated (Stebnicki, 2007). However, without intentional intervention, empathy fatigue may have negative, long-term impacts on a counselor, including potential exit from the field (Stebnicki, 2007). Empathy fatigue causing significant impairment can last anywhere from a few weeks to years, potentially resulting in complete burnout and exit from the field (Stebnicki, 2016). Additionally, impaired counselors are unable to provide high quality services to clients as their emotional bandwidth and resources are depleted, running the risk of potentially harming the

clients they are working with (Stebnicki, 2007). The lack of emotional resources makes empathizing with clients challenging (Stebnicki, 2007), and the genuine display empathy is a key ingredient to effective counseling and a strong therapeutic relationship (Leibert, 2011; Rogers, 1957). To prevent harm to clients and avoid complete burnout, counselors should consistently be attuned to changes in their functioning related to their work. One way that counselors can stay apprised of impacts to their personal and professional functioning is through self-report assessments. A scale measuring empathy fatigue may help provide counselors improve self-awareness of empathy fatigue, and take steps toward addressing such impairment (Merriman, 2015; Posluns & Gall, 2020; Stebnicki, 2016; Young, 2013).

The GAEF (Stebnicki, 2016) is the only instrument that has been created to measure empathy fatigue in professional counselors. The GAEF assessment is an observer-rated measure of empathy fatigue, designed to provide a measure of a counseling professional's current level of functioning (Stebnicki, 2016). The GAEF is divided into five levels, ranging from level one (least impaired) to level five (most impaired). Within each level, there are seven domains, each with a detailed list of symptoms for the observer to relate to what they have noticed within the practitioner. The seven domains are cognitive, emotional, behavioral, physical, spiritual, occupational, and process skills (see Stebnicki, 2016, pp. 539-541). The assessment should be completed by the counselor's colleagues, clients, supervisors, friends/family, and an objective person (e.g., personal counselor). The counselor themselves may also take personal inventory and identify which level of empathy fatigue they have experienced primarily within the last two weeks.

The GAEF provides a detailed depiction of empathy fatigue at each level of impairment, however, there are practical implications that may limit its use with professional counselors.

First, professional counselors are experiencing higher volumes of clients and long wait lists, because of elevated mental health symptoms due to the COVID-19 pandemic (USA Today, 2021). The resources and time that the GAEF requires to complete may not be feasible given the current conditions of the field. Several raters must appraise their interactions and observations with the counselor, as well as provide their rating. Counselors may have difficulty securing the necessary observations needed for a complete assessment. Given the workload of professional counselors, it is likely that getting observer ratings from other professionals within the environment may be difficult. Second, some observers may or may not have a knowledge of the counselor's baseline functioning prior to empathy fatigue setting in. For example, a client may not have the prior context or knowledge of how a counselor engaged with them if they were not experiencing empathy fatigue prior to their work together. Therefore, they may have difficulty identifying whether they are noticing symptoms that are related to empathy fatigue or are the result of another event or characteristic. They also may not have information about the counselor's physical, spiritual, or behavioral functioning because they interact within a fairly unique environment. Ideally, client ratings of the counselor on the GAEF would be compared to other ratings to determine inter-rater agreement.

Although self-report is not without limitations, logistically it may be more feasible for counselors to complete a brief survey about empathy fatigue to learn about their level of impairment. Scores can be calculated for each subscale or factor, which can provide counselors a quick snapshot of their current functioning. Higher scores indicating more severe levels of empathy fatigue may prompt counselors to consider how they might implement self-care skills to manage impairment. For example, if a counselor scores high on the cognitive subscale, they may consider self-care strategies that restore cognitive resources, or reach out to their supervisor for

additional support with completing documentation or tasks that require cognitive effort. If a counselor scores high on the physical subscale, they may consider self-care activities that focus on promoting physical health. Using assessment measures to promote self-awareness can provide a starting point for counselors to consider how they might protect themselves against occupational impairment or fatigue syndromes, which may lead to enhanced self-care practices (Ko & Lee, 2021; Posluns & Gall, 2020). Skovholt (2016) notes the importance of continual monitoring and self-assessment to balance caring for the self, versus caring for others. A self-report measure can also support counselors' self-monitoring of empathy fatigue syndromes over time.

Professional counselors can benefit from brief, clear, and informative scale that will allow them to better understand how empathy fatigue might be impacting their personal and professional functioning. Ideally, a scale would be implemented early in the recognition of potential impairment to move toward prevention, versus treatment, of empathy fatigue, but any awareness can aid in ameliorating distress (Posluns & Gall, 2020). To date, few measures of empathy fatigue exist. This study seeks to fill a gap to support the prevention and treatment of empathy fatigue in professional counselors. Counselors provide life-saving services to individuals, communities, families, children, and couples, and cannot provide effective services if impaired. Promoting the well-being of professional counselors is essential to support the mental health of populations.

Chapter Summary

This current chapter consisted of a review of existing literature that supports the purpose of the study. Measuring empathy fatigue in professional counselors is essential to promoting their personal and professional functioning. Other fatigue syndromes in the helping fields

including burnout, vicarious trauma, secondary traumatic stress (i.e., compassion fatigue) fall short in capturing the toll that counseling can take on the practitioner's spirit, through empathic connection with clients in pain (Stebnicki, 2016). The next chapter will provide an overview of the methodology used to develop and validate the Counselor Empathy Fatigue Scale.

CHAPTER III: METHODOLOGY

Brief Overview

In Chapters One and Two, the author outlined the theoretical foundation and rationale for developing the CEFS. The purpose of this study is to fill a gap in the literature by create a self-report empathy fatigue measure for professional counselors, as few quantitative tools exist to measure this construct. The purpose of the current chapter is to provide an overview of the methodology that will be used to develop and validate the CEFS. The author will also discuss methodology for determining the internal structure and psychometric properties of the CEFS.

Research Questions and Hypotheses

Research Question 1: What is the factor structure of the Counselor Empathy Fatigue Scale (CEFS)?

Hypothesis 1: The CEFS will produce a seven-factor structure that will measure empathy fatigue in professional counselors.

Research Question 2: What is the internal consistency of the CEFS and identified subscales (if applicable)?

Hypothesis 2: The CEFS will have adequate internal consistency as evidenced by Cronbach's alpha of 0.80 or higher on the overall scale and identified subscales.

Research Question 3: What is the evidence for convergent validity of the CEFS using scores from the Counselor Burnout Inventory (CBI; Lee et al., 2007)?

Hypothesis 3: The CEFS will have adequate convergent validity when correlated with the CBI, as evidenced by a strong, significant, positive Pearson product-moment correlation coefficient greater than or equal to .70.

Research Question 4: What is the evidence for discriminant validity of the CEFS using the scores of the compassion satisfaction subscale of the Professional Quality of Life Scale (ProQoL; Stamm, 2010)?

Hypothesis 4: The CEFS will have adequate discriminant validity when correlated with scores on the compassion satisfaction subscale of the ProQoL as evidenced by a weak Pearson product-moment correlation coefficient less than or equal to .30.

Research Question 5: Are participants responding to items on the CEFS in a socially desirable way based on scores from the BIDR-16 (Hart et al., 2015)?

Hypothesis 5: Scores on the CEFS will not be significantly, strongly correlated with scores on the BIDR-16, evidencing that participants did not respond in a socially desirable way to the CEFS.

Development of the CEFS

Based on the scale development recommendations from Bandalos (2018, p.42), the researcher developed the CEFS using the following steps: (a) identify purpose of the scale; (b) identify and define the domain of the construct to be measured; (c) determine item format; (d) generate initial item pool; (e) conduct initial item review and revise (pilot study); (f) conduct a large-scale test of items; (g) analyze items; and (h) conduct reliability and validity analyses.

Step 1: Identify Purpose of the Scale

Identifying the purpose of a scale early on in the development process helps to not only to write items that represent the construct, but also provides clear communication about how the measure can be appropriately used by other researchers (Bandalos, 2018). The purpose of the CEFS is to increase the self-awareness of a helper engaged in a therapeutic counseling relationship about their level of empathy fatigue and which domains may be more greatly

impacted (e.g., emotional, physical, spiritual). Empathy fatigue can negatively impact a counselor's personal and professional functioning (Stebnicki, 2016). Therefore, it is essential that counselors understand how their work is impacting them, so that they can provide the highest quality care to clients. The CEFS is not intended to diagnose or treat empathy fatigue, but rather, to provide a starting point for counselors to consider how their clinical practice may be impacting their functioning. This, in turn, can help them identify when they need to engage in self-care practices to foster wellness that supports personal and professional functioning. Organizations will also be able to use the scale to assess the degree to which their clinicians are experiencing empathy fatigue. This scale is intended to be used with any helping professional who engages in the act of conducting counseling or therapy with clients by employing empathy toward clients who disclose details of pain, distress, and suffering.

The CEFS is intended to serve as a self-awareness tool, so that a counselor's empathy fatigue does not cause significant, irreversible impairment or escalate to exiting the field. The CEFS can be implemented at any stage in a counselor's career, although the theory of empathy fatigue focuses on its prevalence in relatively new counselors (e.g., two to six years of experience). It can also be used as a prevention tool before significant signs of professional impairment. For example, mild levels of empathy fatigue may call for a greater emphasis on consistently practicing self-care skills. A severe level of empathy fatigue may indicate intervention is needed with more intensive rest, self-care, or personal counseling. Depending on the counselor's total scale score or subscale score(s), considerations for wellness and self-care can be made.

Step 2: Identify and Define the Domain of the Construct to be Measured

Once the purpose of the scale was clearly outlined, the researcher generated a detailed definition of the construct being measured. Bandalos (2018) urged that special attention should be given to defining the construct as the operational definition affects all other steps of the scale development process. Aspects to consider when defining the construct include: (1) the degree of specificity, (2) how the construct differs from similar constructs and/or definitions, (3) who it is intended for, and (4) contextual considerations (i.e., settings, roles, etc.). Empathy fatigue is the construct that the CEFS is intending to measure. For the purposes of this study, empathy fatigue is defined as: an exhaustion that manifests holistically (in mind, body, spirit, and occupation) as a result of cumulative, chronic exposure to client distress and empathic engagement (Stebnicki, 2016).

Empathy fatigue is a multidimensional construct, theorized to manifest in several domains, affecting emotions, cognitions, behaviors, physical functioning, spirituality, occupational functioning, and counseling skills (Stebnicki, 2016). The researcher is attempting to use the CEFS to better understand construct and theory of empathy fatigue as a multidimensional phenomenon. The experience of empathy fatigue is highly individualized; each counselor or therapist may experience concerns in some domains, while other areas remain intact, (Stebnicki, 2016).

To further clarify the definition of empathy fatigue, a review of common occupational hazards in the helping professions is warranted. Compassion fatigue, burnout, secondary traumatic stress, countertransference, and vicarious traumatization are terms used to describe the deleterious effects associated with helping those who are suffering (Figley, 2002; Maslach, 2006; McCann & Pearlman, 1990; Stamm, 2010). The similarities and differences among these

constructs, including empathy fatigue, were outlined in chapter two of this dissertation. Empathy fatigue is similar to compassion fatigue, but different in that compassion fatigue is used to refer to the exhaustion that comes with working with trauma survivors (Figley, 1995). Empathy fatigue accounts for the way all pain and suffering of all clients, not just those with trauma, affect the well-being of a counselor (Stebnicki, 2016), in addition to recent studies that provide evidence that the act of compassion does not lead to fatigue (Dowling, 2018; Hofmeyer et al., 2020).

Empathy fatigue can theoretically impact any helping professional who consistently is exposed to client suffering and using empathy. Therefore, for the purposes of this study, empathy fatigue is contextualized within the experiences of professional helpers engaged in a therapeutic, empathic relationship with clients that are suffering or experiencing distress, including counselors, therapists, and social workers. Essentially, empathy fatigue can result when a practicing mental health professional is using empathy while being exposed to consistent experiences of client distress. Empathy is foundational to effective therapeutic practice--counselors and other helping professionals who actively engage in the act of counseling or therapy may experience this unique exhaustion. For the purposes of this instrument, a professional counselor will be defined as an actively practicing clinician who possesses a minimum of a master's degree in counseling. They may be provisionally licensed clinicians (e.g., Licensed professional counselor associate, provisional licensed psychologists, and licensed psychological associates, etc.), or fully licensed clinicians (e.g., Licensed professional counselor, licensed marriage and family therapist, licensed clinical mental health counselor, licensed mental health counselor, licensed psychologist, etc.).

Empathy fatigue is a syndrome that results from working with clients, so professional helpers who are counseling clients may benefit more from learning about their levels of empathy fatigue. Although the construct of empathy fatigue originated in counseling, its experience is not limited to those who call themselves professional counselors. Therefore, any mental health professional who is engaged in a helping relationship on the basis of empathy might be at risk for experiencing empathy fatigue (e.g., clinical social worker, psychologist, etc.). Therefore, the inclusion criteria for this study include mental health professionals in counseling's sister fields of social work and psychology, who engage in therapeutic relationships with clients. Further, participants must be actively providing counseling services to clients (i.e., in a therapeutic relationship) to participate.

The CEFS will fill an existing gap in the counseling literature as there are no Likert-scale, measures of empathy fatigue that are intended to be used as self-report measures. The items in this measure were developed through a careful analysis of research and literature on fatigue syndromes in the helping professions (e.g., vicarious trauma, secondary traumatic stress, compassion fatigue, burnout), with a focus on empathy fatigue as a unique form of exhaustion for professional helpers using empathy within a therapeutic relationship. In the field of counseling, Stebnicki (2016) writes about empathy fatigue as a syndrome that results when hearing client stories over and over, eventually eroding personal and professional resources (mental, physical, emotional, behavioral, spiritual, process skills, and occupational). Empathy fatigue can have either an acute or delayed onset, meaning counselors in any part of their career may experience empathy fatigue. However, it appears that earlier-career counselors are at higher risk of experiencing empathy fatigue (Stebnicki, 2016). It is worth mentioning that each counselor will experience empathy fatigue differently and this list of symptoms is not exhaustive.

Taken together, the more signs and symptoms a clinician displays, the higher the likelihood they may be experiencing empathy fatigue.

The researcher hypothesized that the CEFS would yield a seven-factor solution, aligning with the broad literature review and the GAEF assessment (Stebnicki, 2016). Based on the review of the literature described in chapter two of this dissertation, the researcher initially proposed the following seven factors, based on Stebnicki's (2016) GAEF measure and the theoretical foundations of empathy fatigue.

Proposed Factor 1: Emotional

This subscale captures the affective responses that counselors might have to working continuously with client distress. Practitioners may experience several emotional challenges from their work. A counselor may feel overly connected to their client's emotions, be unable to separate from their client's emotions, feel more negative emotions overall, and feel emotionally dysregulated. Clinicians help their clients process through experiences that come with a range of emotions and are likely to experience their own emotional reactions to clients' stories. Further, the emotional experiences of a practitioner exercising empathy with clients may be distressing. For example, they may feel grief, sadness, frustration, anger, helplessness, despair, or hurt after processing a client's recount of physical abuse. Over time, the personal emotional reactions that the counselor has, coupled with the client's emotions that they are vicariously experiencing while using empathy, their emotional bandwidth may become depleted (Figley, 2002; Stebnicki, 2016). They may notice changes in their own ability to regulate their emotions, may have more extreme moods, feel irritable, or even depressed.

Proposed Factor 2: Cognitive

This subscale was intended to measure the mental fatigue and changes in cognitive functioning empathy fatigue may inflict. For example, a counselor may be more distracted, frequently think about their clients outside of session (preoccupation) or have more negative thoughts about their client's progress (Stebnicki, 2016). Relatedly, these adverse cognitive impacts may reduce their counseling effectiveness, as they may find themselves detached from their clients, having more irrational thoughts, or an inability concentrate on their clients' during counseling sessions. Ultimately, the client's experience is harmed by an inability to mentally attune to their concerns.

Proposed Factor 3: Physical

Although the act of empathy is a cognitive and emotional process (Singer & Klimecki, 2014), empathy fatigue can lead to adverse physical consequences. Muscle tension, a rapid heartbeat, changes in appetite, physical exhaustion, changes in sleeping and/or eating patterns, severe headaches, and low energy, are some of the potential signs and symptoms to monitor. Physical symptoms have the potential to negatively interfere with the counselor's ability to complete routine work activities (Stebnicki, 2016). If the symptoms are severe, a counselor may frequently miss workdays and experience health issues, obviously impacting their workplace environment and client care.

Proposed Factor 4: Behavioral

This subscale focuses on measuring the behavioral changes and maladaptive patterns counselors might engage in if experiencing empathy fatigue. These changes in behavior may manifest at home and/or work, highlighting the importance of careful self-monitoring across life settings. Restlessness, impatience, irritability towards others, and hypervigilance may be signs of

empathy fatigue. Toward clients, these behavioral changes may look like less eye contact, increased cynicism, caution or hesitancy, and changes in speech (e.g., strained speech or changes in rate of speech; Stebnicki, 2007).

Proposed Factor 5: Spiritual

Spirituality is at the heart of what sets empathy fatigue apart conceptually from other occupational hazards (Stebnicki, 2022, personal communication). The clinician might notice a lack of connection to spiritual practices or supports, difficulty engaging in spiritual practices, or lack of motivation to connect spiritually. They may feel confused about the purpose or meaning of their spiritual beliefs, which further alienate them from spiritual supports and refueling practices. On the mild end, a counselor can reassure themselves about the importance of their spiritual beliefs when they come into question, but if the empathy fatigue is severe, they may detach from spirituality and experience a lack of meaning in their life. The gravity of a reduced spiritual capacity is notable, as counseling is often described as a fulfilling and rewarding field. Without a connection to a deeper purpose, sense of meaning making, higher power, etc., a once enriching counseling practice that provided a sense of purpose is lost. The implications of this facet of empathy fatigue are far reaching, and potentially devastating to the meaning one makes from their career in a helping field.

Proposed Factor 6: Occupational

In addition to holistic intrapersonal experiences (covered in the first five proposed factors), empathy fatigue can impact interpersonal and occupational functioning, meaning, relationships with others and varying functions in the workplace. Severe empathy fatigue reduces clinical effectiveness overall in a myriad of ways, as stated previously. Aside from client-related impacts, work functioning may be harmed though absenteeism, cancelling sessions, not getting

along with coworkers, or dreading going to work (Stebnicki, 2007). A counselor's interactions may become more superficial with coworkers, or they may avoid coworker interaction altogether, affecting staff meetings and environmental cohesion at work. A counselor may cancel sessions, leave work early, use a cynical sense of humor, and display a reduced capacity for resiliency.

Proposed Factor 7: Process Skills

Empathy fatigue can hinder the use and effectiveness of foundational helping skills, as the energy to engage in the therapeutic process is depleted. A counselor might miss themes and patterns in a client's story, focus on details of content versus exploring or processing more deeply, or use less active listening skills. They may experience a high degree of countertransference toward their clients and display apprehension, resistance, or lack genuineness in their responses. Opportunities to integrate content, emotions, and experiences, may be overlooked as focusing on content and information about the client's story is less emotionally taxing. Synthesizing information is a higher order thinking operation, which may not be accessible if empathy fatigue is severe.

Cut off scores for the total scale and identified subscales can be used to gauge the severity of empathy fatigue, depending on the factors extracted from exploratory factor analyses. Depending on which subscales produce the highest scores, counselors can practice intentional self-care activities related to those specific areas to mitigate or prevent further destructive consequences. For example, if a counselor scores high on the emotional subscale, they may consider self-care strategies that replenish emotional resources, such as confiding in close friends or family, seeing their own counselor, or journaling what they are experiencing. If a counselor's score on the physical subscale is high, they might consider engaging in activities that restore

their physical well-being, whether that be engaging in exercise, resting, or prioritizing sleep. It is worth noting that each counselor will experience empathy fatigue differently, based on several risk factors (Stebnicki, 2016). Therefore, the CEFS cannot cover all aspects of empathy fatigue, but offer a starting point for professional counselors to increase awareness of how their work and clients may be impacting them. Determining which aspects of functioning empathy fatigue is impacting will be dependent on how the factors are labeled after the exploratory factor analyses.

Although the intended purpose of this instrument is to provide a base for counselors to practice intentional self-care in any one of these areas, occupational and process skills may require different intervention external to the counselor themselves. At work, a counselor may benefit from discussing their experiences with supervisor, however, they may believe that if they tell their supervisor that they are struggling at work, there may be consequences. This measure is not intended to provide a measure of empathy fatigue severity for remediation purposes, but a starting point for a conversation to be had where the counselor can express the toll their work is taking on them without judgment. Supervisors are positioned to provide occupational support and should nonjudgmentally work with the counselor to brainstorm and implement restorative practices for their well-being. Given that counselors may potentially respond in a socially desirable way as to avoid professional consequences or repercussions, a scale measuring social desirability will be included in the survey.

Prior to determining item format, it is good practice to identify whether a measure of the same construct already exists (Bandalos, 2018). The only empathy fatigue assessment to the researcher's knowledge is the Global Assessment of Empathy Fatigue (GAEF; Stebnicki, 2016). Although counselors can use the GAEF as a self-report measure, its intended for supervisors, coworkers, clients, and others who interact with the counselor to observe and report signs and

symptoms of empathy fatigue (Stebnicki, 2016). The GAEF may not be easily translated from practice into research, as no quantifiable total or subscale scale scores can be calculated. The CEFS was designed for use in both practice and research, given its quantitative nature.

For these reasons, the researcher created a self-report measure of empathy fatigue for professional mental health clinicians using a five-point Likert scale format. Using frequency as a proxy measure of severity (i.e., the more frequent a symptom, the more severe), respondents rate their experience of an item on a five-point Likert scale ranging from one to five: (1) *not at all*, (2) *several days*, (3) *about half the days*, (4) *more than half the days*, and (5) *nearly every day*. The greater the score, the more a domain may be impacted. Each item asks a clinician to report the number of days they experienced that symptom in the last two weeks. These specific scale labels (i.e., how many days) help to provide a more objective response, rather than "often" or "seldom" which can be interpreted differently by each person taking the instrument. The CEFS instructions are as follows: *"Below is a list of potential effects that could result from your work as a professional counselor. Please reflect on how many days you experienced the following within the last two weeks. Rate your response on a scale of 1 to 5, 1 being not at all and 5 being nearly every day. Consider your personal and professional life while completing the survey. There are no right or wrong answers, so please respond as honestly and accurately as possible."*

The CEFS is scored continuously, by summing all items to yield a total scale score and summing subscale items to yield subscale scores. Some items (indicated by an asterisk, see table 7) are reverse scored. For example, if a participant rates the item "I felt confident in my ability to regulate my emotions after counseling sessions" with a four, when scoring, that item would be added as a two. The higher the score on the total scale or various subscales, the more severe the empathy fatigue, or more severe the impact may be on a particular dimension.

Step 4: Generate Initial Item Pool

Next, the researcher developed an initial list of items for the CEFS, based on a comprehensive literature review of empathy fatigue and other fatigue syndromes in the helping professions (see chapter 2). Items were modeled after characteristics of the seven dimensions of the GAEF (Stebnicki, 2016) and theoretical components of empathy fatigue from the book titled, *Empathy Fatigue: Healing the Mind, Body, and Spirit of Professional Counselors* (Stebnicki, 2007).

Based on the definition of the initial construct, noncognitive items will cover the breadth and depth of the theoretical phenomenon of empathy fatigue, to include emotional, cognitive, behavioral, physical, spiritual, occupational, and skills-based aspects. Bandalos (2018) and other experts' (DeVellis, 2003) recommend writing a list of three to four times the intended number of items to cover the breadth and depth of the construct to be measured. Factor analysis is a data reduction technique, so having more items in the initial pool will likely yield more favorable results during the analysis (Bandalos, 2018).

The researcher initially drafted 88 total items, before conducting a pilot study to help finalize the number of items. The researcher followed Bandalos' (2018) recommendations for writing Likert items: Items should be short, only contain one complete thought, and concise. Reverse-scored items were included to identify consistent patterns of responding among participants. Items were written with the understanding that the target population for this measure is professional mental health counselors, who possess a minimum of a master's degree. Although items were written using language with this educational-level background in mind, the researcher attempted to avoid clinical jargon to enhance item readability and simplicity.

Step 5: Conduct Initial Item Review and Revise (Pilot Study)

Upon completion of the item pool, the researcher conducted a pilot study to solicit feedback on the measure, before large scale testing. Lee and Lim (2008) recommend conducting content analyses of the initial items with domain experts to enhance the construct validity of the scale, as well as seek feedback from those within the target population to identify issues with item wording. Content experts were asked to provide feedback on the content validity of the items, whether appropriately represented the construct of empathy fatigue, and what content might have been missing from the item list. Individuals from the target population were asked to provide feedback on the clinical relevance, readability, and feasibility of the instrument before finalizing the survey for large-scale administration. More specifically, the researcher recruited professional clinicians within the researcher's personal network to learn about how long the survey took to complete, if the items were understood, and what items might be missing from the instrument. This review process helped to strengthen the content validity of the items and make the survey more user-friendly (Bandalos, 2018).

Prior to conducting the pilot study, the researcher's dissertation chair and a dissertation committee member with expertise in instrument development reviewed the items for clarity, readability, relevance to the construct, grammatical errors, and overall wording. The researcher incorporated feedback on the survey (e.g., instructions) and edited individual items in consultation with the dissertation chair.

Pilot Study: Expert and Target Population Review

Pilot Study Goals. The goals of the pilot study were three-fold. First, the pilot study helped to establish content validity by having experts in empathy fatigue and impairment syndromes review the items, ensuring that the CEFS items adequately cover the breadth and

depth of empathy fatigue in a brief, self-report format. A second aim of the pilot study was to ensure adherence to rigorous methodological practices that would strengthen the CEFS psychometric properties through consultation with instrument development experts. The third goal of the pilot study was to assess and enhance the feasibility of the CEFS by pilot testing the total survey (including validity measures) with a small sample of professional counselors, prior to large-scale testing for the exploratory factor analysis. These three goals were accomplished by recruiting and consulting empathy fatigue and instrument development experts to review the items and provide specific feedback. After expert review, professional counselors were sought to complete the entire survey and share feedback on the relevance, feasibility, and duration of completion. Participant inclusion criteria are defined below.

Expert Review. The researcher used purposive and convenience sampling for experts, as participants needed content expertise in empathy fatigue. A content expert was defined as an individual who holds a doctorate degree in counseling or related field and who has published or presented on the topic of professional fatigue syndromes (empathy fatigue, compassion fatigue, burnout, etc.) at least once. The researcher identified seven individuals who met the above criteria and personally contacted them via e-mail, providing details of the extent of their participation, and a Qualtrics survey with the open-ended questions attached. The e-mail request for the initial review feedback can be found in Appendix B.

Content experts were asked to provide feedback on three features of the measure: (1) the representativeness of each item to the construct of empathy fatigue, (2) the importance of the item in measuring empathy fatigue, and (3) the clarity of the items, via Likert-scale and open-ended questions on a Qualtrics survey. Each question on the feedback survey was rated on a scale of one to four, one being not representative, not necessary, and not clear, and four being

representative, essential to measurement, and clear. A copy of the CEFS feedback survey to experts is provided in Appendix A.

Instrument development experts were recruited via email invitation and consulted via Zoom to provide feedback on the clarity, readability, and structure of the items, as well as the scale development process. An instrument development expert was defined as an individual who possesses a doctoral degree and has research experience and expertise with instrument development methodology. Once feedback from experts was incorporated into the items and survey design procedures, the measure was piloted with professional counselors for final feasibility testing.

Professional counselors were recruited from the researcher's personal network. The researcher notified the pilot study participants that if they agreed to participate, they would be ineligible to participate in the larger dissertation study. Three counselors were emailed with details of the participation and asked if they would be willing to participate. Participants were asked to provide feedback on the feasibility, relevance, and content of the CEFS as it relates to their counseling practice and experience. Participants were also asked to report how long the survey took to complete, to provide a more accurate estimation of completion time for future participants. The researcher was interested in whether they experienced survey fatigue, given that there are quite a few items in the total survey. Initially, only the Compassion Satisfaction subscale of the ProQoL was included, to reduce the total number of items. The researcher asked for pilot study participants' feedback on whether an additional 20 items would deter them from completing the questionnaires. This question helped the researcher decide to include only the Compassion Satisfaction subscale of the ProQoL (10 items), or if the entire ProQoL (30 items)

would be feasible. A complete copy of the Qualtrics pilot survey is included in Appendix A. Each participant was sent a five-dollar Starbucks gift card in thanks for their participation.

Expert Results and Revisions. Three content experts provided their feedback on the initial CEFS item pool, instructions, and Likert scale scoring, yielding a 43% response rate. One expert shared feedback that the item wording potentially changed which domain the item may belong to, specifically the emotional and behavioral symptoms, resulting in the researcher editing the wording of items to clarify which domain they belong to. For example, the item "*I was irritable with my coworkers*" was initially captured in the Emotion domain. It was edited from "*I was irritable"* to "*I felt irritable*" clearly indicating irritability as an emotion, not a behavior (*"I was irritable…").* The researcher then went on to review the rest of the items in the emotion domain and re-wrote some items to include specific emotion-related words, such as "I felt..." or "My moods..." rather than behavioral language.

Experts rated most items as clear, relevant, and necessary to measure empathy fatigue, and offered no suggestions on missing aspects of the construct. However, one expert noted that some items such as "I feel depressed" could closely mirror other mental health concerns unrelated to empathy fatigue, and that it would be difficult to sparse out feelings of depression due to a mental health diagnosis or their work as a counselor. Therefore, these items were re-written to be more specific to counseling situations. For example, "I felt sad when thinking about my clients' problems."

One expert was consulted via Zoom, who did not provide feedback through the Qualtrics survey. The researcher asked questions about cultural implications, population characteristics of who the survey should be normed on (e.g., counselor trainees or professional counselors), and theoretical aspects of empathy fatigue (e.g., differentiating it from burnout and compassion

fatigue). The researcher used the feedback from this expert to inform methodological changes, including limiting participant inclusion criteria to professional counselors, additional demographic questions to include (e.g., occupational setting, counseling specialty, etc.) and inclusion of the seven proposed factors to align with the theory of empathy fatigue.

Target Population Review. Pilot testing the scale with individuals from the target population prior to formal administration helped the researcher to make sure the items were clear and understandable, and allowed the researcher to make any changes that would improve the participant experience (Bandalos, 2018; Lee & Lim, 2008). Bandalos (2018) notes that gathering feedback from the intended target population may help the researcher clarify language that may be confusing, enhance readability of the items, and incorporate overlooked aspects of the construct into scale items. Items may make sense to the researcher as they were the one who constructed the scale, but the population of interest can provide invaluable feedback in this regard, preventing further issues later in the scale development process. The researcher recruited four professional counselors to complete the Qualtrics survey after edits were made based on content expert feedback. The survey included all measures that were to be distributed during the large-scale study. This included: (1) a demographics questionnaire, (2) the CEFS, (3) validation measures (BIDR-16, compassion satisfaction subscale of the ProQoL, and CBI, (4) Likert-scale feedback questions, and (5) short-answer feedback questions. Likert-scale feedback questions and short answer feedback questions were only included in the pilot study survey.

For the purposes of this phase of the pilot study, a professional counselor was defined as an individual who holds a master's level degree or higher in the area of counseling, and must either hold a counseling certification (e.g., National Certified Counselor [NCC], school counseling certification), an associate (e.g., Licensed Professional Counselor Associate [LPCA],

Registered Mental Health Counseling Intern [RMHCI] or full license to practice counseling (e.g., Licensed Professional Counselor [LPC], Licensed Mental Health Counselor [LMHC], Licensed Marriage and Family Therapist [LMFT]). Professional counselors must also be actively counseling clients for a minimum of 15 hours per week (direct-client contact), either providing face to face or telehealth services, as empathy fatigue is directly related to counseling clients (Stebnicki, 2007; 2016).

Target Population Results and Revisions. Three licensed mental health counselors with master's degrees completed the pilot survey, which yielded a 100% response rate. They reported an average of 17-30 hours of direct client contact hours per week. Two participants had been in the field for four years and one participant had been a counselor for nine years. On average, participants reported that the survey took about 15-28 minutes to complete and shared that adding an additional 20 questions to the entire survey would not greatly impact their participation. Given that all participants shared that an additional 20 items would not impact their completion of the survey, the researcher chose to add in the entire ProQoL scale.

One participant suggested that having one or more jobs in different settings may change how participants respond. They shared, "I would've had much different results when I worked with agency and private practice at the same time during supervision years." Therefore, a question asking about additional counseling employment was added to the demographics portion of the survey. Another participant suggested adding questions about social supports related to empathy fatigue may be meaningful, as support was only covered via spirituality-related items. One major theme in their feedback included the effects on the counselor's personal functioning outside of work, suggesting a recognizable spillover of emotions, thoughts, and behaviors into one's personal life. Two participants commented on the idea of empathy fatigue causing an

increased desire for social isolation, or not having enough energy for family and friends. One participant noted:

> We can put on the mask and show up for our clients, but the cost is no longer showing up as ourselves to our family and friends. There's a projected or displaced resentment that occurs. You don't hate what you do, but you hate what it does to you.

Empathy fatigue affects counselors personally and professionally, as counselors use themselves as tools of change (Stebnicki, 2016). Therefore, the following questions were added to the CEFS: *I noticed more difficulties in my personal relationships; My loved ones have commented that I don't seem like myself; My personal relationships have been negatively impacted because of my work;* and *I haven't had as much energy for my relationships with family and friends.* Overall, participants believed the items were clear and that the topic is important to professional counseling. They also deemed the length of the survey reasonable.

Step 6: Conduct a Large-Scale Test of Items

The sixth step in the instrument development process was to conduct a large-scale test of the items once the items were edited and changes are made based on feedback from the pilot study. This large-scale test consisted of recruiting participants who met the inclusion criteria (specified below) and collecting an adequate number of survey responses to conduct EFA, based on recommendations about adequate sample size for EFA (see Bandalos, 2018). Details about participants, recruitment, and study measures are included in the following paragraphs.

