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A First Step: Analyzing the Professional Quality of Life of U.S. College Mental Health Counselors

Jeffrey Yoichi Kuroiwa
University of Texas at El Paso

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A FIRST STEP: ANALYZING THE PROFESSIONAL QUALITY OF LIFE OF U.S.
COLLEGE MENTAL HEALTH COUNSELORS

JEFFREY YOICHI KUROIWA

Doctoral Program in Educational Leadership and Administration

APPROVED:

Eduardo Arellano, Ph.D., Chair

Arturo Olivarez, Ph.D.

Angus Mungal, Ph.D.

Paul Carrola, Ph.D.

Stephen Crites, Ph.D.
Dean of the Graduate School

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A FIRST STEP: ANALYZING THE PROFESSIONAL QUALITY OF LIFE OF U.S.
COLLEGE MENTAL HEALTH COUNSELORS

by

JEFFREY YOICHI KUROIWA, BA, M.Ed.

A DISSERTATION

Presented to the Faculty of the Graduate School of
The University of Texas at El Paso
in Partial Fulfillment
of the Requirements
for the Degree of

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Department of Educational Leadership and Foundations
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ABSTRACT

The study used a demographic questionnaire and the Professional Quality of Life Scale (ProQOL) to conduct a national survey of mental health counselors (N = 236) working at colleges and universities in the United States. It was hypothesized that U.S. college mental health counselors would indicate higher than average scores on the ProQOL subscales for compassion satisfaction, burnout, and secondary traumatic stress. The results show that U.S. college mental health counselors indicate average potential for compassion satisfaction and average risk for developing burnout and secondary traumatic stress. It was also hypothesized that counselors' ProQOL scores would differ between gender, age, and years of work experience groups and interactions among these demographic variables. Analyses using a factorial MANOVA showed that, with one exception, there are no statistically significant scoring differences between or among these demographic variables. The study found that less experienced (< 9 years of work experience) female college mental health counselors scored higher on the secondary traumatic stress subscale than male college mental health counselors with the same range of experience. The results of the study suggest that U.S. college mental health counselors seem resilient in their ability to work in a highly stressful work environment and still derive a sense of occupational or personal satisfaction from doing so. However, in the demographic questionnaire, 64% of college mental health counselors reported that they have considered quitting their job due to work-related stress.

Keywords: college mental health counselors, professional quality of life, compassion satisfaction, compassion fatigue, secondary traumatic stress

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CHAPTER 1: THE PROBLEM

Introduction

College mental health counselors function in an increasingly complex work environment as many campus counseling centers are struggling to keep up with greater demand for services and more of the students who seek assistance have severe mental health problems (Gallagher, 2015; Watkins, Hunt, & Eisenberg, 2012). On a continual basis, college mental health counselors work with many students who are experiencing high levels of anxiety, depression, and suicidal ideation. In the new millennium, college mental health counselors also treat an increasing number of students who have been traumatized by acts of violence and/or sexual assault (Center for Collegiate Mental Health, 2018).

While helping others brings a great deal of occupational satisfaction for some counselors, constant exposure to the suffering and trauma of their clients puts counselors at risk for developing burnout and secondary traumatic stress. These are negative psychological reactions which can adversely affect the counselor's mental health and the quality of work they do (Craig & Sprang, 2010). Both the positive and negative aspects of work in the helping professions influence professional quality of life—the way one feels in relation to their work life (Stamm, 2010). As the first point of contact for most campus mental health concerns, it is important to learn more about the subjective work experience of college mental health counselors. They are, perhaps more than ever, a valued and necessary resource for the campus community and vital contributors to the institutional missions of our colleges and universities.

Background of the Problem

For the purpose of the study, it is important to make the distinction between college mental health counselors and other higher education personnel who may use the title “counselor.” For

instance, a “financial aid counselor” assists college students apply for funds to pay for college but is not qualified to assist students with mental health problems—just as a mental health counselor is not qualified to assist students with financial aid problems. College mental health counselors generally come from graduate counseling programs housed in psychology departments which grant master’s or doctoral degrees in counseling, counseling psychology, or clinical psychology (Van Brunt & ACCA PAPA Committee, 2010). College mental health counselors are the mental health professionals who help students with psychological and emotional problems and have had extensive training and supervised internships before entering the profession. The American Counseling Association (ACA) defines counseling as “a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals (American Counseling Association, 2010).”

It is critical to establish a familiarity with the inherent challenges of providing campus mental health counseling in the 21st century as it provides context for the work college mental health counselors do on a continuous basis. College mental health counselors help students cope with the inherent stressors of being a college student. Traditionally, this has involved helping students navigate their way through developmental milestones such as leaving home for the first time, building identity and autonomy, choosing an academic discipline or career path, establishing new social relationships, and exploring their sexuality as they transition from adolescence to adulthood. However, many of today’s college students are also navigating their way through a seemingly endless barrage of traumatic events that they have experienced, witnessed, or heard about. This is an especially challenging time of their lives as all of these things are happening concurrently.

In the aftermath of tragedies involving college students, such as the mass shooting at Virginia Tech and the high profile suicide of MIT student Elizabeth Shin, questions regarding the mental health of college students and the actions of campus safety and mental health services were among the first to be asked (Capriccioso, 2006; Gallagher, 2012; LaFollette, 2009; Prince, 2015; Rosenbaum & Liebert, 2015; Schwartz & Kay, 2009; Shuchman, 2007; Sontag, 2002; Virginia Tech Review Panel, 2007). Although tragedies of this magnitude are rare, campus mental health issues have become a major concern for higher education administrators, faculty, staff, and students (Douce & Keeling, 2014; Fox & Savage, 2009). *The Chronicle of Higher Education* (2017) commissioned a survey of presidents and student affairs leaders at two- and four-year public and private institutions. The survey asked participants to identify major concerns outside the classroom. Student mental health was overwhelmingly identified as the top concern by 66% of participants (Rubley, 2017).

Colleges and universities are first and foremost educational institutions, not health care providers (Wilson, 2015). Nevertheless, the increased severity of mental health problems among college students and the availability of campus counseling services are growing concerns being addressed in the professional literature as well as the national news media (Brunner et al., 2014; Center for Collegiate Mental Health, 2017; Kalkbrenner, 2016; Rhodan, 2016; Rubley, 2017; Tugend, 2017; M. Wilson, 2017). These concerns have intensified as campus shootings, sexual assaults, and student suicides continue to occur at U.S. colleges and universities generating criticism and questions regarding institutional responsibility for campus safety—particularly in regards to mental health issues (Brunner et al., 2014; Brunner, Wallace, Keyes, & Polychronis, 2017; Meilman, 2016; Schwartz & Kay, 2009; Stone, 2008).

Increased severity of student mental health problems.

The age of onset for many mental health disorders is between 18 and 24, which coincides directly with the average age of student enrollment at colleges and universities (Flatt, 2013). Twenge, Gentile, DeWall, Ma, Laceyfield, and Schurtz (2010) conducted a cross-temporal meta-analysis of longitudinal studies using psychometric tests from 63,706 college students between 1938 and 2007 and found large increases in symptoms of mental illness over successive generations (Brunner et al., 2014). The severity of mental health problems among college students has been increasing over the past several decades and this trend is expected to continue (Benton, Robertson, Tseng, Newton, & Benton, 2003; Bishop, 1990; Brunner et al., 2014; LaFollette, 2009; Mowbray et al., 2006; T. B. Smith et al., 2007; Watkins et al., 2012; R. Wilson, 2015; Xiao et al., 2017).

In the 1988 National Survey of College Counseling Directors (NSCCD), 56% of directors reported an increase in the number of students coming to their center with severe psychological problems (Gallagher, 1988, 2012). In the 2014 version of the same survey, 94% of directors reported this to be true on their campuses (Gallagher, 2015). Directors also reported that 52% of their counseling center clients had severe psychological problems and 8% of these clients had impairments so serious, they could not remain in school, or could only do so with extensive psychological or psychiatric care (Gallagher, 2015).

The Association for University and College Counseling Center Directors (AUCCCD) began conducting its annual director's survey in 2007. Directors have reported an increase in the severity of student mental health concerns and related behavior on their campus over preceding years—including increases in the number of counseling center clients who attempted suicide and

the number counseling center clients who died by suicide (Reetz, Krylowicz, Bershad, Lawrence, & Mistler, 2015; Reetz et al., 2016).

The Center for Collegiate Mental Health (CCMH) is a multidisciplinary, practice-based research network that compiles data on the mental health of college students. The CCMH is located at Counseling and Psychological Services, at Pennsylvania State University and has the largest database on college student mental health in the United States (Mitchell, Oakley, & Dunkle, 2019). According to its website, the CCMH is currently supported by the Association for University and College Counseling Center Directors, the Division of Student Affairs at Pennsylvania State University, and an electronic medical record software manufacturer. Since 2009, the CCMH has compiled an annual report summarizing data contributed by college and university counseling centers that describes de-identified college students who received campus mental health treatment. Data from the 2018 CCMH report show that college students disclosed an increase in non-suicidal self-injury (often in the form of scratching, bruising, cutting, burning, breaking bones) and serious suicidal ideation for the eighth year in a row; an increase in unwanted sexual contact(s) or experience(s) for the fifth year in a row; and an increase in harassing, controlling, and/or abusive behavior from another person for the fifth year in a row (Center for Collegiate Mental Health, 2018).

Mental health concerns present in various campus settings and situations and often affect not just an individual student, but the campus community as a whole (National Association of Student Personnel Administrators, 2017). In extreme instances, the effects of collegiate mental health problems can extend to parents of college students, the communities outside campus grounds, or the nation itself. Recent acts of campus violence, sexual assault, and suicide have called public attention to the increasing number of college students grappling with mental health

problems. (Brunner et al., 2014; Kalkbrenner & Hernández, 2017). The pain and suffering that follows traumatic events such as these cannot be understated or overestimated.

Efforts to manage the “normal” stressors of college life may be challenging for the current generation of college students, known as millennials (22 -37 years old), who have generally been described as being more perfectionistic, stressed, overwhelmed, “damaged” and “at-risk” than students of previous generations (Brunner, Wallace, Reymann, Sellers, & McCabe, 2014; Kitzrow, 2009; Rosenbaum & Liebert, 2015; Watkins et al., 2012). The President of American University, Sylvia Mathews Burwell, notes “Today’s young adults seem to arrive at college with less resiliency and a lower appetite for risk and failure” (Burwell, 2018). Burwell served as the U.S. Secretary of Health and Human Services from 2014–2017.

It is also worth noting that the American Psychological Association (APA) recently conducted a survey of young people aged 15 – 21, known as Generation Z (Gen Z), to evaluate their level of stress. Results of the 2018 APA survey show that gun violence, separation and deportation of immigrant and migrant families, and sexual harassment and assault are significant stressors for Gen Z. Furthermore, the APA reports that Gen Z is the most likely of all generations to report poor mental health and significantly more likely to seek help for mental health issues (American Psychological Association, 2018). The findings are pertinent to the study as Generation Z youth are currently, or will be in the future, attending U.S. colleges and universities.

Campus violence.

As of November 2019, the Virginia Tech shooting in 2007 remains the worst incident of violence to ever occur on a U.S. college campus and the deadliest school shooting in U.S. history (Davenport, 2009). A mentally ill undergraduate student shot and killed 32 students and faculty members, injured 16 others, and then committed suicide. Following the Virginia Tech massacre,

mass shootings at Northern Illinois University, Oikos University, and Umpqua Community College occurred, altering the perception for many students, faculty, and staff, that the college campus is a safe place (Fox & Savage, 2009; Kaminski, Koons-Witt, Thompson, & Weiss, 2010; Sharkin, 2012). In the wake of these mass killings, state laws regarding the permitted carrying of concealed handguns on college campuses, also known as campus carry, are a hotly-debated issue.

In 2000, there were no states that had laws allowing guns on college campuses. As of August 2017, ten states have laws allowing campus carry on public college and university campuses: Arkansas, Colorado, Georgia, Idaho, Kansas, Mississippi, Oregon, Texas, Utah and Wisconsin. Tennessee permits campus carry for faculty and full-time employees of state public colleges and universities—the law does not extend to students or the general public (Hutchens & Melear, 2017b). Twenty-three states give individual colleges and universities the discretion to decide whether or not to allow guns on their respective campuses and the remaining sixteen states prohibit the concealed carry of guns at any college or university (Hutchens & Melear, 2017a). College students who attend institutions that allow campus carry must now assimilate the anxiety-provoking reality that there are people on their campus who are legally armed with a handgun. This is a lot to absorb for students trying to maintain academic responsibilities and manage the various personal and developmental challenges of their lives.

Campus sexual assault.

Researchers have found that 20-25% of females and 6% of males experience attempted or completed sexual assault during the course of their college careers (Dills, Fowler, & Payne, 2016; Krebs, Lindquist, Warner, Fisher, & Martin, 2009; National Sexual Violence Resource Center, 2015). Student concerns for their safety and well-being may be heightened by another recent legislative change that pertains to U.S. colleges and universities. In September of 2017, the

Education Department changed a key part of the government policy on campus sexual assault. A policy guideline which demanded that colleges and universities use “preponderance of the evidence” as the standard of proof when deciding whether a student is responsible for sexual assault was rescinded, giving colleges and universities the choice to abandon the previous standard and opt for a higher standard known as “clear and convincing evidence” (Saul & Taylor, 2017). One could argue that colleges and universities that increase the standard of proof at their institutions will weaken sexual violence protections and discourage students from reporting assaults.

If an institution decides that a student is found to be responsible for sexual assault, disciplinary actions such as probation, suspension, or expulsion may follow. However, even when clear and convincing evidence leads to a conviction of sexual assault, the outcome is not always just. In 2015 Chanel Miller, a 22-year-old who had recently graduated from the University of California, Santa Barbara, attended a Kappa Alpha fraternity party on the campus of Stanford University (Rezvani, 2019). Brock Turner, a member of the Stanford University swim team, sexually assaulted Chanel Miller in an alley outside the fraternity house.

Two graduate students were biking past the fraternity house when they witnessed Turner sexually assaulting Miller in an alley behind a dumpster. The two students noticed that Miller was partially disrobed and appeared to be unconscious. They confronted Turner then chased and detained him when he fled the scene (Koren, 2016). In 2016, a jury found Turner guilty on three counts of felony sexual assault and he faced 14 years in prison. Judge Aaron Persky sentenced Turner to six months in jail but was released after serving three months of the sentence. Public outrage regarding the nature of the crime and the lenient sentence Turner received brought widespread attention to the pervasiveness of sexual assault on college campuses (Salam, 2017). In

2018, Persky was recalled by California voters—the first time a California judge has been recalled in 80 years (de León, 2019). The case also prompted changes in California state law which now provides for a mandatory minimum three-year sentence for a person found guilty of sexually assaulting a victim who is (a) unconscious or (b) prevented from resisting by any intoxicating, anesthetic, or controlled substance (Chokshi, 2016; Larimer, 2016).

Campus suicide.

The National Council on Disability (2017) reports that many college students experience the first onset of mental health problems during this developmental stage of their lives. In any given year, 6% of undergraduate students and 4% of graduate students will have seriously considered suicide while 20% of college students have considered suicide at some point during their college career. In the United States, suicide is the tenth leading cause of death overall and the second leading cause of death among those between the ages of 15 and 24 (Centers for Disease Control and Prevention, 2018). Suicide is the second leading cause of death among college students (Eiser, 2011) and suicide clusters at U.S. colleges and universities have drawn widespread media attention (Iarovici, 2015). The term suicide cluster “...refers to an excessive number of suicides occurring in close temporal *and* geographic proximity because this most closely approximates the concept of an “outbreak” in a particular community” (Gould, Wallenstein, & Davidson, 1989, p. 17).

During the 2009-2010 academic year, six Cornell University students committed suicide; two of them on successive days (Epstein, 2010; Fabris, 2015). Between 2013 and 2017, fourteen University of Pennsylvania students committed suicide; six of them within a span of thirteen months (Tan, 2017). Between September 2016 and January 2017, five Columbia University students committed suicide; one student suicide occurred each month during the five-month span

(Cohen & Italiano, 2017). Appalachian State University, Massachusetts Institute of Technology, New York University, and Tulane University are among several institutions that have suffered the loss of multiple students in suicide clusters since 2000 (Scelfo, 2015). The emotional trauma associated with campus suicide clusters is not limited to the relatives and friends of those who have committed suicide. The campus community of students, faculty, and administrators may also experience distress and disruption under such circumstances.