Target Sample Size

Adequate sample size is critical to conducting rigorous EFA (Bandalos, 2018; Costello & Osborne, 2005). Although researchers have offered recommendations, there are no widely accepted rules for determining an adequate sample size for EFA (Costello & Osborne, 2005).

However, their review of two year's-worth of studies on principle components analysis and EFA, 62.9% of researchers used a sample size based on the participant to item ratio of 10:1 (Costello & Osborne, 2005). Item-ratio calculations to determine adequate sample size are often recommended as the best approach, rather than surveying a specific number of participants (e.g., 300; Bandalos, 2018; Costello & Osborne, 2005). The final version of the CEFS included a total of 79 items. Upon data analysis, the researcher found five duplicate items that were unintentionally included in the Qualtrics survey. Their distributions were examined, and the researcher kept the items that appeared more normally distributed based on visual inspection of the histograms. Prior to running the EFA, the researcher removed items 22, 34, 70, 71, and 72. The duplicate items were: *I found it hard to connect with things that were once meaningful to me*; *I engaged in my regular self-care practices; I believe my work makes a difference in the lives of others; I felt disconnected from a deeper meaning related to my work; I drifted away from my supports that give me a greater sense of connection.*

The researcher aimed for a 7:1 ratio of responses to items, a midpoint between the recommended 5:1 and 10:1 ratio (Bandalos, 2018). Based on this 7:1 ratio, the estimated adequate sample size needed for this study was $N = 553$ participants. Statistical analyses including Kaiser-Meyer-Olkin (KMO) and Bartlett's test of sphericity were conducted prior to running the EFA to ensure that the data was factorable.

Participants

To be eligible to participate in the study, participants had to be at least 18 years old, hold a minimum of a master's degree in counseling or a related helping field, and were currently practicing as a counselor, therapist, or social worker. Participants could have a background in clinical mental health counseling, marriage, couple, and family counseling, school counseling,

rehabilitation counseling, addictions counseling, counseling psychology, clinical social work, etc. as long as they were actively counseling clients at the time of taking the survey. The only exclusion criteria were for master's level trainees currently in school. This was because they may have less clinical experience than practitioners who have graduated and are working in the field. However, that is not to say that trainees cannot experience empathy fatigue. The researcher chose to limit the inclusion criteria in this way as students and professional clinicians working in the field may have experiences related to being in training that may change their responses to the survey questions (M. Stebnicki, Personal communication, July 28, 2022). For example, a counselor trainee may be inexperienced with working with trauma or may be experiencing countertransference for the first time in their careers. Although this may be stressful and bring about holistic changes, it may not be directly related to the stress of cumulative exposure to client pain and suffering.

Sampling Method

This research was funded by a Research and Practice Grant from the Southern Association for Counselor Education and Supervision (SACES) in the amount of $500. Participants were offered to be entered into a drawing for one of twenty $20 Amazon or Walmart gift cards. Participants were recruited through convenience and snowball sampling. The researcher sent the recruitment materials to her professional networks, which included a prewritten email call and study flyer. A QR code to the Qualtrics survey was available on the flyer and a clickable link to the survey was included in the body of the email. Additionally, the flyer was posted in social media groups that professional counselors may be members of. The researcher emailed Counselor Education faculty at CACREP-Accredited counseling programs for them to share recruitment materials with counselors and alumni. The researcher also reached

out to state licensing boards of mental health counselors, therapists, and social workers elicited lists of professional mental health counselors from 35 states. Contact lists from four states were made publicly available and the researcher directly emailed the study materials to provisional or fully licensed clinicians designated as "active." Given the use of convenience and snowball sampling, a true response rate could not be calculated for this study.

Measures

The Qualtrics survey included the following measures: (1) a demographic questionnaire, (2) the CEFS, (3) the Balanced Inventory of Desirable Responding Short Form (BIDR-16; Paulhus, 1991), (4) the Counselor Burnout Inventory (CBI; Lee et al., 2007), and (5) the Professional Quality of Life Scale (ProQoL; Stamm, 2010).

The CBI was used as a measure of convergent validity, as it measures the experience of burnout in professional counselors, a similar construct to empathy fatigue. The researcher included the BIDR-16 as a measure of socially desirable responding. A common pitfall in self-report survey designs is the potential for participants to respond to items in a socially desirable way (McKibben & Silvia, 2017). Given the nature of the CEFS measuring a degree of counselor impairment, respondents may be hesitant to answer truthfully for fear of personal and professional repercussions (e.g., shame, guilt, removal from position). A low correlation between scores on the BIDR-16 and CEFS would provide evidence that participants did not answer the CEFS items in a socially desirable manner (Bandalos, 2018; Lee & Lim, 2008; McKibben & Silvia, 2017). Scores on the compassion satisfaction subscale of the ProQoL were used to estimate discriminant validity of the CEFS as compassion satisfaction includes the positive aspects of working as a helping professional. A description of each instrument including psychometric properties is outlined in the following sections.

CEFS. The CEFS, prior to factor analysis, included 79 items and was developed by the researcher for the purposes of this dissertation study measuring empathy fatigue in mental health professionals. The need for the instrument and theoretical background was outlined in Chapter Two of this dissertation. Respondents rated each item on a five-point Likert-scale ranging from 1 (*not at all*) to 5 (*nearly every day*). Items noted to the researcher were reverse scored, and the sum of all items will be calculated. In addition, each subscale that emerged would yield a total score, and the range of possible scores will be calculated based on the number of items in each factor (see Appendix Q for scoring information). The CEFS prior to exploratory factor analysis is included in Appendix D.

BIDR-16. Social desirability is a common issue in self-report surveys, given that respondents can answer in ways that enhance their self-image, or reduce a negative one (Hart et al., 2015; McKibben & Silvia, 2017). Social desirability measures are often used in conjunction with self-report surveys to determine the degree to which respondents are answering the survey questions honestly, which can ultimately enhance the validity of the survey. Historically, the Marlowe-Crowne Social Desirability Scale (MCSDS; Marlowe & Crowne,1960) was the most popular instrument that measured social desirability bias (Nederhof, 1985; Lee & Lim, 2008). Several limitations of the MCSDS including length, low reliability, and outdated language, prompted scholars to suggest using the BIDR-16, which consists of 16-items. The original BIDR, created by Paulhus (1984), contained 40-items that intended to measure socially desirable responding within two dimensions: impression management (IM) and self-deceptive enhancement (SDE). For this study, the BIDR-16 was used to limit survey fatigue as other instruments included several items. The BIDR-16 has the same subscales as the 40-item version, IM and SDE. Items are rated on an 8-point Likert scale from *1 = totally disagree* to 8 = *totally*

agree) and scored continuously by summing all items to calculate total and subscale scores. Example items include: "I *have not always been honest with myself*" and "*I am a completely rational person.*" Test-retest reliability for the IM and SDE subscales are adequate, $r = .79$, for SDE, and $r = .74$ for IM (Hart et al., 2015). Hart and colleagues (2015) also found evidence for construct validity, providing psychometric support for using BIDR-16. The researcher conducted Pearson correlation analyses with the CEFS and BIDR-16 as a measure of discriminant validity.

CBI. The Counselor Burnout Inventory (CBI; Lee et al., 2007) measures symptoms of burnout in professional counselors. Lee and colleagues (2007) define counselor burnout as "a failure to perform clinical tasks appropriately because of personal discouragement, apathy toward system stress, and emotional/physical strain (p.143). Respondents rate 20-items on a five-point Likert scale ranging from 1 (*never true)* to 5 (*always true*). The CBI has on five subscales: (1) negative work environment, (2) devaluing client, (3) deterioration in personal life, (4) exhaustion, and (5) incompetence (Lee et al., 2007). Example items include "*It is hard to establish rapport with clients*" and "*I feel drained after sessions*." The CBI has strong internal consistency reliability ($\alpha = .88$) and good test-retest reliability ($\alpha = 0.81$; Lee et al., 2007). The CBI was correlated with the CEFS to ascertain evidence of convergent validity, as the CEFS is intended to measure a construct that is similar to Lee and colleagues' (2007) definition of counselor burnout.

PROQOL. The ProQoL is a 30-item assessment measuring positive and negative aspects of working as a helping professional. Based on the Theoretical Model of Compassion Satisfaction and Compassion Fatigue, the ProQoL has three 10-item subscales: compassion satisfaction, burnout, and secondary traumatic stress (Stamm, 2010). The compassion satisfaction subscale of the measure was used to ascertain evidence of discriminant validity of the CEFS, as

it is an opposing construct to empathy fatigue. Compassion satisfaction refers to the positive aspects of working as a helping professional, including feeling satisfied with being a helper. Participants rate each item on a five-point Likert scale, from one (*never*) to five (*very often*). ProQoL scores are calculated and interpreted by the subscales, rather than a total score, and the compassion satisfaction subscale also has good reliability (α = 0.88; Stamm, 2010). Further, there are over 200 published papers that use the ProQoL, and good construct validity has been established (Stamm, 2010). Therefore, using the compassion satisfaction subscale offers a psychometrically sound measure of discriminant validity. Example items on the compassion satisfaction subscale include: "*I feel invigorated after working with those I [help]*" and "*I believe I can make a difference through my work*."

Step 7: Analyze Items (Exploratory Factor Analysis)

Factor analysis is a data-reduction technique frequently used in scale development, that can be used to identify the factor structure of a latent construct, or a construct that cannot be measured directly (Finch, 2020; Lee & Lim, 2008). The structure refers to the features of the model, including how many total factors there are, which factors are related, and how variables (items) load on each factor (Bandalos, 2018). EFA is a procedure that can be used when the researcher has minimal information on the expected factor structure underlying a set of observed variables. When there is a strongly established theoretical framework that explains the factor structure confirmatory factor analysis can be used to determine the fit of the model to the data, confirming the proposed factor structure (Bandalos, 2018; Finch, 2020). Most of the literature on empathy fatigue, albeit minimal, is conceptual (e.g., Dowling, 2018; Hofmeyer et al., 2020; Stebnicki, 2016). Dimensions, or factors, of empathy fatigue have been proposed by Stebnicki (2008), but no researchers to date have empirically examined the hypothetical nature of the

construct. Therefore, for the purposes of determining the underlying factor structure of the CEFS to better understand the facets of empathy fatigue, the researcher used EFA, allowing for the factor structure to emerge from the data. The following section explains the EFA procedures the researcher followed, based on researcher recommendations (e.g., Bandalos, 2018; Finch, 2020; Lee & Lim, 2008; Pallant, 2020; Watson, 2017).

Data Preparation

After the researcher collected an adequate sample size based on expert recommendation, data was prepared, cleaned, and screened for errors using SPSS version 28.0.0.1. Assumptions for factor analysis include normality, linearity, and that any missing data be missing completely at random (MCAR). Normality was evaluated based on checking the skewness and kurtosis of the data distribution for total CEFS scores. Values of skewness and kurtosis should be less than |2.0| for the data to be considered normal (Bandalos, 2018). Although a normal dataset is not a requirement to conduct EFA, non-normally distributed variables can lead to the retention of difficulty factors, which can cause confusion during factor interpretation (Bandalos, 2018). Linearity was assessed by looking at the scatterplots of each variable to determine if there was a nonlinear relationship among any of the variables. The results of these checks are reported in Chapter Four.

One measure of factorability of the dataset is examining correlations between variables by producing an intercorrelation matrix. Correlations should fall within the range of .2 and .8, for the data to be factorable. Any correlation below .2 would indicate that the variables are not related enough to work for factor analysis (Watson, 2017). Correlations above .8 suggest that the variables are too closely related and might be measuring the same thing, which would make

variables loading onto different factors difficult (Watson, 2017). Therefore, the researcher examined the intercorrelation matrix as another check of the factorability of the data.

Finally, the researcher conducted the KMO test and Bartlett's test of sphericity (Watson, 2017). The KMO test measures the strength of the relationship among variables to determine whether they are appropriate for factor analysis. It also is a measure of sampling adequacy for the variables and the overall model (Pallant, 2020; Watson, 2017). A KMO value of .60 or greater indicates the data are suitable for factor analysis (Tabachnick & Fidell, 2013). Barlett's Test of Sphericity Tests the null hypothesis that the intercorrelation matrix is an identity matrix, meaning that no variables are correlated. If significant *(*i.e., $p < 0.05$), the researcher can reject the null hypothesis, providing evidence that the variables are related enough, and thus are appropriate for factor analysis (Watson, 2017). In other words, Bartlett's Test of Sphericity should be significant before proceeding with the EFA (Pallant, 2020). Results of hypothesis testing regarding suitability of the data for factor analysis are included in Chapter Four.

Factor Extraction

Once the data were deemed suitable, the next step of the exploratory factor analysis was to determine how many factors to extract. The purpose of factor extraction is to identify the smallest number of factors (i.e., reach parsimony) that explain the most variance by partitioning variances in each variable (Pallant, 2020; Watson, 2017). To do this, there are several methods that can be used. Researchers recommend using maximum likelihood, common factors, or principal axis factoring in exploratory factor analyses (Lee & Lim, 2008; Watson, 2017). According to Watson (2017) "when the researcher's goal is to extract factors based on shared variance only and determine whether latent factors underlying the data exist" (p. 223) maximum likelihood or principal axis factoring should be used. If the data are normally distributed,

maximum likelihood should be used. If non-normally distributed, principal axis factoring is recommended (Bandalos, 2018; Watson, 2017). The researcher will consult several methods determine the number of factors to retain including examining the scree plot, noting eigenvalues greater than 1.0, conducting a parallel analysis, and assessing the total amount of variance accounted for by the least number of factors (Bandalos 2018; Costello & Osborne, 2005; Watson, 2017).

Factor Rotation

To enhance the interpretability of the initial factors that will be retained, a factor rotation method will be implemented. Factor rotations allow for the researcher to make more meaningful interpretations of the data, as it clarifies and simplifies the data structure (Costello & Osborne, 2005; Watson, 2017). Several rotation methods exist, and oblique and orthogonal rotations are among the most used (Bandalos, 2018; Watson, 2017). The researcher will employ a direct oblimin rotation, which is a common rotation method for exploratory factor analysis (Costello & Osborne, 2005; Finch, 2020; Watson, 2017). Direct oblimin rotation should be used when the factors are likely to be correlated, or, when there is not sufficient evidence that the factors should or should not be correlated based on theory (Bandalos, 2018; Finch, 2020; Osborne, 2015; Watson, 2017). Another goal of factor rotation is to get as close as possible to a simple structure, when each item loads onto only one factor (Watson, 2017). Although finding a simple structure is not likely, the goal of rotation is to come as close to a simple structure as possible, to learn about which observed variables measure the latent construct (Finch, 2020; Watson, 2017). The factor pattern matrix was then examined to determine how close the data are to a simple structure (Watson, 2017).

Factor Interpretation

Following the direct oblimin rotation, factors were labeled, based on a review of the items that load on each factor. If an item loaded lower than a 0.32, it was removed from the scale after consultation with the structural matrix, pattern matrix, and theory (Finch, 2020; Watson, 2017). The reason .32 is used is a cutoff, is that the squared loading equals the amount of variance explained by that variable (Bandalos, 2018). Meaning, about 10% of the variance in a factor is accounted for by variables that load higher than .32 on a factor. This is considered an acceptable threshold for social science research (Bandalos, 2018; Watson, 2017). The items on each factor were examined to determine the theme among the items. Each factor was named based on consultation with theory and the content of the items that loaded on that factor. Once factors were identified and defined, reliability, validity, and socially desirable responding were investigated.

Step 8: Conduct Reliability and Validity Analyses

The researcher conducted reliability and validity analyses were conducted to answer research questions 3a and 3b and examine the psychometric properties of the CEFS. Factor analysis is only a data reduction technique and does not provide information about the psychometrics of the instrument (Bandalos, 2018; Lee & Lim, 2008; Watson, 2017). The researcher calculated three separate bivariate correlations (Pearson product-moment correlations; *r*) between scores on the CEFS and scores on two additional measures: one that measures a similar construct to establish convergent validity, and one scales measuring a different construct to provide evidence of discriminant validity (Lee & Lim, 2008). Pearson product-moment correlations are used to established validity when using interval or ratio variables (Swank & Mullen, 2017).

Reliability

Score reliability analyses were conducted in the Statistical Package for the Social Sciences (SPSS). All data was cleaned, and necessary assumptions were checked. Reliability is a measure of the internal consistency of the items (Lee & Lim, 2008). The researcher calculated Cronbach's alpha, a commonly used coefficient of internal consistency, for the CEFS which derives scores from a Likert scale (Bandalos, 2018; Bardoshi & Erford, 2017; Cronbach, 1951). Values for Cronbach's alpha range from zero to one, and the higher the correlation, the greater the reliability (Cronbach, 1951). The CEFS total scale reliability was hypothesized to be at least $r = .70$ or greater, which is typically acceptable in the social sciences (Lee & Lim, 2008).

Validity

Validity is a psychometric property that provides evidence that the items on the scale measure the hypothesized latent variable and helps to provide information about the theory underlying the construct (Bandalos, 2018). Validity is a vital aspect of instrument development, as it allows the researcher to meaningfully interpret scores on a measure (Bandalos, 2018). By assessing bivariate correlations between scores on similar and different measures, evidence of convergent and discriminant validity can be provided (Lee & Lim, 2008; Swank & Mullen, 2017). Convergent validity is estimated through a Pearson product-moment correlation coefficient, and the stronger the correlation, the greater the evidence that the scale in development relates in construct to an established measure (Bandalos, 2018; Lee & Lim, 2008). Discriminant validity estimates the degree to which constructs are differentiated from each other, by analyzing whether scores on scales measuring different constructs are weakly related (Bandalos, 2018).

Test scores on the compassion satisfaction subscale of the ProQoL were used for discriminant validity and it was hypothesized that there would be a non-significant, weak correlation produced between scores on the measures. It was hypothesized that the correlation between scores on the CEFS and compassion satisfaction subscale of the ProQoL would be weak (less than .3) and nonsignificant ($p > .05$). Scores on the CBI were correlated with scores on the CEFS to provide a measure of convergent validity, as they measure similar constructs. It was hypothesized that the correlation between scores on the CEFS and scores on the CBI would be significant ($p < .05$), positive, and moderate to strong (greater than .7), providing evidence of convergent validity.

The researcher used SPSS to clean and prepare the data prior to running validity analyses. Initial assumptions were checked to determine whether correlation analyses can be conducted. Using Cohen's (1992) guidelines, G*Power analyses determined that a sample size of $n = 84$ would be sufficient to conduct a bivariate correlation with a medium effect size, alpha level of .05, and minimum power of .80 (see Appendix E). The minimum sample size needed for the EFA as much greater than 84, so the researcher was able to conduct validity analyses with adequate power. Prior to conducting validity analyses, the researcher checked the data to see if a linear trend between scores exists, that the data were normally distributed, and no outliers existed (Swank & Mullen, 2017). Given that the large sample size needed for EFA may overpower the validity analyses, the researcher was aware of getting a small correlation that is statistically significant in the analyses, as that could be of concern related to having too much power (Swank & Mullen, 2017).

A Priori Limitations

As with all research, this study has a priori limitations. First, the use of convenience and snowball sampling will not allow for the calculation of a survey response rate, because the researcher would not know how many participants agreed to complete the survey (Fincham, 2008). A response rate is useful in identifying whether the collected sample is representative of the population. Without a response rate, nonresponse bias cannot be calculated, and the researcher could not know the degree to which a representative sample was obtained prior to data analysis.

The literature on empathy fatigue in counseling is sparse, as other topics such as burnout, stress, and compassion fatigue receive more empirical and theoretical examination (Arañez Litam et al., 2020). The CEFS was developed based on existing literature on empathy fatigue, however it is of note that empirical studies on empathy fatigue are limited, which may threaten the construct validity of the instrument. Additionally, empathy fatigue is a dynamic, contextual, multifaceted construct that will vary from counselor to counselor, which makes creating a valid and reliable quantitative measure challenging. Using theory to ground the creation of this instrument will hopefully result in a reliable approximation of empathy fatigue levels.

Empathy fatigue is a type of maladaptive functioning, in response to working as a counselor. Therefore, respondents may be hesitant to answer the questions honestly for fear of repercussions in their work. They may also be reluctant to acknowledging that they are experiencing ill effects due to their work (Ledingham et al., 2019). For example, if a counselor is making cynical comments about their clients to coworkers, they may not be redescent to admit such behavior. This may cause them to answer in a socially desirable way, to avoid feelings of shame. Additionally, they may not be aware that their comments are cynical in nature. Self-

report measures are subject to social desirability bias, where respondents may answer the survey questions in a way that paints them in a good light. Self-report measures are also only as strong as the counselor's level of self-awareness. The counselor may believe they are responding truthfully to the question, simply due to lack of awareness of their behaviors or functioning. These limitations are important to keep in mind and when developing a self-report instrument.

Chapter Summary

The current chapter outlined the methodological processes of developing and validating the CEFS, detailing the seven steps of instrument development proposed by Bandalos (2018), including identifying the purpose of the scale, defining the domain of the construct to be measured, determining item format, generating the initial item pool, conducting initial item review and revisions through a pilot study, conducting a large-scale test of items, analyzing items, and conducting reliability and validity analyses. In the next chapter, the results obtained from the exploratory factor analysis, reliability, and validity testing are discussed.

CHAPTER IV: RESULTS

Chapter three provided an overview of the methodology used to develop the CEFS, procedures to determine the underlying factor structure of the measure, and steps for determining the psychometric properties of the instrument. This chapter includes the results of data analysis for proposed research questions one through five. First, the researcher will describe how the data was cleaned and prepared for analysis. Next, demographic characteristics of the sample are presented, and finally, the results of the analysis used to test the proposed hypotheses are provided. In this chapter, conclusions for support or refuting of hypotheses are introduced, and the subsequent chapter interprets these findings within the context of the extant literature and implications for the field of Counselor Education, training, and clinical practice.

Data Preparation

The data was cleaned and screened for errors using the Statistical Package for the Social Sciences (SPSS) Version 28.0.1.1. At the initial start of recruitment, the researcher encountered robotic responding to survey data, given that recorded responses indicated that the survey was completed multiple times with identical IP Addresses, and the recorded dates and times were identical for each response. Therefore, the researcher meticulously inspected the data prior to any statistical analyses. The researcher used quantitative and qualitative reasoning to flag responses potentially provided by bots as the survey contained Likert scale items and short answer questions. Qualitative, the researcher reviewed the fill-in responses to determine whether the response was reasonable. For example, one response to the question "*On average, how many hours of direct client contact do you have per week?"* One participant wrote '5 years' which was not related at all to the question. This response was flagged as an automated response and removed from the data set.

Quantitatively, frequencies for each variable were ran to determine whether responses to demographic questions that required a numeric answer were within reasonable ranges. The researcher identified six cases where responses seemed abnormal. Three respondents reported not being licensed. Although being fully or provisionally licensed was not part of the study inclusion criteria, upon further inspection of the cases, two written responses appeared incongruent with expected answers (e.g., not being licensed but had 21 years of experience, etc.). These cases were removed from the data set. Two respondents reported an unreasonable amount of time practicing in the field (i.e., -1 years and 770 years) and those cases were deleted after triangulating the legitimacy of those responses. One respondent who reported being 18 years old, running a private practice and working in a group practice was also removed from the data set. Incomplete responses to survey questionnaires were also deleted from the data set. Finally, the researcher noticed $n = 42$ participants reported having, on average, zero direct client contact hours per week. Participants needed to be actively seeing clients to be eligible to participate (i.e., actively practicing). Thus, participants who did not report the average number of direct hours per week or reported this to be zero, these cases were removed from the data set, as they may have answered differently than those who reported having direct contact hours with clients.

Participants

After cleaning and screening the data, the final sample size for this study was $N = 487$, yielding a 6.6 response to item ratio for the EFA. Participants were between the ages of 23 and 78 ($M = 41.28$, $SD = 13.02$). On average, participants reported having 10.28 ($SD = 9.38$) years of experience working in the counseling (or related) field, ranging from one year to 51 years. Most participants, 85% ($n = 414$), identified as women and 8.6% reported being men ($n = 42$). Further, 2.3% of the sample ($n = 11$) reported being non-binary, 0.2% reported identifying as a

transgender man (*n* = 1), 1.2% reported being gender queer/gender fluid/gender non-conforming (*n* = 6). Only one participant reported "I prefer not to say" and another two reported "other." A large majority of the sample identified as Caucasian/White (84.8%; *n* = 413). Fifteen identified as African American (3.1%), seven identified as multiracial (1.4%), five reported being Asian American (1%), three reported being Native American (.6%), and one participant identified as Asian (.2%). Seventeen reported being Hispanic (3.5%) and seven chose to self-identify (1.4%).

Most of the participants, 433 (88.9%), reported that their highest degree earned was a masters with PhD following second 40 (8.2%), and 10 (2.1%) reporting 'other.' Other degrees included PsyD, DMin., DMFT, or having two master's degrees. Participants reported a range of counseling specialties, but the majority reported their specialty area as Clinical Mental Health Counseling (n = 353, 72.5%). Twenty-nine participants reported specializing in Marriage and Family Therapy (6.0%), 26 (5.3%) in Social Work, 18 (3.7%) in Addictions Counseling, 15 (3.1%) in School Counseling, 12 (2.5%) reported Clinical Psychology, four (.8%) were in College Counseling/Student Affairs, two (.4%) were in Rehabilitation, two (.4%) reported Career Counseling, and 23 (4.7%) reported 'other.' Most participants worked full time (*n* = 385, 79.1%) and in private practice (*n* = 209, 42.9%) or outpatient (*n* = 144, 29.6%) settings. Of note, 42 participants (8.6%) reported working in a school, 14 reported working in a residential treatment facility (2.9%), 12 reported working in a college counseling center (2.5%), and 10 reported working in intensive outpatient (2.1%). Fewer than six participants each reported working in inpatient (*n* = 5), hospital (*n* = 4), or partial hospitalization settings (*n* = 4).

About 22% of the sample (*n* = 108) reported working more than one counseling job, and about 22% (n = 106) reported having an additional job that did not include counseling. Most participants in the study were fully licensed (*n* = 365, 74.9%). A total of 119 participants

reported being provisionally licensed (24.4%). Participants reported an average of 23.37 direct client contact hours per week (*SD* = 8.76), ranging from a minimum of two hours a week to a maximum of 50. The most represented credentials in the sample were LPC (*n* = 148, 30.4%), LAC (28, 5.7%), LCPC (25, 5.1%), LCMHC (22, 4.5%), LPCC (19, 3.9%), LMHC (14, 2.9%), LCSW (21, 4.3%), LPCC-S (10, 2.1%). If participants reported having more than one credential (e.g., LPC, LMFT) they were not included in the above statistics as they were reported separately from single credentials. When asked if they were an approved clinical supervisor, 407 (83.6%) reported no. Further, 235 (48.3%) reported specializing in working with trauma.

Results of Hypothesis Testing

Research Question One: What is the Factor Structure of the CEFS?

The researcher first examined assumptions for factor analysis including linearity, multicollinearity, and normality. The data set was also reviewed for missing data. Scatterplots of the variables were examined at the item and total scale level, and linear relationships were observed among variables. Upon examining the intercorrelation matrix among variables, most correlations ranged from .2 to .8, indicating that the variables were sufficiently correlated for factor analysis and multicollinearity was not an issue (Watson, 2017).

Values of skewness and kurtosis were calculated to determine if the data were normally distributed. The skewness for the CEFS total scale was .936 (SE = .111) and kurtosis was .590 (SE = .221), which fell outside of the range of acceptable values (i.e., |2.0| to |7.0|; Bandalos, 2018). Results of normality tests provided further evidence that the data was not normally distributed. The Kolmogorov-Smirnov test was significant (.098, $df = 487$, $p < 0.001$), as was Shapiro-Wilk's test (.938, $df = 487$, $p < 0.001$). Upon visual inspection of the histogram, the data

appeared to be positively skewed, indicating that respondents in general scored relatively low on the overall CEFS (see Figure 1).

Figure 1. CEFS Total Scale Scores

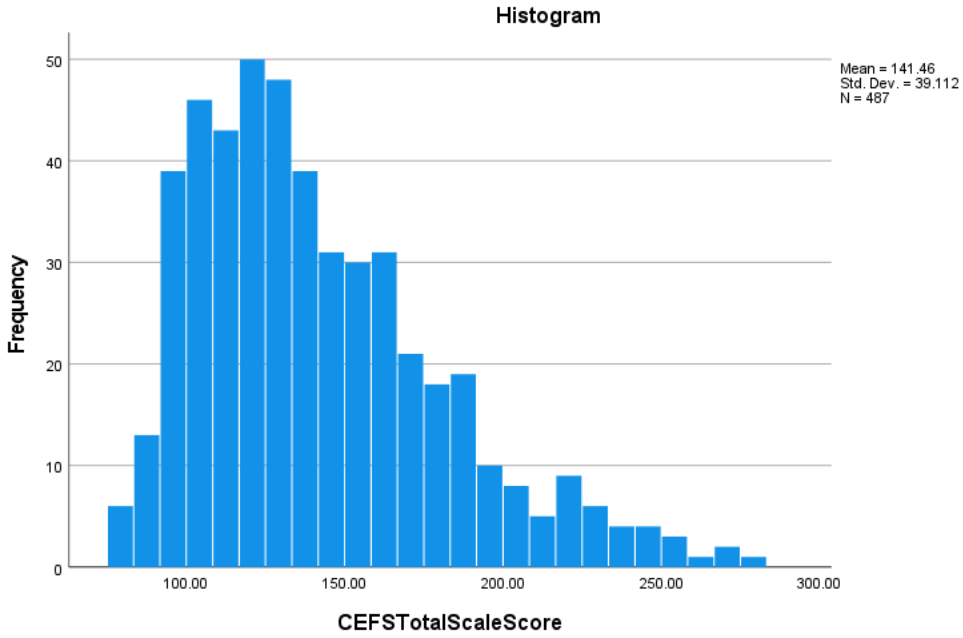
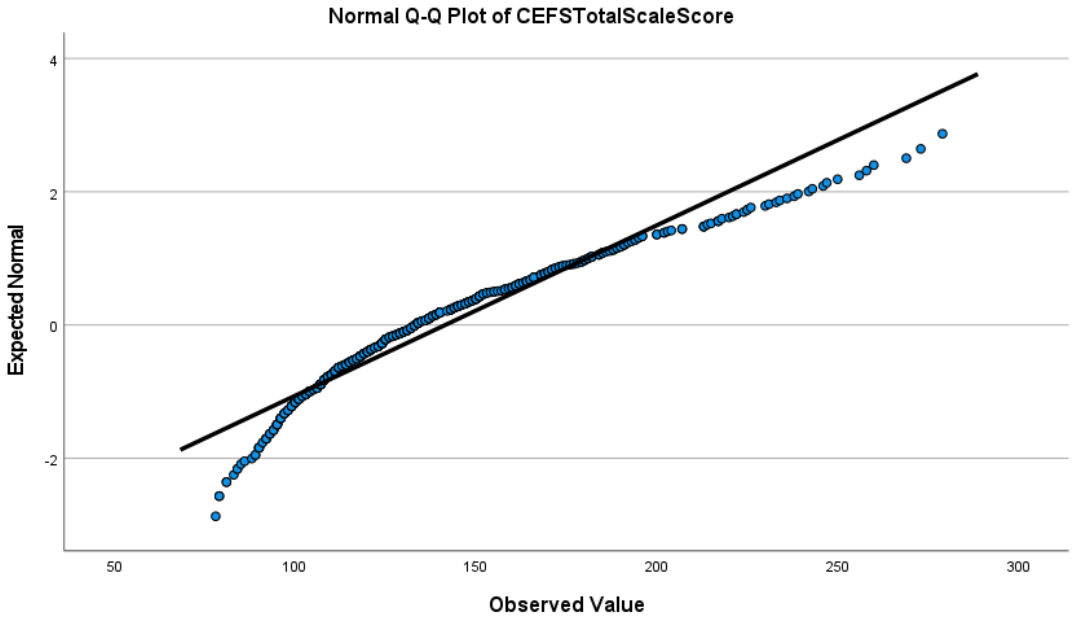


Figure 2. Normal Q-Q Plot of CEFS Total Scale Scores



Missing data is common in research with human participants. Data may be missing due to human error, or an intentional omission of responses to a certain question. It is important to determine whether there are systematic reasons why data would be missing, as it may provide useful information to the researcher and could significantly alter the results of the subsequent analyses (Pallant, 2020). To test whether the data were missing completely at random, the researcher conducted Little's Missing Completely at Random Test (MCAR). The result was not significant (χ^2 = 2049.334, *df* = 3984, *p* = 1.000) providing statistical evidence that the data were missing completely at random meaning that missing data were not likely omitted an intentional way.

Factor Extraction

The researcher then proceeded with the exploratory factor analysis once the data was deemed suitable. The first step was to determine the number of factors to extract from the

variables (i.e., items) in the data set. Given that the data were not normally distributed, the researcher used principal axis factoring (PAF; Watson, 2017). PAF breaks down the reduced correlation matrix into eigenvalues and eigenvectors, also called eigen-decomposition (Bandalos, 2018). PAF is a robust extraction method because it allows the researcher to extract the maximum amount of covariance possible from the reduced covariance matrix (Bandalos, 2018). It is also recommended for use when the assumption of multivariate normality is violated (Bandalos, 2018; Watson, 2017).

Several methods were used to determine how many factors should be retained before rotation. The researcher used Kaiser's criterion, total variance explained, scree plot, and parallel analysis to decide the number of factors to retain. Kaiser's criterion, otherwise known as the "eigenvalues greater than one rule" is widely used in factor analysis, but has been criticized for over factoring (Pallant, 2020). Kaiser's criterion suggested that 15 factors be retained in this initial analysis. The KMO value was .946 and Bartlett's Test of Sphericity significant, (χ^2 = 22983.482, df = 3081, p = .000) indicating the data were excellent for factor analysis. These 15 factors explained 53.68% of the variance (see Table 1).

Table 1. Initial Eigenvalues

	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings
Factor	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total
1	22.016	29.752	29.752	21.611	29.203	29.203	8.695
2	3.842	5.192	34.944	3.381	4.569	33.773	5.202
3	3.030	4.094	39.039	2.572	3.476	37.249	7.324
4	2.301	3.109	42.148	1.857	2.510	39.758	10.702
5	2.106	2.845	44.993	1.692	2.287	42.046	7.117
6	1.907	2.578	47.571	1.446	1.954	44.000	5.971

7	1.813	2.450	50.020	1.365	1.844	45.844	5.908
8	1.478	1.997	52.017	1.016	1.373	47.217	8.365
9	1.425	1.926	53.943	.932	1.260	48.477	5.655
10	1.246	1.683	55.626	.775	1.048	49.525	4.648
11	1.179	1.593	57.219	.738	.998	50.523	8.386
12	1.169	1.579	58.799	.629	.851	51.373	3.328
13	1.065	1.439	60.238	.599	.809	52.182	6.209
14	1.032	1.395	61.632	.566	.765	52.947	5.021
15	1.018	1.375	63.008	.541	.732	53.679	6.813
16	.987	1.334	64.342				
17	.958	1.294	65.637				
18	.943	1.275	66.911				
19	.921	1.245	68.156				
20	.877	1.186	69.342				
21	.863	1.166	70.508				
22	.825	1.114	71.623				
23	.821	1.109	72.732				
24	.791	1.069	73.800				
25	.751	1.015	74.816				
26	.697	.942	75.758				
27	.684	.924	76.682				
28	.666	.901	77.583				
29	.657	.888	78.471				
30	.644	.870	79.341				
31	.622	.840	80.181				
32	.612	.827	81.008				
33	.584	.789	81.797				
34	.559	.756	82.553				
35	.546	.738	83.291				
36	.533	.720	84.011				

37	.523	.707	84.718
38	.507	.685	85.404
39	.482	.652	86.055
40	.472	.637	86.692
41	.464	.627	87.319
42	.458	.619	87.938
43	.435	.588	88.526
44	.414	.560	89.086
45	.400	.540	89.626
46	.388	.524	90.150
47	.385	.520	90.671
48	.380	.514	91.184
49	.370	.501	91.685
50	.357	.483	92.167
51	.355	.480	92.647
52	.344	.465	93.113
53	.339	.457	93.570
54	.329	.444	94.014
55	.317	.428	94.442
56	.306	.414	94.856
57	.294	.398	95.254
58	.287	.388	95.642
59	.269	.364	96.005
60	.254	.343	96.348
61	.244	.330	96.678
62	.240	.325	97.003
63	.235	.317	97.320
64	.224	.303	97.624

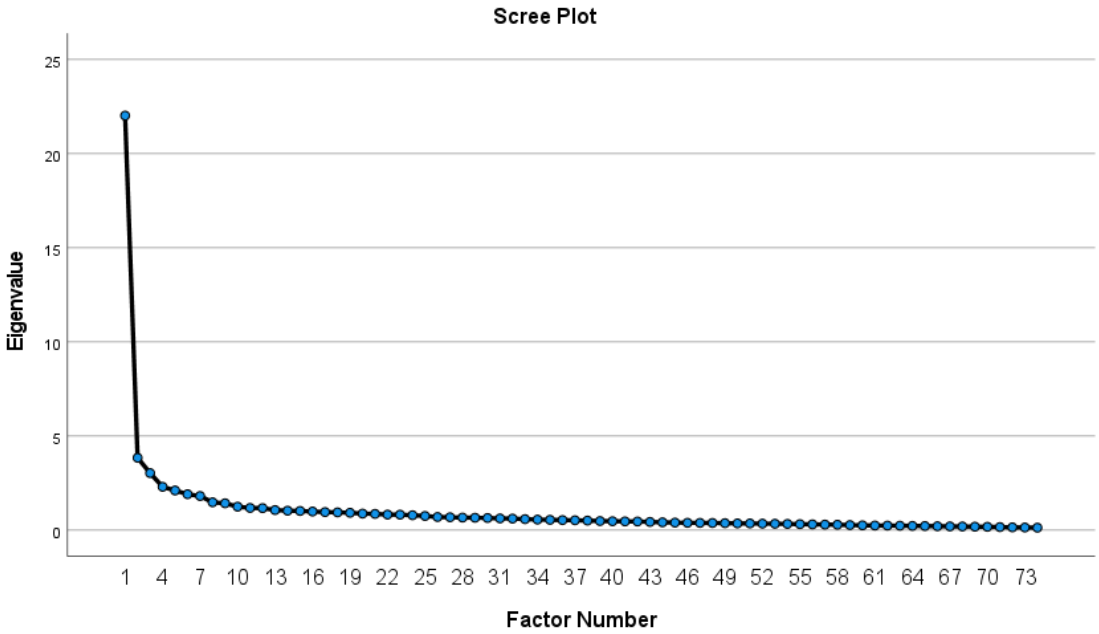
65	.218	.295	97.918
66	.208	.280	98.199
67	.199	.269	98.468
68	.194	.262	98.730
69	.184	.248	98.978
70	.176	.238	99.216
71	.162	.219	99.435
72	.148	.200	99.635
73	.140	.189	99.824
74	.130	.176	100.000

Extraction Method: Principal Axis Factoring.

The factors "above the elbow" in the scree plot suggested there were two, but possibly four factors. The number of factors above where the line in the scree plot turns to become horizonal is how many should be retained (Pallant 2020; Figure 3), which contradicted retaining 16 factors based on Kaiser's criterion. Based on Kaiser's criterion, the four-solution explained 40.06% of the total variance. Given the discrepancy in the suggested number of factors to retain from the scree plot and Kaiser's criterion, the researcher ran a parallel analysis. Parallel analysis is a method that compares the computed eigenvalues to eigenvalues from a randomly generated data set with the same sample size (Pallant, 2020). The results of the parallel analysis indicated the researcher should retain nearly all the factors (i.e., the number of variables in the data set), proving unhelpful in determining the number of factors to retain as the goal is to reduce the overall number of items. Each method's results were conflicting with one another, and thus, the researcher used the scree plot, total variance explained, and the theoretical number of subscales for the measure to decide the number of factors to retain. The researcher consulted several methods in each iteration of the analysis with the goal of parsimony: retaining the least number

of factors for the most variance explained. However, exploratory factor analysis is meant to be exploratory (Bandalos, 2018), to the researcher explored two, three, four, and five factors during the initial stages of data analysis.

Figure 3. Scree Plot



The two-factor solution accounted for 33.41% of the total variance, but 46 of the 74 items had communality values below .4. If the researcher followed Watson's (2017) recommendation to remove these items, the total number of items on the scale would decrease significantly, prior to removing items based on factor loadings. In addition, two factors are quite different than the original seven-factor proposed theory, moving farther away from the theoretical influence of the measure. Therefore, the researcher decided not to use the two-factor model. The three-factor solution accounted for 36.6% of the overall variance with 42 items with communalities below .4. The four-factor model accounted for 39.16% of the variance with 38 items with communalities below .4. Next, the researcher fixed the data to five factors, which accounted for 41.20% of the total variance. To continue exploring this five-factor model, 37 items with communalities below

.4 were removed, as well as additional items with cross-loadings or low loadings. During this process, the fifth factor dropped out of the pattern matrix, indicating that this may not be the appropriate number of factors for the data. Further, four to 10 items are recommended per subscale, which would not have held with the five-factor model (Mvududu & Sink, 2013).

As the scree plot potentially suggested four factors, the researcher then tried fitting the data to a four-factor model. The KMO value was .947 and Bartlett's Test of Sphericity was significant (χ^2 = 19825.14, *df* = 2701, *p* = .000) indicating that the data were well suited for factor analysis. Four factors were ultimately retained because of scree plot recommendations, and parsimony (i.e., the least number of factors explaining the most variance). Items with communalities below .4 were removed as they may not explain enough of the variance in the factor (Watson, 2017). There were 38 items with communalities below .4 (see Table 2). After removing the 38 items, variance explained increased from 39.00% to 54.34%. The factors were then rotated to improve ease of interpretation.

Table 2. Item-Level Communalities

	Initial	Extraction
CEFS1	.436	**.277**
CEFS2	.714	.564
CEFS3	.582	.418
CEFS4	.718	.633
CEFS5	.672	.535
CEFS7	.549	**.380**
CEFS8	.491	**.283**
CEFS9	.597	**.361**
CEFS10	.479	**.275**
CEFS11	.676	.560
CEFS12	.614	**.392**
CEFS13	.520	**.377**
CEFS14	.784	.652
CEFS15	.666	.527

CEFS16	.514	**.369**
CEFS17	.574	.408
CEFS18	.567	.469
CEFS19	.674	.511
CEFS23	.609	.448
CEFS24	.568	.445
CEFS25	.530	**.322**
CEFS27	.533	**.365**
CEFS28	.735	.561
CEFS29	.406	**.272**
CEFS30	.238	**.140**
CEFS31	.699	.559
CEFS32	.557	.436
CEFS33	.751	.626
CEFS35	.745	.659
CEFS36	.739	.569
CEFS37	.696	.527
CEFS39	.450	**.284**
CEFS40	.741	.637
CEFS41	.610	.509
CEFS42	.680	.507
CEFS43	.632	.467
CEFS44	.697	.591
CEFS45	.511	**.272**
CEFS46	.459	**.309**
CEFS47	.475	**.278**
CEFS48	.760	.616
CEFS50	.612	.501
CEFS52	.502	**.383**
CEFS53	.709	.564
CEFS54	.353	**.123**
CEFS55	.450	**.343**
CEFS56	.555	**.377**
CEFS57	.441	**.248**
CEFS59	.633	.447
CEFS60	.557	**.137**
CEFS61	.392	**.283**
CEFS62	.573	**.110**
CEFS63	.390	**.218**

CEFS65	.593	.427
CEFS68	.448	**.276**
CEFS69	.599	.423
CEFS74	.553	.465
CEFS75	.706	.615
CEFS77	.595	.481
CEFS78	.304	**.176**
CEFS 6*	.374	**.159**
CEFS 21*	.551	.450
CEFS 26*	.377	**.174**
CEFS 38*	.528	**.391**
CEFS 49*	.510	**.343**
CEFS 51*	.301	**.128**
CEFS 58*	.422	**.349**
CEFS 64*	.396	**.239**
CEFS 66*	.464	**.229**
CEFS 67*	.425	**.154**
CEFS 73*	.595	.515
CEFS 76*	.500	.403
CEFS 79*	.258	**.075**
CEFS 20*	.450	**.266**

* = Reverse coded item

Factor Rotation

A direct oblimin rotation was employed to rotate the factors for more meaningful interpretation of the construct related to each factor. Following the rotation, item loadings were evaluated. Items that cross-loaded or had low factor loadings (less than .32; Watson, 2017) were removed one by one. Additionally, if variables load strongly on two or more factors, the item should be retained on the factor with the highest loading, providing that the factor loading is at least .10 more than the next highest loading, meaning that there should be at least a .10 difference in the loadings (Watson, 2017). Only two items were removed in this process. First, item five was removed due to cross loading on Factor three and Factor four. Removing item five marginally reduced the total variance explained by 0.05%, from 54.34 to 54.29%, supporting the

removal of this item as the other factor loadings improved in strength. After removing item five, 74 cross-loaded onto Factor two and Factor four. Item 74 was removed which increased the total variance explained to 54.50%. The pattern matrix was then examined to find additional items that cross loaded within .10 units, to which no additional items were flagged. Items 33 and four loaded onto two factors, but their difference was greater than .10 which allowed the researcher to use item 33 on Factor 2 (loading .589) and item 4 on Factor 2 (loading .451). Table 3 shows which items were removed and why. The final CEFS measure included 34-items across four subscales: (1) Decreased personal well-being (11 items), (2) Negative attitude toward work (7 items), (3) Psychosomatic exhaustion (7 items), and (4) Psychological detachment from the counseling process (9 items). The results of the exploratory factor analysis did not support the hypothesized seven factor structure. The final pattern matrix for the 34-item CEFS with four factors is displayed in Table 4.

Table 3. Items Removed from Pattern Matrix

Item #	Item Description	Reason for Removal
5	*I was feeling more generally pessimistic.*	Factor 3 loading: -3.83 Factor 4 loading: -.444
74	*I struggled to empathize with my clients.*	Factor 2 loading: .381 Factor 4 loading: .412

Table 4. Four Factor Pattern Matrix with Loadings for Final CEFS

Item #		Factor			
		1	2	3	4
CEFS 53	*I noticed more difficulties in my personal relationships.*	.736			
CEFS 23	*I drifted away from my supports that give me a greater sense of connection.*	.713			
CEFS 24	*It was harder to connect with my meaning making system (e.g., spirituality, connection to higher power, sense of purpose).*	.661			
CEFS 40	*I found it hard to engage with activities that typically bring me comfort.*	.658			
CEFS 42	*My personal relationships have been negatively impacted because of my work.*	.646			
CEFS 75	*I haven't had as much energy for my relationships with family and friends.*	.643			
CEFS 19	*I found it hard to connect with things that were once meaningful to me.*	.515			
CEFS 36	*I had little energy for things I enjoy (e.g., hobbies, leisure activities).*	.506			
CEFS 44	*I felt more down than I typically do.*	.499			
CEFS 43	*I had difficulty regulating my emotions.*	.424			
CEFS 32	*I experienced changes in my appetite that could be related to stress at work.*	.373			
CEFS 48	*My counseling work did not feel as meaningful as it once did.*		.682		
CEFS 33	*I felt disconnected from a deeper meaning related to my work.*	.353	.604		
CEFS 28	*I did not enjoy my counseling work as much as I typically do.*		.568		
CEFS 11	*I felt more cynical toward my clients.*		.562		
R_CEFS_21	*I believe my work makes a difference in the lives of others. (R)*		.470		

CEFS 4	*I felt negative emotions toward my work.*		.461	-.337	
CEFS 18	*I had a negative outlook on clients' capacity for change.*		.426		
CEFS 14	*After counseling clients, I felt mentally drained.*			-.833	
CEFS 35	*I felt emotionally exhausted after counseling clients in distress.*			-.830	
CEFS 2	*After counseling clients, I felt emotionally depleted.*			-.779	
CEFS 15	*My body felt tense after counseling clients with distressing concerns.*			-.635	
CEFS 37	*My muscles felt more tense than usual.*			-.474	
CEFS 3	*I felt disconnected from my feelings after working with emotionally distressed clients.*			-.472	
CEFS 31	*I had little energy throughout the day.*			-.408	
CEFS 59	*My thought process in session felt disorganized.*				.695
CEFS 17	*I had trouble focusing during counseling sessions.*				.594
CEFS 69	*My attending skills felt more forced than typical.*				.588
CEFS 77	*I found it hard to connect with my client.*				.550
R_CEFS_73	*I felt confident that I put forth my best counseling work. (R)*				.536
CEFS 41	*I was impatient with my clients.*				.517
CEFS 65	*I hoped my client wouldn't show to session.*				.416
R_CEFS_76	*My in-session expression of empathy felt genuine. (R)*				.410
CEFS 50	*I became annoyed with my clients at times.*				.401

Research Question Two

Internal Consistency of the CEFS

To determine internal consistency of the 34-item CEFS, descriptive statistics and a reliability analysis were performed on the remaining items. The mean, standard deviation,

skewness, and kurtosis for the items are reported in Table 5 below. The Likert scale scoring for the CEFS means that mean scores closer to one (1) reflect that participants experienced that phenomenon "not at all" within the last two weeks. A mean of three (3) means that symptom as experienced about half of the days over the past two weeks, and a mean of five (5) means participants were experiencing that phenomena nearly every day for the last two weeks. All item-level means were below three, indicating relatively infrequent experiences of said phenomena. In other words, the distressing symptoms of empathy fatigue were experienced less than half the time during a two-week period. Empathy fatigue levels based on the item means were relatively low for this sample. The total mean empathy fatigue score for this sample was 66.14 (*SD* = 23.95) indicating relatively low empathy fatigue (total scores range from 34, low empathy fatigue, to 170, high empathy fatigue). Item level statistics are presented in Table 5.

SPSS was used to analyze the internal consistency of the total scale and four subscales. Cronbach's alpha coefficients are used for measures of internal consistency for continuous item-response scales (Helms et al., 2006). Table 5 reports the internal consistency reliability results for (1) Decreased personal well-being, (2) negative attitude toward work, (3) Psychosomatic exhaustion, (4) Psychological detachment from counseling process, and the total scale. A Cronbach's alpha coefficient above .7 indicates good internal consistency (DeVellis, 2003). First, reliability for the total CEFS was excellent ($\alpha = .96$). The Cronbach's alpha for Factor 1: decreased personal well-being, was .92 with a mean of 19.88 (*SD* = 8.80). Subscale 2, negative attitude toward work, yielded an alpha of .89 and a mean of 12.65 (*SD* = 5.71). Subscale 3, psychosomatic exhaustion, had an alpha of .90 with a mean of 16.39 (*SD* = 6.74) and subscale 4, psychological detachment from counseling process yielded an alpha coefficient was .87 with a

mean of 16.77 (*SD* = 6.05). The results provide full support for hypothesis two, as the total scale and subscales yielded internal consistency reliability estimates greater than α = .80.

Table 5. Internal Consistency of Subscales and CEFS Total Scale

Subscale	Cronbach's Alpha	Mean (*SD*)
Subscale 1: Decreased personal well-being	.92	19.88 (8.80)
Subscale 2: Negative attitude toward work	.89	12.65 (5.71)
Subscale 3: Psychosomatic exhaustion	. 90	16.39 (6.74)
Subscale 4: Psychological detachment from counseling process	.87	16.77 (6.05)
Total scale (All 34-items)	.96	66.14 (23.95)

Table 6. Final CEFS Item-Level Statistics

Item #	*M*	*SD*	Skewness	Kurtosis
CEFS2	2.60	1.211	.561	-.682
CEFS3	1.89	1.079	1.158	.542
CEFS4	2.06	1.164	1.044	.198
CEFS11	1.69	.971	1.596	2.170
CEFS14	2.68	1.283	.463	-.954
CEFS15	2.14	1.205	1.023	.148
CEFS17	1.99	1.061	1.210	1.021
CEFS18	1.78	.872	1.427	2.426
CEFS19	1.67	.987	1.613	2.065
CEFS23	1.71	1.032	1.577	1.876
CEFS24	1.63	.994	1.676	2.212
CEFS28	1.88	1.153	1.344	.923
CEFS31	2.50	1.268	.722	-.552
CEFS32	1.93	1.246	1.195	.251
CEFS33	1.72	1.059	1.525	1.541
CEFS35	2.46	1.220	.714	-.496
CEFS36	2.28	1.267	.764	-.503
CEFS37	2.12	1.250	.999	-.068
CEFS40	1.72	.985	1.457	1.600
CEFS41	1.52	.734	1.887	5.050
CEFS42	1.60	.973	1.929	3.344

CEFS43	1.56	.853	2.009	4.620
CEFS44	1.91	1.072	1.208	.816
CEFS48	1.71	1.055	1.599	1.864
CEFS50	1.78	.792	1.281	2.530
CEFS53	1.62	.955	1.765	2.882
CEFS59	1.90	1.026	1.303	1.335
CEFS65	2.34	1.236	.903	-.151
CEFS69	1.80	.992	1.311	1.269
CEFS75	2.30	1.348	.783	-.655
CEFS77	1.50	.688	1.378	1.804
CEFS21*	1.8560	1.02134	.991	.025
CEFS73*	2.3306	1.08466	.509	-.586
CEFS76*	1.6481	.96199	1.605	2.127

Table 7. Final CEFS Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
CEFS17	64.1322	542.628	.602	.524	.958
CEFS59	64.2367	542.061	.640	.568	.958
CEFS69	64.3241	545.557	.584	.503	.958
CEFS77	64.6290	554.195	.584	.484	.959
CEFS73*	63.8038	542.632	.592	.535	.958
CEFS41	64.6141	555.272	.514	.529	.959
CEFS65	63.7783	536.596	.621	.538	.958
CEFS50	64.3475	552.099	.559	.571	.959
CEFS76*	64.4755	551.703	.462	.379	.959
CEFS14	63.4392	529.623	.717	.752	.957
CEFS35	63.6610	531.917	.712	.714	.958
CEFS15	63.9808	536.989	.628	.614	.958
CEFS2	63.5160	535.331	.656	.666	.958
CEFS3	64.2495	541.636	.613	.501	.958
CEFS37	64.0085	537.679	.595	.593	.958
CEFS31	63.6077	529.064	.735	.664	.957
CEFS48	64.4158	538.145	.700	.727	.958
CEFS33	64.4179	537.616	.712	.697	.958
CEFS28	64.2537	535.609	.693	.677	.958
CEFS11	64.4392	544.431	.624	.602	.958

CEFS21*	64.2793	551.736	.440	.429	.959
CEFS4	64.0810	534.083	.719	.671	.957
CEFS18	64.3561	551.482	.519	.504	.959
CEFS53	64.5096	544.580	.628	.676	.958
CEFS23	64.4264	546.596	.538	.552	.959
CEFS24	64.4989	546.421	.561	.514	.959
CEFS40	64.4200	539.706	.724	.701	.958
CEFS42	64.5330	543.630	.638	.635	.958
CEFS75	63.8230	527.872	.708	.663	.958
CEFS19	64.4733	540.857	.690	.625	.958
CEFS36	63.8571	529.764	.719	.688	.957
CEFS44	64.2175	536.239	.728	.629	.957
CEFS43	64.5778	548.881	.603	.532	.958
CEFS32	64.1898	537.252	.601	.487	.958

Research Question Three

Evidence of Convergent Validity

Construct validity is the degree to which a set of items measure the intended construct (Swank & Mullen, 2017). Convergent validity is one form of construct validity, which uses bivariate correlations to assess the relationship between two instruments measuring similar constructs (Swank & Mullen, 2017). To provide evidence of convergent validity for the CEFS, the researcher correlated total scale scores on the CEFS and the CBI (Lee et al., 2007). The CBI measures facets of burnout in counselors. As noted in Chapter two of this dissertation, burnout is characterized by emotional exhaustion, depersonalization, and a reduced sense of accomplishment. Empathy fatigue relates to burnout in the emotional toll that working in a helping field takes on the practitioner. Research question three hypothesized that the correlation between scores on the CBI and CEFS would yield a significant, strong, positive correlation (i.e., greater than .7). A strong, positive correlation between scores on a new scale and established

scale measuring a similar construct would provide evidence for convergent validity (Swank & Mullen, 2017).

Scores from the CBI (Lee et al., 2007) were correlated with scores from the CEFS in SPSS to produce a Pearson's *r* bivariate correlation. In this study, the reliability of the CBI was excellent (α = .91). The mean score on the CBI was 44.64 (*SD* = 13.38). The Pearson bivariate correlation between scores on the CEFS and CBI was .82 ($p < .001$), indicating evidence for convergent validity. These results provide support for hypothesis three: that adequate convergent validity for the CEFS exists based on a significant Pearson product-moment correlation greater than .70.

Research Question Four

Evidence of Discriminant Validity

A test of discriminant validity was conducted in the hopes to provide further evidence of construct validity with the CEFS. Evidence of discriminant validity exists when the correlation between two scales measuring different subscales yield a weak or low correlation coefficient (Swank & Mullen, 2017). The researcher used the Compassion Satisfaction subscale of the ProQoL as a measure of discriminant validity, being that compassion satisfaction measures the positive aspects of helping, whereas empathy fatigue measures negative aspects of helping. Compassion satisfaction is the degree of fulfillment or enjoyment one experiences from working as a helping professional (Stamm, 2010).

The Compassion Satisfaction subscale yielded high reliability (α = .93) and participants scored an average of 39.40 (*SD* = 7.18). Compassion satisfaction is scored continuously and scores over 42 indicate high compassion satisfaction, scores between 23 and 41 indicate moderate compassion satisfaction, and scores below 23 reflect low compassion satisfaction.

Therefore, it seems that participants in this sample experienced moderate to high compassion satisfaction.

The Pearson correlation between scores on the CEFS and scores on the Compassion Satisfaction subscale was significant, negative, and moderately strong (r = -.66, p < .001). It was hypothesized that the correlation between the scores on these scales would be .3 or less, indicating a weak relationship. A correlation of .5 indicates a very high correlation (Swank & Mullen, 2017). These results do not support evidence of discriminant validity for the CEFS, which does not provide support for the hypothesis for research question three. However, it is reasonable to expect the correlation would be negative, as empathy fatigue increases, it is likely compassion satisfaction would decrease.

Research Question Five

Socially Desirable Responding

Finally, research question five posed the question, "Are participants responding to items on the CEFS in a socially desirable way based on scores from the BIDR-16?" Assessing for socially desirable responding is important when conducting self-report research, as participants may answer in untruthful ways for several reasons related to their reactions to reading the items (McKibben & Silvia, 2017). It was hypothesized that participants were not responding in a socially desirable way to the items on the CEFS. A nonsignificant correlation would mean that there is no indication of response bias (Hart et al., 2015). The mean for the BIDR-16 was 83.29 (SD = 15.84). For the IM subscale, the mean score was 44.11 (SD = 9.55) and for the SDE subscale, the average score was 39.44 (SD = 9.12).

The correlation between scores on the BIDR-16 (Hart et al., 2015) and CEFS was -.39 (p < .001). Although this correlation is significant, it is moderate-weak (Swank & Mullen, 2017).

Therefore, it appears that there is a moderate, significant negative relationship between scores on the BIDR-16 and scores on the CEFS. The correlation between scores on the IM subscale of the BIDR-17 and the CEFS was -.194 ($p < .001$) and the correlation between scores on the SDE subscale and CEFS was -.477 ($p < .001$). This means that there is a weak, significant negative relationship between participants' desire to project a socially desirable image (impression management) and their responses on the CEFS. On the other hand, SDE means that participants were more likely responding honestly, but tended to respond more positively overall (i.e., in this case, report less empathy fatigue than they are actually experiencing; Hart et al., 2015). Therefore, there is a significant negative relationship between SDE and empathy fatigue. In other words, it appears that as participants are responding more positively, their empathy fatigue scores are decreasing. The accuracy of scores on the CEFS should be interpreted with caution, given that the correlations with the BIDR-16 were significant. However, the correlations might be significant due to the over-powered nature of the correlation analysis in the study (i.e., the larger the sample size, the more likely correlations will be significant).

Based on the significant correlations explained above, the researcher proceeded with a follow-up test to determine how much of the variance in CEFS scores could be explained by scores on the BIDR-16. The researcher conducted a multiple regression analysis using IM and SDE subscales from the BIDR-16 as independent variables, predicting total scale scores on the CEFS (dependent variable). Using IBM SPSS version 28.0.1.1, the researcher first examined the correlations among variables to assess for multicollinearity. Tolerance values should be greater than .10 and VIF values less than 10 indicate no issues with multicollinearity (Pallant, 2020). VIF and tolerance scores from the regression output fell within these ranges, indicating no issues of multicollinearity among the independent variables (VIF = 1.213, tolerance = .825). The

overall model was significant ($F = 82.62$, $df = 474$, $p < .001$) when both IM and SDE subscales were included as predictors of CEFS scores (see Table 9).

However, only the SDE subscale remained significant in terms of its unique contribution (See Table 8). Scores on the SDE subscale explained 25.8% of the variance in total CEFS scores, indicating a fair degree of response bias on the CEFS. Further, SDE subscale scores seem uniquely explained 21.4% of the total variance explained. SDE measures the degree to which participants tended to give honest, but positively biased reports. In this context, we would assert that these responses were downplaying the severity of empathy fatigue symptoms. Social desirability bias was present in this sample, accounting for one-fourth of the variance in scores on the CEFS, which does not support the hypothesis that no social response bias was present in the CEFS scores.

Table 8. Regression Model Summary

Model	R	R2	Adjusted R2	Std. Error of the Estimate
1	.508	.258	.255	33.75073

Predictors: (Constant), BIDR Self-deceptive enhancement, BIDR Impression Management
Dependent Variable: CEFSTotalScaleScore

Table 9. Multiple Regression Results

	B	SE	β	t	Sig.	Part	Tolerance	VIF
Constant	226.909	8.368	-	27.117	<.001*	-	-	-
BIDR IM	.018	.178	.004	.101	.919	.004	.825	1.213
BIDR SDE	-2.187	.187	-.510	-11.715	<.001*	-.463	.825	1.213

Chapter Summary

This chapter presented the results for each research question. First, the researcher examined the underlying factor structure through exploratory factor analysis, then conducted tests of internal consistency reliability, convergent and discriminant construct validity, and whether respondents answered the CEFS survey questions in a socially desirable way. The initial 74-item CEFS with a proposed 7-factor structure was reduced to 34-items and four factors: (1) *decreased personal wellbeing, (2) negative attitude toward work, (3) psychosomatic exhaustion, and (4) psychological detachment from the counseling process* explaining 54.50% of the total variance in empathy fatigue. Strong evidence for internal consistency reliability and convergent validity of the CEFS was provided. Evidence of discriminant validity of the measure was not supported. Finally, evidence of socially desirable responding was found, but not strong. Taken together, the researcher found support for two of the five initial hypotheses.

The following chapter will explore the meaning of these results in the context of the current literature and theoretical framework of the study. Implications for Counselor Education, future research, teaching, and practice will be explored to help infuse the knowledge gained from this study into the extant literature on fatigue syndromes in the helping fields. Limitations will be considered as well. Most importantly, the researcher will provide informed commentary on the

explanation of the results within the context of the counseling field and the importance of acknowledging, studying, and preventing empathy fatigue.

CHAPTER V: DISCUSSION

This chapter is dedicated to explaining and interpreting the study results discussed in the previous chapter. Findings from each of the five research questions will be meaningfully explored within the context of Counselor Education, training, research, and counseling practice. First, a summary of the results is provided as an overview of the general findings. Current research in Counseling and Counselor Education is explored to meaningfully interpret the results of the study. Limitations of the study are discussed, followed by implications for Counselor Education and clinical practice. Areas for future research on empathy fatigue will be explored to further define and understand empathy fatigue as it relates to preventing impairment in counselors.

Brief Summary of Results

The first research question addressed the underlying factor structure of the CEFS using an exploratory factor analysis. It was hypothesized that the structure would include seven distinct factors, based on the theory of empathy fatigue proposed by Stebnicki (2007). Those seven factors were hypothesized to be: emotional, cognitive, physical, behavioral, spiritual, occupational, and process skills (i.e., counseling skills). The final structure included four factors: (1) decreased personal well-being, (2) lack of occupational fulfillment, (3) psychosomatic depletion, and (4) psychological detachment from the counseling process. With 34 total items, these four factors explained a total of 55.40% of the variance in empathy fatigue.

Research question two examined the internal consistency reliability of the CEFS and each of the four subscales. It was hypothesized that each subscale and the total scale would have high reliability (alpha > .8), which was supported by the results. Reliabilities measured by Cronbach's

alpha coefficients were high (alpha > .8), indicating strong reliability for the overall scale and each subscale. Table 5 provided all alpha coefficients.

Research question three was related to evidence of convergent validity for the CEFS. It was hypothesized that scores from the CBI (Lee et al., 2007) would be significantly, positively, and strongly correlated with scores from the CEFS (greater than $r = .7$) which would provide evidence that the CEFS is measuring a similar construct to the CBI. The Pearson Product Moment correlation indicated evidence of convergent validity *(*$r = .82$; $p < .001$), for the CEFS, providing support for hypothesis three.

The fourth research question assessed evidence for discriminant validity of the CEFS. The hypothesis was that scores from the CEFS correlated with scores from the compassion satisfaction subscale of the ProQoL (Stamm, 2010) would yield a weak correlation (less than or equal to .30.), indicating the constructs are not related and the CEFS is measuring a different phenomenon than compassion satisfaction. The results did not support this hypothesis, as the Pearson correlation coefficient was significant, negative, and moderately strong ($r = -.66$, $p < .001$). Although the negative correlation indicates an expected trend (i.e., as empathy fatigue increases, compassion satisfaction decreases) the strength of the relationship was strong. In other words, the CEFS may be more related to compassion satisfaction than hypothesized.

Finally, the fifth research question looked at social desirability response bias by correlating scores on the BIDR-16 (Hart et al., 2015) with scores on the CEFS. It was hypothesized that participants would not be responding in a socially desirable way to the CEFS items, as evidenced by a weak correlation. The correlation between the BIDR-16 and CEFS was -.39 ($p < .001$), meaning that there is a moderate-weak, negative relationship between socially desirable responding and empathy fatigue. The subscales indicated that participants were likely

not responding in a way that projected a desirable image (IM; $r = -.19$, $p < .001$), but may have answered questions in a way that downplayed the severity of empathy fatigue symptoms and appeared as though they were functioning more positively (SDE; $r = -.477$; $p < .001$). A regression analysis determined that scores on the BIDR-16 predicted 25.8% of empathy fatigue. The rest of this chapter explores the meaning of these results considering the extant literature, directions for future research, limitations, and implications for Counselor Education and counseling practice.

Integration with Extant Literature

Factor 1: Decreased Personal Well-Being

As defined in chapter one, empathy fatigue is a state of emotional, mental, physical, spiritual, and occupational exhaustion that occurs as multiple client stories of distress, trauma, grief, loss, adversity, etc. have a cumulative adverse effect on a professional helper engaging in the act of counseling and compromise their empathic abilities (Stebnicki, 2007). The results of this study did not align with the theoretically based proposed factor structure, which encompassed aspects of overall wellbeing (e.g., emotional, mental, physical, etc.) segmented into 'neat' categories of symptoms. Unsurprisingly, the resulting four-factor structure points toward a more complex, interrelated theoretical structure of empathy fatigue that weaves together the person and the professional. For example, the first subscale on the CEFS, *decreased personal wellbeing*, highlights the toll that empathy fatigue has on multiple domains of wellness including social, physical, emotional, and spiritual (Myers et al., 2000). Items that represent negative impacts on various domains of wellness including social, physical, emotional, and spiritual loaded onto this factor.