Growing concern about the prevalence of mental illness, violence, sexual assault and suicide among college students has led many to argue that the nation has reached a campus mental health crisis (Eiser, 2011; Flatt, 2013; Henriques, 2014; LaFollette, 2009; Lee, 2017; Rosenbaum & Liebert, 2015; Schwartz & Kay, 2009; Wilkinson, Infantolino, & Wacha-Montes, 2017; Xiao et al., 2017). In 2017, the National Council on Disability issued a report entitled *Mental Health on College Campuses: Investments, Accommodations Needed to Address Student Needs*. The report addressed the state of mental health on college campuses, acknowledging the argument that there is a mental health crisis and called for institutions of higher education to develop a culture that supports the mental and emotional health of students (National Council on Disability, 2017). This is the current environment in which many college mental health counselors work and these are the circumstances affecting many of the students they work with.

The Helping Professional

Many who work in professions such as education, social work, and healthcare are likely to have chosen their field out of altruism; they have a desire to help others and make a positive difference in the world (Radey & Figley, 2007). In a broad sense, “helping” means engaging in behavior that improves the situation of another person. The concept of empathy is generally understood as the ability to understand and share the feelings of another person. Altruism is the

belief in and practice of both: deliberate behavior intended to benefit another person which is motivated by a set of internalized values and empathetic concern for the other person without expecting something in return (Eisenberg, N. et al., 1999; Smith, K. D., Keating, & Stotland, 1989; Swank, Ohrt, & Robinson, 2013).

For example, nursing and mental health counseling are altruistic professions that involve a high degree of one-to-one, face-to-face interaction with clients who are experiencing distress or trauma. Each interaction involves disclosure of deeply personal medical or psychological information from client to helper. This type of interaction occurs on a continuous cycle for the helper as they will meet with several clients a day, each with unique predicaments. The ability to empathize with those who suffer and help them cope with difficult life challenges contributes to a sense of satisfaction for the helper (Sacco & Copel, 2017). When their ability to help others is validated by positive client outcomes, helpers feel good about the work they do (Ansari & Lodhia, 2013; Stamm, 2010). For instance, when sick patients recover from illness or suicidal clients overcome depression, those who help them often feel that the work they do is fulfilling and meaningful. Even when client outcomes are not as they had hoped for, many helping professionals still feel a sense of satisfaction that the work they do contributes to the betterment of society.

For college mental health counselors, the ability to help students cope with distress or trauma can be very rewarding but the nature of this work involves secondary trauma exposure on a constant basis which can have negative emotional and psychological effects for the counselor (Alkema, Linton, & Davies, 2008; Bride & Figley, 2007; Figley, 1995). Secondary trauma exposure differs from primary exposure in that the counselor does not experience the traumatic event first hand, the person being helped does (Stamm, 2012). The counselor is indirectly exposed to trauma through their client's firsthand account of the traumatic event.

In the context of a counseling session, a client recounts being in a car crash that killed their sibling. The client's direct exposure to trauma (being in the car with their sibling prior to the crash, experiencing the crash, realizing that their sibling had died as a result of the crash) is primary and the counselor's indirect exposure is secondary (listening to the client's account of being in a car crash that killed their sibling). Secondary trauma exposure is an inherent occupational hazard for those in helping professions and can have adverse effects on the helper's emotional and psychological health. This phenomenon has been variously referred to as "vicarious traumatization", "secondary traumatic stress", and "compassion fatigue" and will be discussed further in chapter two.

Statement of the Problem

College mental health counselors are essential to the psychological well-being of students and the campus community as providers of emotional support and informed consultation for administrators, faculty, and staff regarding mental health concerns (Schwartz & Kay, 2009; Sharkin, 2004). Mental health counselors bear the emotional and psychological weight of student disclosures of hardship and trauma on a continuous basis. Data gathered from counseling center director surveys and the Center for Collegiate Mental Health is important to campus mental health practitioners and contributes to a growing body of research that informs the profession (Center for Collegiate Mental Health, 2018; Gallagher, 2012; LeViness, Bershada, Gorman, Braun, & Murray, 2018). These data resources also keep higher education administrators and policy makers informed about the state of collegiate mental health. However, other than basic demographics, these resources do not collect additional data from the mental health counselors who spend the most time with students. Though trained, supervised, and practiced in the work of helping others manage stressful life events, counselors are human beings with the capacity to experience exhaustion,

frustration, and trauma just like anyone else. In the climate of a campus mental health crisis, it is imperative to gain timely insight regarding the subjective work experience of college mental health counselors.

Significance of the Problem

The bulk of what we know about college mental health counselors on a national level has been limited to surveys of counseling center directors (Gallagher, 2012; Reetz et al., 2016; Vespia, 2007). The National Survey of College Counseling Centers (NSCCC) was conducted annually from 1981 until 2014. The NSCCC annual survey was discontinued after the Board of Directors for the Association for University and College Counseling Center Directors (AUCCCD) withdrew financial support for the NSCCC and began its own organizational membership survey (Gallagher, 2012). The first AUCCCD survey was conducted in 2007 and continues annually. Both surveys have provided valuable demographic information about the directors as well as the policies, procedures and clinical services of their counseling centers. Data regarding college mental health counselors in these surveys is demographic in nature (e.g., race/ethnicity, gender, and sexual orientation), providing little insight about their subjective work experience.

College counseling center directors spend the majority of their time tending to administrative duties while staff counselors spend the majority of their work day providing direct counseling services to students (Smith et al., 2007). According to the NSCCC survey, counselors spend an average of 76% of their time providing direct counseling services to students (Gallagher, 2015). According to the 2018 AUCCCD survey, non-administrative staff counselors spend an average of 64% of their time providing direct counseling services. This is a sharp contrast when compared to counseling center directors who spend an average of 34% of their time providing direct counseling services (LeViness et al., 2018).

The subjective work experience of college mental health counselors was the data of interest as we know very little about the helping professionals in this increasingly specialized field of mental health work. *The Chronicle of Higher Education* (2019) recently asked campus administrators and counseling center directors to comment on the work college mental health counselors do. Melissa Boston, associate dean of student health and counseling at Manhattanville College, said, “While all of us have chosen this profession because we have a passion for helping others, avoiding the risk of vicarious trauma and burnout is not easy” (Kafka, 2019). In the same article, David Onestak, director of the Counseling Center at James Madison University, responded, “The pressures that counseling-center clinicians face are at an all-time high” (Kafka, 2019). Onestak also stated that rising rates of depression and burnout are “the lived experience of most counseling-center clinicians” but no one knows how high these rates are because there are no studies solely of college mental-health caregivers (Kafka, 2019) The present study was intended to contribute to the research literature and fill a perceived gap in our understanding of college mental health counselors.

Purpose of the Study

The purpose of the study was to examine the professional quality of life of U.S. college mental health counselors. More specifically, the study examined whether college mental health counselors exhibit differences in their scores on the ProQOL subscales of compassion satisfaction, burnout, and secondary traumatic stress, based on gender, age, and years of work experience. The study also examined for possible interactions between college mental health counselors’ gender, age, and years of work experience that may relate to their scores on the ProQOL subscales of compassion satisfaction, burnout, and secondary traumatic stress.

Stamm (2010) defines professional quality of life as “the quality one feels in relation to their work as a helper” (p. 8) which is influenced by both the positive and the negative aspects of work in the helping professions. According to Stamm’s theory of Compassion Satisfaction and Compassion Fatigue, the positive aspects of work generate compassion satisfaction, a construct defined by the feeling of pleasure associated with the work one does. Compassion fatigue is a construct defined by the negative aspects of work and breaks down into two factors that involve distinctly different negative experiences for the helping professional. The first factor is burnout, a psychological syndrome that develops over time and is characterized by feelings of exhaustion and detachment associated with the workplace. The second factor is secondary traumatic stress, a psychological syndrome which has a rapid onset and is characterized by feelings of fear and avoidance associated with the work of helping others who have been traumatized (Stamm, 2010). A detailed discussion of compassion satisfaction, burnout and secondary trauma will be provided in chapter two.

The Professional Quality of Life Scale (ProQOL) and a demographic questionnaire were used to conduct a national survey of mental health counselors at U.S. colleges and universities on the Association for University and College Counseling Center Directors Listserv. The ProQOL is a self-report instrument used to screen a helping professional’s subjective level of compassion satisfaction, burnout and secondary traumatic stress. The ProQOL is not a diagnostic tool. The ProQOL does not provide medical or psychological diagnoses nor is it intended to be used for such purposes (Stamm, 2010). It may be useful to think of the ProQOL as a “thermometer” used to check the “temperature” of a helping professional’s positive and negative work experience. A more thorough discussion of professional quality of life will be presented in chapter two. A detailed

description of the Professional Quality of Life Scale will be provided in chapter three. The research questions and research hypotheses for the study are presented next.

Research Questions

There are eight research questions for the study:

- RQ1: *Do U.S. college mental health counselors exhibit statistically significant differences in their mean scores on the ProQOL subscales for compassion satisfaction, burnout, and secondary traumatic stress from the established means ($M = 50$) published in The Concise ProQOL Manual (Stamm, 2010)?*
- RQ2: *Do male and female college mental health counselors in the U.S. exhibit statistically significant differences in their scores on the ProQOL subscales for compassion satisfaction, burnout, and secondary traumatic stress?*
- RQ3: *Do U.S. college mental health counselors exhibit statistically significant differences in their scores on the ProQOL subscales of compassion satisfaction, burnout, and secondary traumatic stress based on age?*
- RQ4: *Do U.S. college mental health counselors exhibit statistically significant differences in their scores on the ProQOL subscales of compassion satisfaction, burnout, and secondary traumatic stress and different levels of work experience?*
- RQ5: *Is there an interaction between the gender and age of U.S. college mental health counselors as it relates to their scores on the ProQOL subscales of compassion satisfaction, burnout, and secondary traumatic stress?*
- RQ6: *Is there an interaction between the gender and years of experience of U.S. college mental health counselors as it relates to their scores on the ProQOL subscales of compassion satisfaction, burnout, and secondary traumatic stress?*

RQ7: *Is there an interaction between the age and years of experience of U.S. college mental health counselors as it relates to their scores on the ProQOL subscales of compassion satisfaction, burnout, and secondary traumatic stress?*

RQ8: *Is there an interaction between the gender, age, and years of experience of U.S. college mental health counselors as it relates to their scores on the ProQOL subscales of compassion satisfaction, burnout, and secondary traumatic stress?*

Research Hypotheses

There are eight research hypotheses for the study:

RH1: U.S. college mental health counselors exhibit statistically significant differences in their mean scores on the ProQOL subscales for compassion satisfaction, burnout, and secondary traumatic stress from the established means ($M = 50$) published in *The Concise ProQOL Manual* (Stamm, 2010).

RH1a: U.S. college mental health counselors exhibit a statistically significant higher mean score on the compassion satisfaction subscale than the established mean ($M = 50$) published in *The Concise ProQOL Manual* (Stamm, 2010).

RH1b: U.S. college mental health counselors exhibit a statistically significant higher mean score on the burnout subscale than the established mean ($M = 50$) published in *The Concise ProQOL Manual* (Stamm, 2010).

RH1c: U.S. college mental health counselors exhibit a statistically significant higher mean score on the secondary traumatic stress subscale than the established mean ($M = 50$) published in *The Concise ProQOL Manual* (Stamm, 2010).

RH2: There are statistically significant differences between male and female college mental

health counselors in the U.S. and their mean scores on the ProQOL subscales for compassion satisfaction, burnout, and secondary traumatic stress.

RH3: There are statistically significant differences among U.S. college mental health counselors and their mean scores on the ProQOL subscales of compassion satisfaction, burnout, and secondary traumatic stress based on age.

RH4: There are statistically significant differences among U.S. college mental health counselors and their mean scores on the ProQOL subscales of compassion satisfaction, burnout, and secondary traumatic stress and different levels of work experience.

RH5: There is an interaction between the gender and age of U.S. college mental health counselors as it relates to their mean scores on the ProQOL subscales for compassion satisfaction, burnout, and secondary traumatic stress.

RH6: There is an interaction between the gender and years of experience of U.S. college mental health counselors as it relates to their mean scores on the ProQOL subscales for compassion satisfaction, burnout, and secondary traumatic stress.

RH7: There is an interaction between the age and years of experience of U.S. college mental health counselors as it relates to their mean scores on the ProQOL subscales for compassion satisfaction, burnout, and secondary traumatic stress.

RH8: There is an interaction between the gender, age, and years of experience of U.S. college mental health counselors as it relates to their mean scores on the ProQOL subscales for compassion satisfaction, burnout, and secondary traumatic stress.

Assumptions and Delimitations of the Study

There are three main assumptions of the study. First, the researcher assumes that the participants involved are a representative sample of mental health counselors at colleges and

universities in the United States. Second, it is assumed that the self-reported demographic information of participants is accurate and sufficiently free of systematic and measurement error. Third, it is assumed that participants will respond honestly to all inquiries involved in the study (demographics, work-related questions, and the ProQOL scale).

Delimitations of the study include factors related to the intended population of interest, the sampling procedure, and the research design selected. First, the investigator targeted mental health counselors whose college or university is a member of the Association for University and College Counseling Center Directors (AUCCCD). The rationale to limit the population to be sampled was to better ensure that prospective participants in the study are mental health counselors providing direct counseling services to students in a college or university in the United States. To the best of my knowledge through research efforts, there is no national data base listing of mental health counselors employed by U.S. colleges and universities. Additionally, to the best of my knowledge, there is no national data base regarding campus counseling center staffing demographics such as the number of employed mental health counselors at each institution. Because selection of participants in this study cannot be considered random, generalization of results is limited. However, with more than 800 member institutions, the size of the AUCCCD membership and its associated requirements for membership better ensured an adequate sample size representing the population of interest.

Second, the study utilized a snowball sampling technique which relied on counseling center directors to forward the study packet to their counseling staff. There was no way to guarantee that counseling center directors would choose to allow their staff to participate in the study. It was, perhaps, aspirational to expect or assume that most AUCCCD directors would want their counseling staff to participate in the study, solely based on the subject matter.

Third, this investigator chose to employ an ex post facto, quasi-experimental research design for this study. The study involves the independent variables of gender, age, and years of work experience, which already exist and cannot be changed or manipulated. The study examined whether college mental health counselors exhibit differences in their scores on the ProQOL subscales of compassion satisfaction, burnout, and secondary traumatic stress, based on gender, age, and years of work experience. The study also examined for possible interactions between college mental health counselors' gender, age, and years of work experience that may relate to their scores on the ProQOL subscales of compassion satisfaction, burnout, and secondary traumatic stress. The research design does not allow for manipulation of any of the variables in the study. Therefore, it does not allow for definitive statement of a cause-and-effect relationship between any of these variables.

Summary

Mental health counselors are increasingly essential to the institutional support of students at colleges and universities throughout the United States. They are the providers of emotional support for students but also provide informed consultation regarding mental health concerns for campus administrators, faculty, staff, students, and parents. The nation is in the midst of a campus mental health crisis as reports of violence, sexual assault, and student suicide at U.S. colleges and universities have become familiar headlines in the news. The volatility of this situation has captured the attention of campus communities, academic and political leaders and the public at large. Reports of a dramatic increase in the number of students seeking campus counseling services are alarming when studies show that the severity of student mental health problems has been steadily increasing for the past several decades. Many campus counseling centers are struggling to meet the needs of their students due to a lack of resources. College mental health counselors are

the first point of contact for most campus mental health concerns. They have, in effect, become “risk managers” (Davenport, 2009) as they counsel troubled and traumatized students on a regular basis and serve as consultants to administrators, faculty, staff, and parents.