Seven items on the *decreased personal wellbeing* factor included statements about interpersonal relationships and meaning making activities. This finding aligns with the emphasis on spirituality and meaning proposed in the original theory, which differentiates empathy fatigue from other syndromes like burnout, vicarious trauma, and compassion fatigue (Stebnicki, 2007, 2016), and may help explain why items related to meaning making loaded strongly on this factor. When a practitioner experiences empathy fatigue, they may question their sense of spirituality as they wrestle with existential ideas such as "why do bad things happen to good people?" and "what is the meaning of suffering?" (Personal communication, Stebnicki, 2022). This spiritual questioning might lead practitioners to disconnect from their spiritual sense of self. This distancing is of grave concern, as spirituality is a protective factor against stress (Grouden & Jose, 2015) and burnout (Polsuns & Gall, 2019). If spirituality and meaning making serve as a protective factor and a counselor has trouble engaging with these practices, they may be more vulnerable to impairment.

However, items such as "I noticed more difficulties in my personal relationships" and "I haven't had much energy for my relationships with my family and friends" loaded on this factor as well, highlighting the toll empathy fatigue has on the practitioner's personal life. Social support and engaging in meaningful social relationships for the purpose of support can be a powerful coping strategy against stress and burnout (Newton et al., 2020). In a study where researchers explored counselor trainees' experiences of burnout, social support was found to be related to reduced burnout (Newton et al., 2020). Further, they noted that relational support from friends and family may indirectly relate to trainees' ability to engage in cognitive reappraisal, a coping strategy that can prevent burnout from escalating to impairment (Newton et al., 2020).

Any mental health professional engaging in the act of counseling use their own resources as the instrument for change (Parsons & Zhang, 2014). This means that being exposed to clients' pain and suffering can not only take a toll on the professional, but the counselor as a person including their friends, relationships, family life, and spiritual practices. Factor one represented items about personal relationships, energy for hobbies and leisure, emotion regulation, and connection to meaning making/spirituality. Each of these components contributes to a person's sense of self and overall wellness. This aligns with another study on sources of meaning making, that found family and interpersonal relationships predict meaning making (Grouden & Jose, 2015). Relationships are part of how we create meaning in our lives, as those we care about are important to us and contribute positively to our overall well-being (Grouden & Jose, 2015). Lawson & Myers (2010) also found that spending time with partner/family was the top CSB among counselors in their study. In fact, counselors who scored high in their overall wellness noted that turning to spiritual beliefs was among their highest CSB. As these researchers indicated, spirituality and relationships with friends and family are important components to wellness and burnout prevention (Polsuns & Gall, 2019).

Factor 2: Negative Attitude Toward Work

Items in this factor included: *I felt more cynical toward my clients, I felt negative emotions toward my work, I had a negative outlook on my client's capacity for change,* and *I felt disconnected from a deeper meaning related to my work.* The items on this factor relate to the overall displeasure and loss of satisfaction with the work of being a clinician. The concepts in this factor align closely with depersonalization and cynicism in burnout (Maslach & Jackson, 1981). A hallmark symptom of burnout is cynicism, where the worker has "negative, callous, or excessively detached response to other people and other aspects of the job" (Maslach, 2003, p.

2003). Although many of the items on this factor relate directly to a sense of negative affect surrounding counseling, other items included *I did not enjoy my counseling work as much as I typically do, my counseling work did not feel as meaningful as it once did,* and *I believe my work makes a difference in the lives of others.* These items seem to tell the story of a loss of zest for working in the mental health profession and that it does not seem to hold the same value for the clinician as it once did. This component of the subscale is where empathy fatigue deviates from the burnout literature. In addition to having negative feelings toward clients, negative attitudes toward the work also arise.

Factor 3: Psychosomatic Exhaustion

This factor included themes of emotional, cognitive, and physical exhaustion. Items such as: *After counseling clients, I felt mentally drained; My body felt tense after counseling clients with distressing concerns; I felt disconnected from my feelings after working with emotionally distressed clients; I had little energy throughout the day; and I felt emotionally exhausted after counseling clients in distress* highlighted the nature of a holistic exhaustion, in mind, body, and spirit. This sense of exhaustion is echoed across impairment syndromes including burnout and compassion fatigue (Figley, 1995; Maslach, 2003). However, burnout is characterized primarily by emotional exhaustion (Maslach & Jackson, 1981). Maslach and Jackson (1981) note: "As their emotional resources are depleted, workers feel they are no longer able to give of themselves at a psychological level" (p. 99). Although this points to psychological and emotional exhaustion, the items on the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1981) only address emotional exhaustion. The items on the CEFS point to exhaustion that is multidimensional.

Compassion fatigue, although fatigue is mentioned in the name, speaks less to exhaustion as a hallmark symptom and more to the experience of PTSD-like symptoms. Compassion fatigue is used interchangeably with secondary traumatic stress (Figley, 2002). Compassion fatigue, defined as "a state of tension and preoccupation with the traumatized patients by re-experiencing the traumatic events, avoidance/numbing of reminders persistent arousal (e.g., anxiety) associated with the patient" (Figley, 2002, p. 1435) relates more closely to secondary traumatic stress disorder, where the clinician experiences trauma responses in reaction to the trauma exposure. Similarities in compassion fatigue and empathy fatigue come in the form of their etiology- through the exercise of empathic connection. However, the results of this study demonstrate that within empathy fatigue, there is a sense of holistic exhaustion that comes from counseling clients in distress.

Factor 4: Psychological Detachment from the Counseling Process

The psychological disconnection of a practitioner experiencing empathy fatigue seems to be unique to empathy fatigue, differentiating it from other impairment syndromes. Vicarious trauma causes a cognitive shift in the way the clinician views the world, themselves, and others, as a result of exposure to secondary traumatic events (MaCann & Pearlman, 1990). Compassion fatigue, also referred to as secondary traumatic stress, incorporates the idea that clinicians who are exposed to client trauma can develop trauma responses and symptoms themselves (Figley, 1995). To capture a different phenomenon, perhaps one more aligned with the psychological detachment related to empathy fatigue, Singer and Klimecki (2014) posit using the term 'empathic distress fatigue' as an alternative to the more commonly used 'compassion fatigue.' "Empathic distress refers to a strong aversive and self-oriented response to the suffering of others, accompanied by the desire to withdraw from a situation in order to protect oneself from

excessive negative feelings." (Singer & Klimecki, 2014, p. 875). This active cognitive detachment that arose in the factor structure of the CEFS speaks to the clinician's instinctual self-protective mechanisms.

Maslach (2003) also discussed the tendency toward self-preservation behaviors in workers experiencing burnout: "...Exhaustion leads workers to engage in other actions to distance themselves emotionally and cognitively from their work, presumably as a way to cope with work demands" (Maslach, 2003, p. 190). It is unclear whether exhaustion is the force behind the disconnection when it comes to empathy fatigue, or the intense emotional nature of client stories. In the burnout literature, exhaustion comes from having too much work and too many demands (Maslach, 2003). It appears that empathy fatigue may relate more to the kinds of stories that clients are sharing, which directly links to the unique work of mental health professionals engaging in empathic therapeutic relationships with clients.

Further, treatment and prevention strategies would look different depending on the source of psychological disconnection. If it was more related to exhaustion, clinicians may focus more on restoring energy sources through wellness practices such as getting enough sleep, exercising, and eating nutritious meals. If the disconnection comes from over-empathizing or being "too close" to painful client stories, the clinician may benefit from personal therapy to understand the countertransference reaction happening with their client. No matter the cause, these are very different coping mechanisms and the reason behind the urge to disconnect for self-preservation warrants further exploration, particularly due to the potential harm a disconnected clinician may pose to clients.

In addition to disconnecting psychologically to self-protect, avoidance and detachment behaviors impair the clinician's ability to connect with their client, distancing themselves from

feeling the emotions of the person they should be empathizing with. Without empathy, clients may feel unsafe, judged, or even stigmatized for their concerns, which is never a desired outcome of counseling. Supervisors' role in identifying behaviors of psychological detachment in their supervisees counseling work relates directly to their responsibility to client welfare. A further explanation of how supervisors might support clinicians, and by extension protect the wellbeing of their clients, is provided later in this chapter.

Theoretical Comparison to Burnout

An unexpected, yet plausible finding from this study is the theoretical similarity between empathy fatigue and burnout. Burnout has been widely studied in a vast array of helping fields and occupations (e.g., Joshi & Sharma, 2020; Lee et al., 2007; Leung et al., 2022; May et al., 2020; Yang & Hayes, 2020), and consists of exhaustion, depersonalization, and a sense of ineffectiveness in the workplace (Maslach & Jackson, 1981). Lee et al. (2007) identified five facets of burnout in counselors: negative work environment, exhaustion, incompetence, devaluing client, and deterioration in personal life. In this study, themes of decreased personal well-being, negative attitudes toward work, psychological detachment, and exhaustion related to empathy fatigue align similarly with aspects of burnout, described by Lee et al. (2007). This is an interesting finding, given that the conditions under which burnout occurs relate more to the structural components of the work environment including being overworked, having lack of autonomy over scheduling, lack of resources, etc. (Maslach, 2003; Maslach & Jackson, 1981). Empathy fatigue seems to align closely with symptoms of burnout, with the main distinction being that what causes the impairment differs. Empathy fatigue is theorized to come from exposure to clients' therapeutic material, stories of pain, grief, loss, suffering, and hopelessness (Stebnicki, 2016), rather than working conditions.

Considering Lee et al.'s (2007) conceptualization of burnout in counselors, empathy fatigue appears to mirror symptoms of burnout very closely. Clinicians begin to care less about their clients (depersonalization) and acquire more cynical attitudes toward the work and those they serve (Yang & Hayes, 2020). A primary distinction between empathy fatigue and burnout, however, is the role that meaning making and spirituality play in empathy fatigue, which aligns with how empathy fatigue has been conceptualized in the literature (Stebnicki, 2007). Stebnicki (Personal communication, July, 2022) argued that empathy fatigue impacts a counselor's sense of meaning making as they are exposed to suffering, including the way they see themselves as helpers. As a result of being exposed to horrific atrocities in their clients' lives, counselors begin to question why things happen, the meaning of suffering, and their role in helping to heal others--a role which they may question as they continue to hear of daily stories of compounded pain and suffering. Further, meaning making, spirituality, and interpersonal relationships are often self-protective coping mechanisms that may be compromised by empathy fatigue, which may lead to further impairment. Spirituality and spending time with family and friends are common career sustaining behaviors (CSB) in counselors that directly relate to supporting their overall wellness (Lawson & Myers, 2010). If empathy fatigue negatively affects a counselor's wellness resources, impairment may be harder to prevent as those tools are less accessible, creating a cycle of impairment.

Empathy Fatigue and Compassion Satisfaction

The compassion satisfaction subscale of the ProQoL (Stamm, 2010) was used as a measure of discriminant validity when scores were correlated with scores from the CEFS. The results did not support the hypothesis that compassion satisfaction and empathy fatigue are separate constructs, as the results suggest a negative, but strong and significant relationship

between compassion satisfaction and empathy fatigue (r = -.66, p < .001). This finding was surprising because compassion satisfaction is "characterized by feeling satisfied by one's job and from the helping itself" (Stamm, 2010, p. 21). It also includes having happy, positive thoughts, people feel successful, competent, and want to continue making a difference (Stamm, 2010).

Although surprising, there may be a few potential explanations for this finding. First, a priori power calculations determined that n = 84 participants would adequately power the validity correlations, with a .05 alpha level and .80 power. The study had 487 participants which was well over the adequate number needed to find a significant result. Therefore, because the study was overpowered when it came to running validity tests, it is highly likely that a correlation would be significant, even if there is no significant relationship (i.e., a type I error; Swank & Mullen, 2017).

While the statistical significance of the correlation was unexpected, the direction of the correlation makes sense, as compassion satisfaction is a positive construct and empathy fatigue is negative. Therefore, as one increases, we would expect the other to decrease. The strong relationship indicates that the constructs are not "opposite" to one another, and might be more related than hypothesized, given the occupational fulfillment and meaning making nature of compassion satisfaction. This negative relationship between positive and negative aspects of helping aligns with similar findings in studies examining compassion satisfaction, compassion fatigue, and burnout mental health professionals (Chang & Shin, 2021; Cummings et al., 2021; Ray et al., 2013; Rossi et al., 2012). Rossi et al., (2012) found an inverse relationship between compassion fatigue, burnout, and compassion satisfaction in community mental health workers. Compassion satisfaction was also found to be significantly negatively related to emotional exhaustion (r = -.52, p < .01) and cynicism (r = −.70, p < .01) in frontline mental health care

professionals (Ray et al., 2013). Cummings and colleagues (2021) found a strong inverse relationship between compassion satisfaction and burnout in helping professionals working as victim advocates, as well as that compassion satisfaction influenced the relationship between burnout and vicarious trauma and burnout and secondary traumatic stress.

Mean Level of Empathy Fatigue

A somewhat surprising finding in this study was that participants in this sample reported low empathy fatigue overall. Participants reported an average empathy fatigue score of 66.14 and having an average of 23.37 direct client hours per week. This relatively low level of empathy fatigue and moderate amount of direct client contact help to explain the positive skew shown in Figure 1. Depending on the counseling specialty, level of experience, business operations, desired income, and scheduling needs, this could be considered reasonably close to full time caseload (GoodTherapy, 2020). If the average number of clients were closer to 30 hours per week or above, levels of empathy fatigue may have been higher, due to a higher dosage of client suffering. Further, the researcher received several emails from recruited participants that indicated they were no longer in the field due to being burnt out or "needing to step away" for a while. Empathy fatigue scores may be lower because if clinicians had left the field due to insurmountable empathy fatigue or burnout, they would not have been included in the sampling frame.

Additionally, counselors and mental health professionals typically report higher levels of wellness than non-mental health professionals (Lawson, 2007). "As expected, therapist trainees reported substantially less compassion fatigue than did non-therapists" (O'Brien and Haaga, 2015, p. 414). This finding is similar for helping professions, like psychology. O'Brien and

Haaga (2015) found that therapist trainees reported substantially less compassion fatigue than non-therapists, supporting their hypothesis that therapist resilience mitigates compassion fatigue.

In addition to simply being a therapist or counselor, practitioners who are younger and newer to the field tend to report more burnout and less compassion satisfaction compared to experienced clinicians (Cook et al., 2021; Craig and Sprang, 2010; Fye et al., 2021). The average age of participants in this study was 41 and had an average of 10 years of experience in the field. This result aligns with previous research findings, suggesting that those with fewer years of experience in the field, or even those still in training, report higher levels of burnout and compassion fatigue than those who have several years of experience (Can & Watson, 2019) demographic makeup of the sample in this study may explain why rates of empathy fatigue were lower, overall. All participants in this study were either provisionally or fully licensed and were not currently in training (e.g., graduate program).

Socially Desirable Responding

It also appears that participants in this sample may have under reported the severity of their empathy fatigue symptoms, as evidenced by a significant correlation between scores on the IM subscale of the BIDR-16 and CEFS scores. Scores on the IM and SDE subscales of the BIDR-16 accounted for a considerable amount (25.8%) of the variance in total CEFS scores. Further, scores on the SDE subscale uniquely predicted 21.4% out of the total 25.8%. This means that participants were responding to the items in a way that may have downplayed the reality of their actual symptoms, and that they were answering honestly, but their responses were positively biased. Participants did not respond as much in a way that inflated their self-image.

Considering the high degree of socially desirable responding, a few explanations are possible for this finding. The presence of a high degree of social desirability bias may be because

empathy fatigue is a potentially uncomfortable topic to disclose. Practitioners may not want to indicate that they are experiencing impairment, for fear of professional repercussions. Further, as the researcher is in the counseling field, participants may not have wanted to admit they were impaired to another clinician. Participants were recruited through state licensing board contact lists which may have inhibited accurate responses about their level of empathy fatigue. Although anonymous, participants might have feared state licensing bodies access to the data.

Burnout stigma is a relatively novel phenomenon that may be an important consideration related to accurate reporting of empathy fatigue symptoms. Burnout stigma refers to the perception that burnt out individuals are less competent than non-burnt-out professionals (May et al., 2020). In the mental health literature at large, stigmatized attitudes toward mental health conditions create barriers to treatment and prevention (Feist et al., 2020; May et al., 2020; Sickel et al., 2014). Like mental health stigma, burnout stigma perpetuates shame among those who experience it, decreasing their propensity to seek help (May et al., 2020; Mullen & Crowe, 2017). The prevalence of burnout stigma has become apparent in medical professionals as suicide rates in medical doctors rose during COVID-19 (Feist et al., 2020). A possible explanation for a large amount of socially desirable responding, particularly the kind where participants are responding more positively, is the stigma that comes with impairment (Crowe et al., 2020). In a field where wellness and proper professional functioning are ethically mandated for counselors, there may be personal and professional consequences for clinicians who disclose that they are impaired. Whether fear of punishment is responsible for this pattern of responding, clinicians must be offered a nonjudgmental place where they can seek support if they are experiencing impairment. Implications for counselor education and supervision regarding reducing burnout stigma related are provided in the subsequent sections.

Compassion Does Not Fatigue

Part of the purpose of this study was to further clarify the nuanced differences between established fatigue syndromes including compassion fatigue, burnout, and empathy fatigue. Recent fMRI studies suggest that compassion and empathy activate different neural pathways in the brain (Hofmeyer et al., 2020; Singer & Klimecki, 2014) and are separate constructs. Empathy is an affective response, whereas compassion is more cognitive in nature (Singer & Klimecki, 2014). Based on the results of this study, it appears that compassion fatigue is different than empathy fatigue. Compassion fatigue has an emotional component that includes exhaustion, frustration, and depression, similar to burnout (Stamm, 2010). Compassion fatigue also includes secondary traumatic stress, which is a negative affect related to experiencing work-related trauma (Stamm, 2010). Conceptually, empathy fatigue relates more to the way in which counselors connect to their work and the impact their work has on their personal functioning. For example, the fourth factor on the CEFS, *psychological disconnection from the counseling process,* highlights the way counseling skills are negatively impacted by empathy fatigue. Whereas, compassion fatigue, defined by Stamm (2010), only addresses the affective response of the clinician, not the impact on their counseling skills or personal relationships, factor one on the CEFS, *decreased personal wellbeing*, encompasses the tendency for interpersonal relationships with friends, family, and loved ones to be negatively impacted by empathy fatigue. The conceptualization of compassion fatigue does not include connections to friends, family, or other social relationships in the clinician's life. Therefore, empathy fatigue appears to take a more personal toll on the practitioner than compassion fatigue.

Compassion satisfaction being strongly but negatively related to empathy fatigue is a unique finding of this study. Compassion is connected to the desire to help others and alleviate

their suffering (Singer & Klimecki, 2014). Compassion is a cognitive experience that can potentially buffer the negative effects of burnout and compassion fatigue and increase positive, restorative feelings, even when exposed to others' distress (Bentley et al., 2021; Cummings et al., 2021; Delaney, 2018; Hofmeyer et al., 2020). Singer and Klimecki (2014) noted that "...A short-term compassion training of several days can foster positive feelings and related brain activations, even when persons are exposed to the distress of others." (p. 877). This phenomenon is supported by neuroscience studies and the neurobiology of empathy and compassion (Hofmeyer et al., 2020; Singer and Klimecki, 2014). This finding may highlight the need for compassion training as an antidote to empathy fatigue and encourage practitioners to use compassion as a protective mechanism against the harmful effects of empathy fatigue and burnout (Singer and Klimecki, 2014).

Limitations

Sampling Strategy

Recruiting participants primarily from publicly available state licensing board contact lists may have excluded counselors that have left the field due to burnout or empathy fatigue. Practitioners who exited the field may have chosen not to renew their license, which would cause them to fall outside of the sampling frame. It is likely that practitioners who are no longer providing mental health services may have responded differently to questions about empathy fatigue than those who are actively practicing. The high degree of social desirability bias also warrants caution when interpreting the results of the study. Future research should continue to assess the degree of socially desirable responding when assessing for empathy fatigue. Researchers may also consider dispersing the BIDR-16 items throughout the instrument being

assessed, rather than grouping them together in a separate measure (Hart et al., 2015; Paulhus, 1998).

Automated Responding

During the initial phase of recruitment, posting on social media yielded unusable data. The researcher determined that the responses were produced by bots, which was linked directly to sharing the call to participate on the researcher's personal Facebook page. Several data triangulation procedures were used to determine that the responses were not coming from human participants. The researcher quickly created a new copy of the survey, to distribute directly to participants via publicly available contact lists of actively practicing clinicians from several states across the US. This new survey also included a "Captcha" question, where participants had to select a box stating "I am not a robot" which helps to deter automated responding. However, it is plausible that the "new" data could have contained responses that did not come from humans and could have influenced the results. Without a more sophisticated Qualtrics package to prevent bots from gaining access to the survey, the researcher was not able to definitively determine whether responses came from bots or humans. The researcher did check several sources and visually inspected the quantitative and qualitative data for suspicious responding patterns and was confident that the new data was provided by humans.

Lack of Sample Diversity

The sample in this study lacked diversity in a variety of identities, which could have influenced the results. Being mostly white and female (85%), this sample does not capture the wide range of based on clinicians with different racial and gender identities. Age was arguably the demographic with the most diversity, with ages ranging from 23 to 71 ($M = 41.28$, $SD = 13.02$) potentially capturing a wide range of age-related experiences. Most participants

completed a master's degree (89%) and specialized in clinical mental health counseling (72.5%), which does not represent all counselors, psychologists, and social workers practicing in the field. There may be differences in empathy fatigue for clinicians who have a different degree than a masters, or specialize in a different area (e.g., school counseling, addictions counseling). Researchers have suggested that there is a relationship between the type of presenting concern and compassion fatigue (Stamm, 2010) as client factors influence the experience of compassion fatigue symptoms. Future research should measure empathy fatigue within various counseling or clinical specialties to determine if there are differences in the experience of empathy fatigue based on working with specific populations and presenting concerns.

Empathy fatigue is differentiated from other fatigue syndromes because of its emphasis on spirituality. Spirituality is closely tied to culture, and with a more diverse sample, results may have been different. A demographic question about current spiritual/religious affiliation should be included in future studies to learn more about participants' spiritual backgrounds and whether differing spiritual backgrounds/practices relate to experiences of empathy fatigue. Further, different cultural groups may experience this phenomenon differently, depending on the types of meaning making practices, interpersonal supports, and values. Unfortunately, the results of this study cannot be generalized to a diverse sample of practitioners.

Implications for Counselor Education and Supervision

Training

Understanding the signs and symptoms of any condition, mental or physical, are essential to its prevention and early identification. Counselor training programs need to educate their students about the causes, signs, and symptoms of empathy fatigue in addition to other impairment syndromes like burnout, compassion fatigue, and vicarious trauma (Can & Watson,

2019; Figley, 1995; Merriman, 2015). If they are educated about empathy fatigue—as they are about other impairment syndromes, counselors-in-training and practicing counselors may be better equipped to acknowledge the distress they are experiencing (Merriman, 2015). Given that novice and younger practitioners may be at higher risk for burnout and impairment (Cook et al., 2021; Craig and Sprang, 2010; Fye et al., 2021; Thompson et al., 2014), providing education early on in a counselor training program can potentially mitigate the deleterious effects of empathy fatigue.

Counselor educators have a duty to infuse wellness education across counseling curricula that emphasizes and models the importance of wellness practices (Gibson et al., 2020; Testa & Sangganjanavanich, 2016). Unsurprisingly, it is not enough to simply educate students about the importance of wellness. Counselor educators must provide opportunities for encourage them through experiential learning (e.g., assignments, class discussions, practicing wellness activities in class). Similarly, clinical supervisors can help their supervisees identify strategies for increasing personal wellness or provide constructive feedback if they notice that a supervisee might be struggling with empathy fatigue.

Counselor educators are also encouraged to normalize and destigmatize seeking help for impairment. The high amount of socially desirable responding from this study underscores the importance of talking about impairment in a way that does not feel blaming, punishing, or shaming. Although protecting the public through gatekeeping is of upmost importance for counselor educators, counselors may be reluctant to disclose that they are impaired. If counselors are not seeking support or communicating the difficulties they are experiencing, they may continue to see clients and ignore the fact that they are struggling. At that point, clients may be impacted by a counselor who is, at best ineffective and at worst, potentially causing harm. If

counselor educators can encourage trainees to find colleagues, mentors, and supervisors that they feel comfortable reaching out to for support, they may be more likely to seek support if their wellbeing is compromised. If impaired counselors are not seeking support and continue to see clients while impaired, the field of counseling will have a much larger issue on their hands.

Just as it is ethical practice to warn trainees about the potential downsides of counseling practice, counselor educators have a duty to communicate and demonstrate the importance of wellness throughout the curricula. Teaching counseling students about the importance of wellness has been echoed by scholars and educators in the counseling field (Dye et al., 2020; Gibson et al., 2020; Newton et al., 2020; Sommer, 2008). Not only is it imperative that counselor trainees understand the ethical mandate to practice self-care and wellness, but cultivate a realistic sense of incremental, sustained wellness throughout their counselor development and career. Wellness should be discussed in training programs as a practice and a process, a sustained behavior, rather than a destination to arrive at. "CITs and counseling professionals may benefit from more long-term cognitive (e.g., mindfulness), emotional (e.g., emotion regulation practices), and behavioral (e.g., interpersonal relationships) change, thereby reducing the effects of burnout within the counseling profession" (Newton et al., 2020, p. 263). Counselor educators should also encourage students to use wellness practices outside of academic and clinical settings in the hopes that these strategies will influence professional functioning (Testa & Sangganjanavanich, 2016).

Wellness is also encouraged to be promoted among fellow counselors through psychoeducation, modeling, and encouragement (Gibson et al., 2020). The CSI Counselor Wellness Competencies (Gibson et al., 2020) highlight the continuum of wellness in counselors' lives and importance of the various roles that counselors have, especially outside of their

professional life. This mention of the continuum of wellness for counselors mirrors the results of the CEFS as it relates to personal well-being. Counselors are not just mental health professionals, but are spouses, partners, siblings, parents, children, friends, etc. (Gibson et al., 2020). Attending to personal relationships with loved ones, friends, and family are important aspects of counselors' lives that help to promote holistic wellness and should be encouraged by fellow practitioners and counselor educators (Barden et al., 2015; Gibson et al., 2020).

Supervision

Clinical supervision is an excellent time for supervisors to educate counselors about the symptoms of empathy fatigue and assess for its impact. Several researchers call for increased attention to issues of professional impairment during supervision (Figley, 1995; Lanier & Carney, 2019; Merriman, 2015; Sommer, 2008). Throughout the supervisory relationship, supervisors can explain that empathy fatigue may take a toll not only on the counselors' skills, but also their personal wellbeing, relationships, and meaning making practices. Further, feelings of detachment or cynicism toward their clients or work may be an indication of empathy fatigue. Explaining the signs and symptoms of empathy fatigue not only provides vital information to supervisees, but models that it is okay to disclose if they believe they might be experiencing empathy fatigue, which may help supervisees to feel comfortable disclosing when they are struggling.

Supervisors hold power within the supervisory relationship given the evaluative nature of supervision. Therefore, some logistical work-related variables may be within the supervisor's control to help protect their counselors from unmanageable working conditions. For example, if supervisors have control over their supervisee's workload, they can work to make the number of

clients, especially trauma clients, reasonable for their counselors. Counselors with higher caseloads may at risk for increased distress (Lanier & Carney, 2019).

In addition to educating and monitoring supervisees for signs and symptoms of empathy fatigue, supervisors should actively support and address counselor wellness. The Wellness Model of Supervision (WELMS; Lenz & Smith, 2010) provides a framework that supervisors can use to provide education, assess, plan, and evaluate supervisee wellness. The CEFS can be implemented during the assessment phase, or throughout supervision, to better understand how empathy fatigue may be impacting a counselor's personal and professional wellness. Supervision can, and should, include active practice of wellness strategies including mindfulness and emotion regulation techniques (Testa & Sangganjanavanich, 2016; Sommer, 2008). Exercises such as guided meditations, yoga, deep breathing, grounding techniques, mindfulness, and relaxation exercises can be taught to supervisees to enhance wellness (Dye et al., 2020; Testa & Sangganjanavanich, 2016; Thompson et al., 2014).

Although one of the intended purposes of this instrument is to provide support for counselors' self-awareness of impairment, intervention may require seeking support from sources external to the counselor. At work, a clinician may benefit from discussing their difficulties with a supervisor. However, it is important that the clinician can seek support, versus punishment, if they express occupational impairment. Further, supervisors should encourage counselors to discuss their need for support and if they are experiencing any symptoms of burnout, stress, or doubts about their competence (Crowe et al., 2020). The CEFS is not intended to measure empathy fatigue for remediation purposes, but offer a starting point for a conversation, where the counselor can express their concerns without judgment. Supervisors are

positioned to provide nonjudgmental, personal and professional support and are encouraged to help the counselor to brainstorm and implement restorative practices for their well-being.

Implications for Counseling Practice

This instrument was intended to help practitioners recognize signs and symptoms of impairment and inform empathy fatigue mitigation and prevention efforts. Therefore, some of the most important implications from this study are for those who are currently practicing, engaged in important therapeutic relationships with their clients. The ACA Code of Ethics (ACA, 2014) mandates counselors to practice wellness and self-care to reduce burnout and professional impairment. This mandate is clear, yet broad, in defining what it means to "practice and maintain wellness." To define these expectations more clearly for counselors, Chi Sigma Iota (CSI) endorsed the Counselor Wellness Competencies (Gibson et al., 2020) which includes a section on "Stress, Burnout, and Impairment." The competency reads: Counselors engage in self-reflective practices that allow them to assess their holistic wellness in order to develop and maintain professional effectiveness by addressing stress, burnout, and impairment (Gibson et al., 2020). The competencies go further to mention the importance of self-awareness and continual self-assessment for signs of impairment (Gibson et al., 2020). The CEFS provides another tool for counselors to use in their ethical obligation to self-monitor their wellness. The 34-item instrument can be used as a repeated measure to monitor signs and symptoms over time. The instrument takes about five to ten minutes to complete and uses continuous scoring to increase the utility and feasibility of using this assessment in a practical way. Each subscale gives the clinician information about how their fatigue might manifest, which can prompt the use of specific coping strategies to improve functioning. Further, clinicians under supervision can complete the CEFS, discuss the results with their supervisor, and ask for support where needed.

Empathy can take a toll on a practitioners' spiritual and meaning making practices (Stebnicki, 2007). On the flip side, this study highlighted the detriment that empathy fatigue can have on meaning making practices and spiritual supports, which are often areas of strength and coping. Spirituality is seen as a protective factor for mitigating the harmful effects of burnout (Browning et al., 2019) and support greater overall wellbeing (Grouden & Jose, 2015; Polsuns & Gall, 2020; Stebnicki, 2016). In one study, turning to spiritual beliefs was identified as a career-sustaining behavior (CSB) for counselors (Lawson & Myers, 2011). CSBs are what counselors or mental health professionals do to improve their professional quality of life (Stevanovic & Rupert, 2004).

Directions for Future Research

Given the dearth of research on empathy fatigue, and the potential impact it can have on client care, there is a clear need for further studies to examine empathy fatigue and several of its components. First and foremost, a confirmatory factor analysis should be conducted to confirm the factor structure of the CEFS with a sample of mental health professionals to provide further evidence for the theoretical structure of empathy fatigue. More broadly, future research can explore the sources of empathy fatigue, to determine if client stories are truly the fire that fans the flames of empathy fatigue, rather than working conditions (i.e., burnout).

This study was not able to capture professionals who had already left the field due to impairment. It is likely that there are characteristics about these professionals that are important to understand, as leaving a field of practice is a big decision. Qualitative studies interviewing counselors and other mental health professionals about what led to leaving the field may provide needed insight into empathy fatigue and the toll it can take on practitioners.

Counselors who have been practicing for more than five to ten years tend to report less burnout and compassion fatigue (Can & Watson, 2019; Craig & Sprang, 2010; Fye et al., 2021; Thompson et al., 2014; Turgoose & Maddox, 2017). Novice and early career counselors report higher rates of burnout overall (Cook et al., 2021; Fye et al., 2021). Future researchers should examine differences in empathy fatigue among novice and experienced practitioners. Qualitative data may help researchers understand what contributes to the difference in levels of empathy fatigue based on length of time in the field. Additionally, a counselor's personal trauma history is an identified risk factor for higher levels of burnout, compassion fatigue, and vicarious trauma (Thompson et al., 2014; Turgoose & Maddox, 2017). Future researchers should examine this relationship in empathy fatigue as well to determine whether these trends are similar.

Finally, studies exploring the stigma behind reporting empathy fatigue and burnout are warranted. A better understanding of the factors related to disclosing impairment are necessary for trends to change in the field. Practitioners should be encouraged to disclose their concerns to trusted supervisors and colleagues without fear of reprimand, and based on the results of this study, it appears there is something preventing clinicians from being completely truthful about their level of empathy fatigue.

Chapter Summary

This chapter interpreted the meaning of the study results within the context of the current literature base. Implications for counselor education, supervision, and clinical practice were explored, as well as directions for future research. Empathy fatigue is an emerging construct that warrants additional empirical attention to continue differentiating it from burnout, vicarious trauma, secondary traumatic stress, and other impairment syndromes.

The purpose of this study was to identify the underlying factor structure of the Counselor Empathy Fatigue Scale and provide evidence of reliability and validity for the measure. The final 34-item measure included four subscales: (1) decreased personal wellbeing, (2) negative attitude toward work, (3) psychosomatic exhaustion, and (4) psychological detachment from counseling process, and evidence was found to support its reliability and convergent validity. Results did not provide evidence for discriminant validity or lack of socially desirable responding and reasons for these findings were explored in the current chapter. Overall, the CEFS is a brief, useful self-report tool that mental health professionals can use to increase their awareness of empathy fatigue symptoms. Mental health practitioners who engage in therapeutic relationships with clients hold powerful spaces for healing pain and suffering, which can take a toll on the practitioner. Most importantly, this measure filled a gap in the literature that highlighted the toll that listening to stories of pain, distress, and suffering in addition to stories of trauma can take on mental health professionals. The importance of personal and professional wellness cannot be understated when working in a high touch field, like counseling. It is the author's hope that this study illuminates the important role that mental health professionals play in the lives of their clients, and empowers them to seek support, nourish their wellness, and maintain a fulfilling career in a meaningful helping profession.

REFERENCES

Abramson, A. (2021). *Cultivating empathy*. Https://Www.Apa.Org. https://www.apa.org/monitor/2021/11/feature-cultivating-empathy

Adams, S. A., & Riggs, S. A. (2008). An exploratory study of vicarious trauma among therapist trainees. *Training and Education in Professional Psychology*, *2*(1), 26–34. https://doi.org/10.1037/1931-3918.2.1.26

American Counseling Association. (2014). ACA code of ethics. Retrieved from http://www.counseling.org/docs/ethics/2014-aca-code-of-ethics.pdf

American Psychological Association (October, 2021). *2021 COVID-19 Practitioner Survey*. Retrieved August 2, 2022, from https://www.apa.org/pubs/reports/practitioner/covid-19-2021

American Psychological Association (March, 2022). *Psychological fallout of COVID may be with us for years, APA CEO says*. https://www.Apa.Org. Retrieved May 10, 2022, from https://www.apa.org/news/apa/2022/covid-psychological-fallout

Arañez Litam, S. D., Ausloos, C. D., & Harrichand, J. J. S. (2021). Stress and resilience among professional counselors during the COVID-19 pandemic. *Journal of Counseling & Development*, *99*(4), 384–395. https://doi.org/10.1002/jcad.12391

Arimon-Pagès, E., Torres-Puig-Gros, J., Fernández-Ortega, P., & Canela-Soler, J. (2019). Emotional impact and compassion fatigue in oncology nurses: Results of a multicentre study. European *Journal of Oncology Nursing*, *43*, 101666. https://doi.org/10.1016/j.ejon.2019.09.007

As Part of President Biden's Mental Health Strategy, HHS Awards Nearly $105 Million to States and Territories to Strengthen Crisis Call Center Services in Advance of July Transition to 988. (April 19, 2022). Retrieved May 17, 2022, from https://www.samhsa.gov/newsroom/press-announcements/20220419/hhs-awards-105-million-states-territories-strengthen-crisis-call-center-services

Auerbach, J., & Miller, B. F. (2020). COVID-19 exposes the cracks in our already fragile mental health system. *American Journal of Public Health, 110*(7), 969–970. https://doi.org/10.2105/AJPH.2020.305699

Bandalos, D. L. (2018). *Measurement theory and applications for the social sciences.* The Guilford Press.

Barden, S. M., Conley, A. H., & Young, M. E. (2015). Integrating health and wellness in mental health counseling: Clinical, educational, and policy implications. *Journal of Mental Health Counseling, 37*(2), 152–163.

Bardhoshi, G., & Erford, B. T. (2017). Processes and procedures for estimating score reliability and precision. *Measurement and Evaluation in Counseling and Development, 50*(4), 256–263. https://doi.org/10.1080/07481756.2017.1388680

Batson, C. D. (2009). These things called empathy: Eight related but distinct phenomena. In J. Decety & W. Ickes (Eds.), *The social neuroscience of empathy* (pp. 3–15). MIT Press. https://doi.org/10.7551/mitpress/9780262012973.003.0002

Beaumont, E., Durkin, M., Hollins Martin, C. J., & Carson, J. (2016). Measuring relationships between self-compassion, compassion fatigue, burnout and well-being in student counsellors and student cognitive behavioural psychotherapists: A quantitative survey.

Counselling & Psychotherapy Research, *16*(1), 15–23. https://doi.org/10.1002/capr.12054

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice*, *16*(3), 252–260. https://doi.org/10.1037/h0085885

Bride, B. E., Radey, M., & Figley, C. R. (2007). Measuring compassion fatigue. *Clinical Social Work Journal*, 35(3), 155–163. https://doi.org/10.1007/s10615-007-0091-7

Browning, B. R., McDermott, R. C., & Scaffa, M. E. (2019). Transcendent characteristics as predictors of counselor professional quality of life. *Journal of Mental Health Counseling*, *41*(1), 51–64. https://doi.org/10.17744/mehc.41.1.05

Can, N., & Watson, J. C. (2019). Individual and relational predictors of compassion fatigue among counselors-in-training. *The Professional Counselor*, *9*(4), 285–297. https://doi.org/10.15241/nc.9.4.285

Castonguay, L. G., Constantino, M. J., & Holtforth, M. G. (2006). The working alliance: Where are we and where should we go? *Psychotherapy: Theory, Research, Practice, Training*, *43*(3), 271–279. https://doi.org/10.1037/0033-3204.43.3.271

Cavanagh, N., Cockett, G., Heinrich, C., Doig, L., Fiest, K., Guichon, J. R., Page, S., Mitchell, I., & Doig, C. J. (2020). Compassion fatigue in healthcare providers: A systematic review and meta-analysis. *Nursing Ethics*, *27*(3), 639–665. https://doi.org/10.1177/0969733019889400

Cetrano, G., Tedeschi, F., Rabbi, L., Gosetti, G., Lora, A., Lamonaca, D., Manthorpe, J., & Amaddeo, F. (2017). How are compassion fatigue, burnout, and compassion satisfaction affected by quality of working life? Findings from a survey of mental health staff in Italy. *BMC Health Services Research, 17*(1), 755. https://doi.org/10.1186/s12913-017-2726-x

Chang, J., & Shin, S. (2021). A path model for burnout in community mental health professionals. *International Journal of Environmental Research and Public Health*, *18*(18), 9763. https://doi.org/10.3390/ijerph18189763

Cieslak, R., Shoji, K., Luszczynska, A., Taylor, S., Rogala, A., & Benight, C. C. (2013). Secondary trauma self-efficacy: Concept and its measurement. *Psychological Assessment, 25*, 917–928. http://dx.doi.org/10 .1037/a0032687

Clark, A. J. (2007). *Empathy in counseling and psychotherapy: Perspectives and practices*. Lawrence Erlbaum Associates.

Clark, A. J. (2010). Empathy: An integral model in the counseling process. *Journal of Counseling & Development*, *88*(3), 348–356. https://doi.org/10.1002/j.1556-6678.2010.tb00032.x

Coetzee, S. K., & Laschinger, H. K. S. (2018). Toward a comprehensive, theoretical model of compassion fatigue: An integrative literature review. *Nursing & Health Sciences, 20*(1), 4–15. https://doi.org/10.1111/nhs.12387

Cohen, J. (1992). A power primer. *Psychological Bulletin, 112*, 155–159. https://doi.org/10.1037/0033-2909.112.1.155

Cook, R. M., Fye, H. J., Jones, J., & Baltrinic, E. R. (2021). Self-reported symptoms of burnout in novice professional counselors: A content analysis. *The Professional Counselor, 11*(1), 31–45. https://doi.org/10.15241/rmc.11.1.31

Costello, A. B., & Osborne, J. (2005). Best practices in exploratory factor analysis: Four recommendations for getting the most from your analysis. *Practical Assessment, Research, and Evaluation, 10*(7), 1–9. https://doi.org/10.7275/JYJ1-4868

Craig, C. D., & Sprang, G. (2010). Compassion satisfaction, compassion fatigue, and burnout in a national sample of trauma treatment therapists. *Anxiety, Stress & Coping, 23*(3), 319–339. https://doi.org/10.1080/10615800903085818

Cronbach, L. J. (1951). Coefficient alpha and the internal structure of tests. *Psychometrika*, 16(3), 297–334.

Crowe, A., Mullen, P., & Spargo, A. (n.d.). *Counselor, know thyself. The impact of mental health literacy and stigma on stress and satisfaction in practicing counselors*. 20.

Crowne, D. P., & Marlowe, D. (1960). A new scale of social desirability independent of psychopathology. *Journal of Consulting Psychology, 24*(4), 349.

Cuff, B. M. P., Brown, S. J., Taylor, L., & Howat, D. J. (2016). Empathy: A review of the concept. *Emotion Review, 8*(2), 144–153. https://doi.org/10.1177/1754073914558466

Cummings, C., Singer, J., Hisaka, R., & Benuto, L. T. (2021). Compassion satisfaction to combat work-related burnout, vicarious trauma, and secondary traumatic stress. *Journal of Interpersonal Violence*, *36*(9–10), NP5304–NP5319. https://doi.org/10.1177/0886260518799502

Dayal, H., Buck, G., & Clandinin, D. J. (2021). A narrative inquiry into counsellor trainees' experiences of working with trauma. *Reflective Practice*, *22*(4), 474–487. https://doi.org/10.1080/14623943.2021.1915268

Decety, J., & Jackson, P. L. (2004). The functional architecture of human empathy. *Behavioral and Cognitive Neuroscience Reviews, 3*(2), 71–100. https://doi.org/10.1177/1534582304267187

Decety, J., Smith, K. E., Norman, G. J., & Halpern, J. (2014). A social neuroscience perspective on clinical empathy. *World Psychiatry, 13*(3), 233–237. https://doi.org/10.1002/wps.20146

Demand for Mental Health and Addiction Services Increasing as COVID-19 Pandemic Continues to Threaten Availability of Treatment Options. (September, 2020). National Council for Mental Wellbeing. Retrieved March 5, 2022, from https://www.thenationalcouncil.org/press-releases/demand-for-mental-health-and-addiction-services-increasing-as-covid-19-pandemic-continues-to-threaten-availability-of-treatment-options/

DeVellis, R. (2003). *Scale development: Theory and applications* (2nd ed. ed., Applied social research methods series, v. 26). Sage Publications.

Dowling, T. (2018). Compassion does not fatigue! *The Canadian Veterinary Journal, 59*(7), 749–750.

Eby, L. T., & Rothrauff-Laschober, T. C. (2012). The relationship between perceptions of organizational functioning and voluntary counselor turnover: A four-wave longitudinal study. *Journal of Substance Abuse Treatment, 42*(2), 151–158. https://doi.org/10.1016/j.jsat.2011.10.008

Elder, C. L. (2021). Empathy and compassion as predictors or counselor burnout and resilience [ProQuest Information & Learning]. In *Dissertation Abstracts International*: Section B: The Sciences and Engineering (Vol. 82, Issue 10–B).

Elder, C. L., Norris, E. K., & Morgan, L. M. (2022, March 8). *Counselor burnout during COVID-19*. Counseling Today. https://ct.counseling.org/2022/03/counselor-burnout-during-covid-19/

Feist, J. B., Feist, J. C., & Cipriano, P. (2020). Stigma compounds the consequences of clinician burnout during covid-19: A call to action to break the culture of silence. *NAM Perspectives*. https://doi.org/10.31478/202008b

Figley, C. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized.* NY: Brunner/Routledge.

Figley, C. R., & Stamm, B. H. (1996). Psychometric Review of Compassion Fatigue Self-Test. In B. H. Stamm (Ed.), *Measurement of Stress, Trauma, and Adaptation* (pp. 127-130). Lutherville, MD: Sidran Press.

Figley, C. (2002). Compassion fatigue: Psychotherapists' chronic lack of self-care. *Journal of Clinical Psychology*, *58*(11), 1433–1441. https://doi.org/10.1002/jclp.10090

Finch, W. H. (2020). *Exploratory Factor Analysis.* SAGE Publications, Inc. https://doi.org/10.4135/9781544339900

For Therapists: How to Identify Your Ideal Client Load. (n.d.). Retrieved January 27, 2023, from https://www.goodtherapy.org/for-professionals/business-management/private-practices/article/for-therapists-how-to-identify-your-ideal-client-load

Freud, S. (1912). The dynamics of transference. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud, Volume XII* (pp. 97-108). Hogarth Press.

Fuenfhausen, K., Young, S., Cashwell, C., & Musangali, M. (2017). History and evolution of clinical mental health counseling. In J. Young, & C. Cashwell (Eds.), *Clinical mental health counseling: Elements of effective practice* (pp. 2-30). SAGE Publications, Inc., https://dx.doi.org/10.4135/9781071801253.n3

Fye, H. J., Cook, R. M., Choi, Y.-J., & Baltrinic, E. R. (2021). Professional quality of life and affective distress among prelicensed counselors. *Journal of Counseling & Development, 99*(4), 429–439. https://doi.org/10.1002/jcad.12395

Gabbert, F., Hope, L., Luther, K., Wright, G., Ng, M., & Oxburgh, G. (2021). Exploring the use of rapport in professional information-gathering contexts by systematically mapping the evidence base. *Applied Cognitive Psychology*, *35*(2), 329–341. https://doi.org/10.1002/acp.3762

Gibson, D. M., Pence, C., Kennedy, S. D., Gerlach, J., Degges-White, S., & Watson, J. (2021). Development of the counselor wellness competencies. *Journal of Counselor Leadership and Advocacy, 8*(2), 130–145. https://doi.org/10.1080/2326716X.2021.1925997

Grouden, M. E., & Jose, P. E. (2015). Do sources of meaning differentially predict search for meaning, presence of meaning, and wellbeing. *International Journal of Wellbeing, 5*(1), Article 1. https://www.internationaljournalofwellbeing.org/index.php/ijow/article/view/313

Hall, J. A., & Schwartz, R. (2019). Empathy present and future. *The Journal of Social Psychology*, *159*(3), 225–243. https://doi.org/10.1080/00224545.2018.1477442

Hart, C. M., Ritchie, T. D., Hepper, E. G., & Gebauer, J. E. (2015). The balanced inventory of desirable responding short form (BIDR-16). *SAGE Open, 5*(4), 2158244015621113. https://doi.org/10.1177/2158244015621113

Helms, J. E., Henze, K. T., Sass, T. L., & Mifsud, V. A. (2006). Treating cronbach's alpha reliability coefficients as data in counseling research. *The Counseling Psychologist, 34*(5), 630–660. https://doi.org/10.1177/0011000006288308

Hensel, J. M., Ruiz, C., Finney, C., & Dewa, C. S. (2015). Meta-analysis of risk factors for secondary traumatic stress in therapeutic work with trauma victims. *Journal of Traumatic Stress, 28*(2), 83–91. https://doi.org/10.1002/jts.21998

Hofmeyer, A., Kennedy, K., & Taylor, R. (2020). Contesting the term 'compassion fatigue': Integrating findings from social neuroscience and self-care research. *Collegian, 27*(2), 232–237. https://doi.org/10.1016/j.colegn.2019.07.001

Holland, K. M., Jones, C., Vivolo-Kantor, A. M., Idaikkadar, N., Zwald, M., Hoots, B., Yard, E., D'Inverno, A., Swedo, E., Chen, M. S., Petrosky, E., Board, A., Martinez, P., Stone, D. M., Law, R., Coletta, M. A., Adjemian, J., Thomas, C., Puddy, R. W., … Houry, D. (2021). Trends in US emergency department visits for mental health, overdose, and violence outcomes before and during the COVID-19 pandemic. *JAMA Psychiatry, 78*(4), 372–379. https://doi.org/10.1001/jamapsychiatry.2020.4402

Holmes, M. R., Rentrope, C. R., Korsch-Williams, A., & King, J. A. (2021). Impact of covid-19 pandemic on posttraumatic stress, grief, burnout, and secondary trauma of social workers in the United States. *Clinical Social Work Journal.* https://doi.org/10.1007/s10615-021-00795-y

Howe, D. (2019). Empathy, respect and dignity in social work. In *The Routledge Handbook of Social Work Theory* (pp. 109–121). Routledge. https://doi.org/10.4324/9781315211053-10

Jimenez, R. R., Andersen, S., Song, H., & Townsend, C. (2021). Vicarious trauma in mental health care providers. *Journal of Interprofessional Education & Practice, 24*, 100451. https://doi.org/10.1016/j.xjep.2021.100451

Jirek, S. L. (2020). Ineffective organizational responses to workers' secondary traumatic stress: A case study of the effects of an unhealthy organizational culture. *Human Service Organizations: Management, Leadership & Governance, 44*(3), 210–228. https://doi.org/10.1080/23303131.2020.1722302

Joinson, C. (1992). Coping with compassion fatigue. *Nursing*, *22*(4), 116, 118–119, 120.

Joshi, G., & Sharma, G. (2020). Burnout: A risk factor amongst mental health professionals during COVID-19. *Asian Journal of Psychiatry*, *54*, 102300. https://doi.org/10.1016/j.ajp.2020.102300

Kaluzeviciute, G. (2020). The role of empathy in psychoanalytic psychotherapy: A historical exploration. *Cogent Psychology*, *7*(1), 1748792. https://doi.org/10.1080/23311908.2020.1748792

Kaplan, D. M., Tarvydas, V. M., & Gladding, S. T. (2014). 20/20: A Vision for the future of counseling: The new consensus definition of counseling. *Journal of Counseling & Development*, *92*(3), 366–372. https://doi.org/10.1002/j.1556-6676.2014.00164.x

Klimecki, O., & Singer, T. (2012). *Empathic distress fatigue rather than compassion fatigue? Integrating findings from empathy research in psychology and social neuroscience.* In Oakley, et al., 2012. *Pathological Altruism*. Oxford University Press.

Ko, H., & Lee, S. M. (2021). Effects of imbalance of self- and other-care on counselors' burnout. *Journal of Counseling & Development, 99*(3), 252–262. https://doi.org/10.1002/jcad.12372

Kottler, J. A., & Balkin, R. S. (2017). *Relationships in counseling and the counselor's life*. American Counseling Association.

Kreitzer, L., Brintnell, S. E., & Austin, W. (2020). Institutional barriers to healthy workplace environments: From the voices of social workers experiencing compassion fatigue. *The British Journal of Social Work, 50*(7), 1942–1960. https://doi.org/10.1093/bjsw/bcz147

Kulkarni, S., Bell, H., Hartman, J. L., & Herman-Smith, R. L. (2013). Exploring individual and organizational factors contributing to compassion satisfaction, secondary traumatic stress, and burnout in domestic violence service providers. *Journal of the Society for Social Work and Research, 4*(2), 114–130. https://doi.org/10.5243/jsswr.2013.8

Lai, L., Ren, Z., Yan, Y., Niu, G., Zhao, C., Luo, M., & Zhang, L. (2021). The double-edged-sword effect of empathy: The secondary traumatic stress and vicarious posttraumatic growth of psychological hotline counselors during the outbreak of COVID-19. *Acta Psychologica Sinica, 53*(9), 992–1002. https://doi.org/10.3724/SP.J.1041.2021.00992

Lambert, M. J. (1992). Psychotherapy outcome research: Implications for integrative and eclectic therapists. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 94–129). Basic Books.

Lanier, B. A., & Carney, J. S. (2019). Practicing counselors, vicarious trauma, and subthreshold PTSD: Implications for counselor educators. *The Professional Counselor, 9*(4), 334–346. https://doi.org/10.15241/bal.9.4.334

Laska, K. M., Gurman, A. S., & Wampold, B. E. (2014). Expanding the lens of evidence-based practice in psychotherapy: A common factors perspective. Psychotherapy, 51, 467–481. http://dx.doi.org/10.1037/a0034332

Lawson, G. (2007). Counselor wellness and impairment: A national survey. *Journal of Humanistic Counseling, Education and Development*, *46*(1), 20-S.

Lawson, G., & Myers, J. E. (2011). Wellness, professional quality of life, and career-sustaining behaviors: What keeps us well? *Journal of Counseling & Development*, *89*(2), 163–171. https://doi.org/10.1002/j.1556-6678.2011.tb00074.x

Ledingham, M. D., Standen, P., Skinner, C., & Busch, R. (2019). "I should have known". The perceptual barriers faced by mental health practitioners in recognising and responding to their own burnout symptoms. *Asia Pacific Journal of Counselling and Psychotherapy*, *10*(2), 125–145. https://doi.org/10.1080/21507686.2019.1634600

Lee, S. M., Baker, C. R., Cho, S. H., Heckathorn, D. E., Holland, M. W., Newgent, R. A., Ogle, N. T., Powell, M. L., Quinn, J. J., Wallace, S. L., & Yu, K. (2007). Development and initial psychometrics of the counselor burnout inventory. *Measurement and Evaluation in Counseling and Development*, *40*(3), 142–154. https://doi.org/10.1080/07481756.2007.11909811

Lee, D., & Lim, H. (2008). Scale construction. In P. P. Heppner, B. E. Wampold, & D. M. Kivlighan (Eds.), *Research design in counseling* (3rd ed.) (pp. 494-510). Brooks/Cole.

Leibert, T. W. (2011). The dimensions of common factors in counseling. *International Journal for the Advancement of Counselling*, *33*(2), 127–138. https://doi.org/10.1007/s10447-011-9115-7

Lenz, A. S., & Smith, R. L. (2010). Integrating wellness concepts within a clinical supervision model. *The Clinical Supervisor*, *29*(2), 228–245. https://doi.org/10.1080/07325223.2010.518511

Leung, T., Schmidt, F., & Mushquash, C. (2022). A personal history of trauma and experience of secondary traumatic stress, vicarious trauma, and burnout in mental health workers: A systematic literature review. *Psychological Trauma: Theory, Research, Practice, and Policy.* Advance online publication. https://doi.org/10.1037/tra0001277

Lewis, T. F. (2017). Evidence regarding the internal structure: Confirmatory factor analysis. *Measurement and Evaluation in Counseling and Development*, *50*(4), 239–247. https://doi.org/10.1080/07481756.2017.1336929

Ludick, M., & Figley, C. R. (2017). Toward a mechanism for secondary trauma induction and reduction: Reimagining a theory of secondary traumatic stress. *Traumatology, 23*(1), 112–123. https://doi.org/10.1037/trm0000096

Martin-Cuellar, A., Atencio, D. J., Kelly, R. J., & Lardier, D. T. (2018). Mindfulness as a moderator of clinician history of trauma on compassion satisfaction. *The Family Journal, 26*(3), 358–368. https://doi.org/10.1177/1066480718795123

Maslach, C., & Jackson, S. E. (1981). The measurement of experienced burnout. *Journal of Organizational Behavior*, *2*(2), 99–113. https://doi.org/10.1002/job.4030020205

Maslach, C. (2003). Job burnout: New directions in research and intervention. *Current Directions in Psychological Science*, *12*(5), 189–192. https://doi.org/10.1111/1467-8721.01258

May, R. W., Terman, J. M., Foster, G., Seibert, G. S., & Fincham, F. D. (2020). Burnout stigma inventory: Initial development and validation in industry and academia. *Frontiers in Psychology, 11*. https://www.frontiersin.org/articles/10.3389/fpsyg.2020.00391

McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, *3*(1), 131–149. https://doi.org/10.1007/BF00975140

Myers, J. E., & Sweeney, T. J. (2004). The indivisible self: An evidence-based model of wellness. *Journal of Individual Psychology, 60*(3), 234-245.

Mvududu, N. H., & Sink, C. A. (2013). Factor analysis in counseling research and practice. Counseling Outcome Research & Evaluation, 4, 75–98. https://doi.org/10.1177/2150137813494766

Norcross, J. C., & Lambert, M. J. (2011). Evidence-based therapy relationships. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (pp. 3–21). Oxford University Press. https://doi.org/10.1093/acprof:oso/9780199737208.003.0001

Pallant, J. (2020). SPSS Survival Manual: A step by step guide to data analysis using IBM SPSS (7th ed.). Routledge. https://doi.org/10.4324/9781003117452

Pearlman, L. A., & Mac Ian, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice, 26*(6), 558–565. https://doi.org/10.1037/0735-7028.26.6.558

Piaget, J. (1971). The theory of stages in cognitive development. In *Measurement and Piaget* (pp. ix, 283–ix, 283). McGraw-Hill.

Posluns, K., & Gall, T. L. (2020). Dear mental health practitioners, take care of yourselves: A literature review on self-care. *International Journal for the Advancement of Counseling, 42*(1), 1–20. https://doi.org/10.1007/s10447-019-09382-w

McKibben, W. B., & Silvia, P. J. (2017). Evaluating the distorting effects of inattentive responding and social desirability on self-report scales in creativity and the arts. *The Journal of Creative Behavior, 51*(1), 57–69. https://doi.org/10.1002/jocb.86

Mental health counselors | Data USA. (2019). Retrieved July 13, 2022, from https://datausa.io/profile/soc/mental-health-counselors

Mental health professionals are the ones taking care of us: Who's taking care of them? USA Today. (February, 2021). Retrieved October 16, 2021, from https://www.usatoday.com/in-depth/life/health-wellness/2021/02/11/covid-pandemic-mental-health-professionalsstruggling-burnout/4134511001/

Mental health. (n.d.). [World Health Organization]. Mental Health. Retrieved July 29, 2022, from https://www.who.int/health-topics/mental-health

Merriman, J. (2015). Enhancing counselor supervision through compassion fatigue education. *Journal of Counseling & Development, 93*(3), 370–378. https://doi.org/10.1002/jcad.12035

Miller, A., Unruh, L., Wharton, T., Liu, X. "Albert," & Zhang, N. "Jackie." (2017). The relationship between perceived organizational support, perceived coworker support, debriefing and professional quality of life in Florida law enforcement officers. *International Journal of Police Science & Management, 19*(3), 129–139. https://doi.org/10.1177/1461355717717995

Motta, R. W. (2008). *Secondary trauma. International Journal of Emergency Mental Health, 10*(4), 291–298.

Mullen, P. R., & Crowe, A. (2017). Self-stigma of mental illness and help seeking among school counselors. *Journal of Counseling & Development*, *95*(4), 401–411. https://doi.org/10.1002/jcad.12155

Myers, J. E., Sweeney, T. J., & Witmer, J. M. (2000). The wheel of wellness counseling for wellness: A holistic model for treatment planning. *Journal of Counseling and Development, 78*(3), 251–266. http://dx.doi.org/10.1002/j.1556-6676.2000.tb01906.x

Nederhof, A. J. (1985). Methods of coping with social desirability bias: A review. *European Journal of Social Psychology, 15*(3), 263–280. https://doi.org/10.1002/ejsp.2420150303

Newell, J. M., & MacNeil, G. A. (2010). Professional burnout, vicarious trauma, secondary traumatic stress, and compassion fatigue: A review of theoretical terms, risk factors, and preventive methods for clinicians and researchers. *Best Practices in Mental Health: An International Journal*, *6*(2), 57–68.

Newton, T. L., Ohrt, J. H., Guest, J. D., & Wymer, B. (2020). Influence of mindfulness, emotion regulation, and perceived social support on burnout. *Counselor Education and Supervision*, *59*(4), 252–266. https://doi.org/10.1002/ceas.12187

O'Brien, J. L., & Haaga, D. A. F. (2015). Empathic accuracy and compassion fatigue among therapist trainees. *Professional Psychology: Research and Practice*, *46*(6), 414–420. https://doi.org/10.1037/pro0000037

O'Keefe, L. C., Brown, K. C., & Christian, B. J. (2014). Policy perspectives on occupational stress. *Workplace Health & Safety*, *62*(10), 432–438. https://doi.org/10.3928/21650799-20140813-02

Osborne, J. W. (2015). What is rotating in exploratory factor analysis? *Practical Assessment, Research, and Evaluation, 20*(2), 1-7. https://doi.org/10.7275/HB2G-M060

Parsons, R. D., & Zhang, N. (2014). *Becoming a skilled counselor*. SAGE Publications.

Paulhus, D. L. (1984). Balanced Inventory of Desirable Responding [Database record]. APA PsycTests. https://doi.org/10.1037/t08059-000

Pehlivan, T., & Güner, P. (2020). Effect of a compassion fatigue resiliency program on nurses' professional quality of life, perceived stress, resilience: A randomized controlled trial. *Journal of Advanced Nursing, 76*(12), 3584–3596. https://doi.org/10.1111/jan.14568

Posluns, K., & Gall, T. L. (2020). Dear mental health practitioners, take care of yourselves: A literature review on self-care. *International Journal for the Advancement of Counseling*, *42*(1), 1–20. https://doi.org/10.1007/s10447-019-09382-w

Prasad, K., McLoughlin, C., Stillman, M., Poplau, S., Goelz, E., Taylor, S., Nankivil, N., Brown, R., Linzer, M., Cappelucci, K., Barbouche, M., & Sinsky, C. A. (2021). Prevalence and correlates of stress and burnout among U.S. healthcare workers during the COVID-19 pandemic: A national cross-sectional survey study. *EClinicalMedicine*, 35. https://doi.org/10.1016/j.eclinm.2021.100879

Quick, J. C., & Henderson, D. F. (2016). Occupational stress: Preventing suffering, enhancing wellbeing. *International Journal of Environmental Research and Public Health, 13*(5), 459. https://doi.org/10.3390/ijerph13050459

Ray, S. L., Wong, C., White, D., & Heaslip, K. (2013). Compassion satisfaction, compassion fatigue, work life conditions, and burnout among frontline mental health care professionals. *Traumatology*, *19*(4), 255–267. https://doi.org/10.1177/1534765612471144

Reynolds, W. M. (1982). Development of reliable and valid short forms of the Marlowe-Crowne Social Desirability Scale. *Journal of Clinical Psychology*, *38*(1), 119–125. https://doi.org/10.1002/1097-4679(198201)38:1<119::AID-JCLP2270380118>3.0.CO;2-I

Rettie, H., & Daniels, J. (2020). Coping and tolerance of uncertainty: Predictors and mediators of mental health during the COVID-19 pandemic. *American Psychologist.* Advance Online Publication. https://doi.org/10.1037/amp0000710

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Counseling Psychology*, *21*(2), 95–103. https://doi.org/10.1037/h0045357

Rogers C. R. (1980). *A way of being.* Houghton Mifflin.

Rossi, A., Cetrano, G., Pertile, R., Rabbi, L., Donisi, V., Grigoletti, L., Curtolo, C., Tansella, M., Thornicroft, G., & Amaddeo, F. (2012). Burnout, compassion fatigue, and compassion satisfaction among staff in community-based mental health services. *Psychiatry Research*, *200*(2), 933–938. https://doi.org/10.1016/j.psychres.2012.07.029

Rothschild B. & Rand M. L. (2006). *Help for the helper: the psychophysiology of compassion fatigue and vicarious trauma* (1st ed.). W.W. Norton.

Sampaio, M., Haro, M. V. N., De Sousa, B., Melo, W. V., & Hoffman, H. G. (2021). Therapists make the switch to telepsychology to safely continue treating their patients during the COVID-19 pandemic. Virtual reality telepsychology may be next. *Frontiers in Virtual Reality*, *1*, 576421. https://doi.org/10.3389/frvir.2020.576421

Sauter, S., Murphy, L., Colligan, M., Swanson, N., Hurrell, Jr., J., Scharf Jr., F., Sinclair, R., Grubb, P., Goldenhar., Alterman, T., Johnston, J., Hamilton, A., & Tisdale, J. (1999). *Stress at Work.* U.S. Department of Health and Human Services NIOSH Publication No. 99-101. Retrieved from: https://www.cdc.gov/niosh/docs/99-101/

Sharifi, M., Asadi-Pooya, A. A., & Mousavi-Roknabadi, R. S. (2020). Burnout among healthcare providers of COVID-19: A systematic review of epidemiology and recommendations. *Archives of Academic Emergency Medicine*, 9(1), e7. https://doi.org/10.22037/aaem.v9i1.1004

Sickel, A., Seacat, J., & Nabors, N. (2014). Mental health stigma update: A review of consequences. *Advances in Mental Health*, *12*, 202–215. https://doi.org/10.1080/18374905.2014.11081898

Silver, J., Caleshu, C., Casson-Parkin, S., & Ormond, K. (2018). Mindfulness among genetic counselors is associated with increased empathy and work engagement and decreased burnout and compassion fatigue. *Journal of Genetic Counseling*, *27*(5), 1175–1186. https://doi.org/10.1007/s10897-018-0236-6

Singh, J., Karanika-Murray, M., Baguley, T., & Hudson, J. (2020). A systematic review of job demands and resources associated with compassion fatigue in mental health professionals. *International Journal of Environmental Research and Public Health*, *17*(19), 6987. https://doi.org/10.3390/ijerph17196987

Skovholt T. M. (2001). *The resilient practitioner: Burnout prevention and self-care strategies for counselors therapists teachers and health professionals.* Allyn and Bacon.

Sommer, C. A. (2008). Vicarious traumatization, trauma-sensitive supervision, and counselor preparation. *Counselor Education and Supervision*, *48*(1), 61–71.

Sprang, G., Ford, J., Kerig, P., & Bride, B. (2018). Defining secondary traumatic stress and developing targeted assessments and interventions: Lessons learned from research and leading experts. *Traumatology, 25*(2), 72–81. https://doi.org/10.1037/trm0000180

Sprang, G., Lei, F., & Bush, H. (2021). Can organizational efforts lead to less secondary traumatic stress? A longitudinal investigation of change. *American Journal of Orthopsychiatry, 91*(4), 443–453. https://doi.org/10.1037/ort0000546

Stamm, B. H. (1995). Preface. In B. H. Stamm (Ed.). *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (pp. ix–xii). Sidran Press.

Stamm, B. H. (2002). Measuring compassion satisfaction as well as fatigue: Developmental history of the Compassion Satisfaction and Fatigue Test. In C. R. Figley (Ed.), *Treating compassion fatigue* (pp. 107–119). Routledge.

Stamm, B. H. (2005). *The ProQOL Manual: The Professional Quality of Life Scale: Compassion satisfaction, burnout & compassion fatigue/secondary trauma scales*. Sidran Press.

Stamm, B. H. (2009). Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL). /www.isu.edu/~bhstamm or www.proqol.org

Stamm, B. H. (2010). *The Concise ProQOL Manual, 2nd Ed*. https://doi.org/ProQOL.org

Stebnicki, M. (2000). Rehabilitation stress and grief reactions among rehabilitation professionals: Dealing effectively with empathy fatigue. *Journal of Rehabilitation, 66*, 23–29.

Stebnicki, M. A. (2007). Empathy fatigue: Healing the mind, body, and spirit of professional counselors. *American Journal of Psychiatric Rehabilitation*, *10*(4), 317–338. https://doi.org/10.1080/15487760701680570

Stebnicki, M. A. (2016). From empathy fatigue to empathy resiliency. In I. Marini & M. A. Stebnicki (Eds.), *The professional counselor's desk reference* (pp. 533–545). Springer Publishing Company.