The purpose of the study was to examine the professional quality of life among U.S. college mental health counselors using the Professional Quality of Life Scale (ProQOL). Professional quality of life is defined as the quality one feels in relation to the work they do as a helping professional. The ProQOL is a self-report measure that asks participants to rate their subjective levels of compassion satisfaction, burnout, and secondary traumatic stress. Compassion satisfaction is defined as the feeling of pleasure associated with the work one does. Burnout is a work-related stress reaction that develops over time and involves feelings of exhaustion and detachment from the workplace. Secondary traumatic stress is a psychological syndrome that develops rapidly and is characterized by feelings of fear and avoidance associated with the work of helping others who have been traumatized. Although many college mental health counselors find their work to be personally satisfying, the pressure to meet the needs and expectations of those who seek and rely on their services can be overwhelming. Heavy workloads and constant exposure to the suffering of others leave college mental health counselors vulnerable to burnout and secondary traumatic stress reactions (Kitzrow, 2009).

A national survey was sent out to colleges and universities on the Association for University and College Counseling Center Directors Listserv. The study was comprised of a demographic questionnaire and the Professional Quality of Life Scale. The study is the first to examine the professional quality of life of U.S. college mental health counselors and seeks to inform leaders in higher education about the important, and increasingly difficult, work mental health counselors do. Campus administrators, faculty, staff, and parents rely on college mental

health counselors to provide adequate care for students who are inundated with multiple, concurrent life challenges. Without the institutional support to provide relief from the stressors associated with the current campus mental health crisis, college mental health counselors are increasingly vulnerable to burnout and secondary traumatic stress reactions as occupational pressure will continue to build (Kitzrow, 2009; Rodolfa & Park, 1993; Stone & Archer Jr, 1990).

The next chapter is intended to better inform the reader with a review of the literature on college counseling centers, the occupational nature of college mental health counselors, professional quality of life, and the concepts of compassion satisfaction, burnout, and secondary traumatic stress.

CHAPTER 2: REVIEW OF THE LITERATURE

The previous chapter described the current campus mental health crisis in the United States and how college mental health counselors are at risk for developing burnout and secondary traumatic stress due to excessive workloads and a lack of resources. The study proceeds with a review of the literature on the most valuable components of institutional efforts to manage the campus mental health crisis: college counseling centers and the mental health counselor.

This chapter begins with a brief history of college counseling centers in the United States to illustrate how campus service provision has evolved over time. This is followed by a description of counselor training and staffing concerns. Next, the counseling process is described in general terms and the cyclical nature of the work counselors do is illustrated. A description of the roles and responsibilities typically assumed or assigned to college mental health counselors is also provided.

The chapter continues with discussion of the Compassion Satisfaction–Compassion Fatigue Theory (Stamm, 2010) which serves as the theoretical framework for this study. This segment of the literature review includes discussion of professional quality of life, compassion satisfaction, compassion fatigue and the commonly associated concepts of vicarious traumatization, secondary traumatic stress, and burnout. Finally, a review of research studies utilizing the ProQOL is provided.

The Evolution of College Counseling Centers

Mental health counseling services first began in U.S. colleges and universities in the 1920s and were generally referred to as mental hygiene programs (Prescott, 2008). At that time, these services primarily involved the practice of psychiatry and there was social stigma associated with utilizing them. There were also strong feelings of opposition from some faculty members who

viewed such programs as a form of “coddling” academically underachieving students (Prescott). During the 1930s, counseling centers were focused on helping young people with significant life changes like having to leave home, doing well in school, and finding employment during the Great Depression (LaFollette, 2009). Following the Second World War in the 1940s, mental health services expanded into vocational planning and job training as many veterans returned from service and were given the opportunity to attend college through financial assistance provided by the G.I. Bill (Hodges, 2001). During the 1950s, counseling centers began addressing the more personal and social dimensions of student’s lives as a focus on the emotional maturation process of college students took precedence (Sharkin, 2012).

The most significant period of growth in the development of the college counseling profession occurred between 1960 and 1980 (Meadows, 2000). During the 1960s and 1970s, the student population in higher education became increasingly diverse following the Civil Rights Movement and the women’s liberation movement. This created a need for counselors with specialized training in order to serve growing numbers of students in a more complex social and cultural campus environment (LaFollette, 2009). In 1971, the International Association of Counseling Services (IACS) adopted common standards to govern the accreditation of counseling services at different types of institutions of higher education (Sharkin, 2012).

Counseling centers in the 1980s began incorporating testing services for national testing programs such as the Scholastic Aptitude Test and the Graduate Record Exam (Weissberg, 1987). However, research studies emerged in the 1980s showing that the severity of problems treated in counseling centers had grown. The focus of counseling services began to move away from the traditional developmental approach to the medical model with an emphasis on assessment and diagnosis of mental health disorders (Hodges, 2001; LaFollette, 2009). During the 1990s and into

the 2000s, increasing numbers of students with serious psychological problems became the primary challenge facing college counseling centers (Benton et al., 2003; Bishop, 1990; Gilbert, 1989; Stone & Archer Jr, 1990).

College Counseling Centers in the 21st Century

In the new millennium, more campus counseling centers utilize a medical model of service provision than in previous decades as the number of students seeking treatment has continued to rise and many more of these students present with serious mental health problems (Kadambi, Audet, & Knish, 2010; LaFollette, 2009). Mental illness has become a major public health and policy issue as treatment needs have outpaced the supply of available or affordable mental healthcare resources in communities across the United States (Schwartz & Kay, 2009). Many students in need of assistance have little or no health insurance coverage so they come to campus counseling centers because services at many centers are free or available at a low cost. The influx of students coming to college counseling centers is partly due to the availability of mental health care that was previously inaccessible for many students (Kitzrow, 2009). Consequently, many colleges and universities are providing more services for seriously ill students for longer periods of time (Schwartz & Kay, 2009).

The average number of students seeking campus counseling services between 2009 and 2015 grew by 30% while the average institutional enrollment grew by only 6% (Center for Collegiate Mental Health, 2016); 88% of counseling centers reported an increase in the number of students seeking services during this period (Xiao et al., 2017). According to the 2018 Association for University and College Counseling Directors Survey, 66% of students who received counseling services stated that counseling services helped with their academic performance and 63% stated that counseling services helped them stay in school (LeViness et al., 2018). Today's college

students are more willing to seek help for mental health concerns (Locke et al., 2016) which may be related to their views about mental health treatment (National Association of Student Personnel Administrators, 2017).

A study of population-level trends in mental health service utilization by college students between 2007 and 2017 found that rates of perceived and personal stigma associated with counseling services decreased from 64.2% to 46.0% and from 11.4% to 5.7%, respectively (Lipson, Lattie, & Eisenberg, 2018). The Healthy Minds Study (Eisenberg, D., Lipson, Beck, Dalal, & Despot, 2014) conducted a survey to examine college students' views about mental health and found that 97% of participants reported that they would willingly accept someone who has received mental health counseling as a close friend and 85% of participants reported a belief that most people would willingly accept someone who has received mental health counseling as a close friend. Students were also asked if they knew where to go on campus if they needed professional help for their mental or emotional health and 65% responded that they were aware of campus mental health resources (Eisenberg et al., 2014).

Thus, while increasing numbers of students with severe mental health problems are seeking help at campus counseling centers, receptivity to mental health treatment among the college student population in general has also increased. Despite booming demand for services, many college counseling centers are expected to meet these challenges without a corresponding increase in staff (Kadambi et al., 2010; Kitzrow, 2009; Locke, Wallace, & Brunner, 2016; Shelesky, Weatherford, & Silbert, 2016; Smith, T. B. et al., 2007). The average student to staff ratio at counseling centers is 1833:1, with some providing service for up to 16% of their institution's students each year (Shelesky et al., 2016).

Most college counseling centers are now departments within the division of student affairs, with the director of counseling services reporting to the vice president, associate vice president, or assistant vice president of that division (Mitchell et al., 2019; Sharkin, 2012). Although some colleges and universities charge students a fee for counseling or psychological services, most provide free counseling services which are funded by student service fees (Mair, 2016; Schwartz & Kay, 2009).

Risk management and liability concerns in the new millennium.

There is growing pressure for U.S. colleges and universities to protect students from suicide and acts of violence as they are struggling, not only with the tragic loss of life, but with liability issues arising from student deaths (Sontag, 2002). The potential financial and reputational damage to colleges and universities facing legal action is enormous. Of prime importance in such legal matters is determining whether or not a special relationship existed between the college or university and the student who committed an act of violence against themselves or others (Westefeld et al., 2006). A “special relationship” implies that the college or university has a duty to act with reasonable care to prevent a foreseeable student death (Dyer, 2007). What did the institution or its personnel do to prevent a student death? What did the institution or its personnel fail to do to prevent a student death? This is a concern pertinent to faculty, staff, and administrators as legal questions regarding institutional responsibility for the safety of students emerge in the aftermath of these types of traumatic events (Westefeld et al., 2006).

In April of 2000, Elizabeth Shin, a 19-year-old sophomore at the Massachusetts Institute of Technology (MIT) was found on the floor of her dorm room engulfed in flames. A few days later, Shin died from third-degree burns that covered 65% of her body (Wang, 2002). The state medical examiner ruled that Shin’s death was self-inflicted (Associated Press, 2005). Elizabeth

Shin had a well-documented history of psychological problems throughout her time at MIT. As a freshman in 1999, Shin overdosed on medications and was hospitalized for a week at a local psychiatric hospital. Upon her release from the hospital, Shin was referred to MIT Mental Health Services and began treatment there that would continue until her death in 2000. During this time, Shin often told MIT mental health clinicians, MIT administrators, and fellow students that she was having suicidal ideations and intentions (Wang, 2002).

Shin's parents filed a \$27.65 million wrongful death civil lawsuit against MIT claiming that they were unaware of the severity of their daughter's mental health problems and that MIT failed to inform them of Elizabeth's precarious deterioration or to act "in loco parentis to the deceased" (Sontag, 2002). Documents in the lawsuit filed by Shin's parents identified MIT faculty, staff, and administrators who were advised about or involved in managing concerns related to Elizabeth's mental health problems (Wang, 2002). The Chief of MIT Mental Health Services and several other medical doctors on staff were named as defendants, as were two Associate Deans, the MIT Chief of Campus Police, a campus police dispatcher, a campus police officer, the housemaster at Elizabeth's dormitory, and Elizabeth's academic advisor. The filed complaint also left open the possibility of naming additional MIT personnel as defendants.

Student suicide, once viewed as the ultimate risk management concern for college campuses, has been matched by risk management fears about campus homicides (Davenport, 2009). In 2009, Katherine Rosen, a twenty-year-old student at the University of California, Los Angeles (UCLA), was working in her chemistry class when, without provocation, she was stabbed in the chest and neck by a fellow student. The assailant had received treatment for depression and possible schizophrenia at UCLA's Counseling and Psychological Services department prior to the assault (Dolan, 2018). Despite life-threatening injuries, Rosen survived the assault and filed a

lawsuit against UCLA alleging that the university knew of the assailant's mental health problems and should have warned and protected Rosen. The assailant was charged with attempted murder but found not guilty by reason of insanity and Rosen's lawsuit against UCLA was halted by a California appellate court.

In March of 2018, nine years after Rosen was assaulted, the California Supreme Court overturned the appellate court's decision allowing Rosen to proceed with her lawsuit against UCLA. The Court ruled that public colleges and universities have a duty to protect their students from foreseeable violence in classrooms and school-sponsored curricular activities (Bauer-Wolf, 2018; Dolan, 2018). The California Supreme Court's unanimous decision is among the first of its kind in the nation and the first by a state high court to address liability for violence committed on campus since the Virginia Tech shootings in 2007 (Dolan). Although the Court's ruling only pertains to public colleges and universities in the state of California, the stage was set for a national debate about campus safety and student mental health issues.

Today's college mental health counselors shoulder a great deal of responsibility to the students they serve. College mental health counselors also bear the expectations of campus administrators, faculty, staff, residence life personnel, parents, and the general public to prevent undesirable outcomes related to student mental health issues from ever occurring (Baker, 2015; Coll & Rice, 1993; Fu & Cheng, 2017; Kitzrow, 2009; Moss, 2017; Schwartz, 2013; R. Wilson, 2015; Xiao et al., 2017). Such expectations are unrealistic as it is impossible for a counselor, a counseling center or an institution to know or anticipate what all individual students are thinking, feeling or experiencing at any given time (Kafka, 2019). Campus mental health counselors help those who seek services and counseling centers engage in preventative outreach efforts by educating the campus community about mental health issues.

Despite these mounting pressures, many college counseling centers currently lack the resources to serve their campus community as effectively as needed (Baker, 2015; Flatt, 2013; Much, Wagener, & Hellenbrand, 2009; Stone & Archer Jr, 1990; Stone, Vespia, & Kanz, 2000; Xiao et al., 2017). According to the conservation of resources theory (COR), burnout occurs when resources are too limited to meet work demands (Hobfoll, 1989). COR theory proposes that demands and resources are distinctively related to burnout with excessive job demands strongly associated with emotional exhaustion and lack of resources associated with a lack of a sense of personal accomplishment (Lee, Lim, Yang, & Lee, 2011). Being overworked and under-resourced in the workplace can contribute to burnout which is commonly associated with absenteeism, poor job performance, and turnover (Carrola, Olivarez, & Karcher, 2016; Kahill, 1988). The chapter proceeds with a description of the occupational nature of being a college mental health counselor.

Counselor Training and Staffing Concerns

Most college counselors come into the profession from training programs in counseling psychology, clinical psychology, counseling and human services, mental health counseling, counselor education, and social work (Center for Collegiate Mental Health, 2017; Gallagher, 2015; Sharkin, 2012). Counseling psychology is the field having the longest association with college counseling centers (Sharkin, 2012) which have traditionally served as training sites for graduate students in counseling psychology programs (Neimeyer, Bowman, & Stewart, 2001). This may be due to a shared commitment to clinical, research, and training activities. The majority of college mental health counselors have earned either a doctoral degree (PhD, PsyD, or EdD) or a master's degree (MA, MS, MSW, or MEd) (Sharkin).

Licensure to practice mental health counseling can be acquired at the master's or doctoral level and most college counseling centers require it of their clinicians (Sharkin, 2012). It has been

common practice for counseling centers to be predominately staffed by those with doctoral degrees (Stone et al., 2000) but the number of college counselors with a master's degree is growing, particularly in smaller college counseling centers (Vespia, 2007). Mental health counselors are trained to develop basic, requisite counseling skills which include, but are not limited to: unconditional positive regard for the client, active listening, empathic engagement, rapport building, maintenance of client confidentiality, flexibility in therapeutic approach, clinical evaluation and assessment, and the ability to make treatment recommendations based on sound clinical judgment (Adams, Vasquez, & Prengler, 2015; Brems, 2001; Matthews & Walker, 2015).

Training background and professional experience are important considerations of occupational “fit” in college counseling centers. For example, a counselor with a master's degree may have many years of counseling experience, but no training or experience doing psychological testing. A counselor with a doctorate may have, comparatively speaking, much less counseling experience but much more experience doing research, psychological testing, and clinical supervision. There are also circumstances in which the hiring of a doctoral-level candidate is required. If the college counseling center is accredited by the American Psychological Association as a predoctoral internship site, the center must have doctoral-level professionals on staff to provide clinical supervision of interns—which also fulfills the requirements for the intern's licensure (American Psychological Association Committee on Accreditation, 2015; Rodolfa & Keilin, 2006; Sharkin, 2012). Decisions on how to meet the needs of the institution, the counseling center and the student population play a significant role in staffing decisions at college counseling centers.

The “feminization of psychology”

There is a gender imbalance in the field of psychology that began in 1950 (Metzner, Rajecki, & Lauer, 1994) and continues today. This trend is referred to as the “feminization of psychology” (Goodheart & Markham, 1992) and has been monitored by, among others, the American Psychological Association (APA). *The Changing Gender Composition of Psychology* (2017) is an APA report that updated its 1995 task force report on the gender composition in the field of psychology. The following are highlights from that report: In 2012, 4,543 psychology doctorates were awarded to women compared to 1,562 for men. In 2013, women made up 58% of APA membership and currently hold more than half of APA governance positions. In 2014, women made up 80% of master’s and doctoral students in health service provider-related psychology programs. In 2014, there were 52,967 women enrolled in graduate departments of psychology compared to 17,344 men.

The gender imbalance in the field of psychology is also reflected in each of the AUCCCD director surveys from 2014 to 2018. The percentage of directors who responded to these surveys and identified as female has increased every year since 2014 and has not dropped below 60%. In the 2018 AUCCCD survey, 68% of directors are women and 74% of these directors identify as psychologists. In the same survey, directors reported that 74% of their staff employees are female but did not specify how many of them are mental health counselors (LeViness et al., 2018).

For those unfamiliar with the field of mental health counseling, there may be a general uncertainty about the nature of the work counselors do. Assumptions, misconceptions, stereotypes and sociocultural norms regarding psychological counseling can be barriers to an informed understanding of the profession. The next section provides a general description of the counseling process and how it is typically conducted.

The Counseling Process

In broad terms, mental health counselors help people with emotional and psychological issues improve their sense of well-being, reduce stress, and resolve problems (American Psychological Association, 2017). In practice, the counseling process fundamentally involves meeting with a new client for the first time, engaging in the work of counseling with that client, terminating the working relationship with that client, then beginning again with another new client. Skovholt (2005) conceived a model of functioning he termed the Cycle of Caring which describes this continuous series of attachments and separations that mental health counselors must navigate as part of the counseling profession (see Figure 1).

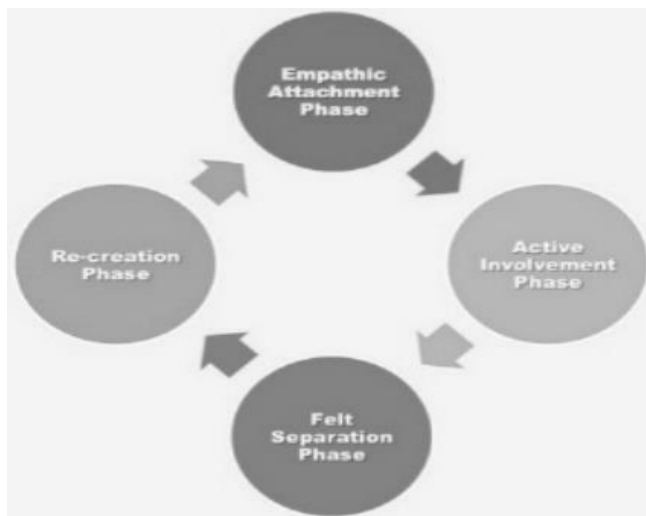


Figure 1. The Cycle of Caring (Skovholt & Trotter-Mathison, 2014)

The cycle begins with the Empathic Attachment Phase which involves forming a professional attachment with the client. The challenge for the counselor is to be emotionally involved yet emotionally distant (Skovholt, 2005). The counselor is united with the client in the understanding of their distress yet separate from experiencing the same emotional distress suffered by the client. The Active Involvement Phase is the longest of the three phases in which the counselor focuses on achieving therapeutic objectives shared by the client. The prominent

challenge for counselors during this phase is to monitor for emotional depletion and fatigue as exposure to the client's concerns may begin to weigh on the counselor (Skovholt). The Felt Separation Phase marks the end of the counseling process. The challenge for counselors is to avoid exhaustion and depletion as they separate from the emotional burden of client concerns as well as the relationship with their client (Skovholt). The Re-creation Phase refers to the downtime, or non-working time, counselors have before engaging with their next client. The challenge for counselors is to decompress and disconnect from their previous client's concerns and re-energize themselves before meeting with the next client (Skovholt). It is important to note that downtime varies depending on the number of clients a counselor meets with. For many college mental health counselors, the downtime between student counseling sessions can be very brief. It is not uncommon for some college mental health counselors, who meet with several students each day, to function in all phases of the Cycle of Caring during the course of one work day.

Campus Counseling Services

The spectrum of presenting concerns a college mental health counselor may be tasked to address on any given work day is broad, unpredictable, and unique to each student-client. During the initial meeting, the counselor must assess whether the student seeking assistance is appropriate for campus counseling services. This is largely based on the type and severity of presenting problems identified by the student. The primary tasks are to assess whether the student is an eminent danger to themselves or others, evaluate the student's mental health needs, and then make clinical recommendations (Sharkin, 2012). Depending on the severity of the student's presenting concerns, the counselor may recommend ongoing counseling sessions at the counseling center or refer the student to a more appropriate treatment modality in the community.

In general, students who present with problems that are of a situational or developmental nature are good candidates for campus counseling services. Additional positive criteria suggesting that the student is a good fit for campus counseling services: a desire to relieve presenting symptoms, ability to identify concerns and goals to be addressed in counseling, demonstrates insight or introspection, motivated to make changes, and the capacity for developing a counseling relationship (Sharkin, 2012).

Students who are inappropriate for campus counseling services often present with poor motivation for counseling or are in need of more intensive treatment modalities that are beyond the scope of the counseling center's service capabilities. There are some well-resourced colleges and universities with psychiatrists on staff, who can prescribe psychotropic medications; some have working relationships with city, county, or state mental health facilities; others have neither (Sharkin, 2012). If a student presents an eminent danger to themselves or others, the mental health counselor must ensure that the student is transported to a medical facility for a psychiatric evaluation (Gallagher, 2015; Reetz et al., 2016; Sharkin, 2012).

According to the 2018 Association for University and College Counseling Center Directors survey, college mental health counselors spend 64% of their work day providing direct counseling services to students (LeViness et al., 2018). However, most college mental health counselors assume additional roles and responsibilities as a function of their professional training and identity as the mental health experts on campus (Gallagher, 2015; Sharkin, 2012). Some of these commonly associated roles and responsibilities will be discussed next.

College Counselor Roles and Responsibilities

College counselors serve five primary functions: provision of counseling services, crisis intervention, consultation and outreach, training and supervision, and administrative duties (Sharkin, 2012). Factors such as the size of the institution, whether it is a public or private institution, whether it is a residential or commuter campus, and the size and expertise of the counseling center staff, determine the scope of services and how much time is devoted to these functions. Having already discussed the counseling role, the remaining primary functions of college mental health counselors are briefly described next.

Crisis intervention.

College counselors are called upon in crisis situations when students exhibit behaviors that warrant concern. Professors often contact the counseling center expressing concerns for the well-being of a student, asking what can or should be done (Sharkin, 2012). These concerns may be the result of unusual or troubling behaviors exhibited in the classroom such as extreme agitation or aggressiveness. Some professors may be alarmed by recurring themes of death, suicide or violence toward others in writing assignments submitted by a student. Others may report that one of their students is frequently observed, laughing, arguing, or seemingly engaged in discussion with a non-existent other. The following are additional examples of situations in which counselors are asked to intervene: when a student experiences a panic attack in class, when a student reports having been assaulted or raped, when a student appears to be experiencing a psychotic episode in the form of delusions or hallucinations, when a student engages in deliberate self-injury, or when a student or a class of students are shocked by the death of a loved one, a faculty member or fellow classmate. The aforementioned are among the many other situations that may require mental health crisis intervention.

Crisis interventions occur in various environments around campus such as emergency walk-ins at the counseling center, after-hours emergencies at student housing, urgent referrals by faculty, staff, or administration, and classroom or office grief debriefings following the death of a student, staff, or faculty member (Center for Collegiate Mental Health, 2017; National Council on Disability, 2017; Reetz et al., 2016; Sharkin, 2012; T. B. Smith et al., 2007; Vespia, 2007). Additionally, efforts to support the entire campus community and promote feelings of solidarity, comfort or hope occur in the wake of natural disasters, mass shootings or other traumatic events that affect large numbers of people.

Consultation and outreach.

College counseling staff regularly provide consultation services to students, staff, faculty, administrators, and parents regarding mental health concerns. Mental health counselors often field questions from the campus community, as well as parents of college students, regarding mental health concerns. These inquiries come in the form of phone calls, emails, or walk-ins. Outreach efforts typically involve the provision of psychoeducational programs and activities that take counselors out of their offices and into the campus community (Archer & Cooper, 1999). Many colleges and universities include, invite, or require a representative from campus mental health services to attend new student orientation events to inform incoming students about the availability of campus counseling services. Mental health and well-being are essential to meaningful learning, so it is critical that institutions of higher education develop services that are accessible to students while removing stigma from help-seeking behaviors (National Association of Student Personnel Administrators, 2017). Workshops on stress management, coping skills for anxiety and depression, anger management, communication skills, assertiveness, self-esteem, suicide prevention, and

sexual assault prevention are popular topics commonly presented to college students on an ongoing basis (Sharkin, 2012; T. B. Smith et al., 2007).

Training and supervision.

The training and supervision of graduate and doctoral students, postdoctoral residents and fellows is an important and desirable component of college counseling centers (Boyd et al., 2003). Accredited training programs in college counseling centers must provide trainees with a specific set of training experiences in order to meet accreditation standards. Trainees who work with students must be supervised closely by experienced, qualified counseling center staff to ensure they receive appropriate clinical services (American Psychological Association Committee on Accreditation, 2015).

As previously discussed, presidents and student affairs leaders in higher education have identified student mental health and diversity/multicultural issues as serious concerns on campus (Rubley, 2017). Whether seasoned with years of experience or new to the profession, college mental health counselors must expand their clinical knowledge and counseling skillset in order to serve an increasingly diverse student population (LaFollette, 2009; T. B. Smith et al., 2007). The National Center for Education Statistics (NCES) reports that between 1976 and 2014, the percentage of Hispanic college students rose from 4% to 17%, the percentage of Asian/Pacific Islander students rose from 2% to 7%, the percentage of Black students rose from 10% to 14% percent, the percentage of American Indian/Alaska Native students rose from 0.7% to 0.8%, and the percentage of White students fell from 84% to 58%. Nonresident aliens composed 5% of the student population (National Center for Education Statistics, U.S. Department of Education, 2017). It is equally important to note that increased accessibility to higher education in the United States has enabled higher enrollment of disadvantaged minorities who have historically had less

opportunity to attend college (Flatt, 2013). Upticks in demand for counseling services may also be related to greater numbers of financially disadvantaged students being able to utilize campus counseling centers at little to no cost.

There has also been a significant increase in the number of students aged 25 and older attending U.S. colleges and universities. From 2004-2014, the enrollment of students under the age of 25 increased by 18% while the number of students aged 25 years and older increased by 16%. However, from 2014-2025, the NCES projects that a 13% increase in students under the age of 25 will be outpaced by an 18% increase in students 25 years of age or older. In 2015, there were a total of 19.9 million college students; 59% (11.8 million) of them were under the age of 25 and 41% (8.1 million) were students aged 25 years and older (National Center for Education Statistics, U.S. Department of Education, 2017).

These demographic changes in the student population could extend to demographic changes in the students who utilize campus counseling centers. College mental health counselors are likely to see a more culturally diverse caseload than they are accustomed to working with and must be prepared for the possibility. For example, increasing numbers of students may come to the counseling center with concerns about racism, social justice, or immigration policy. Students aged 25 years and older may seek counseling for stage of life concerns that differ from those commonly associated with the “traditional” college-aged student under 25.

Administrative duties.

Directors of counseling centers have a broad spectrum of administrative responsibilities: strategic planning, goal setting, budget management, supervision of staff, resource allocation, evaluation of services, completion of annual reports, and provision of accountability data for senior-level administrators (Boyd et al., 2003). Many counseling center directors also serve as

consultants for campus health and safety committees, campus threat assessment teams, and campus policy/program initiatives. Many staff mental health counselors also serve as important members of campus committees but this varies widely among counseling centers and is often determined by staffing and scheduling demands (Sharkin, 2012). Critical administrative tasks for all mental health counselors is the documentation of student-client contacts and maintenance of student counseling records (Mitchell, 2007). Appropriate records of psychological services must comply with state and federal laws as well as professional ethics code (American Psychological Association, 2007). College counseling centers and the mental health counselors that work within them serve as the foundation for the study. Having established a general understanding of the main components of campus mental health service, the chapter continues with discussion of the Compassion Satisfaction-Compassion Fatigue theory.

Compassion Satisfaction-Compassion Fatigue Theory

Stamm's (2010) Compassion Satisfaction-Compassion Fatigue theory serves as the framework for the current study. The principle of this theory is that one's professional quality of life is comprised of both the positive (compassion satisfaction) and the negative (compassion fatigue) aspects of work in the helping professions. It is "the quality one feels in relation to their work as a helper" (Stamm, p. 8). Compassion satisfaction is about the pleasurable thoughts, feelings, and beliefs associated with the work one does. Compassion fatigue is about the negative experiences associated with work as a helping professional and breaks down into two factors that are distinctly different. The first factor is burnout, a psychological syndrome that develops over time and is characterized by feelings of exhaustion and detachment associated with the workplace. The second factor is secondary traumatic stress, a psychological syndrome which has a rapid onset and is characterized by feelings of fear and avoidance associated with the work of helping others

who have been traumatized. See Figure 2 below for a diagram of Stamm's conceptual model of professional quality of life.

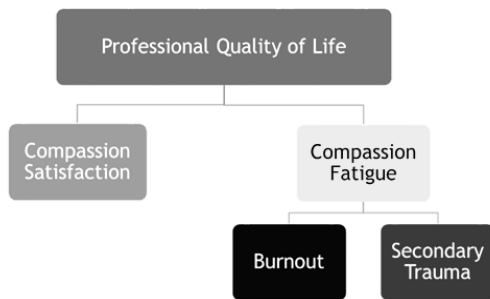


Figure 2. Diagram of Professional Quality of Life, Reprinted from Stamm (2010)

Professional Quality of Life

The positive and the negative aspects of work in the helping professions are influenced by three key environments: the work environment, the client environment, and the personal (helper's) environment (Stamm, 2010). According to Compassion Satisfaction-Compassion Fatigue theory, these environments are independent of one another, each with specific concerns. These environments can also have a collective influence in how one feels about their professional quality of life. For instance, dysfunction in one environment may be more manageable for the helping professional than dysfunction in three environments.

The quality of work environments can have a significant impact on professional quality of life. Counseling centers with adequate resources, helpful coworkers, and supportive administrators can be work environments in which staff morale is high and mental health counselors feel encouraged to carry out the difficult work they do. These factors may contribute to professional quality of life in a positive manner. Conversely, work environments that are understaffed, overloaded with work, and saddled with unrealistic expectations may be discouraging or stifling, and contribute to professional quality of life in a negative manner.

For college mental health counselors, the client environment is a constantly shifting assortment of circumstances presented by numerous individual students seeking assistance. Positive aspects of the client environment might involve: counseling work that results in a student's improved ability to manage previously debilitating episodes of anxiety; a student with poor self-esteem seeks counseling, works to develop greater self-confidence, and becomes more socially interactive with others; or a depressed student on the verge of dropping out, seeks counseling and improves their mood which enables him/her to graduate with a college degree. Successful outcomes in the client environment can positively influence a mental health counselor's professional quality of life. Negative aspects of the client environment for mental health counselors may involve helping students who: have suffered the death of a loved one, engage in self-injurious behaviors, are experiencing hallucinations, delusions, or other psychotic symptomology, exhibit a threatening or frightening demeanor during a counseling session, have been the victim of sexual assault, or have constant suicidal ideations or, in worst case scenario, commit suicide. These types of work experiences can influence a college mental health counselor's professional quality of life in a negative manner.

The personal environment of those in helping professions also contributes to professional quality of life. The helping professional has life experiences that can affect the way they feel on any given day just like anyone else. Positive aspects of the mental health counselor's personal environment that can enhance professional quality of life might include supportive friends and family, being physical fit, enjoyable hobbies and interests, financial stability, or satisfying interpersonal relationships. Getting divorced, the death of a loved one, having to declare bankruptcy, or being struck with serious illness are examples of negative life events in the personal

environment which could adversely affect professional quality of life. The next section will expand on the concept of compassion satisfaction.

Compassion Satisfaction

Compassion satisfaction is the pleasure one derives from the ability to do one's work well (Stamm, 2010) and contribute to the well-being of others (Radey & Figley, 2007). The positive aspects of work, client, and personal environments influence one's degree of compassion satisfaction. Supportive work environments, successful outcomes with clients, and good health are factors that can positively shape a mental health counselor's perception of the work they do and how they feel about doing it. Research suggests that increasing levels of compassion satisfaction may improve the quality of work and the care counselors provide to those they are attempting to help (Alkema et al., 2008). Researchers have also found that compassion satisfaction is negatively correlated with secondary traumatic stress (Pelon, 2017). This suggests that higher levels of compassion satisfaction may serve as a protective barrier to secondary traumatic stress. While the description of compassion satisfaction seems straightforward, Stamm notes that it is possible for helping professionals to experience high compassion satisfaction and high compassion fatigue simultaneously (2010). For example, a mental health counselor is secondarily exposed to trauma when a student talks about the death of a loved one, but also feels a sense of satisfaction in their ability to help the student through the grieving process.