Stevanovic, P., & Rupert, P. A. (2004). Career-sustaining behaviors, satisfactions, and stresses of professional psychologists. *Psychotherapy: Theory, Research, Practice, Training*, *41*, 301–309. https://doi.org/10.1037/0033-3204.41.3.301

Sutton, L., Rowe, S., Hammerton, G., & Billings, J. (2022). The contribution of organisational factors to vicarious trauma in mental health professionals: A systematic review and narrative synthesis. *European Journal of Psychotraumatology, 13*(1), 2022278. https://doi.org/10.1080/20008198.2021.2022278

Swank, J. M., & Mullen, P. R. (2017). Evaluating evidence for conceptually related constructs using bivariate correlations. *Measurement and Evaluation in Counseling and Development, 50*(4), 270–274. https://doi.org/10.1080/07481756.2017.1339562

Tabachnick, B. G., & Fidell, L. S. (2013). *Using multivariate statistics* (6th ed.). Pearson.

The State of Mental Health in America. (n.d.). Mental Health America. Retrieved May 17, 2022, from https://www.mhanational.org/issues/state-mental-health-america

Testa, D., & Sangganjanavanich, V. F. (2016). Contribution of mindfulness and emotional intelligence to burnout among counseling interns. *Counselor Education and Supervision, 55*(2), 95–108. https://doi.org/10.1002/ceas.12035

Thompson, I. A., Amatea, E. S., & Thompson, E. S. (2014). Personal and contextual predictors of mental health counselors' compassion fatigue and burnout. *Journal of Mental Health Counseling*, *36*(1), 58–77. https://doi.org/10.17744/mehc.36.1.p61m73373m4617r3

Trippany, R. L., Kress, V. E. W., & Wilcoxon, S. A. (2004). Preventing vicarious trauma: What counselors should know when working with trauma survivors. *Journal of Counseling & Development, 82*(1), 31–37. https://doi.org/10.1002/j.1556-6678.2004.tb00283.x

Turgoose, D., & Maddox, L. (2017). Predictors of compassion fatigue in mental health professionals: A narrative review. *Traumatology, 23*(2), 172–185. https://doi.org/10.1037/trm0000116

Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry, 14*(3), 270–277. https://doi.org/10.1002/wps.20238

Watkins, M. W. (2018). Exploratory factor analysis: A guide to best practice. *Journal of Black Psychology, 44*(3), 219–246. https://doi.org/10.1177/0095798418771807

Watson, J. C. (2017). Establishing evidence for internal structure using exploratory factor analysis. *Measurement and Evaluation in Counseling and Development, 50*(4), 232–238. https://doi.org/10.1080/07481756.2017.1336931

What is Nursing & What do nurses do? | ANA Enterprise. (n.d.). ANA. Retrieved May 23, 2022, from https://www.nursingworld.org/practice-policy/workforce/what-is-nursing/

Wiseman, T. (1996). A concept analysis of empathy. *Journal of Advanced Nursing, 23*, 1162–1167. https://doi.org/10.1046/j.1365-2648.1996.12213.x

Wondra, J. D., & Ellsworth, P. C. (2015). An appraisal theory of empathy and other vicarious emotional experiences. *Psychological Review*, *122*(3), 411–428. https://doi.org/10.1037/a0039252

Yang, Y., & Hayes, J. A. (2020). Causes and consequences of burnout among mental health professionals: A practice-oriented review of recent empirical literature. *Psychotherapy, 57*(3), 426–436. https://doi.org/10.1037/pst0000317

Young, M. E. (2013). *Learning the art of helping: Building blocks and techniques* (5th ed.). Merrill Prentice Hall.

APPENDIX A: PILOT STUDY QUALTRICS SURVEYS

Survey document begins on next page.

UNC GREENSBORO
Department of Counseling and Educational Development

Directions

Development of the Counselor Empathy Fatigue Scale: Pilot Study

Thank you for your willingness to serve as a participant in my pilot study. I am developing a scale called the Counselor Empathy Fatigue Scale (CEFS), which is a quantitative, self-report measure of empathy fatigue in counselors. Empathy fatigue is defined as: a form of exhaustion and depletion of resources that can manifest holistically in counselors (emotionally, cognitively, physically, spiritually, occupationally, behaviorally and in counseling skills) due to consistent exposure to client distress/pain/suffering and empathic engagement.

The purpose of this pilot study is to gain feedback on the relevance and feasibility of this scale. The scale is being created for use with professional counselors, so it is important to have feedback from those currently working in the field. Your experience as a professional counselor will help provide meaningful feedback to strengthen and revise the instrument, before large scale testing.

If you wish to participate in this study, please follow the instructions and answer all questions in this survey. This data is not being formally published, therefore, no Institutional Review Board approval was necessary. However, your participation is completely voluntary.

You will answer a series of Likert-scale questions, followed by questions that will ask you for your feedback on the experience of taking the CEFS **and** the entire survey. Please be as specific as possible in your feedback, and do not hesitate to provide your honest feedback. Your thoughts and suggestions are greatly appreciated. **Please time how long it takes you to complete the survey question (in minutes) from the start of the survey, as we would like to know about how long it takes to complete.**

If you have any questions or concerns, please reach out to me at mawhitbeck@uncg.edu, or my dissertation chair, Dr. Carrie Wachter Morris (cawmorris@uncg.edu).

Thank you for your time, energy, and effort in providing feedback on this survey, and for all you do to serve your clients.

CEFS (WHITBECK)

Empathy fatigue is a form of exhaustion and depletion of resources that can manifest holistically (emotionally, cognitively, physically, spiritually, occupationally, behaviorally and in counseling skills). Professional counselors may experience empathy fatigue due to consistent exposure to client distress/pain/suffering and empathic engagement.

Counselor Empathy Fatigue Scale (CEFS) Instructions:

Below is a list of potential effects that could result from your work as a professional counselor. Please reflect on how many days you experienced the following within the **last two weeks.** Rate your response on a scale of 1 to 5, 1 being not at all and 5 being nearly every day. Consider your personal and professional life while completing the survey. There are no right or wrong answers, so please respond as honestly and accurately as possible.

	1 Not at all	2 Several days	3 About half the days	4 More than half the days	5 Nearly every day
1. I noticed myself taking on the emotions of my client.	○	○	○	○	○
2. After counseling clients, I felt emotionally depleted.	○	○	○	○	○
3. I felt emotionally exhausted after counseling clients in distress.	○	○	○	○	○
4. I was negatively impacted by empathizing with my client.	○	○	○	○	○
5. I had difficulty regulating my emotions.	○	○	○	○	○
6. I felt more down than I typically do.	○	○	○	○	○
7. I felt disconnected from my feelings after working with emotionally distressed clients.	○	○	○	○	○
	1 Not at all	2 Several	3 About half	4 More than	5 Nearly

	1 Not at all	2 Several days	3 About half the days	4 More than half the days	5 Nearly every day
		days	the days	half the days	every day
8. I felt negative emotions toward my work.	O	O	O	O	O
9. I was feeling more generally pessimistic.	O	O	O	O	O
10. I felt confident in my ability to regulate my emotions after counseling sessions.	O	O	O	O	O
11. My emotional highs and lows were more heightened than they have been in the past.	O	O	O	O	O
12. I felt sad when thinking about my clients' problems.	O	O	O	O	O
13. I felt more cynical toward my clients.	O	O	O	O	O
14. I noticed myself ruminating about my client's story once the session was over.	O	O	O	O	O

	1 Not at all	2 Several days	3 About half the days	4 More than half the days	5 Nearly every day
15. I was preoccupied with thoughts about my client's safety after our session.	O	O	O	O	O
16. After counseling clients, I felt mentally drained.	O	O	O	O	O
17. I had trouble focusing during counseling sessions.	O	O	O	O	O
18. I had a negative outlook on clients' capacity for change.	O	O	O	O	O
19. I believed my clients were being honest and forthright with me.	O	O	O	O	O
20. My thought process in session felt disorganized.	O	O	O	O	O
21. I spent a considerable amount of time outside of session thinking about client problems.	O	O	O	O	O

	1 Not at all	2 Several days	3 About half the days	4 More than half the days	5 Nearly every day
22. I believed I was responsible for the progress my clients made in counseling.	O	O	O	O	O
23. I had little energy throughout the day.	O	O	O	O	O
24. My body felt tense after counseling clients with distressing concerns.	O	O	O	O	O
25. I had trouble sleeping after counseling clients in emotional distress.	O	O	O	O	O
26. I experienced changes in my appetite that could be related to stress at work.	O	O	O	O	O
27. I had little energy for things I enjoy (e.g., hobbies, leisure activities).	O	O	O	O	O

	1 Not at all	2 Several days	3 About half the days	4 More than half the days	5 Nearly every day

CEFS Continued

	1 Not at all	2 Several days	3 About half the days	4 More than half the days	5 Nearly every day
28. My muscles felt more tense than usual.	○	○	○	○	○
29. I noticed physical body aches not caused by a pre-existing medical condition.	○	○	○	○	○
30. I found myself having headaches when my work felt more stressful.	○	○	○	○	○
31. I felt energized.	○	○	○	○	○
32. I had to remind myself to relax.	○	○	○	○	○
33. I was impatient with my clients.	○	○	○	○	○
34. I was irritable with my coworkers.	○	○	○	○	○

	1 Not at all	2 Several days	3 About half the days	4 More than half the days	5 Nearly every day
35. I was more hypervigilant than typical.	○	○	○	○	○
36. My attending skills felt more forced than typical.	○	○	○	○	○
37. I became annoyed with my clients at times.	○	○	○	○	○
38. I made frequent eye contact with my clients.	○	○	○	○	○
39. I found it hard to engage with my typical spiritual practices.	○	○	○	○	○
40. My counseling work did not feel as meaningful as it once did.	○	○	○	○	○
41. I felt purpose in my spirituality.	○	○	○	○	○

	1 Not at all	2 Several days	3 About half the days	4 More than half the days	5 Nearly every day
42. I felt a lack of spiritual connection.	○	○	○	○	○
43. I drifted away from my spiritual supports.	○	○	○	○	○
44. I found it hard to connect with things that were once meaningful to me.	○	○	○	○	○
45. It was harder to connect with my spirituality/belief system.	○	○	○	○	○
46. I engaged in my regular spiritual practices.	○	○	○	○	○

	1 Not at all	2 Several days	3 About half the days	4 More than half the days	5 Nearly every day

CEFS Continued

	1 Not at all	2 Several days	3 About half the days	4 More than half the days	5 Nearly every day
47. My beliefs about the world have come into question because of my work with clients.	○	○	○	○	○
48. I have become more hardened to the world after hearing about difficult client stories.	○	○	○	○	○
49. I believe my work makes a difference in the lives of others.	○	○	○	○	○

	1 Not at all	2 Several days	3 About half the days	4 More than half the days	5 Nearly every day
50. I missed at least one day of work due to feeling emotionally depleted.	O	O	O	O	O
51. My counseling sessions consisted of mostly information gathering.	O	O	O	O	O
52. I cancelled sessions because I was not feeling like myself.	O	O	O	O	O

	1 Not at all	2 Several days	3 About half the days	4 More than half the days	5 Nearly every day
53. I hoped my client wouldn't show.	O	O	O	O	O
54. I felt connected to my colleagues at work.	O	O	O	O	O
55. I actively participated in meetings.	O	O	O	O	O
56. I did not enjoy my counseling work as much as I typically do.	O	O	O	O	O
57. I had rigid boundaries between myself and my coworkers.	O	O	O	O	O
58. It took me longer to establish rapport with clients than it typically does.	O	O	O	O	O

	1 Not at all	2 Several days	3 About half the days	4 More than half the days	5 Nearly every day
59. I found it hard to connect with my client.	O	O	O	O	O
60. I had a poor working alliance with my clients.	O	O	O	O	O
61. I struggled to empathize with my clients.	O	O	O	O	O
62. My in-session expression of empathy felt genuine.	O	O	O	O	O
63. I rarely challenged clients because I could relate to what they were going through.	O	O	O	O	O
64. I noticed that I used more closed questions in session than I typically do.	O	O	O	O	O

	1 Not at all	2 Several days	3 About half the days	4 More than half the days	5 Nearly every day
65. I felt confident that I put forth my best counseling work.	O	O	O	O	O
66. I gave my clients more direct advice than I usually do.	O	O	O	O	O
67. I actively listened to my clients' concerns.	O	O	O	O	O
68. I frequently reflected my client's feelings in session.	O	O	O	O	O
69. I experienced negative countertransference.	O	O	O	O	O

	1 Not at all	2 Several days	3 About half the days	4 More than half the days	5 Nearly every day

Default Question Block

Instructions: This questionnaire is designed to measure the counselor's burnout level. There are no right or wrong answers. Try to be as honest as you can. Beside each

statement, circle the number that best describes how you feel.

	1 Never True	2 Rarely True	3 Sometimes True	4 Often True	5 Always True
1. Due to my job as a counselor, I feel tired most of the time.	O	O	O	O	O
2. I feel I am an incompetent counselor.	O	O	O	O	O
3. I am treated unfairly in my workplace.	O	O	O	O	O
4. I am not interested in my clients and their problems.	O	O	O	O	O
5. My relationships with family members have been negatively impacted by my work as a counselor.	O	O	O	O	O
6. I feel exhausted due to my work as a counselor.	O	O	O	O	O
7. I feel frustrated by my effectiveness as a counselor.	O	O	O	O	O

	1 Never True	2 Rarely True	3 Sometimes True	4 Often True	5 Always True
8. I feel negative energy from my supervisor.	O	O	O	O	O
9. I have become callous toward clients.	O	O	O	O	O
10. I feel like I do not have enough time to engage in personal interests.	O	O	O	O	O
11. Due to my job as a counselor, I feel overstressed.	O	O	O	O	O
12. I am not confident in my counseling skills.	O	O	O	O	O
13. I feel bogged down by the system in my workplace.	O	O	O	O	O
14. I have little empathy for my clients.	O	O	O	O	O

	1 Never True	2 Rarely True	3 Sometimes True	4 Often True	5 Always True
15. I feel I do not have enough time to spend with my friends.	O	O	O	O	O
16. Due to my job as a counselor, I feel tightness in my back and shoulders.	O	O	O	O	O
17. I do not feel like I am making a change in my clients.	O	O	O	O	O
18. I feel frustrated with the system in my workplace.	O	O	O	O	O
19. I am no longer concerned about the welfare of my clients.	O	O	O	O	O
20. I feel I have poor boundaries between work and my personal life.	O	O	O	O	O

BIDR-16 Hart et al., 2015

Directions: Using the scale below as a guide, select the response for each statement to indicate how much you agree with it.

	1- Totally disagree							8- Totally agree
	1	2	3	4	5	6	7	8
1. I have not always been honest with myself.	O	O	O	O	O	O	O	O
2. I always know why I like things.	O	O	O	O	O	O	O	O

	1- Totally disagree							8- Totally agree
	1	2	3	4	5	6	7	8
3. It's hard for me to shut off a disturbing thought.	O	O	O	O	O	O	O	O
4. I never regret my decisions.	O	O	O	O	O	O	O	O
5. I sometimes lose out on things because I can't make up my mind soon enough.	O	O	O	O	O	O	O	O
6. I am a completely rational person.	O	O	O	O	O	O	O	O
	1	2	3	4	5	6	7	8
7. I am very confident of my judgments.	O	O	O	O	O	O	O	O
8. I have sometimes doubted my ability as a lover.	O	O	O	O	O	O	O	O
9. I sometimes tell lies if I have to.	O	O	O	O	O	O	O	O
10. I never cover up my mistakes.	O	O	O	O	O	O	O	O
11. There have been occasions when I have taken advantage of someone.	O	O	O	O	O	O	O	O
12. I sometimes try to get even rather than forgive and forget.	O	O	O	O	O	O	O	O
	1	2	3	4	5	6	7	8
13. I have said something bad about a friend behind their back.	O	O	O	O	O	O	O	O
14. When I hear people talking privately, I avoid listening.	O	O	O	O	O	O	O	O
15. I never take things that don't belong to me.	O	O	O	O	O	O	O	O
16. I don't gossip about other people's business.	O	O	O	O	O	O	O	O

ProQoL Compassion Satisfaction

When you counsel people you have direct contact with their lives. As you may have found, your compassion for those you counsel can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a counselor. 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 get satisfaction from being able to counsel people.	O	O	O	O	O
2. I feel invigorated after working with those I counsel.	O	O	O	O	O
3. I like my work as a counselor.	O	O	O	O	O
4. I am pleased with how I am able to keep up with counseling techniques and protocols.	O	O	O	O	O
5. My work makes me feel satisfied.	O	O	O	O	O
6. I have happy thoughts and feelings about those I counsel and how I could help them.	O	O	O	O	O
7. I believe I can make a difference through my work.	O	O	O	O	O
8. I am proud of what I can do to counsel.	O	O	O	O	O
9. I have thoughts that I am a "success" as a counselor.	O	O	O	O	O

	1 = Never	2 = Rarely	3 = Sometimes	4 = Often	5 = Very Often
10. I am happy that I chose to do this work.	○	○	○	○	○

Demographics

What is your age?

What is your gender identity?

- ☐ Man
- ☐ Woman
- ☐ Transgender Man
- ☐ Transgender Woman
- ☐ Non-binary
- ☐ Two-Spirit
- ☐ Gender Queer/Gender Fluid/Gender Non-conforming
- ☐ I prefer not to say
- ☐ Self-identify: (Please describe)

Which of the following best describes your racial identity? (Select all that apply).

- ☐ African American
- ☐ Asian-American
- ☐ Caucasian/White (Non-Hispanic)
- ☐ Hispanic
- ☐ Native American
- ☐ Pacific/Islander
- ☐ Asian
- ☐ Multi-racial
- ☐ Self-identify: (Please describe)

What is your highest degree completed?

- ○ Bachelors
- ○ Masters
- ○ PhD

What is your training specialty? (e.g., Clinical mental health counseling, school counseling, etc.)

What setting do you currently work in? (e.g., Outpatient, private practice, residential treatment, etc).

On average, how may direct client contact hours do you have a week?

Are you fully or provisionally licensed?

- ○ Fully licensed
- ○ Provisionally licensed

What are your credentials? (e.g., LMHC, NCC)

Are you an Approved Clinical Supervisor? (ACS)

- ○ Yes
- ○ No

How many years have you been a counselor? (i.e., providing direct counseling services to clients)

Do you specialize in working with trauma?

- Yes
- No

Block 1

The following questions are about your experience and feedback about the Counselor Empathy Fatigue Scale (CEFS; the first questionnaire you took) and the overall survey (CEFS and other questionnaires). Please be as open and honest as possible; your feedback is greatly appreciated!

What behaviors would you expect someone with empathy fatigue to exhibit?

Related to the CEFS, were there aspects of empathy fatigue that were missing? If so, what would you add?

How long did it take you to complete the entire survey (in minutes?)

Was there a point that you felt that the survey became too long? (e.g., that you were tired of answering questions?) If so, where was that point?

We are considering adding 20 more items to this survey. Would an additional 20 items significantly change your willingness or ability to complete the entire survey?

- Yes
- No

What could be improved? (either about the entire survey or the CEFS?)

General comments and feedback:

CEFS Feedback

Based on your experience taking the Counselor Empathy Fatigue Scale, please select the rating that best describes your response to the prompt.

	Strongly Disagree	Disagree	Agree	Strongly Agree
The survey items were worded clearly.	○	○	○	○
The instructions were clear.	○	○	○	○
The survey content related to the effects of my work as a counselor.	○	○	○	○
This survey would be helpful for me to identify areas where my work may be impacting me.	○	○	○	○
I could see myself using this survey to monitor my empathy fatigue.	○	○	○	○

	Strongly Disagree	Disagree	Agree	Strongly Agree
This survey would help me choose which self-care activities might be best to engage in.	○	○	○	○
I think professional counselors could benefit from learning about empathy fatigue.	○	○	○	○

UNC GREENSBORO
Department of Counseling and Educational Development

Counselor Empathy Fatigue Scale Pilot Study

Thank you for your interest and participation in this study. This feedback survey is part of a pilot test that I am conducting for my dissertation. Your feedback is instrumental to the development of the Counselor Empathy Fatigue Scale (CEFS) that will be used to improve counselors' awareness of empathy fatigue. Your time, expertise, and feedback is greatly appreciated by myself and my dissertation committee.

Please review the initial item pool and rate the items on representativeness, importance, and clarity, in relation to the construct of measuring empathy fatigue. There are also a few questions to provide written feedback at the end of the survey. If you have any comments, questions, or concerns, please contact Megan A. Whitbeck at mawhitbeck@uncg.edu or her dissertation chair Dr. Carrie Wachter Morris at cawmorris@uncg.edu.

Items

Column 1: Please rate the level of representativeness of item in measuring empathy fatigue on a scale of 1-4, with 4 being the most representative.

- 1 = item is not representative
- 2 = item needs major revisions to be representative
- 3 = item needs minor revisions to be representative
- 4 = item is representative

Column 2: Please rate the importance of the item in measuring empathy fatigue on a scale of 1-4, with 4 being the most essential.

- 1 = item is not necessary to measure empathy fatigue
- 2 = item provides some information but is not essential to measuring empathy fatigue
- 3 = item is useful but not essential to measure empathy fatigue
- 4 = item is essential to measure empathy fatigue

Column 3: Please rate the level of clarity for each item on a scale of 1-4, with 4 being the most clear.

- 1 = item is not clear
- 2 = item needs major revisions
- 3 = item needs minor revisions
- 4 = item is clear

Construct 1: Emotional effects

	Representativeness of item in measuring empathy fatigue				Importance of item in measuring empathy fatigue				Clarity of item			
	Not representative	Major revisions	Minor revisions	Representative	Not necessary	Provides some info, not necessary	Item useful, not essential	Item is essential	Not clear	Major revisions	Minor revisions	Clear
1. I found myself feeling down after working with a client who was depressed.	O	O	O	O	O	O	O	O	O	O	O	O
2. I felt keyed up or anxious after working with a client who was anxious.	O	O	O	O	O	O	O	O	O	O	O	O
3. I felt emotionally drained after counseling clients.	O	O	O	O	O	O	O	O	O	O	O	O
4. I felt emotionally exhausted after counseling clients in distress.	O	O	O	O	O	O	O	O	O	O	O	O
5. I strongly felt my client's emotions.	O	O	O	O	O	O	O	O	O	O	O	O
6. I was negatively impacted by feeling what my client was feeling.	O	O	O	O	O	O	O	O	O	O	O	O

	Representativeness of item in measuring empathy fatigue				Importance of item in measuring empathy fatigue				Clarity of item			
	Not representative	Major revisions	Minor revisions	Representative	Not necessary	Provides some info, not necessary	Item useful, not essential	Item is essential	Not clear	Major revisions	Minor revisions	Clear
7. I had difficulty regulating my emotions.	O	O	O	O	O	O	O	O	O	O	O	O
8. My emotions did not feel like my own.	O	O	O	O	O	O	O	O	O	O	O	O
9. I felt confident in my ability to regulate my emotions after counseling sessions. (R)	O	O	O	O	O	O	O	O	O	O	O	O
10. My moods were more intense (more highs and lows).	O	O	O	O	O	O	O	O	O	O	O	O
	Not representative	Major revisions	Minor revisions	Representative	Not necessary	Provides some info, not necessary	Item useful, not essential	Item is essential	Not clear	Major revisions	Minor revisions	Clear
11. I felt depressed.	O	O	O	O	O	O	O	O	O	O	O	O
12. I felt overwhelmed.	O	O	O	O	O	O	O	O	O	O	O	O
13. I had a negative outlook on my clients.	O	O	O	O	O	O	O	O	O	O	O	O
14. I felt more negative emotions toward my work.	O	O	O	O	O	O	O	O	O	O	O	O
15. I felt more negative emotions toward my clients.	O	O	O	O	O	O	O	O	O	O	O	O
16. I did not enjoy my counseling work as much as I typically do.	O	O	O	O	O	O	O	O	O	O	O	O
17. I felt excited to go to work. (R)	O	O	O	O	O	O	O	O	O	O	O	O
18. I did not look forward to counseling clients in distress.	O	O	O	O	O	O	O	O	O	O	O	O
19. I felt more irritable toward my clients.	O	O	O	O	O	O	O	O	O	O	O	O

Construct 2: Cognitive effects

	Representativeness of item in measuring empathy fatigue				Importance of item in measuring empathy fatigue				Clarity of item			
	Not representative	Major revisions	Minor revisions	Representative	Not necessary	Provides some info, not necessary	Item useful, not essential	Item is essential	Not clear	Major revisions	Minor revisions	Clear
20. I noticed myself thinking about my clients' problems once the session was over.	O	O	O	O	O	O	O	O	O	O	O	O
21. After counseling clients, I felt mentally drained.	O	O	O	O	O	O	O	O	O	O	O	O
22. I felt responsible for my clients' progress.	O	O	O	O	O	O	O	O	O	O	O	O

	Representativeness of item in measuring empathy fatigue				Importance of item in measuring empathy fatigue				Clarity of item			
	Not representative	Major revisions	Minor revisions	Representative	Not necessary	Provides some info, not necessary	Item useful, not essential	Item is essential	Not clear	Major revisions	Minor revisions	Clear
23. I took on my clients' problems when they were not my own to solve.	○	○	○	○	○	○	○	○	○	○	○	○
24. I had trouble focusing during counseling sessions.	○	○	○	○	○	○	○	○	○	○	○	○
25. I found it hard to connect to my client.	○	○	○	○	○	○	○	○	○	○	○	○
	Not representative	Major revisions	Minor revisions	Representative	Not necessary	Provides some info, not necessary	Item useful, not essential	Item is essential	Not clear	Major revisions	Minor revisions	Clear
26. I was distracted during counseling sessions.	○	○	○	○	○	○	○	○	○	○	○	○
27. I often thought my clients would not get better.	○	○	○	○	○	○	○	○	○	○	○	○
28. My mind wandered during counseling sessions.	○	○	○	○	○	○	○	○	○	○	○	○
29. I spend a considerable amount of time thinking about my client's problems at home.	○	○	○	○	○	○	○	○	○	○	○	○
30. I didn't find my counseling work to be as meaningful as I once did.	○	○	○	○	○	○	○	○	○	○	○	○
31. I believe my work makes a difference in the lives of others. (R)	○	○	○	○	○	○	○	○	○	○	○	○

Construct 3: Physical effects

	Representativeness of item in measuring empathy fatigue				Importance of item in measuring empathy fatigue				Clarity of item			
	Not representative	Major revisions	Minor revisions	Representative	Not necessary	Provides some info, not necessary	Item useful, not essential	Item is essential	Not clear	Major revisions	Minor revisions	Clear
32. I had little energy throughout the day.	○	○	○	○	○	○	○	○	○	○	○	○
33. My body felt tense after counseling clients with distressing concerns.	○	○	○	○	○	○	○	○	○	○	○	○
34. I had trouble sleeping after working with a client whom I am close to.	○	○	○	○	○	○	○	○	○	○	○	○

	Representativeness of item in measuring empathy fatigue				Importance of item in measuring empathy fatigue				Clarity of item			
	Not representative	Major revisions	Minor revisions	Representative	Not necessary	Provides some info, not necessary	Item useful, not essential	Item is essential	Not clear	Major revisions	Minor revisions	Clear
35. I had trouble sleeping after working with a client who was in distress.	○	○	○	○	○	○	○	○	○	○	○	○
36. I had little energy for things I enjoy (e.g., hobbies, leisure activities).	○	○	○	○	○	○	○	○	○	○	○	○
	Not representative	Major revisions	Minor revisions	Representative	Not necessary	Provides some info, not necessary	Item useful, not essential	Item is essential	Not clear	Major revisions	Minor revisions	Clear
37. I noticed my heart racing.	○	○	○	○	○	○	○	○	○	○	○	○
38. I noticed that my muscles felt tense.	○	○	○	○	○	○	○	○	○	○	○	○
39. I noticed physical body aches not caused by a pre-existing medical condition.	○	○	○	○	○	○	○	○	○	○	○	○
40. I felt energized. (R)	○	○	○	○	○	○	○	○	○	○	○	○

Construct 4: Behavioral effects

	Representativeness of item in measuring empathy fatigue				Importance of item in measuring empathy fatigue				Clarity of item			
	Not representative	Major revisions	Minor revisions	Representative	Not necessary	Provides some info, not necessary	Item useful, not essential	Item is essential	Not clear	Major revisions	Minor revisions	Clear
41. I was impatient with my clients.	○	○	○	○	○	○	○	○	○	○	○	○
42. I was irritable with my coworkers.	○	○	○	○	○	○	○	○	○	○	○	○
43. I felt restless.	○	○	○	○	○	○	○	○	○	○	○	○
44. I felt impatient at work.	○	○	○	○	○	○	○	○	○	○	○	○
45. I felt impatient outside of work hours.	○	○	○	○	○	○	○	○	○	○	○	○
46. I was hypervigilant during my sessions with clients.	○	○	○	○	○	○	○	○	○	○	○	○
47. I was hypervigilant outside of sessions with clients.	○	○	○	○	○	○	○	○	○	○	○	○
	Not representative	Major revisions	Minor revisions	Representative	Not necessary	Provides some info, not necessary	Item useful, not essential	Item is essential	Not clear	Major revisions	Minor revisions	Clear
48. I believed I was competing with coworkers.	○	○	○	○	○	○	○	○	○	○	○	○

	Representativeness of item in measuring empathy fatigue				Importance of item in measuring empathy fatigue				Clarity of item			
	Not representative	Major revisions	Minor revisions	Representative	Not necessary	Provides some info, not necessary	Item useful, not essential	Item is essential	Not clear	Major revisions	Minor revisions	Clear
49. I made frequent eye contact with my clients. (R)	O	O	O	O	O	O	O	O	O	O	O	O
50. I gave my clients the benefit of the doubt. (R)	O	O	O	O	O	O	O	O	O	O	O	O
51. I made cynical comments to my clients.	O	O	O	O	O	O	O	O	O	O	O	O
52. I felt more cynical toward my clients.	O	O	O	O	O	O	O	O	O	O	O	O
53. I became annoyed with clients at times.	O	O	O	O	O	O	O	O	O	O	O	O

Construct 5: Spiritual effects/Connectedness to higher power

	Representativeness of item in measuring empathy fatigue				Importance of item in measuring empathy fatigue				Clarity of item			
	Not representative	Major revisions	Minor revisions	Representative	Not necessary	Provides some info, not necessary	Item useful, not essential	Item is essential	Not clear	Major revisions	Minor revisions	Clear
54. I found it hard to engage with my typical spiritual practices.	O	O	O	O	O	O	O	O	O	O	O	O
55. My spiritual practices have become less meaningful.	O	O	O	O	O	O	O	O	O	O	O	O
56. I felt purpose in my spirituality. (R)	O	O	O	O	O	O	O	O	O	O	O	O
57. I felt a lack of spiritual connection.	O	O	O	O	O	O	O	O	O	O	O	O
	Not representative	Major revisions	Minor revisions	Representative	Not necessary	Provides some info, not necessary	Item useful, not essential	Item is essential	Not clear	Major revisions	Minor revisions	Clear
58. I drifted away from my spiritual supports.	O	O	O	O	O	O	O	O	O	O	O	O
59. It was harder to connect with my spirituality/belief system.	O	O	O	O	O	O	O	O	O	O	O	O
60. I engaged in typical spiritual practices. (R)	O	O	O	O	O	O	O	O	O	O	O	O
61. I found little meaning in my spiritual beliefs.	O	O	O	O	O	O	O	O	O	O	O	O

Construct 6: Occupational effects

	Representativeness of item in measuring empathy fatigue				Importance of item in measuring empathy fatigue				Clarity of item			
	Not representative	Major revisions	Minor revisions	Representative	Not necessary	Provides some info, not necessary	Item useful, not essential	Item is essential	Not clear	Major revisions	Minor revisions	Clear
62. I missed at least one day of work due to feeling depleted.	O	O	O	O	O	O	O	O	O	O	O	O

	Representativeness of item in measuring empathy fatigue				Importance of item in measuring empathy fatigue				Clarity of item			
	Not representative	Major revisions	Minor revisions	Representative	Not necessary	Provides some info, not necessary	Item useful, not essential	Item is essential	Not clear	Major revisions	Minor revisions	Clear
63. I struggled to give clients the benefit of the doubt.	O	O	O	O	O	O	O	O	O	O	O	O
64. My counseling sessions were mostly clients sharing content and stories, versus deeper processing.	O	O	O	O	O	O	O	O	O	O	O	O
65. Processing intense emotional situations with clients was draining.	O	O	O	O	O	O	O	O	O	O	O	O
66. I believe I am responsible for the progress my clients make in counseling.	O	O	O	O	O	O	O	O	O	O	O	O
67. If a client is not getting better, it is mostly my fault.	O	O	O	O	O	O	O	O	O	O	O	O
	Not representative	Major revisions	Minor revisions	Representative	Not necessary	Provides some info, not necessary	Item useful, not essential	Item is essential	Not clear	Major revisions	Minor revisions	Clear
68. I cancelled a session because I was not feeling like myself.	O	O	O	O	O	O	O	O	O	O	O	O
69. I hoped my client wouldn't show.	O	O	O	O	O	O	O	O	O	O	O	O
70. I felt connected to my colleagues at work. (R)	O	O	O	O	O	O	O	O	O	O	O	O
71. I participated actively in meetings. (R)	O	O	O	O	O	O	O	O	O	O	O	O
72. I dreaded having counseling sessions.	O	O	O	O	O	O	O	O	O	O	O	O
73. I dreaded going to work.	O	O	O	O	O	O	O	O	O	O	O	O

Construct 7: Process Skills

	Representativeness of item in measuring empathy fatigue				Importance of item in measuring empathy fatigue				Clarity of item			
	Not representative	Major revisions	Minor revisions	Representative	Not necessary	Provides some info, not necessary	Item useful, not essential	Item is essential	Not clear	Major revisions	Minor revisions	Clear
74. I did not establish rapport as quickly as I typically do.	O	O	O	O	O	O	O	O	O	O	O	O
75. I did not establish rapport as easily as I typically do.	O	O	O	O	O	O	O	O	O	O	O	O

	Representativeness of item in measuring empathy fatigue				Importance of item in measuring empathy fatigue				Clarity of item			
	Not representative	Major revisions	Minor revisions	Representative	Not necessary	Provides some info, not necessary	Item useful, not essential	Item is essential	Not clear	Major revisions	Minor revisions	Clear
76. I found it difficult to connect with my clients.	O	O	O	O	O	O	O	O	O	O	O	O
77. I struggled to empathize with my clients.	O	O	O	O	O	O	O	O	O	O	O	O
78. My expression of empathy in session felt forced.	O	O	O	O	O	O	O	O	O	O	O	O
79. My in-session expression of empathy felt disingenuous.	O	O	O	O	O	O	O	O	O	O	O	O
80. My in-session expression of empathy felt genuine. (R)	O	O	O	O	O	O	O	O	O	O	O	O
81. I rarely challenged clients because they don't listen anyway.	O	O	O	O	O	O	O	O	O	O	O	O
	Not representative	Major revisions	Minor revisions	Representative	Not necessary	Provides some info, not necessary	Item useful, not essential	Item is essential	Not clear	Major revisions	Minor revisions	Clear
82. I noticed that I used more closed questions with my clients.	O	O	O	O	O	O	O	O	O	O	O	O
83. I felt confident that I put forth my best counseling work. (R)	O	O	O	O	O	O	O	O	O	O	O	O
84. I was more direct with my clients than I typically am.	O	O	O	O	O	O	O	O	O	O	O	O
85. I actively listened to my clients' concerns. (R)	O	O	O	O	O	O	O	O	O	O	O	O
86. I processed my client's story on a deeper level. (R)	O	O	O	O	O	O	O	O	O	O	O	O
87. I frequently reflected my client's feelings in session. (R)	O	O	O	O	O	O	O	O	O	O	O	O
88. I experienced negative countertransference.	O	O	O	O	O	O	O	O	O	O	O	O

Block 2

What feedback do you have about how the items relate to the construct of empathy fatigue?