Compassion Fatigue

As college mental health counselors assist students cope with personal trauma, they effectively share the emotional weight of these traumatic experiences by listening and empathizing with the student. Disclosures of traumatic experience involve associated images that come naturally to the mental health counselor as they do to anyone listening to a descriptive account.

For example, while in session, a student tells the counselor about being physically assaulted by another person. Depending on details of the traumatic event, the counselor might have visual images of the student being struck or running for safety—not because it is desired, but because it is a natural human response to form mental images when listening to a descriptive account. Due to the occupational nature of counseling work, some college mental health counselors are exposed to the unique trauma scenarios of different students, several times a day, day after day, week after week, and so on. This constant exposure to trauma can lead to compassion fatigue.

Research examining the negative effects of trauma work on mental health professionals has been growing for the past twenty years (Arvay, 2001; Stamm, 2010). Bride, Radey and Figley (2007) clearly articulate the weight of this phenomenon, “It is now widely recognized that the indirect exposure to trauma involves an inherent risk of significant emotional, cognitive, and behavioral changes in the clinician” (p. 155). What is not as widely recognized, is what to call this phenomenon (Sprang, Clark, & Whitt-Woosley, 2007). Review of the literature on compassion fatigue reveals three related concepts—all of which address the negative impact of clinical work with those who have been traumatized (Bride, Radey, & Figley, 2007). The terms *compassion fatigue*, *vicarious traumatization*, and *secondary traumatic stress* are often used interchangeably in the literature on secondary trauma exposure. This has resulted in a lack of conceptual clarity regarding what constitutes compassion fatigue (Bride et al., 2007; Craig & Sprang, 2010; Elwood, Mott, Lohr, & Galovski, 2011; Figley, 1995; Figley, 2002; Huggard & Nimmo, 2013; Kanno & Giddings, 2017; Najjar, Davis, Beck-Coon, & Carney-Doebbeling, 2009; Sprang, Clark, & Whitt-Woosley, 2007; Stamm, 1997; Stamm, 2010). Subtle differences among these terms warrant further discussion.

Joinson (1992) first used the term compassion fatigue in a study of emergency department nurses and proposed that nurses absorb the traumatic stress of their patients as a result of empathic engagement with them. Others have described compassion fatigue as a stress reaction that emerges suddenly and without warning causing a sense of helplessness, confusion, and isolation (Najjar et al., 2009); a state of physical, emotional, and spiritual exhaustion, hopelessness, disconnection from others, and decreased capacity or receptivity for empathic interactions with clients (Pelon, 2017); and a condition in which therapists avoid hearing traumatic materials, experience traumatic imagery related to traumatic materials, and suffer from physical symptoms such as headaches, heart palpitations, gastrointestinal problems, and sleep disturbance (Kanno & Giddings, 2017). In general, compassion fatigue involves a reduction in a helping professional's capacity or interest in being empathetic towards those they help which impairs the ability to do their work effectively.

The term vicarious traumatization was introduced by McCann and Pearlman (1990) to describe the negative psychological effects mental health professionals may experience as a result of repeated exposure to the traumatic experiences of clients. The most notable distinction about the concept of vicarious traumatization is that it involves cognitive changes in mental health counselors that develop as a result of their trauma work with others (Elwood et al., 2011). These cognitive changes may occur as short-term reactions to a particular client's trauma or long-term alterations in the mental health counselor's own beliefs, expectations, and assumptions about self and others (McCann & Pearlman). A mental health counselor who is experiencing vicarious traumatization may relate client trauma to their own theories or beliefs about safety, trust, power, esteem, intimacy, control and independence (Pearlman & Saakvitne, 1995). For example, a mental health counselor who works with rape victims develops a heightened sense of vulnerability and concerns about personal safety become the overwhelming priority in life. People can no longer be

trusted as their motives to interact are now suspect. A previous perception that people are basically good has been replaced by a pessimistic and cynical belief that people only care about themselves and what they can get from others.

Secondary traumatic stress is "...a state experienced by those helping people in distress; it is an extreme state of tension and preoccupation with the suffering of those being helped to the degree that it is traumatizing to the helper" (Figley & Gould, 2005). Mental health counselors are trained to be objective, analytical professionals and to put their personal feelings aside when working with clients. However, one cannot avoid compassion and empathy, the requisite tools of helping professionals (Figley, 2002). Compassion is an emotion associated with caring and concern for others (Stebnicki, 2007) whereas empathy is about "a way of being" that involves entering the private, perceptual world of another with a non-judgmental sensitivity to what that person is feeling and experiencing (Rogers, 1980). In counseling work, traumatic stress is passed from client to counselor through empathic engagement (Sprang et al., 2007).

Elwood, Mott, Lohr, and Falovski (2011) suggested that vicarious traumatization and secondary traumatic stress can be applied to many populations but compassion fatigue refers exclusively to those working in helping professions such as mental health counseling, social work, nursing, and first-responders. Figley (1995) describes compassion fatigue as a consequence of the work of helping others: "There is a cost to caring. Professionals who listen to clients' stories of fear, pain, and suffering, may feel similar fear, pain, and suffering because they care" (p. 1).

Compassion fatigue is a term more readily accepted by professionals as it is thought to be less stigmatizing than vicarious traumatization or secondary traumatic stress (Bride et al., 2007; Figley, 1995). Although these terms are semantically similar, compassion fatigue sounds and "feels" less punitive. The term compassion fatigue is akin to the term *battle fatigue*, which refers

to the negative psychological effects experienced by veterans of combat exposure (Reisman, 2016). Both terms relate to stress reactions brought about by exposure to trauma in the occupational environment. It is widely understood and accepted that when combatants return from warfare, some of them will have been traumatized by the experience. If a mental health professional is experiencing compassion fatigue, they may be more inclined to address it with a colleague, work supervisor, or health care professional if it is perceived or “normalized” as a possible occupational consequence of constant exposure to the trauma of others.

In Stamm’s Professional Quality of Life model, compassion fatigue is considered on two factors of a helping professional’s negative, work-related experience: burnout and secondary traumatic stress. These are separate constructs with distinctly different experiential characteristics.

Burnout

The concept of burnout was first introduced as a condition in which a worker becomes unable to function due to exhaustion (Freudenberger, 1974). Researchers have since expanded on the concept of burnout and describe it as a psychological syndrome of emotional exhaustion (e.g., fatigue, hopelessness, unhappiness), depersonalization (e.g., disconnectedness, insensitivity to the work environment), and reduced sense of personal accomplishment (e.g., belief that one’s work efforts make no difference) (Maslach, Schaufeli, & Leiter, 2001). Burnout develops gradually over time and can occur in any profession, not just those involved with trauma work (Elwood et al., 2011). It is a prolonged response to work-related conditions and chronic stressors on the job (Leiter & Maslach, 2003), most often associated with heavy workloads and non-supportive work environments (Stamm, 2010). Incidence of burnout has been found to be higher among those in mental health professions as opposed to primary health care workers (Imai, Nakao, Tsuchiya, Kuroda, & Katoh, 2004) and has been found to negatively affect job performance, absenteeism

rates, and occupational turnover (Carrola, Olivarez, & Karcher, 2016). Mental health counselors who are “burned out” begin to disengage from their work and may result in failure to perform clinical tasks efficiently or appropriately because exhaustion has led to an apathetic view of the work, those they work with, and the clients they work for (Choi, Puig, Kim, Lee, & Lee, 2014).

Secondary Traumatic Stress

Symptoms of secondary traumatic stress are nearly identical to those of post-traumatic stress disorder (PTSD) which include: (a) feelings of fear associated with the work one does, (b) intrusive thoughts and images of the traumatic event, (c) avoidance of thoughts, feelings, activities, or situations that remind of the traumatic event, (d) detachment from others, (e) difficulty falling or staying asleep, (f) irritability or angry outbursts, (g) difficulty concentrating, (h) hyperarousal or exaggerated startle response, and (i) physiologic reactivity (e.g., increased heart rate or sweaty palms) to cues that remind a person of the traumatic event (Figley, 1995). The difference between the two is: PTSD involves direct exposure to trauma (e.g., the client was physically assaulted) whereas secondary traumatic stress involves indirect exposure to trauma (e.g., the counselor listens to a client’s account of being physically assaulted) (Elwood et al., 2011; Figley, 1995; Figley, 2002). Secondary traumatic stress is believed to be less severe than PTSD and to involve a faster rate of recovery (Figley, 1995; Kanno & Giddings, 2017).

Compassion Fatigue, Vicarious Traumatization, and Secondary Traumatic Stress

While the incidence of developing serious problems associated with the negative aspects of work in helping professions appears to be low (Stamm, 2010), the effects of such an occurrence could extend to the mental health counselor’s personal relationships, their student-clients, or other counselors in the center. The cumulative effect of hearing multiple accounts of trauma and the associated descriptions and images can be unsettling or disturbing enough for some counselors,

that they become preoccupied with the suffering of others. Despite having been educated, trained and supervised in the treatment of others, mental health counselors are not immune to painful thoughts, images, and feelings associated with exposure to their clients' traumatic experiences (McCann & Pearlman, 1990).

Possible Consequences of Counselor Burnout and Secondary Traumatic Stress

There are *hidden costs of caring* for organizations whose care-giving professionals are experiencing burnout and secondary traumatic stress: higher rates of physical illness, greater use of sick time, and higher turnover rates (Austin, Goble, Leier, & Byrne, 2009; Ray, Wong, White, & Heaslip, 2013; White, 2006). Studies on burnout involving mental health professionals have found that emotional exhaustion, the primary symptom of burnout (Maslach et al., 2001), is linked to intention to quit as well as actual turnover (Geurts, Schaufeli, & De Jonge, 1998; Knudsen, Ducharme, & Roman, 2009). There are also “ripple” effects of burnout that have negative consequences for others. For example, if a mental health counselor is experiencing burnout and takes a sick day to recoup, each of the clients that were scheduled to be seen that day have, by extension, been affected by burnout (Carrola et al., 2016).

Administrative policies and funding for student services in higher education institutions have become more conservative (T. B. Smith et al., 2007). Trends toward increased accountability in higher education administration often involve budget cuts and administrative decisions that can be unfavorable for various campus departments. This can create significant challenges for student support service departments, such as counseling centers, as personnel must contend with greater workloads and less institutional support (Bishop, 1990; Bishop, 2006; Sharkin, 2012).

Colleges and universities that are willing to invest in reducing college mental health counselors' risk for developing negative effects associated with helping those who have been

traumatized have the potential to improve financial savings by reducing turnover and adverse events associated with burnout and secondary traumatic stress (Kelly, Runge, & Spencer, 2015). In terms of institutional student support services, the primary resource for mental health concerns is the campus counseling center and its mental health professionals. As campus counseling centers face increasing demand for mental health services from students with serious mental health concerns, it is in the best interests of the institutions and the students they serve, that educational leaders support the well-being of mental health counselors. The literature review continues with studies of compassion fatigue, burnout, and secondary traumatic stress using the ProQOL Scale.

Previous Research on College Mental Health Counselors

At the national level, research on the subjective work experience of college mental health counselors is limited and most of these studies involve small-scale studies of local, regional, or demographic college counselor populations (Casas, Furlong, & Castillo, 1980; Coll, 1989; Hayman & Covert, 1986; Kadambi, Audet, & Knish, 2010). A review of the extant literature on the subject revealed two studies done at the national level. One study, conducted in 1989, investigated burnout among college counselors but was limited to doctoral-level counselors at institutions with doctoral training programs (Ross, Altmaier, & Russell, 1989). The sample population was not representative of all college mental health counselors because many U.S. colleges and universities employ master's level counselors and many institutions do not have doctoral training programs. The other study was a 2007 survey of American College Counseling Association (ACCA) members. In this study, 45% of the participants held some type of administrative position such as counseling center director or associate director. This distinction is important as results found that non-administrative counseling staff spent 81% of their work time providing counseling services to students while center administrators spent 62% of their work time

providing counseling services and 38% doing administrative duties (T. B. Smith et al., 2007). Results from the 2018 AUCCCD survey show that counseling center directors spend considerably less time counseling students than in years past. Counseling center directors reportedly spend 34% of their time providing direct counseling services to students and the remainder of their time is spent doing other administrative duties (LeViness et al., 2018).

Research Studies Using the ProQOL

The following research studies utilized the ProQOL with those in helping professions that often involve secondary trauma exposure. I was unable to find any studies using the ProQOL with a national sample of college mental health counselors, but have provided these studies to illustrate the benefits and practicality of the Professional Quality of Life Scale.

In 2013, a study of frontline mental health care professionals (nursing, social work, psychology, psychiatry, case managers and mental health workers) examined the relationships among compassion satisfaction, compassion fatigue, burnout, and work life conditions. There are six areas of work life in which conflict between the employee's expectations and the job are predictive of burnout: workload; degree of autonomy; recognition for work contributions; quality of the relationships with those at work; openness and respect in the workplace; and congruence between the organization's priorities and values and those of employees (Maslach & Leiter, 1997). Results found that higher levels of compassion satisfaction, lower levels of secondary traumatic stress, and higher overall degree of fit in the six areas of work life were predictive of lower burnout in front line mental health care professionals (Ray et al., 2013).

A study of trauma therapists (Sodeke-Gregson, Holtum, & Billings, 2013) found the majority of participants to have average potential for compassion satisfaction and average risk for burnout. However, 70% of scores indicated high risk for secondary traumatic stress, 30% at

average risk, and 0.0% at low risk. The researchers suggested that the negative effects of working with traumatized clients was balanced by the potential for positive outcomes from the work they do as a majority indicated an average level of compassion satisfaction. Compassion satisfaction was found to be negatively correlated with both burnout and secondary traumatic stress, and burnout was positively correlated with secondary traumatic stress.

Colorado child protection caseworkers and supervisors completed a ProQOL survey while attending a professional seminar (Conrad & Kellar-Guenther, 2006). Participant scores indicated high potential for compassion satisfaction, low risk for burnout and high risk for secondary traumatic stress. This finding supports Stamm's (2010) theory that one can experience high compassion satisfaction and high secondary traumatic stress simultaneously.

An employee assistance program (EAP) is a benefit that many businesses and organizations, including many colleges and universities, provide to their employees free of charge. EAP counselors provide confidential mental health counseling and crisis intervention services, usually offsite of the workplace. EAPs are intended to provide a resource for employees to address problems that could impact job performance. A national survey utilizing the ProQOL was conducted with members of the Employee Assistance Professionals Association. Results found that EAP professionals in the study had high potential for compassion satisfaction, were at low risk for burnout, and average or moderate risk for secondary traumatic stress (Jacobson, 2006).

Nursing and mental health counseling are professions in which there is a high occurrence of secondary trauma exposure. Accordingly, there are many ProQOL studies involving nurses, such as the one that examined a team of trauma nurses at a Midwestern Level I trauma center (Berg, Harshbarger, Ahlers-Schmidt, & Lippoldt, 2016). ProQOL scores indicated that 58% were at moderate to high risk for burnout and 75% of nurses were at moderate to high risk for secondary

traumatic stress. Another separate study surveyed 221 critical care nurses at an academic hospital (Sacco, Ciurzynski, Harvey, & Ingersoll, 2015) and found that all participants scored within the average range for all three subscales of the ProQOL. The juxtaposition of these two studies illustrates how ProQOL scores can vary among work groups in the same profession but different environments. The nurses in the first study indicated moderate risk for burnout and high risk for secondary traumatic stress while the nurses in the second study indicated an effective balance in professional quality of life because there were no statistically significant high indicators for burnout nor secondary traumatic stress.

Much of the research on the relationship of age as it pertains to burnout has found that younger workers report higher levels of burnout than older workers (Craig & Sprang, 2010; Kelly et al., 2015; Maslach et al., 2001; Maslach, 2003). Review of research studies on gender differences among mental health professionals suggest that female clinicians may be more susceptible to secondary traumatic stress. A sample of 1,121 mental health providers in a rural southern state completed the ProQOL scale and the female gender was found to be associated with higher levels of secondary traumatic stress (Sprang et al., 2007). A systematic review of gender findings in secondary traumatic stress studies using the ProQOL found that the research shows greater susceptibility to secondary traumatic stress among female clinicians (Baum, 2016). A study of child welfare workers in Florida (Van Hook & Rothenberg, 2009) found average potential for compassion satisfaction and high risk for secondary traumatic stress and burnout. Higher levels of compassion satisfaction were found to be correlated with lower levels of burnout and secondary traumatic stress across participant's demographic variables. Females and younger (18-29) child welfare workers were found to be at higher risk for secondary traumatic stress and burnout.

A study was conducted with social work students at a U.S. university who were working in field placements (Harr & Moore, 2011). Results found that the students indicated high potential for compassion satisfaction and average risk for secondary traumatic stress and burnout. The researchers suggest that the level of satisfaction social work students derive from helping others is greater at this initial stage of their professional life and that the findings may support Stamm's (2010) theory that a high level of compassion satisfaction can serve as a protective barrier to secondary traumatic stress and burnout.

These research studies illustrate the broad spectrum of helping professions that have been examined using the ProQOL. Review of the extant literature on college mental health issues reveals that little attention has been paid to research involving the mental health counselors who are relied upon to manage the mental health concerns of our colleges and universities. This study will contribute to the growing body of research focused on college mental health issues by providing data on the subjective work experience of a national sample of college mental health counselors.

Summary

The literature review provided a broad overview of key concerns relative to the study. The reader has been familiarized with the evolution of college counseling centers in the United States and the most pressing issues currently facing campus counseling centers in the United States. The average number of students seeking counseling services between 2009 and 2015 grew by 30% while the average institutional enrollment grew by only 6%. A greater number of students who have severe mental health problems are attending college and many of them utilize campus counseling services. The current generation of college students is more receptive to seeking mental health counseling than previous generations of students. When considering these factors together,

the average student to counseling staff ratio of 1,833:1 is likely to be inadequate for many college counseling centers. Risk management concerns related to campus mental health issues have become a top priority for U.S. colleges and universities and these concerns were addressed in the literature review.

A general overview of the counseling process was provided in order to familiarize the reader with the occupational nature of being a college mental health counselor. A review of the numerous occupational duties and associated responsibilities that college mental health counselors assume was provided to illustrate how counselors must function as skilled, multi-tasking risk-managers for the campus community.

Stamm's (2010) compassion satisfaction-compassion fatigue theory serves as the structural framework for the study and the reader was informed how the work environment, client environment, and personal environment influence a college mental health counselor's professional quality of life. The components that define professional quality of life were discussed at length. Compassion satisfaction is the pleasure one derives from the ability to do one's work well and contribute to the well-being of others. Supportive work environments and adequate resources are examples of factors that can positively shape a mental health counselor's perception of the work they do and how they feel about doing it. Burnout is a psychological syndrome of emotional exhaustion, depersonalization, and reduced sense of personal accomplishment most often associated with heavy workloads and non-supportive work environments. Secondary traumatic stress is a negative psychological stress reaction similar to post-traumatic stress disorder. It develops rapidly and is characterized by feelings of fear associated with the work one does. For college mental health counselors, secondary traumatic stress involves indirect exposure to student accounts of trauma and hardship on a continuous basis. Secondary traumatic stress often results in

higher rates of physical illness, greater use of sick time, and higher turnover rates. Colleges and universities that invest in reducing mental health counselors' risk for developing burnout and secondary traumatic stress can potentially improve financial savings by reducing turnover and adverse consequences associated with these negative, work-related stress reactions. Review of the literature did not reveal any studies using the Professional Quality of Life scale (ProQOL) with a national sample of college mental health counselors. Several studies using the ProQOL with those in helping professions was provided in order to illustrate its practical application. In the next chapter, the methodology of the study is presented.

CHAPTER 3: METHODOLOGY

This chapter provides the framework for the approach to examine the research questions in the study. First, the description of the research design and the rationale for the design will be discussed. Second, the specific research questions are presented with their corresponding specific research hypotheses based on literature review. Third, the participants of the study will be identified and rationale for the selection is discussed. Fourth, the sampling procedure is described. Fifth, descriptions of the instruments are provided, the data collection procedures are explained, and the reliability and validity of the instrument is provided. Sixth, dependent and independent variables of the study are identified and described. Finally, a discussion of the statistical techniques and their assumptions are presented.

Research Design

A descriptive approach is valuable in social science research because human nature is an inherent variable in the study of fields such as education, psychology, and sociology (Knupfer & McLellan, 1996). The study is descriptive research as the investigator seeks to examine subjective reports of experiences among college mental health counselors. Descriptive research is frequently used to describe characteristics or behaviors of a sample population as they are in present time. In the context of the study, “present time” is defined as being within the last 30 days at the time of completing the survey. This is because the ProQOL instructs the participant to submit responses based on their subjective experience during the past 30 days (Stamm, 2010). The ProQOL will be discussed further in the instruments section.

The investigator employed a quasi-experimental research design to investigate possible relationships between reported levels of compassion satisfaction, burnout, and secondary traumatic stress as measured by the ProQOL and the demographic variables of gender, age, and years of

counseling experience as collected from a demographic questionnaire completed by participants. Social science research is largely based on ex post facto designs when it is not acceptable or possible to manipulate characteristics of human participants (Salkind, 2010) as was the case with the demographic data of interest for the current study. The ex post facto research design enables the investigator to seek out possible relationships among variables by observing an existing condition (compassion satisfaction, burnout, and secondary traumatic stress) then searching “in reverse” for characteristics (age, gender, years of counseling experience) that possibly contribute to or influence the existing condition. The study is quasi-experimental as it is an investigation of these relationships between specific groups of participant characteristics (age, gender, years of experience) and their ProQOL subscale (compassion satisfaction, burnout, and secondary traumatic stress) scores. Because the design does not allow for manipulation of any of the variables, it does not allow for definitive statements of cause-and-effect relationships between any of these variables (Gelo, Braakmann, & Benetka, 2008). Also, prospective participants in the study are not placed into control or experimental groups so the generalizability of results are limited (Price, Chiang, & Jhangiani, 2015).

Research Questions

The nation is in the midst of a campus mental health crisis as evidenced by multiple mass shootings on college campuses, outbreak clusters of student suicides, and high-profile reports of campus sexual assault. College mental health counselors are the first point of contact for most campus mental health problems and they are struggling to keep up with increased student demand for services. However, little is known about counselors’ subjective work experience under these dire circumstances. I was unable to find any research studies examining compassion satisfaction,

burnout and secondary traumatic stress among U.S. college mental health counselors. There are eight research questions for the study:

RQ1: *Do U.S. college mental health counselors exhibit statistically significant differences in their mean scores on the ProQOL subscales for compassion satisfaction, burnout, and secondary traumatic stress from the established means ($M = 50$) published in The Concise ProQOL Manual (Stamm, 2010)?*

RQ2: *Do male and female college mental health counselors in the U.S. exhibit statistically significant differences in their scores on the ProQOL subscales for compassion satisfaction, burnout, and secondary traumatic stress?*

RQ3: *Do U.S. college mental health counselors exhibit statistically significant differences in their scores on the ProQOL subscales of compassion satisfaction, burnout, and secondary traumatic stress based on age?*

RQ4: *Do U.S. college mental health counselors exhibit statistically significant differences in their scores on the ProQOL subscales of compassion satisfaction, burnout, and secondary traumatic stress and different levels of work experience?*

RQ5: *Is there an interaction between the gender and age of U.S. college mental health counselors as it relates to their scores on the ProQOL subscales of compassion satisfaction, burnout, and secondary traumatic stress?*

RQ6: *Is there an interaction between the gender and years of experience of U.S. college mental health counselors as it relates to their scores on the ProQOL subscales of compassion satisfaction, burnout, and secondary traumatic stress?*

RQ7: *Is there an interaction between the age and years of experience of U.S. college mental health counselors as it relates to their scores on the ProQOL subscales of compassion satisfaction, burnout, and secondary traumatic stress?*

RQ8: *Is there an interaction between the gender, age, and years of experience of U.S. college mental health counselors as it relates to their scores on the ProQOL subscales of compassion satisfaction, burnout, and secondary traumatic stress?*

Since its creation in the late 1990s, the ProQOL scale has become “the most commonly used measure of the positive and negative effects of working with people who have experienced extremely stressful events” (Stamm, 2010). The *Comprehensive Bibliography of Documents Specifically Using the ProQOL Measure* (Stamm, 2016) lists an abundance of studies with various groups in helping professions that involve secondary trauma exposure, but none that specifically examine college mental health counselors. However, the literature review suggests that there is ample evidence that the ProQOL is a practical tool to measure levels of compassion satisfaction, burnout, and compassion fatigue with this specific population. Based on the review of studies using the ProQOL with those in helping professions, the following are hypothesized:

Research Hypotheses

There were 8 specific research questions for the current study. The first research question was the fundamental inquiry of the study and was intended to examine the overall status of U.S. college mental health counselors’ professional quality of life. This required testing for statistically significant differences between counselors’ mean scores on each of the ProQOL subscales of compassion satisfaction, burnout, and secondary traumatic stress and the established means of the instrument. Thus, the first research hypothesis (RH1) includes three sub-hypotheses; one for each of the ProQOL subscales (RH1a, RH1b, and RH1c). Research questions 2, 3, and 4 examined

whether college mental health counselors exhibited statistically significant differences in their ProQOL scores between gender groups, between age groups, or between years of experience groups. Research questions 5, 6, 7, and 8 examined for possible interaction effects among the college mental health counselors' gender, age, and years of experience that account for statistically significant differences in college mental health counselors' ProQOL scores. The following were the specific research hypotheses for the study:

RH1: U.S. college mental health counselors exhibit statistically significant differences in their mean scores on the ProQOL subscales for compassion satisfaction, burnout, and secondary traumatic stress from the established means ($M = 50$) published in The Concise ProQOL Manual (Stamm, 2010).

RH1a: U.S. college mental health counselors exhibit a statistically significant higher mean score on the compassion satisfaction subscale than the established mean ($M = 50$) published in the Concise ProQOL Manual (Stamm, 2010).

RH1b: U.S. college mental health counselors exhibit a statistically significant higher mean score on the burnout subscale than the established mean ($M = 50$) published in the Concise ProQOL Manual (Stamm, 2010).

RH1c: U.S. college mental health counselors exhibit a statistically significant higher mean score on the secondary traumatic stress subscale than the established mean ($M = 50$) published in the Concise ProQOL Manual (Stamm, 2010).

RH2: There are statistically significant differences between male and female college mental health counselors in the U.S. and their mean scores on the ProQOL subscales for compassion satisfaction, burnout, and secondary traumatic stress.

- RH3: There are statistically significant differences among U.S. college mental health counselors and their mean scores on the ProQOL subscales of compassion satisfaction, burnout, and secondary traumatic stress based on age.
- RH4: There are statistically significant differences among U.S. college mental health counselors and their mean scores on the ProQOL subscales of compassion satisfaction, burnout, and secondary traumatic stress and different levels of work experience.
- RH5: There is an interaction between the gender and age of U.S. college mental health counselors as it relates to their mean scores on the ProQOL subscales for compassion satisfaction, burnout, and secondary traumatic stress.
- RH6: There is an interaction between the gender and years of experience of U.S. college mental health counselors as it relates to their mean scores on the ProQOL subscales for compassion satisfaction, burnout, and secondary traumatic stress.
- RH7: There is an interaction between the age and years of experience of U.S. college mental health counselors as it relates to their mean scores on the ProQOL subscales for compassion satisfaction, burnout, and secondary traumatic stress.
- RH8: There is an interaction between the gender, age, and years of experience of U.S. college mental health counselors as it relates to their mean scores on the ProQOL subscales for compassion satisfaction, burnout, and secondary traumatic stress.

Participants

Mental health counselors in U.S. colleges and universities were the population of interest. More specifically, the investigator targeted mental health counselors who are employed at colleges or universities that are member institutions of the Association for University and College Counseling Center Directors (AUCCCD). The AUCCCD website identifies the association as a

nonprofit, international organization for counseling center directors with a 2018 membership of 886 universities and colleges. According to AUCCCD policy, “Membership is limited to institutions of higher education with a counseling center that provides confidential mental health counseling and developmental counseling to college students per state mental health laws and professional ethical guidelines” (Association for University and College Counseling Center Directors, 2019). AUCCCD policy further stipulates that the college or university holds the membership, and that each member institution may only designate one counseling center director as its representative member.

The rationale to limit the population to be sampled was to better ensure that participants in the study were mental health counselors providing direct counseling services to students enrolled in a college or university in the United States. Because selection of participants in the study cannot be considered random, generalization of results is limited. With a current membership of 886 institutions, the size of AUCCCD membership and its associated requirements for membership better ensured an adequate sample size representing the population of interest.

Participants in the study were (a) at least 18 years of age at the time of participation as this is the age of consent, (b) English-speaking as all materials in the study were presented in English, (c) holders of a master’s or doctoral degree and professional licensure that enables them to provide mental health counseling services as this better ensured the educational attainment background and capacity to pass a licensure exam, and (d) a provider of in-person/face-to-face counseling services (as opposed to telephonic or video mental health counseling) to students at a college or university in the United States. These requirements were meant to better ensure statistical analysis of comparable demographic data.

Sampling Procedure

The investigator employed a snowball sampling technique to recruit participants for this study. Snowball sampling is a type of convenience sample often used by researchers when trying to recruit participants who are hard to find or that have to meet certain criteria participate in a study (Cohen & Arieli, 2011). Snowball sampling is also well-suited for studies that require the assistance of “insiders” to locate study participants when the focus of study is on a sensitive issue concerning a private matter (Biernacki & Waldorf, 1981). The rationale for choosing this particular sampling procedure was guided by the opportunity to gain access to U.S. college and university mental health counselors via one convenient gateway: The Association for University and College Counseling Center Directors (AUCCCD). An email requesting participation in this study was sent to all counseling center directors on the Association for University and College Counseling Center Directors (AUCCCD) Listserv. The strategy to access mental health counselors at AUCCCD-member institutions required the assistance of the counseling center Director at my AUCCCD-member institution. This is due to the fact that only the director of an AUCCCD-member institution has access to the AUCCCD Listserv. Having access to the AUCCCD Listserv simplified the search for prospective participants of the targeted population for the study.

The email request (Appendix A) briefly described the purpose of the study, the rationale for it, and invited AUCCCD counseling center directors to have their counseling staff participate. The email request included a link to the study’s survey for directors to view and distribute. Directors were also advised that the study had IRB approval to collect all data via an anonymous survey link. Counseling center directors who agreed to allow their staff to participate in the study forwarded the data collection survey which included an informed consent document (Appendix B), a demographic questionnaire (Appendix C), and the Professional Quality of Life Scale –

Version 5 (Appendix D) to their counseling staff, giving them the opportunity to participate in the study.

Data Collection Instruments

The study utilized two instruments: a demographic questionnaire developed by the researcher (Appendix C) and The Professional Quality of Life Scale – Version 5 (ProQOL) (Stamm, 2010) (Appendix D). Qualtrics software (Version 2018) was used to create the questionnaire for collection of participant demographic data. Permission to use the ProQOL is given as such: “The ProQOL measure may be freely copied as long as (a) author is credited, (b) no changes are made other than those authorized below, and (c) it is not sold” (Stamm, 2010). The stipulation (b) allows changing of the terms [help] and [helper] on the ProQOL scale to [counsel] and [counselor]. The ProQOL was chosen for the study because it is a practical tool that measures three different constructs: compassion satisfaction, burnout, and secondary traumatic stress. The ProQOL is easy to distribute and complete, has wide-spread use in contemporary research involving the caregiving professions. The time needed for study participants to complete the demographic questionnaire and the ProQOL Scale was estimated to be 10 minutes.