What is missing that should be included to adequately measure empathy fatigue?

What constructs or measures would you suggest for determining convergent and discriminant validity for the CEFS?

Please rank the strongest 3-5 items in each category by providing their numbers below.

- O [ ] Emotional
- O [ ] Cognitive
- O [ ] Physical
- O [ ] Behavioral
- O [ ] Spiritual
- O [ ] Occupational

○ [ ] Process Skills

Some items are similarly worded, or ultimately get to the same point. If you noticed some that were similar, what do you recommend in terms of consolidating these items?

Please use this space to share your overall feedback, thoughts, or suggestions you have about the items and/or the overall measure.

APPENDIX B: RECRUITMENT EMAIL TO CONTENT EXPERTS

Subject line: Empathy Fatigue in Professional Counselors: Brief Pilot Feedback Request

Dear *Participant,*

My name is Megan A. Whitbeck, and I am a third-year doctoral student in the Department of Counseling and Educational Development at the University of North Carolina at Greensboro. I am currently working on my dissertation on empathy fatigue in professional counselors, to develop a self-report measure of empathy fatigue that helps give counselors better insight into how their work may be holistically impacting them (to inform targeted, intentional restoration strategies that sustain their professional wellness). I am passionate about helping our counselors stay well during such stressful times, to best serve their clients, and remain fulfilled in their career.

I am writing in regard to your expertise in the topic area of empathy fatigue. I am conducting a pilot study, to inform the development of this instrument. I am looking for content experts that would be willing to review and provide feedback on the assessment item pool that I have developed, after thorough consultation with the literature and my dissertation chair, Dr. Carrie Wachter Morris. I recognize that this time can be a busy one, but your time and participation in my pilot study would be immensely appreciated.

Your participation in this pilot study would include providing your feedback on the items' representativeness of empathy fatigue, how important they are to measuring empathy fatigue, and their clarity. I have created a Qualtrics survey to make it easier to provide your feedback, but you can review the item pool in the attached word document as well, prior to completing the Qualtrics survey. I am also hoping to receive your thoughts on the following questions (also in Qualtrics survey):

1. What feedback do you have about how the items relate to empathy fatigue?
2. What is missing that should be included to adequately measure empathy fatigue?
3. What constructs or measures might you suggest to determine convergent and discriminant validity for the CEFS?
4. Please rank the strongest 3-5 items in each category by providing their numbers below.
5. Please share your overall feedback and any thoughts or suggestions you have about the items.

Should you choose to participate, you can do so by following this link to the Qualtrics survey. I anticipate participation to be no more than 30-60 minutes of your time.

I hope that you will consider this invitation to share your feedback and expertise, as it is important to me that this instrument truly capture empathy fatigue so that it can be used to help counselors better understand the potential impacts of their work.

Please feel free to reach out with any questions that you may have, to myself, at mawhitbeck@uncg.edu, or my dissertation chair, Dr. Carrie Wachter Morris at cawmorris@uncg.edu.

I truly appreciate your time and consideration.

Warmly,

Megan A. Whitbeck

APPENDIX C: PILOT STUDY EMAIL TO TARGET POPULATION REVIEWERS

Subject line: Counselor Empathy Fatigue Pilot Study Participation Opportunity

Dear Participant,

My name is Megan A. Whitbeck, and I am a third-year doctoral student in the Department of Counseling and Educational Development at the University of North Carolina at Greensboro. I am currently working on my dissertation study on empathy fatigue in professional counselors. I am developing a self-report measure of empathy fatigue that will hopefully improve counselors' self-awareness about how their work may be holistically impacting them (to inform what self-care strategies they may implement to sustain their professional wellness). I am passionate about helping counselors stay well during such stressful times, to best serve their clients, and remain fulfilled in their career.

I am writing to ask if you would be willing to participate in a pilot study to help inform the development of my instrument, the Counselor Empathy Fatigue Scale (CEFS). Your participation would include taking the survey that will be used for my dissertation study, and providing feedback. Your feedback and thoughts about the survey will help improve the experience of taking the survey.

Because I am not formally publishing the results from this pilot study, no IRB approval was required. However, your participation is voluntary, and your feedback and responses will be anonymous.

If you wish to participate in this pilot study, please click the following link that will take you to the Qualtrics survey:

https://uncg.qualtrics.com/jfe/form/SV_6u3hjmshCDTldcy

If you have any questions or concerns, please email me at mawhitbeck@uncg.edu or my dissertation chair, Dr. Carrie Wachter Morris at cawmorris@uncg.edu. I appreciate your consideration and thank you for all of your hard work as a counselor, to help improve the lives of your clients.

All my best,

Megan

APPENDIX D: INITIAL CEFS (PRIOR TO EFA)

Scale Instructions: Below is a list of potential effects that could result from your work as a professional counselor. Please reflect on how many days you experienced the following within the **last two weeks.** Rate your response on a scale of 1 to 5, 1 being not at all and 5 being nearly every day. Consider your personal and professional life while completing the survey. There are no right or wrong answers, so please respond as honestly and accurately as possible.

1	2	3	4	5
Not at all	Several days	About half the days	More than half the days	Nearly every day

1. I noticed myself taking on the emotions of my client.
2. After counseling clients, I felt emotionally depleted.
3. I felt disconnected from my feelings after working with emotionally distressed clients.
4. I felt negative emotions toward my work.
5. I was feeling more generally pessimistic.
6. I felt confident in my ability to regulate my emotions after counseling sessions.
7. My emotional highs and lows were more heightened than they have been in the past.
8. I felt sad when thinking about my clients' problems.
9. I noticed physical body aches not caused by a pre-existing medical condition.
10. I found myself having headaches when my work felt more stressful.
11. I felt more cynical toward my clients.
12. I noticed myself ruminating about my client's story once the session was over.
13. I was preoccupied with thoughts about my client's safety after our session.
14. After counseling clients, I felt mentally drained.
15. My body felt tense after counseling clients with distressing concerns.
16. I had trouble sleeping after counseling clients in emotional distress.
17. I had trouble focusing during counseling sessions.
18. I had a negative outlook on clients' capacity for change.
19. I believed my clients were being honest and forthright with me.
20. I spent a considerable amount of time outside of session thinking about client problems.
21. I did not enjoy my counseling work as much as I typically do.

22. I had a poor working alliance with my clients.
23. I believed I was responsible for the progress my clients made in counseling.
24. I had little energy throughout the day.
25. I experienced changes in my appetite that could be related to stress at work.
26. I felt emotionally exhausted after counseling clients in distress.
27. I had little energy for things I enjoy (e.g., hobbies, leisure activities).
28. My muscles felt more tense than usual.
29. I felt energized.
30. I was impatient with my clients.
31. My personal relationships have been negatively impacted because of my work.
32. I had difficulty regulating my emotions.
33. I felt more down than I typically do.
34. I was irritable with my coworkers.
35. I experienced negative countertransference.
36. I was more hypervigilant than typical.
37. I became annoyed with my clients at times.
38. It was harder to connect with my spirituality/belief system.
39. I made frequent eye contact with my clients.
40. I had to remind myself to relax.
41. I noticed more difficulties in my personal relationships.
42. My beliefs about the world have come into question because of my work with clients.
43. I had rigid boundaries between myself and my coworkers.
44. It took me longer to establish rapport with clients than it typically does.
45. I have become more hardened to the world after hearing about difficult client stories.
46. My loved ones have commented that I don't seem like myself.
47. I was negatively impacted by empathizing with my client.
48. I have felt comfortable reaching out to my social support system.
49. I found it hard to engage with my typical spiritual practices.
50. My counseling work did not feel as meaningful as it once did.
51. I felt purpose in my spirituality.
52. I felt a lack of spiritual connection.

53. I drifted away from my spiritual supports.
54. I found it hard to connect with things that were once meaningful to me.
55. I engaged in my regular spiritual practices.
56. My thought process in session felt disorganized.
57. I believe my work makes a difference in the lives of others.
58. I missed at least one day of work due to feeling emotionally depleted.
59. My counseling sessions consisted of mostly information gathering.
60. I cancelled sessions because I was not feeling like myself.
61. I gave my clients more direct advice than I usually do.
62. I actively listened to my clients' concerns.
63. I hoped my client wouldn't show to session.
64. I felt connected to my colleagues at work.
65. I actively participated in meetings.
66. I noticed that I used more closed questions in session than I typically do.
67. My attending skills felt more forced than typical.
68. I felt confident that I put forth my best counseling work.
69. I struggled to empathize with my clients.
70. I haven't had as much energy for my relationships with family and friends.
71. My in-session expression of empathy felt genuine.
72. I found it hard to connect with my client.
73. I rarely challenged clients because I could relate to what they were going through.
74. I frequently reflected my client's feelings in session.

APPENDIX E: MAIN STUDY QUALTRICS SURVEY LINK

Survey document starts on next page.

UNC GREENSBORO
Department of Counseling and Educational Development

Directions

UNIVERSITY OF NORTH CAROLINA AT GREENSBORO
CONSENT TO ACT AS A HUMAN PARTICIPANT
Version 2 9/27/2022

Project Title: Initial Development and Validation of the Counselor Empathy Fatigue Scale (CEFS)

Principal Investigator and Faculty Advisor: Megan A. Whitbeck and Dr. Carrie A. Wachter Morris

What are some general things you should know about research studies?
You are being asked to take part in a research study. Your participation in the study is voluntary. You may choose not to join, or you may withdraw your consent to be in the study, for any reason, without penalty.

Research studies are designed to obtain new knowledge. This new information may help people in the future. There may not be any direct benefit to you for being in the research study. There also may be risks to being in research studies. If you choose not to be in the study or leave the study before it is done, it will not affect your relationship with the researcher or the University of North Carolina at Greensboro. Details about this study are discussed in this consent form. It is important that you understand this information so that you can make an informed choice about being in this research study.

You can download a copy of this consent form by clicking this link. If you have any questions about this study at any time, you can reach out to Megan A. Whitbeck at mawhitbeck@uncg.edu or Dr. Carrie A. Wachter Morris at cawmorris@uncg.edu or (336) 365-6895.

What is the study about?
This is a research project. Your participation is voluntary. The purpose of this study is to learn more about the concept of empathy fatigue in professional counselors by exploring and validating the Counselor Empathy Fatigue Scale (CEFS). Empathy fatigue is a compounded, holistic exhaustion in several domains of functioning (e.g., emotional, physical, cognitive, spiritual, occupational) that results from counseling clients who share stories of pain and suffering.

Why are you asking me?
You are being asked to participate in this study likely because you hold a minimum master's degree in counseling or a related field, are at least 18, and are actively counseling clients. The researcher is seeking participants to analyze and validate a scale on empathy fatigue in counselors and related helping professionals (e.g., therapists, social workers, psychologists, etc.).

What will you ask me to do if I agree to be in the study?
If you choose to participate in this study, you will be asked to complete an anonymous series of questionnaires about your thoughts, feelings, behaviors, and reactions to your work as a counselor. The survey should take you about 25-30 minutes or less to complete. The survey will be completed on Qualtrics, a survey software that allows you to participate from your mobile phone or computer.

What are the risks to me?
The Institutional Review Board at the University of North Carolina at Greensboro has determined that participation in this study poses minimal risk to participants. Survey questions cover a range of symptoms that one might experience because of their work in the mental health field and may bring up uncomfortable emotions. You may choose to skip questions if you do not feel comfortable answering them. However, your answers will not be identifiable to anyone, including the researchers.

Some of the questions in this survey ask you about feelings of anxiety and depression. Should you need additional support, please reach out to the mental health resources provided:

- Dial 988- National Suicide and Crisis Lifeline
- Text "HOME" to 741741 to reach a crisis counselor via the Crisis Text Line
- Visit www.psychologytoday.com to find a mental health care provider in your area

If you have questions, want more information or have suggestions, please contact Megan Whitbeck at mawhitbeck@uncg.edu or Dr. Carrie A. Wachter Morris at camorris@uncg.edu or (336) 365-6895.

If you have any concerns about your rights, how you are being treated, concerns or complaints about this project or benefits or risks associated with being in this study please contact the Office of Research Integrity at UNCG toll-free at (855)-251-2351.

Are there any benefits to society as a result of me taking part in this research?
The benefits to taking part in this research include the potential for empathy fatigue to be better understood by counselors and researchers. Ultimately, a greater level of self-awareness of empathy fatigue can help prevent and reduce personal and professional impairment in the mental health field, providing better counseling services to clients. Learning more about empathy fatigue may help counselors more effectively engage in appropriate self-care strategies for wellness.

Are there any benefits to *me* for taking part in this research study?
There are no benefits to you for taking part in this research study. However, you will be part of a larger benefit of helping the counseling field support the well-being of its clinicians.

Will I get paid for being in the study? Will it cost me anything?
Upon completing the survey, you can choose to share your email in a separate survey not tied to your data to be entered into a random drawing for one of twenty $20 gift cards to either Amazon or Walmart, of the participant's choosing. If you do not complete the entire survey, you will not have the opportunity to be entered into the drawing. Participants will also be able to participate in a workshop on empathy fatigue for counselors for 1 NBCC Approved CE credit. Interested participants can provide their email to be sent more information about receiving access to the workshop.

How will you keep my information confidential?
Your responses to this research study are completely anonymous. No identifying information will be collected, including no IP addresses, no names, or no email addresses. However, if you use a public computer to complete the study, privacy of others walking past the computer cannot be guaranteed. Absolute confidentiality of data provided through the Internet cannot be guaranteed due to the limited protections of Internet access. Please be sure to close your browser when finished so no one will be able to see what you have been doing. Your responses will be stored electronically in a UNCG-cloud-based Box file and on the researchers' UNCG Qualtrics account, only accessed on a password-protected computer. The following data security statement is from Qualtrics: *Qualtrics complies with applicable data privacy laws in its role as a data controller of its own data and as a data processor of customer data. Specifically, Qualtrics is GDPR (General Data Protection Regulation) and CCPA (California Consumer Privacy Act) compliant and provides technology that enables our customers to be compliant as well.* Data files will be uploaded into data analysis software, so will need to be stored locally on the researcher's password protected computer during data analysis phase, but then will be deleted once data analysis is complete. All data will be de-identified to ensure participant information remains confidential. All information in this study is strictly confidential unless disclosure is required by law.

Will my de-identified data be used in future studies?
Your de-identified data will be kept indefinitely and may be used for future research without your additional consent.
What if I want to leave the study?
You have the right to refuse to participate or to withdraw at any time, without penalty. If you do withdraw, it will not affect you in any way. If you choose to withdraw, you may request that any of your data which has been collected be destroyed unless it is in a de-identifiable state. The investigators also have the right to stop your participation at any time. This could be because you have had an unexpected reaction, or have failed to follow instructions, or because the entire study has been stopped.

What about new information/changes in the study?
If significant new information relating to the study becomes available which may relate to your willingness to continue to participate, this information will be provided to you.

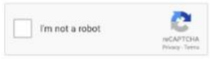
You can download a copy of the informed consent by clicking the following link: Informed consent

Voluntary Consent by Participant:

By clicking the appropriate button below to move forward, you are agreeing that you read this informed consent document, that you fully understand the contents of this document, and are openly willing consent to take part in this study. All of your questions concerning this study have been answered. By clicking the appropriate button below, you are agreeing that you are 18 years of age or older and are agreeing to participate.

Do you wish to particiate?

- ○ Yes, I am at least 18 years old. I have read and understood the content of this consent document, I meet the requirements to participate, and I wish to participate.
- ○ No, I do not wish to participate in this research study or do not meet the requirements to participate.



CEFS (WHITBECK)

Instructions:
Below is a list of potential effects that could result from your work as a professional counselor. Please reflect on how many days you experienced the following within the **last two weeks.** Rate your response on a scale of 1 to 5, 1 being not at all and 5 being nearly every day. Consider your personal and professional life while completing the survey. There are no right or wrong answers, so please respond as honestly and accurately as possible.

	1 Not at all	2 Several days	3 About half the days	4 More than half the days	5 Nearly every day
1. I noticed myself taking on the emotions of my client.	○	○	○	○	○
2. After counseling clients, I felt emotionally depleted.	○	○	○	○	○
3. I felt disconnected from my feelings after working with emotionally distressed clients.	○	○	○	○	○
4. I felt negative emotions toward my work.	○	○	○	○	○
5. I was feeling more generally pessimistic.	○	○	○	○	○
6. I felt confident in my ability to regulate my emotions after counseling sessions.	○	○	○	○	○
7. My emotional highs and lows were more heightened than they have been in the past.	○	○	○	○	○
8. I felt sad when thinking about my clients' problems.	○	○	○	○	○

	1 Not at all	2 Several days	3 About half the days	4 More than half the days	5 Nearly every day
9. I noticed physical body aches not caused by a pre-existing medical condition.	○	○	○	○	○
10. I found myself having headaches when my work felt more stressful.	○	○	○	○	○
11. I felt more cynical toward my clients.	○	○	○	○	○
12. I noticed myself ruminating about my client's story once the session was over.	○	○	○	○	○
13. I was preoccupied with thoughts about my client's safety after our session.	○	○	○	○	○
14. After counseling clients, I felt mentally drained.	○	○	○	○	○
15. My body felt tense after counseling clients with distressing concerns.	○	○	○	○	○

	1 Not at all	2 Several days	3 About half the days	4 More than half the days	5 Nearly every day
16. I had trouble sleeping after counseling clients in emotional distress.	O	O	O	O	O

	1 Not at all	2 Several days	3 About half the days	4 More than half the days	5 Nearly every day
17. I had trouble focusing during counseling sessions.	O	O	O	O	O
18. I had a negative outlook on clients' capacity for change.	O	O	O	O	O
19. I found it hard to connect with things that were once meaningful to me.	O	O	O	O	O
20. I engaged in my regular self-care practices.	O	O	O	O	O
21. I believe my work makes a difference in the lives of others.	O	O	O	O	O
22. I felt disconnected from a deeper meaning related to my work.	O	O	O	O	O
23. I drifted away from my supports that give me a greater sense of connection.	O	O	O	O	O
24. It was harder to connect with my meaning making system (e.g., spirituality, connection to higher power, sense of purpose).	O	O	O	O	O

	1 Not at all	2 Several days	3 About half the days	4 More than half the days	5 Nearly every day
25. I questioned my beliefs about the world because of my work with clients.	O	O	O	O	O
26. I believed my clients were being honest and forthright with me.	O	O	O	O	O
27. I spent a considerable amount of time outside of session thinking about client problems.	O	O	O	O	O
28. I did not enjoy my counseling work as much as I typically do.	O	O	O	O	O
29. I had a poor working alliance with my clients.	O	O	O	O	O

	1 Not at all	2 Several days	3 About half the days	4 More than half the days	5 Nearly every day

CEFS Continued

	1 Not at all	2 Several days	3 About half the days	4 More than half the days	5 Nearly every day
30. I believed I was responsible for the progress my clients made in counseling.	O	O	O	O	O
31. I had little energy throughout the day.	O	O	O	O	O
32. I experienced changes in my appetite that could be related to stress at work.	O	O	O	O	O
33. I felt disconnected from a deeper meaning related to my work.	O	O	O	O	O

	1 Not at all	2 Several days	3 About half the days	4 More than half the days	5 Nearly every day
34. I drifted away from my supports that give me a greater sense of connection.	O	O	O	O	O
35. I felt emotionally exhausted after counseling clients in distress.	O	O	O	O	O

	1 Not at all	2 Several days	3 About half the days	4 More than half the days	5 Nearly every day
36. I had little energy for things I enjoy (e.g., hobbies, leisure activities).	O	O	O	O	O
37. My muscles felt more tense than usual.	O	O	O	O	O
38. I felt energized.	O	O	O	O	O
39. I have become more hardened to the world after hearing about difficult client stories.	O	O	O	O	O
40. I found it hard to engage with activities that typically bring me comfort.	O	O	O	O	O
41. I was impatient with my clients.	O	O	O	O	O

	1 Not at all	2 Several days	3 About half the days	4 More than half the days	5 Nearly every day
42. My personal relationships have been negatively impacted because of my work.	O	O	O	O	O
43. I had difficulty regulating my emotions.	O	O	O	O	O
44. I felt more down than I typically do.	O	O	O	O	O
45. I was irritable with my colleagues.	O	O	O	O	O
46. I experienced negative countertransference.	O	O	O	O	O
47. I was more hypervigilant than typical.	O	O	O	O	O

	1 Not at all	2 Several days	3 About half the days	4 More than half the days	5 Nearly every day
48. My counseling work did not feel as meaningful as it once did.	O	O	O	O	O
49. I felt connected to a purpose greater than myself.	O	O	O	O	O
50. I became annoyed with my clients at times.	O	O	O	O	O

	1 Not at all	2 Several days	3 About half the days	4 More than half the days	5 Nearly every day

CEFS Continued

	1 Not at all	2 Several days	3 About half the days	4 More than half the days	5 Nearly every day
51. I made frequent eye contact with my clients.	O	O	O	O	O
52. I had to remind myself to relax.	O	O	O	O	O
53. I noticed more difficulties in my personal relationships.	O	O	O	O	O

	1 Not at all	2 Several days	3 About half the days	4 More than half the days	5 Nearly every day
54. I had rigid boundaries between myself and my colleagues.	O	O	O	O	O
55. It took me longer to establish rapport with clients than it typically does.	O	O	O	O	O
56. My loved ones have commented that I don't seem like myself.	O	O	O	O	O
57. I was negatively impacted by empathizing with my client.	O	O	O	O	O
58. I felt comfortable reaching out to communities that I typically engage with for support.	O	O	O	O	O

	1 Not at all	2 Several days	3 About half the days	4 More than half the days	5 Nearly every day
59. My thought process in session felt disorganized.	O	O	O	O	O
60. I missed at least one day of work due to feeling emotionally depleted.	O	O	O	O	O
61. My counseling sessions consisted of mostly information gathering.	O	O	O	O	O
62. I cancelled sessions because I was not feeling like myself.	O	O	O	O	O
63. I gave my clients more direct advice than I usually do.	O	O	O	O	O
64. I actively listened to my clients' concerns.	O	O	O	O	O
65. I hoped my client wouldn't show to session.	O	O	O	O	O
66. I felt connected to my colleagues at work.	O	O	O	O	O

	1 Not at all	2 Several days	3 About half the days	4 More than half the days	5 Nearly every day
67. I actively participated in work meetings.	O	O	O	O	O
68. I noticed that I used more closed questions in session than I typically do.	O	O	O	O	O
69. My attending skills felt more forced than typical.	O	O	O	O	O
70. I found it hard to connect with things that were once meaningful to me.	O	O	O	O	O
71. I engaged in my regular self-care practices.	O	O	O	O	O
72. I believe my work makes a difference in the lives of others.	O	O	O	O	O
73. I felt confident that I put forth my best counseling work.	O	O	O	O	O
74. I struggled to empathize with my clients.	O	O	O	O	O

	1 Not at all	2 Several days	3 About half the days	4 More than half the days	5 Nearly every day
75. I haven't had as much energy for my relationships with family and friends.	O	O	O	O	O

	1 Not at all	2 Several days	3 About half the days	4 More than half the days	5 Nearly every day
76. My in-session expression of empathy felt genuine.	○	○	○	○	○
77. I found it hard to connect with my client.	○	○	○	○	○
78. I rarely challenged clients because I could relate to what they were going through.	○	○	○	○	○
79. I frequently reflected my client's feelings in session.	○	○	○	○	○

	1 Not at all	2 Several days	3 About half the days	4 More than half the days	5 Nearly every day

Default Question Block

Instructions: This questionnaire is designed to measure the counselor's burnout level. There are no right or wrong answers. Try to be as honest as you can. Beside each statement, circle the number that best describes how you feel.

	1 Never True	2 Rarely True	3 Sometimes True	4 Often True	5 Always True
1. Due to my job as a counselor, I feel tired most of the time.	○	○	○	○	○
2. I feel I am an incompetent counselor.	○	○	○	○	○
3. I am treated unfairly in my workplace.	○	○	○	○	○
4. I am not interested in my clients and their problems.	○	○	○	○	○
5. My relationships with family members have been negatively impacted by my work as a counselor.	○	○	○	○	○
6. I feel exhausted due to my work as a counselor.	○	○	○	○	○
7. I feel frustrated by my effectiveness as a counselor.	○	○	○	○	○

	1 Never True	2 Rarely True	3 Sometimes True	4 Often True	5 Always True

8. I feel negative energy from my supervisor.	○	○	○	○	○
9. I have become callous toward clients.	○	○	○	○	○
10. I feel like I do not have enough time to engage in personal interests.	○	○	○	○	○
11. Due to my job as a counselor, I feel overstressed.	○	○	○	○	○
12. I am not confident in my counseling skills.	○	○	○	○	○
13. I feel bogged down by the system in my workplace.	○	○	○	○	○
14. I have little empathy for my clients.	○	○	○	○	○

	1 Never True	2 Rarely True	3 Sometimes True	4 Often True	5 Always True

15. I feel I do not have enough time to spend with my friends.	○	○	○	○	○
16. Due to my job as a counselor, I feel tightness in my back and shoulders.	○	○	○	○	○

	1 Never True	2 Rarely True	3 Sometimes True	4 Often True	5 Always True
17. I do not feel like I am making a change in my clients.	○	○	○	○	○
18. I feel frustrated with the system in my workplace.	○	○	○	○	○
19. I am no longer concerned about the welfare of my clients.	○	○	○	○	○
20. I feel I have poor boundaries between work and my personal life.	○	○	○	○	○

BIDR-16 Hart et al., 2015

Directions: Using the scale below as a guide, select the response for each statement to indicate how much you agree with it.

	1- Totally disagree	2	3	4	5	6	7	8- Totally agree
1. I have not always been honest with myself.	○	○	○	○	○	○	○	○
2. I always know why I like things.	○	○	○	○	○	○	○	○
3. It's hard for me to shut off a disturbing thought.	○	○	○	○	○	○	○	○
4. I never regret my decisions.	○	○	○	○	○	○	○	○
5. I sometimes lose out on things because I can't make up my mind soon enough.	○	○	○	○	○	○	○	○
6. I am a completely rational person.	○	○	○	○	○	○	○	○
	1- Totally disagree	2	3	4	5	6	7	8- Totally agree
7. I am very confident of my judgments.	○	○	○	○	○	○	○	○
8. I have sometimes doubted my ability as a lover.	○	○	○	○	○	○	○	○
9. I sometimes tell lies if I have to.	○	○	○	○	○	○	○	○
10. I never cover up my mistakes.	○	○	○	○	○	○	○	○
11. There have been occasions when I have taken advantage of someone.	○	○	○	○	○	○	○	○
12. I sometimes try to get even rather than forgive and forget.	○	○	○	○	○	○	○	○
	1- Totally disagree	2	3	4	5	6	7	8- Totally agree
13. I have said something bad about a friend behind their back.	○	○	○	○	○	○	○	○
14. When I hear people talking privately, I avoid listening.	○	○	○	○	○	○	○	○
15. I never take things that don't belong to me.	○	○	○	○	○	○	○	○
16. I don't gossip about other people's business.	○	○	○	○	○	○	○	○

ProQoL Stamm 2010

When you counsel people you have direct contact with their lives. As you may have found, your compassion for those you counsel can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a counselor. 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 counsel.	○	○	○	○	○
3. I get satisfaction from being able to counsel 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 counsel.	○	○	○	○	○
7. I find it difficult to separate my personal life from my life as a counselor.	○	○	○	○	○
8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I counsel.	○	○	○	○	○

	1 = Never	2 = Rarely	3 = Sometimes	4 = Often	5 = Very Often
9. I think that I might have been affected by the traumatic stress of those I counsel.	○	○	○	○	○
10. I feel trapped by my job as a counselor.	○	○	○	○	○
11. Because of my counseling, I have felt "on edge" about various things.	○	○	○	○	○
12. I like my work as a counselor.	○	○	○	○	○
13. I feel depressed because of the traumatic experiences of the people I counsel.	○	○	○	○	○
14. I feel as though I am experiencing the trauma of someone I have counseled.	○	○	○	○	○
15. I have beliefs that sustain me.	○	○	○	○	○
16. I am pleased with how I am able to keep up with counseling techniques and protocols.	○	○	○	○	○

	1 = Never	2 = Rarely	3 = Sometimes	4 = Often	5 = Very Often
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 counselor.	○	○	○	○	○
20. I have happy thoughts and feelings about those I counsel and how I could help them.	○	○	○	○	○
21. I feel overwhelmed because my case 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 counsel.	○	○	○	○	○
24. I am proud of what I can do to counsel.	○	○	○	○	○

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

	1 = Never	2 = Rarely	3 = Sometimes Sometimes	4 = Often	5 = Very Often Often
25. As a result of my counseling, I have intrusive, frightening thoughts.	○	○	○	○	○
26. I feel "bogged down" by the system.	○	○	○	○	○
27. I have thoughts that I am a "success" as a counselor.	○	○	○	○	○
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.	○	○	○	○	○

Block 6

Demographics

The following questions include demographic information and questions about your counseling background and work.

What is your age?

What is your gender identity?

- ☐ Man
- ☐ Woman
- ☐ Transgender Man
- ☐ Transgender Woman
- ☐ Non-binary
- ☐ Two-Spirit
- ☐ Gender Queer/Gender Fluid/Gender Non-conforming
- ☐ I prefer not to say
- ☐ Self-identify: (Please describe)

Which of the following best describes your racial identity? (Select all that apply).

- ☐ African American
- ☐ Asian-American
- ☐ Caucasian/White (Non-Hispanic)
- ☐ Hispanic
- ☐ Native American
- ☐ Pacific/Islander
- ☐ Asian
- ☐ Multi-racial
- ☐ Self-identify: (Please describe)

What is the highest degree you've completed?

- ○ Masters
- ○ PhD
- ○ Other: (Please specify)

What is your primary training specialty?

- ○ Clinical mental health counseling
- ○ Marriage, couple, and family counseling
- ○ School counseling
- ○ Addiction counseling
- ○ Career counseling
- ○ Rehabilitation counseling
- ○ College counseling/student affairs
- ○ Social work
- ○ Clinical psychology
- ○ Other (please specify):

Do you work full time or part time?

- Full-time
- Part-time

What setting do you currently work in? (e.g., Outpatient, private practice, residential treatment, etc).

- Outpatient
- Inpatient
- Residential treatment facility
- Hospital
- Intensive outpatient
- School
- College counseling center
- Private practice
- Partial hospitalization
- Other: (Please Specify)

Do you have more than one counseling job?

- Yes
- No

What is your other counseling job(s)?

Do you have another job in addition to counseling, that is not counseling?

- Yes
- No

What is your other non-counseling job?

On average, how may direct client contact hours do you have a week?

Are you fully or provisionally licensed?

- Fully licensed
- Provisionally licensed
- Not licensed

What are your credentials? (e.g., LMHC, NCC, LPC, LCSW, etc.)

Are you an Approved Clinical Supervisor? (ACS)

- Yes
- No

How many years have you been practicing as a counselor? (i.e., providing direct counseling services to clients)

Do you specialize in working with trauma?