Demographic Questionnaire

The demographics of age, gender, and years of work experience were collected for statistical analyses with the ProQOL. Additional information was collected along with the aforementioned: highest degree level, licensure status, type of institution employed at, approximate student enrollment at the participant’s college or university, and the average number of students a participant provides counseling services to each work day. Participants were also asked to approximate the number of students seen in the past 5 working days who reported the following serious trauma-related concerns: (a) suicide attempt, (b) suicidal ideation, (c) non-

suicidal self-injurious behavior (d) unwanted touching of a sexual nature by another, (e) rape or sexual assault (assault by forced penetration), (f) physical assault by another, (g) verbal assault by another and (h) the death of someone important to them. Finally, participants were asked whether they have ever taken time off from work for or considered quitting their job due to work-related stress. The purpose for inclusion of these additional items on the demographic questionnaire was to gain a more informed understanding of the college mental health counselor's work experience.

The Professional Quality of Life Scale

The Professional Quality of Life Scale - Version 5 (ProQOL) is a 30-item self-report measure of the positive and negative effects of working with people who have experienced trauma. The ProQOL is comprised of three subscales with 10 items designated for each of the constructs examined: compassion satisfaction, burnout, and secondary traumatic stress. For each of the 30 items, participants are instructed to assesses how frequently they have experienced symptoms in the last 30 days. The items are answered on a 5-point Likert scale: 1 = Never, 2 = Rarely, 3 = Sometimes, 4 = Often, and 5 = Very Often. Example items for each of the subscales are taken directly from the ProQOL (Stamm, 2010) to illustrate: Compassion Satisfaction subscale: "I get satisfaction from being able to counsel people." Burnout subscale: "I feel overwhelmed because my caseload seems endless." Secondary Traumatic Stress subscale: "I jump or am startled by unexpected sounds."

Likert scales are a ratings format that most people are familiar with as they are consistently used in surveys to measure things such as attitude, satisfaction, or quality. Likert scales are one of the most frequently used tools in social science and attitude research studies (Croasmun & Ostrom, 2011). The format provides a way to measure people's feelings, perceptions, and other psychological constructs quantitatively (Spector, Paul E., 1992). There has been some controversy

whether ordinal data (i.e., Never, Rarely, Sometimes, Often, and Very Often) can be treated as interval data (Allen & Seaman, 2007). However, because the ordinal variables of the ProQOL scale have defined values (i.e., 1 = Never, 2 = Rarely, 3 = Sometimes, 4 = Often, and 5 = Very Often) the ProQOL is both a categorical and a continuous rating scale since there is an underlying measurement continuum. Despite the controversy, many contend that parametric tests can be used to analyze Likert-type scale responses (Carifio & Perla, 2008; Croasmun & Ostrom, 2011; De Winter & Dodou, 2010; Gaito, 1980; Glass, Peckham, & Sanders, 1972; Lubke & Muthén, 2004; Spector, P. E., 2004; Sullivan & Artino Jr, 2013).

The Concise ProQOL Manual (Stamm, 2010) shows the average score for the Compassion Satisfaction subscale is 50, with a standard deviation of 10, and alpha scale reliability of 0.88. Approximately 25% of people score 57 or higher and approximately 25% score 44 or lower (Stamm). Higher scores suggest that the person feels a sense of satisfaction in the work they do and lower scores suggest that the person may be experiencing problems with their job (Stamm).

The Concise ProQOL Manual (Stamm, 2010) shows the average score for the Burnout subscale is 50 with a standard deviation of 10 and an alpha scale reliability of 0.75. Approximately 25% of people score 56 or higher and approximately 25% score 43 or lower (Stamm). Scores below 50 suggest minimal concern for burnout and most likely reflects a positive feeling about the ability to be effective at work (Stamm). A score of 56 or higher indicates possible feelings of ineffectiveness and suggests that the person should consider what kind of work factors might be contributing to a person's feeling that they are not effective at their job (Stamm).

The Concise ProQOL Manual (Stamm, 2010) shows the average score for the Secondary Traumatic Stress subscale is 50 with a standard deviation of 10 and an alpha scale reliability of 0.81. Approximately 25% of people score 56 or higher and approximately 25% of people score 42

or lower (Stamm). A score of 56 or higher suggests that the one should consider whether a work-related experience is generating a feeling of fear (Stamm).

Stamm (2010) reports that the construct validity of the ProQOL is supported by use of the instrument in more than 200 published papers. Geoffrion, Lamothe, Morizot, and Giguère (2019) conducted an assessment of the ProQOL using confirmatory factor analysis and bifactor modeling. Their findings support the ProQOL's convergent validity, discriminate validity, and the theoretical underpinnings of the scale. In other words, the ProQOL has good construct validity and measures what it purports to measure.

As noted above, *The Concise ProQOL Manual* (Stamm, 2010) lists alpha reliabilities for the ProQOL subscales as: compassion satisfaction ($\alpha = .88$), burnout ($\alpha = .75$), and secondary traumatic stress ($\alpha = .81$). Reliability of the ProQOL is further supported by Heritage, Rees and Hegney (2018) who found similarly good alpha scale reliabilities for the compassion satisfaction ($\alpha = .90$), burnout ($\alpha = .80$), and secondary traumatic stress ($\alpha = .84$) subscales.

The Professional Quality of Life Scale (ProQOL) is one of the most widely used measures of compassion satisfaction, burnout, and secondary traumatic stress among helping professionals (Geoffrion, Lamothe, Morizot, & Giguère, 2019; Stamm, 2010). The ProQOL has been translated to 26 languages and the ProQOL website provides a bibliography of 667 ProQOL studies across the globe (Stamm). The ProQOL is not a diagnostic test. Scores on the ProQOL provide suggestions, not medical or mental health diagnoses. As such, interpretation of ProQOL scores suggest “potential for compassion satisfaction” and “potential risk for developing burnout or secondary traumatic stress.”

List of Variables

The dependent variables of the study are participant scores on the ProQOL subscales of compassion satisfaction, burnout, and secondary traumatic stress. The independent variables for the study are gender, age, and the number of years of experience working as a mental health counselor. *The Concise ProQOL Manual* (Stamm, 2010) provides some ProQOL scoring data across several demographic categories based on a data bank of 1,289 cases from multiple studies using the ProQOL.

The mean scores on each of the three ProQOL subscales are provided across two age categories in the ProQOL manual: 18 - 35 years of age, and 36 years of age and up. For the current study, the age categories of the sample population (N = 236) were not proportional to those provided in the ProQOL manual. Based on the data collected for the study, age categories were transformed to be more representative of the sample population. For the purpose of the study, these age groupings were operationally defined as: *younger* (18 - 40 years of age) and *older* (41 years of age and up). Based on the data collected for the study, the years of experience categories provided in the ProQOL manual (less than 5 years, 5 - 15 years, greater than 15 years) were also transformed to be more representative of the sample population. For the purpose of the study, counselor's years of experience categories were operationally defined as: *less experienced* (less than 9 years), *moderately experienced* (9 - 17 years), and *highly experienced* (greater than 17 years).

Participant classifications were determined solely by the self-report of participants. All participants fell into only one of each of the three independent variable categories. The participants' reported gender identity placed them in one of two possible categories: male or female. The participants' reported age placed them in one of two possible categories: younger or

older. The participants' reported number of years of experience working as a mental health counselor placed them in one of three possible categories: less experienced, moderately experienced, or highly experienced.

Statistical Tests Used in the Study

For the statistical purposes of the study, scores for compassion satisfaction, burnout, and secondary traumatic stress were considered according to the cut scores as listed in *The Concise ProQOL Manual* (Stamm, 2010) to indicate protective factors (compassion satisfaction) or relative risk (burnout and secondary traumatic stress). The Bottom Quartile (25th Percentile) is considered low risk. The Mean (50th Percentile) is considered average or moderate risk. The Top Quartile (75th Percentile) is considered high risk (see Table 1).

Table 1
Cut Scores for the ProQOL (Reprinted from Stamm, 2010)

Quartile	CS	BO	STS
Bottom Quartile (25 th Percentile)	44	43	42
Mean (50 th Percentile)	50	50	50
Top Quartile (75 th Percentile)	57	56	56

Note. CS = Compassion Satisfaction, BO = Burnout, STS = Secondary Traumatic Stress.

For RQ1, there are three sub-hypotheses which were examined via one-sample *t*-tests. The rationale for the following hypotheses were based on the previously cited research studies using the ProQOL and the literature review regarding the current mental health crisis at U.S. colleges and universities. For RH1a, assumptions for the *t*-test were examined as it was hypothesized that U.S. college mental health counselors would indicate a statistically significant higher mean score on the compassion satisfaction subscale than the established mean (M = 50) published in *The*

Concise ProQOL Manual (Stamm, 2010). For RH1b, assumptions for the *t*-test were examined as it was hypothesized that U.S. college mental health counselors would indicate a statistically significant higher mean score on the burnout subscale than the established mean ($M = 50$) published in *The Concise ProQOL Manual* (Stamm, 2010). For RH1c, assumptions for the *t*-test were examined as it was hypothesized that U.S. college mental health counselors would indicate a statistically significant higher mean score on the secondary traumatic stress subscale than the established mean ($M = 50$) published in *The Concise ProQOL Manual* (Stamm, 2010).

Some helping professionals who work with those who have been traumatized develop psychological problems due to secondary exposure to trauma, but this occurrence is somewhat rare (Stamm, 2010). Furthermore, some of the previously discussed research studies in which participants indicated high risk for secondary traumatic stress involved specialized trauma therapists (Sodeke-Gregson et al., 2013), child welfare workers (Van Hook & Rothenberg, 2009), and child protective services workers (Conrad & Kellar-Guenther, 2006). These helping professionals work with specific groups of clients involving specific stress-inducing circumstances for both the client and the helping professional. For example, specialized trauma therapists work with those who have had horrific or terrifying experiences such as combat veterans or victims of natural disasters. This type of specialized trauma work involves constant exposure to client pain and suffering on a continuous basis. Those who work with traumatized children must contend with the challenge of helping and protecting the defenseless while maintaining the professionalism to do their work efficiently and effectively. College mental health counselors also work with students who have been traumatized. Although the nature of their work does not have the built-in guarantee that all of the clients they work with have been traumatized in some way, they are exposed to student reports of trauma more frequently as greater numbers of students come to campus

counseling centers with severe mental health problems. It is therefore hypothesized that college mental health counselors exhibit scores on the secondary traumatic stress subscale that are higher than the established mean.

The study utilized multivariate analysis of variance (MANOVA) as the statistical treatment of choice for research questions RQ2 to RQ8. MANOVA provides a single, overall statistical test to investigate for possible relationships and interactions between three dependent variables (ProQOL scores on compassion satisfaction, burnout, and secondary traumatic stress subscales) and several independent variables (gender, age groups, and of years of experience) instead of performing multiple individual statistical tests.

Perhaps more importantly, the use of MANOVA is an efficient way to examine whether or not independent variables relate to patterns of response on the dependent variables (Carey, 1998). For example, MANOVA can easily indicate whether there is a statistically significant difference among ProQOL scores for compassion satisfaction, burnout, and secondary traumatic stress between participants based on gender, age, and years of experience. This example represents a (2 x 2 x 3) factorial design with gender (male or female) as one factor, age (younger or older) as the second factor and years of experience (less experienced, moderately experienced, and highly experienced) as the third factor. Scores on the compassion satisfaction, burnout, and secondary traumatic stress subscales represent the three outcome measures. Before these analyses were performed, the statistical assumptions associated with the use of MANOVA were tested (i.e. multivariate normality, linearity among dependent variables, and homogeneity of variance-covariance matrices). If a statistical significance was detected at this stage, then univariate F-test followed. For the three levels of years of experience variable, a Tukey's test for multiple comparisons was performed.

Timeframe for the Study

A request for participation in the study was sent to counseling center directors on the Association for University and College Counseling Center Directors Listserv. Data collection for the study began on October 1, 2018 and ended on October 31, 2018. Follow-up email reminders asking directors to allow their counseling staff to participate in the study were sent on Monday of each week during the month of October. It was impossible to anticipate whether potential participants for the study were employed at colleges and universities that operate on a quarter system or a semester system. The month of October overlaps and covers both academic calendars. It was preferable to conduct data collection during a month that coincided with the spring or fall semester calendar as college enrollments drop during the summer months at many colleges and universities in the United States.

Summary

The purpose of the study was to examine the professional quality of life among college mental health counselors in the United States. The investigator employed an ex post facto, quasi-experimental research design to investigate possible relationships between mental health counselor's reported levels of compassion satisfaction, burnout, and secondary traumatic stress and counselor demographics of gender, age, and years of counseling experience. This investigator sought a deeper understanding of the positive and negative aspects of the college mental health counselor's work experience by investigating 8 research questions to gain further insight. A review of research studies using the ProQOL suggested that several hypotheses were warranted.

The population of interest was college mental health counselors whose college or university is a member of the Association for University and College Counseling Center Directors (AUCCCD). The investigator employed a snowball sampling technique as an e-mail invitation to

participate in this study was sent to directors on the AUCCCD Listserv. The invitation also included a study packet comprised of an informed consent document, a demographic questionnaire, and the Professional Quality of Life Scale – Version 5. If the director agreed to allow their counseling staff to participate, the director forwarded the study packet to their counseling staff. The ProQOL Scale – Version 5 is a 30-item self-report survey that measures the positive and negative effects of working with those who have experienced trauma and produces scores on subscales for compassion satisfaction, burnout, and secondary traumatic stress. The total estimated time to complete data collection instruments was 10 minutes. The study packet included a direct email link to this investigator for data submission. The investigator gathered submitted data for statistical analysis and interpretation. The next chapter discusses the results of the study.

CHAPTER 4: RESULTS OF THE STUDY

The purpose of the study was to examine the professional quality of life among U.S. college mental health counselors and investigate possible relationships between their reported levels of compassion satisfaction, burnout, and secondary traumatic stress and the demographics of gender, age, and years of work experience. A descriptive research design was used to learn more about college mental health counselors via anonymous survey responses. The final sample size consisted of 236 mental health counselors employed at colleges and universities in the United States.

Participants in the study completed an online survey which consisted of a demographic questionnaire and the Professional Quality of Life Scale – Version 5 (ProQOL). The ProQOL is a 30-item, self-report instrument which measures the positive and negative effects of helping others who have been traumatized. The ProQOL has three subscales that measure separate and distinctly different constructs: compassion satisfaction, burnout, and secondary traumatic stress. Counselors' scores on the ProQOL subscales are the dependent variables in the study. Counselor demographics of gender, age, and years of work experience are the independent variables in the study. The ProQOL has good construct validity (Stamm, 2010) and alpha scale reliability (Heritage, Rees, & Hegney, 2018). There were 236 usable survey responses submitted online via an anonymous link to the researcher.

Profile of Participants

At the time of participation, all participants in the study were mental health counselors at least 18 years of age, held a master's or a doctorate, and were licensed to provide mental health counseling services. Additionally, all participants in the study were employed at a college or university in the United States whose institution is a member of the Association for University and College Counseling Center Directors.

Among the 236 participants, 81% (N = 190) identified as female and 19% (N = 46) as male. Participants ranged in age from 25 to 76 years old ($M = 43.39$, $SD = 10.84$). See Figure 3 for a complete age distribution of the sample population. The participant's level of education was nearly evenly divided with 47% (N = 110) having earned a master's degree, and 53% (N = 126) having earned a doctorate. Participants in the study represent a broad range of experience providing mental health counseling services ($M = 14.47$, $SD = 9.42$). Figure 4 shows the number of years of counseling experience reported by all participants. The minimum of 1 year of experience represented 2% of the sample (N = 5) and the maximum of 50 years of experience represented .4% of the sample (N = 1). The most frequently reported was 10 years of experience and represented 10% of the sample population (N = 24). See Table 2 for counselor demographics of gender, age and years of experience; these are the independent variables of the study.