- Yes
- No

APPENDIX F: COUNSELOR BURNOUT INVENTORY (LEE ET AL., 2007)

Counselor Burnout Inventory

Counseling Program

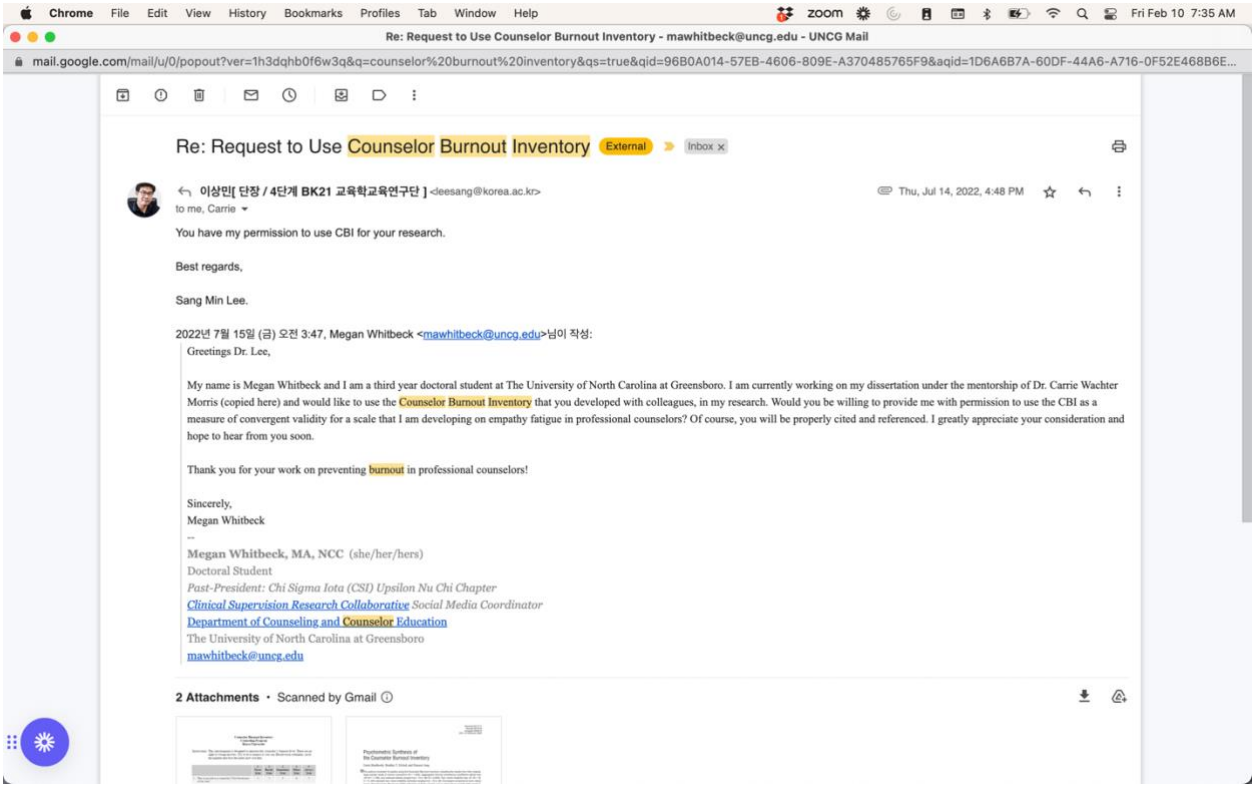
Korea University

Instructions: This questionnaire is designed to measure the counselor's burnout level. There are no right or wrong answers. Try to be as honest as you can. Beside each statement, circle the number that best describes how you feel.

	1 **Never True**	**2** **Rarely True**	**3** **Sometimes True**	**4** **Often True**	**5** **Always True**
1. Due to my job as a counselor, I feel tired most of the time.	1	2	3	4	5
2. I feel I am an incompetent counselor.	1	2	3	4	5
3. I am treated unfairly in my workplace.	1	2	3	4	5
4. I am not interested in my clients and their problems.	1	2	3	4	5
5. My relationships with family members have been negatively impacted by my work as a counselor.	1	2	3	4	5
6. I feel exhausted due to my work as a counselor.	1	2	3	4	5
7. I feel frustrated by my effectiveness as a counselor.	1	2	3	4	5
8. I feel negative energy from my supervisor.	1	2	3	4	5
9. I have become callous toward clients.	1	2	3	4	5
10. I feel like I do not have enough time to engage in personal interests.	1	2	3	4	5
11. Due to my job as a counselor, I feel overstressed.	1	2	3	4	5
12. I am not confident in my counseling skills.	1	2	3	4	5

13. I feel bogged down by the system in my workplace.	1	2	3	4	5
14. I have little empathy for my clients.	1	2	3	4	5
15. I feel I do not have enough time to spend with my friends.	1	2	3	4	5
16. Due to my job as a counselor, I feel tightness in my back and shoulders.	1	2	3	4	5
17. I do not feel like I am making a change in my clients.	1	2	3	4	5
18. I feel frustrated with the system in my workplace.	1	2	3	4	5
19. I am no longer concerned about the welfare of my clients.	1	2	3	4	5
20. I feel I have poor boundaries between work and my personal life.	1	2	3	4	5

APPENDIX G: PERMISSION TO USE CBI



Chrome File Edit View History Bookmarks Profiles Tab Window Help — Fri Feb 10 7:35 AM

Re: Request to Use Counselor Burnout Inventory - mawhitbeck@uncg.edu - UNCG Mail

mail.google.com/mail/u/0/popout?ver=1h3dqhb0f6w3q&q=counselor%20burnout%20inventory&qs=true&qid=96B0A014-57EB-4606-809E-A370485765F9&aqid=1D6A6B7A-60DF-44A6-A716-0F52E468B6E...

Re: Request to Use Counselor Burnout Inventory External Inbox ×

이상민[단장 / 4단계 BK21 교육학교육연구단] <leesang@korea.ac.kr> Thu, Jul 14, 2022, 4:48 PM

to me, Carrie

You have my permission to use CBI for your research.

Best regards,

Sang Min Lee.

2022년 7월 15일 (금) 오전 3:47, Megan Whitbeck <mawhitbeck@uncg.edu>님이 작성:

Greetings Dr. Lee,

My name is Megan Whitbeck and I am a third year doctoral student at The University of North Carolina at Greensboro. I am currently working on my dissertation under the mentorship of Dr. Carrie Wachter Morris (copied here) and would like to use the Counselor Burnout Inventory that you developed with colleagues, in my research. Would you be willing to provide me with permission to use the CBI as a measure of convergent validity for a scale that I am developing on empathy fatigue in professional counselors? Of course, you will be properly cited and referenced. I greatly appreciate your consideration and hope to hear from you soon.

Thank you for your work on preventing burnout in professional counselors!

Sincerely,
Megan Whitbeck

--

Megan Whitbeck, MA, NCC (she/her/hers)
Doctoral Student
Past-President: Chi Sigma Iota (CSI) Upsilon Nu Chi Chapter
Clinical Supervision Research Collaborative Social Media Coordinator
Department of Counseling and Counselor Education
The University of North Carolina at Greensboro
mawhitbeck@uncg.edu

2 Attachments • Scanned by Gmail

APPENDIX H: BIDR-16 (HART ET AL., 2015)

THE BALANCED INVENTORY OF DESIRABLE RESPONDING SHORT FORM

(BIDR-16; HART ET AL., 2015)

Using the scale below as a guide, write a number beside each statement to indicate how much you agree with it.

Response scale: 1 (totally disagree) – 8 (totally agree)

Note that Paulhus has also used 5-point or 7-point scales for the long version.

____ 1. I have not always been honest with myself.

____ 2. I always know why I like things.

____ 3. It's hard for me to shut off a disturbing thought.

____ 4. I never regret my decisions.

____ 5. I sometimes lose out on things because I can't make up my mind soon enough.

____ 6. I am a completely rational person.

____ 7. I am very confident of my judgments

____ 8. I have sometimes doubted my ability as a lover.

____ 9. I sometimes tell lies if I have to.

____ 10. I never cover up my mistakes.

____ 11. There have been occasions when I have taken advantage of someone.

____ 12. I sometimes try to get even rather than forgive and forget.

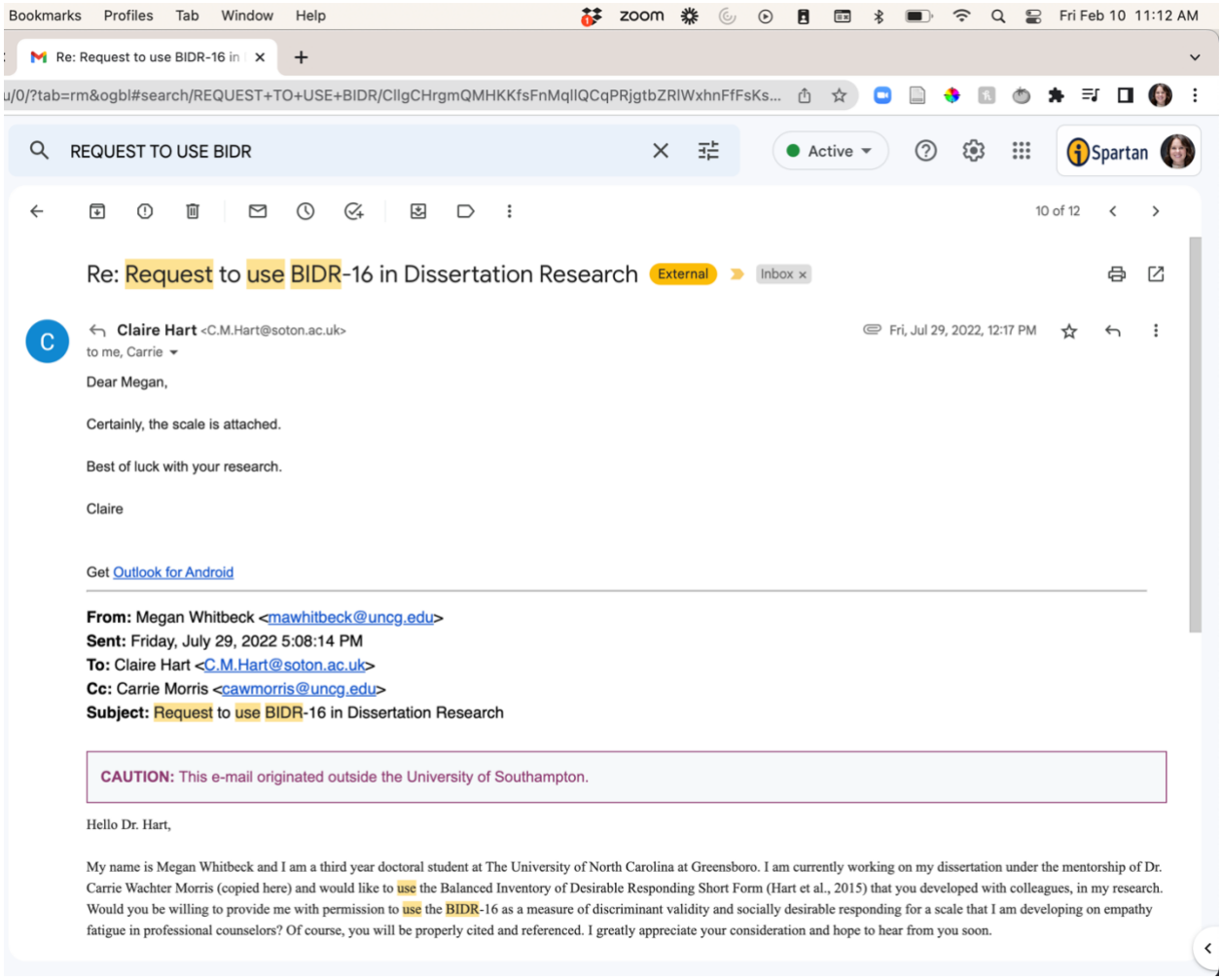
____ 13. I have said something bad about a friend behind his/her back.

____ 14. When I hear people talking privately, I avoid listening.

____ 15. I never take things that don't belong to me.

____ 16. I don't gossip about other people's business.

APPENDIX I: PERMISSION TO USE THE BIDR-16



Bookmarks Profiles Tab Window Help zoom Fri Feb 10 11:12 AM

Re: Request to use BIDR-16 in

u/0/?tab=rm&ogbl#search/REQUEST+TO+USE+BIDR/CllgCHrgmQMHKKfsFnMqlIQCqPRjgtbZRlWxhnFfFsKs...

REQUEST TO USE BIDR

Active

Spartan

10 of 12

Re: Request to use BIDR-16 in Dissertation Research External Inbox ×

Claire Hart <C.M.Hart@soton.ac.uk>
to me, Carrie

Fri, Jul 29, 2022, 12:17 PM

Dear Megan,

Certainly, the scale is attached.

Best of luck with your research.

Claire

Get Outlook for Android

From: Megan Whitbeck <mawhitbeck@uncg.edu>
Sent: Friday, July 29, 2022 5:08:14 PM
To: Claire Hart <C.M.Hart@soton.ac.uk>
Cc: Carrie Morris <cawmorris@uncg.edu>
Subject: Request to use BIDR-16 in Dissertation Research

CAUTION: This e-mail originated outside the University of Southampton.

Hello Dr. Hart,

My name is Megan Whitbeck and I am a third year doctoral student at The University of North Carolina at Greensboro. I am currently working on my dissertation under the mentorship of Dr. Carrie Wachter Morris (copied here) and would like to use the Balanced Inventory of Desirable Responding Short Form (Hart et al., 2015) that you developed with colleagues, in my research. Would you be willing to provide me with permission to use the BIDR-16 as a measure of discriminant validity and socially desirable responding for a scale that I am developing on empathy fatigue in professional counselors? Of course, you will be properly cited and referenced. I greatly appreciate your consideration and hope to hear from you soon.

APPENDIX J: PROFESSIONAL QUALITY OF LIFE SCALE (STAMM, 2010)

*Note: The word *help, helper,* and *helping* have been replaced with *counsel, counselor,* and *counseling.*

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.

APPENDIX K: PERMISSION TO USE THE PROQOL

Permission to Use the ProQOL

Thank you for your interest in using the Professional Quality of Life Measure (ProQOL). Please share the following information with us to obtain permission to use the measure:

Please provide your contact information:

Email Address

mawhitbeck@uncg.edu

Name

Megan Whitbeck

Organization Name, if applicable

University of North Carolina Greensboro

Country

United States

Please tell us briefly about your project:

I am interested in examining work-related factors that influence compassion fatigue in mental health counselors.

What is the population you will be using the ProQOL with?

Mental health counselors, for research

In what language/s do you plan to use the ProQOL?

Listed here are the languages in which the ProQOL is currently available (see https://proqol.org/ProQol_Test.html). If you wish to use a language not listed here, please select "Other" and specify which language/s.

English

The ProQOL measure may be freely copied and used, without individualized permission from the ProQOL office, as long as:

- **You credit The Center for Victims of Torture and provide a link towww.ProQOL.org;**
- **It is not sold; and**
- **No changes are made, other than creating or using a translation, and/or replacing "[helper]" with a more specific term such as "nurse."**

Note that the following situations are acceptable:

- **You can reformat the ProQOL, including putting it in a virtual format**
- **You can use the ProQOL as part of work you are paid to do, such as at a training: you just cannot sell the measure itself**

Does your use of the ProQOL abide by the three criteria listed above? (If yes, you are free to use the ProQOL immediately upon submitting this form. If not, the ProQOL office will be in contact in order to establish your permission to use the measure.)

Yes

Thank you for your interest in the ProQOL! We hope that you find it useful. You will receive an email from the ProQOL office that records your answers to these questions and provides your permission to use the ProQOL.

We invite any comments from you about the ProQOL and the experience of using it at proqol@cvt.org. Please also contact us if you have any questions about using the ProQOL, even if you noted them on this form. Note that unfortunately, our capacity is quite limited so we may not be able to respond to your note: however, we greatly appreciate your engagement.

APPENDIX L: RECRUITMENT FLYER

APPENDIX M: PARTICIPANT RECRUITMENT EMAILS

Subject line: Counselor Empathy Fatigue Scale: Dissertation Study Request for Participants

Dear Potential Participant,

Hello! My name is Megan Whitbeck and I am a third year doctoral student in the Counseling and Counselor Education program at The University of North Carolina at Greensboro (UNCG). I am currently seeking participants for my dissertation study titled, *Initial Development and Validation of the Counselor Empathy Fatigue Scale (CEFS),* which has been approved by the UNCG Institutional Review Board (IRB-FY23-67). Counselors provide vital mental health services to clients, but may experience fatigue in mind, body, and spirit, from their work as a counselor.

For this study, I am recruiting counselors to validate a measure on empathy fatigue that meet the following criteria:

- At least 18 years old
- Hold at least master's degree in counseling or related helping field
- Currently practicing as a counselor or therapist (e.g., school counselor, social worker, psychologist, marriage and family therapist, etc.)

If you meet the criteria above and are interested in participating, you will be asked to complete a series of questionnaires related to personal characteristics and experiences as a counselor. Your participation is voluntary and confidential, and the survey will only take about 25-30 minutes to complete. Should you choose to participate, you will have the option to be entered into a random drawing for one of twenty $20.00 Amazon or Walmart e-gift cards. Interested participants will also be eligible to receive information about a free webinar on empathy fatigue for 1.0 NBCC Approved CE.

You can follow this link to participate: https://uncg.qualtrics.com/jfe/form/SV_0TzCvxMIOM8vwUu

If you have any questions, please feel free to reach out to me at mawhitbeck@uncg.edu or my dissertation chair, Dr. Carrie A. Wachter Morris at cawmorris@uncg.edu.

I appreciate your consideration in participating in this study.

Warmly,

Megan Whitbeck

Subject line: Counselor Empathy Fatigue Scale: Dissertation Study Request for Participants

Dear counseling program,

My name is Megan Whitbeck and I am a third-year doctoral student in the Counseling and Counselor Education program at The University of North Carolina at Greensboro (UNCG). I am currently seeking participants for my dissertation study titled, *Development and Validation of the Counselor Empathy Fatigue Scale (CEFS),* which has been approved by the UNCG Institutional Review Board (IRB-FY23-67). If

you would be willing to share the following message below with alumni from your counseling program, I would truly appreciate it. Thank you for your time and consideration.

~~~~~~~~~~~~~~~~~~~~

Dear Potential Participant,

Hello! My name is Megan Whitbeck and I am a third year doctoral student in the Counseling and Counselor Education program at The University of North Carolina at Greensboro (UNCG). I am currently seeking participants for my dissertation study titled, *Initial Development and Validation of the Counselor Empathy Fatigue Scale (CEFS),* which has been approved by the UNCG Institutional Review Board (IRB-FY23-67). Counselors provide vital mental health services to clients, but may experience fatigue in mind, body, and spirit, from their work as a counselor.

For this study, I am recruiting counselors to validate a measure on empathy fatigue that meet the following criteria:

- At least 18 years old
- Hold at least master's degree in counseling or related helping field
- Currently practicing as a counselor or therapist (e.g., school counselor, social worker, psychologist, marriage and family therapist, etc.)

If you meet the criteria above and are interested in participating, you will be asked to complete a series of questionnaires related to personal characteristics and experiences as a counselor. Your participation is voluntary and confidential, and the survey will only take about 25-30 minutes to complete. Should you choose to participate, you will have the option to be entered into a random drawing for one of twenty $20.00 Amazon or Walmart e-gift cards. Interested participants will also be eligible to receive information about a free webinar on empathy fatigue for 1.0 NBCC Approved CE.

You can follow this link to participate: https://uncg.qualtrics.com/jfe/form/SV_0TzCvxMIOM8vwUu

If you have any questions, please feel free to reach out to me at mawhitbeck@uncg.edu or my dissertation chair, Dr. Carrie A. Wachter Morris at cawmorris@uncg.edu.

I appreciate your consideration in participating in this study.

Warmly,

Megan Whitbeck

Subject line: Counselor Empathy Fatigue Scale: Dissertation Study Request for Participants

Dear *Organization*,

My name is Megan Whitbeck and I am a third-year doctoral student in the Counseling and Counselor Education program at The University of North Carolina at Greensboro (UNCG). I am currently seeking participants for my dissertation study titled, *Development and Validation of the Counselor Empathy Fatigue Scale (CEFS),* which has been approved by the UNCG Institutional Review Board (IRB-FY23-67). If you would be willing to share the following message below with counselors at your organization, I would
~~~~~~~~~~~~~~~~~~~~

truly appreciate it. Thank you for your time, consideration and for the work that you do, supporting the mental health of your clients and community!

~~~~~~~

Dear Potential Participant,

Hello! My name is Megan Whitbeck and I am a third year doctoral student in the Counseling and Counselor Education program at The University of North Carolina at Greensboro (UNCG). I am currently seeking participants for my dissertation study titled, *Initial Development and Validation of the Counselor Empathy Fatigue Scale (CEFS),* which has been approved by the UNCG Institutional Review Board (IRB-FY23-67). Counselors provide vital mental health services to clients, but may experience fatigue in mind, body, and spirit, from their work as a counselor.

For this study, I am recruiting counselors to validate a measure on empathy fatigue that meet the following criteria:

- At least 18 years old
- Hold at least master's degree in counseling or related helping field
- Currently practicing as a counselor or therapist (e.g., school counselor, social worker, psychologist, marriage and family therapist, etc.)

If you meet the criteria above and are interested in participating, you will be asked to complete a series of questionnaires related to personal characteristics and experiences as a counselor. Your participation is voluntary and confidential, and the survey will only take about 25-30 minutes to complete. Should you choose to participate, you will have the option to be entered into a random drawing for one of twenty $20.00 Amazon or Walmart e-gift cards. Interested participants will also be eligible to receive information about a free webinar on empathy fatigue for 1.0 NBCC Approved CE.

You can follow this link to participate: https://uncg.qualtrics.com/jfe/form/SV_0TzCvxMIOM8vwUu

If you have any questions, please feel free to reach out to me at mawhitbeck@uncg.edu or my dissertation chair, Dr. Carrie A. Wachter Morris at cawmorris@uncg.edu.

I appreciate your consideration in participating in this study.

Warmly,

Megan Whitbeck
~~~~~~~

APPENDIX N: SOCIAL MEDIA RECRUITMENT POST

Hello! I am currently recruiting participants for my dissertation study titled "Initial Development and Validation of the Counselor Empathy Fatigue Scale." The purpose of this study is to create a scale measuring empathy fatigue in counselors, that can be used to help improve counselor self-awareness of empathy fatigue and promote well-being. If you are a professional counselor who is at least 18 years old, has a master's degree in counseling, holds either provisional or full licensure and would like to participate in a 25-30-minute survey, please click here: https://uncg.qualtrics.com/jfe/form/SV_d5daJB5bJiI5kwe. If you complete the survey questions, you will have the opportunity to be entered into a random drawing for one of twenty $20 Amazon e-gift cards. If you know anyone who meets the criteria and may be interested in participating, feel free to forward them the flyer and post. Your time and consideration are much appreciated!

APPENDIX O: MAIN STUDY INFORMED CONSENT

UNIVERSITY OF NORTH CAROLINA AT GREENSBORO

CONSENT TO ACT AS A HUMAN PARTICIPANT

Project Title: Development and Validation of the Counselor Empathy Fatigue Scale (CEFS)

Principal Investigator and Faculty Advisor (if applicable): Megan A. Whitbeck and Dr. Carrie A. Wachter Morris

What are some general things you should know about research studies?

You are being asked to take part in a research study. Your participation in the study is voluntary. You may choose not to join, or you may withdraw your consent to be in the study, for any reason, without penalty.

Research studies are designed to obtain new knowledge. This new information may help people in the future. There may not be any direct benefit to you for being in the research study. There also may be risks to being in research studies. If you choose not to be in the study or leave the study before it is done, it will not affect your relationship with the researcher or the University of North Carolina at Greensboro.

Details about this study are discussed in this consent form. It is important that you understand this information so that you can make an informed choice about being in this research study.

You can download a copy of this consent form by clicking this link. If you have any questions about this study at any time, you can reach out to Megan A. Whitbeck at mawhitbeck@uncg.edu or Dr. Carrie A. Wachter Morris at cawmorris@uncg.edu or (336) 365-6895.

What is the study about?

This is a research project. Your participation is voluntary. The purpose of this study is to learn more about the concept of empathy fatigue in professional counselors by exploring and validating the Counselor Empathy Fatigue Scale. Empathy fatigue is a personal and professional exhaustion that results from counseling clients who are suffering.

Why are you asking me?

You are being asked to participate in this study because you are either a provisionally or fully licensed professional counselor over the age of 18, that provides direct counseling services to clients for an average of 15 hours per week.

What will you ask me to do if I agree to be in the study?

If you choose to participate in this study, you will be asked to complete an anonymous series of questionnaires about your thoughts, feelings, behaviors, and reactions to your work as a counselor. The survey should take you about 25-30 minutes or less to complete. The survey will be completed on Qualtrics, a survey software that allows you to participate from your mobile phone or computer.

What are the risks to me?

The Institutional Review Board at the University of North Carolina at Greensboro has determined that participation in this study poses minimal risk to participants. Survey questions cover a range of symptoms that one might experience, and may bring up uncomfortable emotions. You may choose to skip questions if you do not feel comfortable answering them. However, your answers will not be identifiable to anyone, including the researchers.

Some of the questions in this survey ask you about feelings of anxiety and depression. Should you need additional assistance, please reach out to the mental health resources provided:

- Dial 988- National Suicide and Crisis Lifeline
- Text "HOME" to 741741 to reach a crisis counselor via the Crisis Text Line
- Visit www.psychologytoday.com to find a mental health care provider in your area

If you have questions, want more information or have suggestions, please contact Megan Whitbeck at mawhitbeck@uncg.edu or Dr. Carrie A. Wachter Morris at camorris@uncg.edu or (336) 365-6895.

If you have any concerns about your rights, how you are being treated, concerns or complaints about this project or benefits or risks associated with being in this study please contact the Office of Research Integrity at UNCG toll-free at (855)-251-2351.

Are there any benefits to society as a result of me taking part in this research?

The benefits to taking part in this research include the potential for empathy fatigue to be better understood by counselors and researchers. Ultimately, a greater level of self-awareness of empathy fatigue can help prevent and reduce personal and professional impairment in the mental health field, providing better counseling services to clients. Learning more about empathy fatigue can help a counselor engage in appropriate and effective self-care strategies for wellness.

Are there any benefits to *me* for taking part in this research study?

There are no benefits to you for taking part in this research study. However, you will be part of a larger benefit of helping the counseling field support the well-being of their clinicians.

Will I get paid for being in the study? Will it cost me anything?

Upon completing the survey, if you choose, you can be entered into a drawing for one of two randomly drawn $20 Amazon gift cards. However, if you do not complete the entire survey, you will not have the opportunity to be entered into the raffle.

How will you keep my information confidential?

Your responses to this research study are completely anonymous. No identifying information will be collected, including no IP addresses, no names, or no email addresses. However, if you use a public computer to complete the study, privacy of others walking past the computer cannot be guaranteed. Absolute confidentiality of data provided through the Internet cannot be guaranteed due to the limited protections of Internet access. Please be sure to close your browser when finished so no one will be able to see what you have been doing. Your responses will be stored electronically on a password-protected computer. All data will be de-identified to ensure participant information remains confidential. All information in this study is strictly confidential unless disclosure is required by law.

Will my de-identified data be used in future studies?

Your de-identified data will be kept indefinitely and may be used for future research without your additional consent.

What if I want to leave the study?

You have the right to refuse to participate or to withdraw at any time, without penalty. If you do withdraw, it will not affect you in any way. If you choose to withdraw, you may request that any of your data which has been collected be destroyed unless it is in a de-identifiable state. The investigators also have the right to stop your participation at any time. This could be because you have had an unexpected reaction, or have failed to follow instructions, or because the entire study has been stopped.

What about new information/changes in the study?

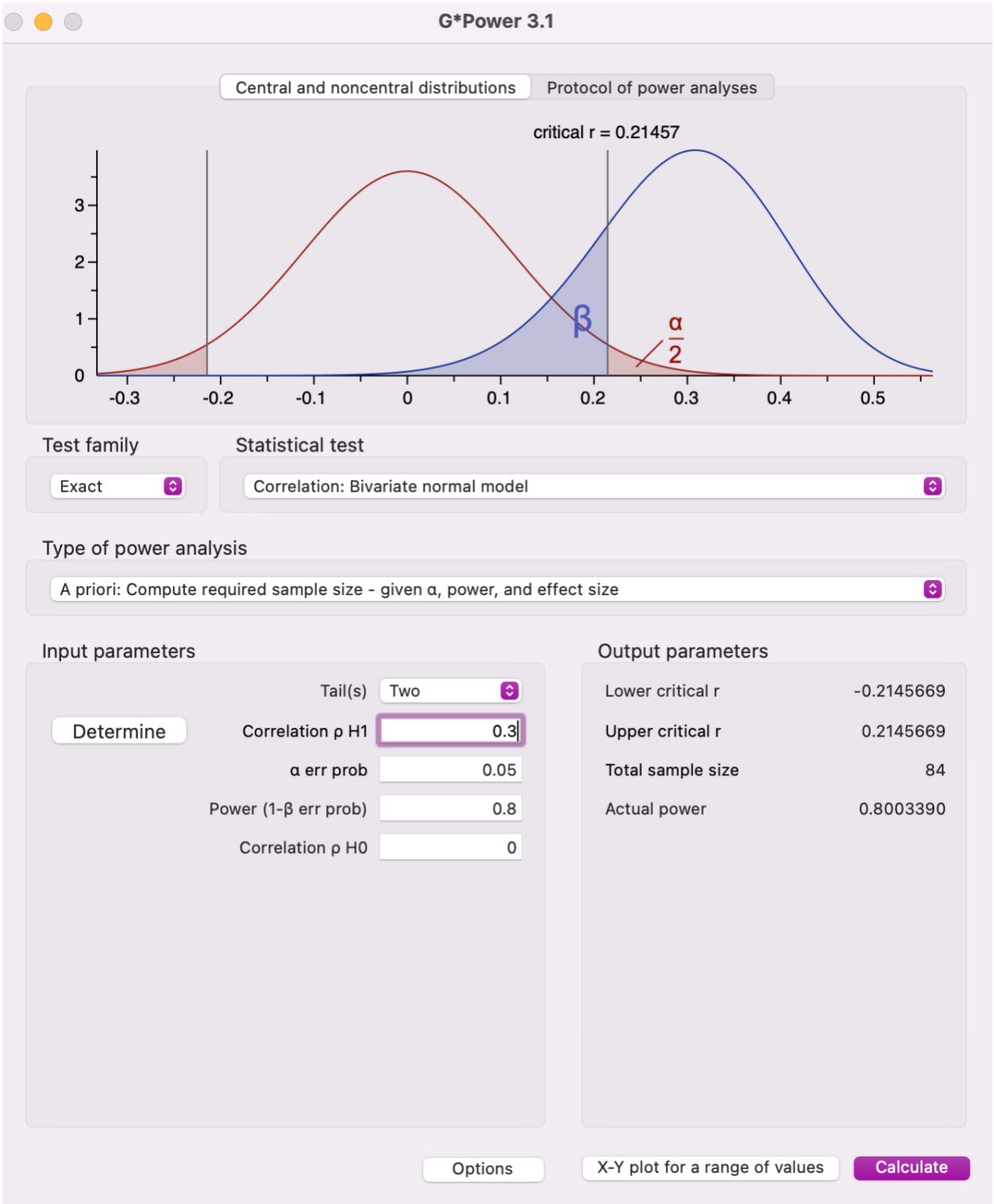
If significant new information relating to the study becomes available which may relate to your willingness to continue to participate, this information will be provided to you.

Voluntary Consent by Participant:

By clicking the appropriate button below to move forward, you are agreeing that you read, or it has been read to you, and you fully understand the contents of this document and are openly willing consent to take part in this study. All of your questions concerning this study have been answered. By clicking the appropriate button below, you are agreeing that you are 18 years of age or older and are agreeing to participate.

- Yes, I am at least 18 years old. I have read and understood the content of this consent document, I meet the requirements to participate, and I wish to participate.
- No, I do not wish to participate in this research study or do not meet the requirements to participate.

APPENDIX P: POWER ANALYSES FOR BIVARIATE CORRELATIONS (VALIDITY)



APPENDIX Q: FINAL CEFS

Counselor Empathy Fatigue Scale (CEFS; Whitbeck, 2023)

Scale Instructions: Below is a list of potential effects that could result from your work as a professional counselor. Please reflect on how many days you experienced the following within the **last two weeks.** Rate your response on a scale of 1 to 5, 1 being not at all and 5 being nearly every day. Consider your personal and professional life while completing the survey. There are no right or wrong answers, so please respond as honestly and accurately as possible.

1	2	3	4	5
Not at all	Several days	About half the days	More than half the days	Nearly every day

1. I noticed more difficulties in my personal relationships.
2. I drifted away from my supports that give me a greater sense of connection.
3. It was harder to connect with my meaning making system (e.g., spirituality, connection to higher power, sense of purpose).
4. I found it hard to engage with activities that typically bring me comfort.
5. My personal relationships have been negatively impacted because of my work.
6. I haven't had as much energy for my relationships with family and friends.
7. I found it hard to connect with things that were once meaningful to me.
8. I had little energy for things I enjoy (e.g., hobbies, leisure activities).
9. I felt more down than I typically do.
10. I had difficulty regulating my emotions.
11. I experienced changes in my appetite that could be related to stress at work.
12. My counseling work did not feel as meaningful as it once did.
13. I felt disconnected from a deeper meaning related to my work.
14. I did not enjoy my counseling work as much as I typically do.
15. I felt more cynical toward my clients.
16. I believe my work makes a difference in the lives of others. (R)
17. I felt negative emotions toward my work.
18. I had a negative outlook on clients' capacity for change.
19. After counseling clients, I felt mentally drained.
20. I felt emotionally exhausted after counseling clients in distress.
21. After counseling clients, I felt emotionally depleted.
22. My body felt tense after counseling clients with distressing concerns.
23. My muscles felt more tense than usual.
24. I felt disconnected from my feelings after working with emotionally distressed clients.
25. I had little energy throughout the day.
26. My thought process in session felt disorganized.
27. I had trouble focusing during counseling sessions.
28. My attending skills felt more forced than typical.

29. I found it hard to connect with my client.
30. I felt confident that I put forth my best counseling work. (R)
31. I was impatient with my clients.
32. I hoped my client wouldn't show to session.
33. My in-session expression of empathy felt genuine. (R)
34. I became annoyed with my clients at times.

Scoring procedures

The CEFS uses continuous scoring to calculate a total scale score and subscale scores. Reverse score items 16, 30, and 33 and add scores.

Factor 1: Items 1-11

Factor 2: Items 12-18

Factor 3: Items 19-25

Factor 4: Items 26-34

Reverse scored items: 16, 30, 33

Scores range from 34 to 170. A score of 34 indicates no presence of empathy fatigue. A score of 170 indicates high levels of empathy fatigue and should be cause for concern and further assessment.

Please contact the author Megan A. Whitbeck if you wish to use the Counselor Empathy Fatigue Scale.