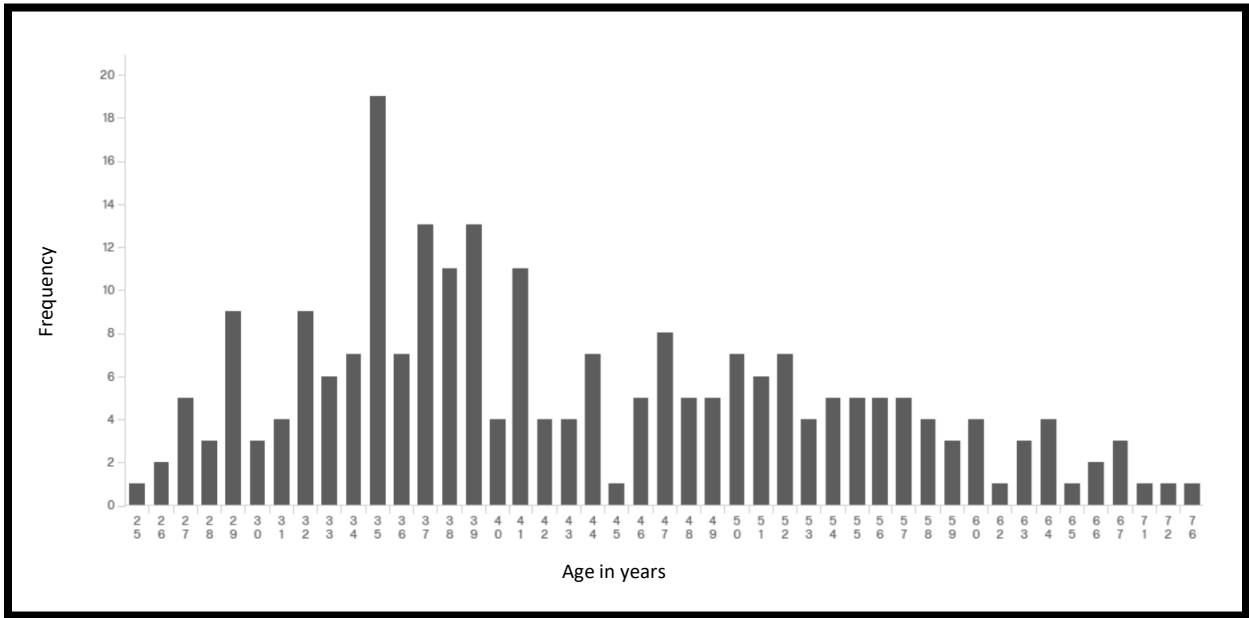


Figure 3. Age distribution of participants

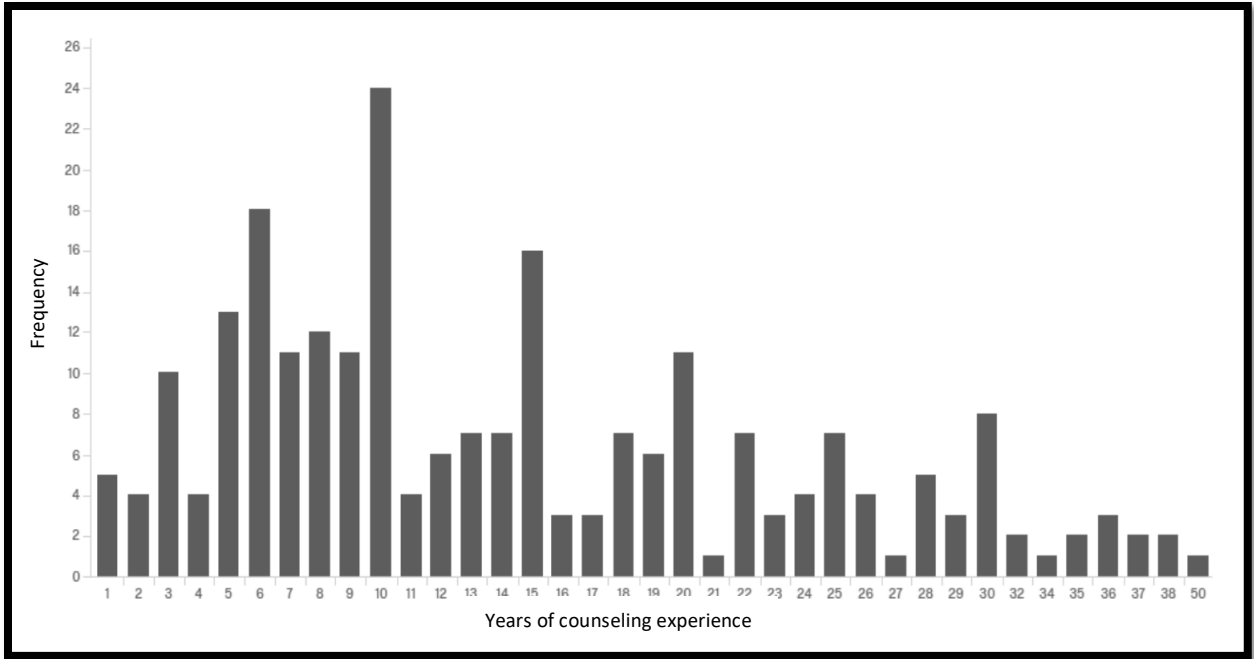


Figure 4. Years of counseling experience distribution of participants

Table 2

Counselor Demographics

Independent Variables	<u>N</u>	<u>%</u>	<u>M</u>	<u>SD</u>
Gender				
Female	190	81		
Male	46	19		
Total	236	100		
Age				
Younger (18 – 40)	114	48		
Older (41 or more)	122	52		
Age total	236	100	43.39	10.84

Years of Experience

Less Experienced (1 - 8)	76	32		
Moderately Experienced (9 - 17)	80	34		
Highly Experienced (18 or more)	80	34		
Years of Experience total	236	100	14.47	9.42

N = 236

Half of all participants in the study (N = 119) reported being employed at a 4-year public university. See Table 3 below for a summary of participants' reported institution types and respective representation in the study. Participants reported a wide range of campus enrollments at these types of institutions from a low of 200 to a high of 65,000. The highest percentage of participants in the study, 5%, reported their campus enrollment to be 2,000. See Figure 5 below for the visual representation of campus enrollments reported by participants.

Table 3

Type of Institution Where Participant is Employed

Institution Type	N	% of sample population
Community college	4	2
4-year public college	19	8
4-year public university	119	50
4-year private college	51	22
4-year private university	40	17
Other	3	1

N = 236

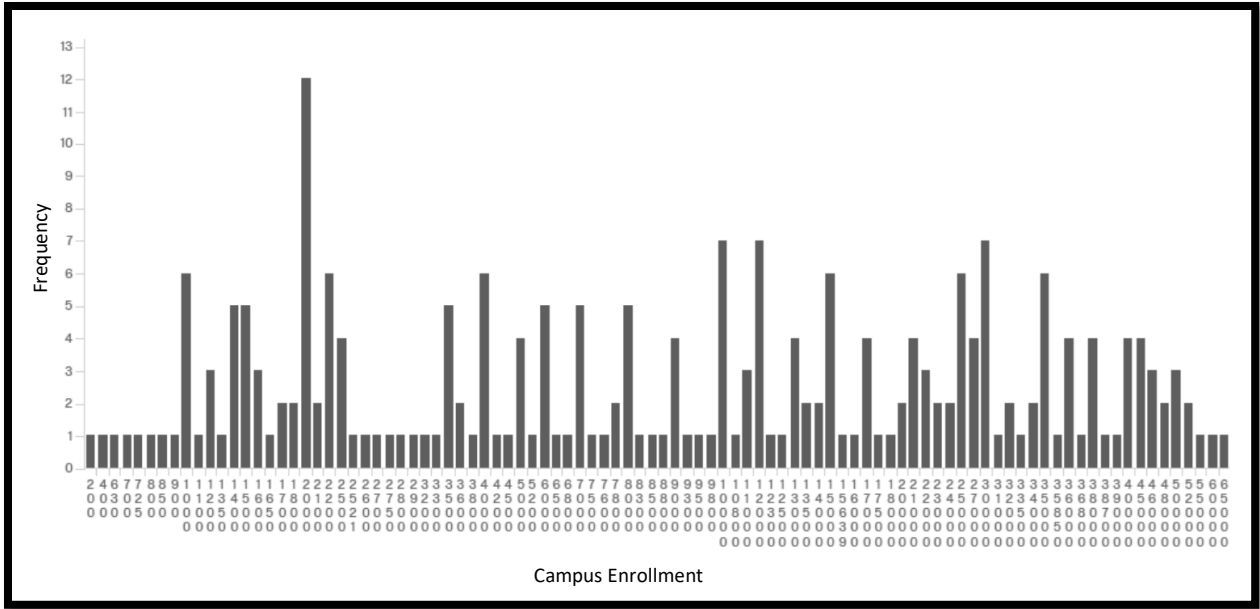


Figure 5. Reported campus enrollments

Participants were asked to quantify the average number of students they provide face-to-face counseling services to each work day. Reported numbers ($M = 5.31$, $SD = 2.98$) ranged from seeing as few as 1 student a day to a maximum of 20 students a day. Figure 6 shows that 16.8% reported seeing 4 students each work day, 17.2% reported seeing 6 students, and the majority of participants (32.8%) reported seeing 5 students each work day.

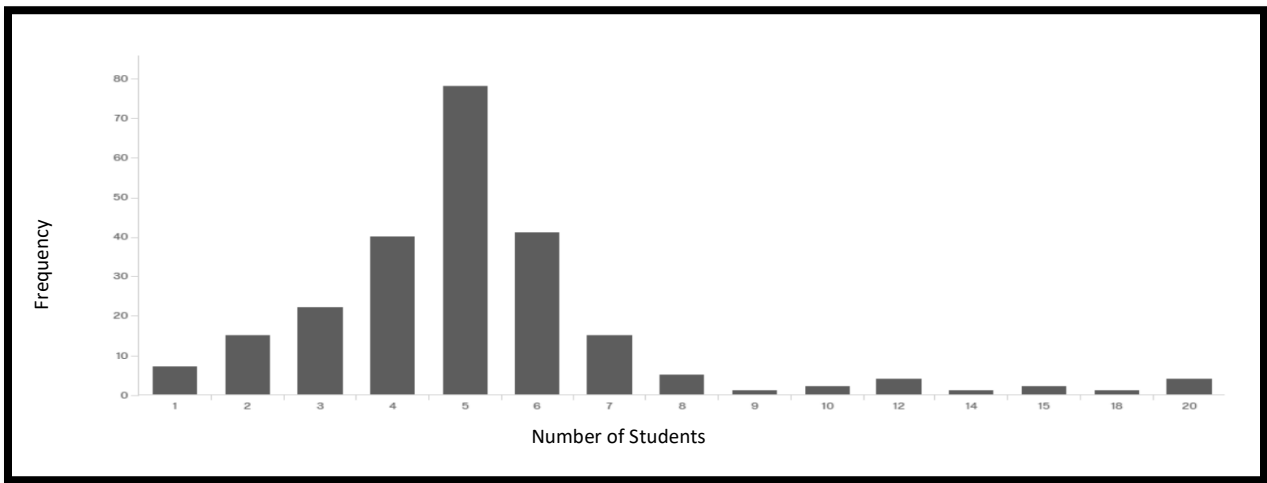


Figure 6. Average number of students participants counsel each work day

Study participants were asked to consider the past five working days and estimate the number of students they counseled who reported trauma-related experiences such as suicidal ideation or attempt, self-injury, sexual/verbal/physical assault, or the death of someone they knew. Student reports of trauma are factors that can contribute to occupational burnout and secondary traumatic stress reactions for mental health counselors. Participant recollections of the past five working days are a reasonable span of time for one to consider as shorter recall periods make it less likely that one will forget to report a salient event (Kjellsson, Clarke, & Gerdtham, 2014). Errors in memory recall increase with the length of the recall period and often result in forgetting or under-reporting salient events (Bhandari & Wagner, 2006).

Table 4 shows that, in their past five working days, 64% of the participants (N = 151) counseled at least 1 and as many as 5 students who reported a suicide attempt; 2% (N = 5) counseled at least 6 and as many as 10 students who reported a suicide attempt. Student reports of suicidal ideation were prevalent as 98% of all participants (N = 231) counseled at least one student who reported experiencing suicidal ideation. Nearly half (49%) of the participants counseled at least 1 and as many as 5 students who reported suicidal ideation; 39% counseled between 6 and 10 students; 8% between 11 and 15 students and 2% of the participants counseled 16 or more students with suicidal ideations in the past five working days. Only 2% of the total number of participants (N = 5) reported that none of the students they counseled in the past five working days reported suicidal ideation. Reports of nonsuicidal self-injury, such as cutting or burning, were also notable: 77% of the participants (N = 181) counseled between 1 and 5 students who reported having engaged in these types of behaviors.

There were numerous student accounts of sexual trauma as 66% of participants (N = 164) provided counseling services for at least 1 and as many as 5 students who reported that they had

been the victim of a rape or sexual assault (anal, oral, or vaginal penetration by force); 5% (N = 13) reported counseling between 6 and 10 students; and 2% (N = 5) reported counseling between 11 and 15 students. In addition, 61% of participants (N = 143) counseled between 1 and 5 students who had experienced unwanted touching of a sexual nature by another.

Study participants provided services to at least 1 and as many as 5 students who reported the following: 43% of the participants (N = 102) counseled students who reported having been physically assaulted by another; 58% of participants (N = 137) counseled students who reported having been verbally assaulted by another; and 73% of participants (N = 171) counseled students who reported the death of someone they knew.

Table 4

Number of Students Counseled in the Past Five Days Who Reported Trauma-related Experience

Trauma-related experience	None	1 – 5	6 – 10	11 – 15	16 +
Suicide attempt	34% (80)	64% (151)	2% (5)	0% (0)	0% (0)
Suicidal ideation	2% (5)	49% (115)	39% (91)	8% (20)	2% (5)
Nonsuicidal, self-injury	9% (21)	77% (181)	14% (32)	0% (1)	0% (1)
Unwanted touching	21% (49)	61% (143)	15% (35)	3% (7)	0% (2)
Rape/Sexual assault	27% (64)	66% (154)	5% (13)	2% (5)	0% (0)
Physical assault	55% (129)	43% (102)	2% (5)	0% (0)	0% (0)
Verbal assault	22% (52)	58% (137)	15% (35)	4% (10)	1% (2)
Death of Someone	17% (40)	73% (171)	9% (22)	1% (3)	0% (0)

N = 236

Finally, participants were asked two questions that were worded in as straightforward a manner as possible to better ensure that they would not be misunderstood or misinterpreted:

1. *Has work-related stress ever resulted in taking time off for personal mental health reasons (to include calling in sick as a "mental health day")?*

Among all participants, 61% (N = 143) responded "Yes" and 39% (N = 93) responded "No."

2. *Have you ever considered quitting your job as a mental health counselor due to work-related stress?*

Among all participants, 64% (N = 151) responded "Yes" and 36% (N = 85) responded "No."

Data Screening

Participants for the study were recruited via email invitation sent to all counseling centers on the Association for University and College Counseling Center Directors (AUCCCD) Listserv. The online survey was generated by the researcher using the Qualtrics software (Qualtrics, Version October, 2018). There were 236 usable questionnaires collected between October 1st, 2018 and October 31, 2018. There was no missing data as the survey was built to force a response to each inquiry. Data from incomplete surveys was neither collected nor counted in the sample population.

Initial inspection of the data revealed that 250 college mental health counselors accessed the survey. However, 12 of the 250 counselors indicated that they did not meet the criteria for participation in the study and the number of participants in the sample population was reduced to 238. Next, an examination of data anomalies among the descriptive statistics and frequency distributions of the 238 participants was conducted using the Explore function in IBM SPSS (Version 25). Finally, the Mahalanobis distance statistic was used to identify multivariate outliers (Kline, 2015). There were outliers found across two of the dependent variables with a maximum Mahalanobis distance larger than the critical value of 12.193 ($df = 3$). These two cases were

removed from the data set which eliminated all outliers and reduced the total number of participants in the study to 236.

An a priori examination of the needed statistical power was performed using GPower, a software program that performs statistical power analyses for the most common statistical tests in behavioral research (Faul, Erdfelder, Lang, & Buchner, 2007). Determination of adequate sample size was conducted with the following guidelines: a small effect ($p = .05$) size, three outcome variables (ProQOL subscales), three independent factors with interactions, and a power probability of 0.95. Results indicated that a minimum sample size of 198 was required to meet these guidelines.

Statistical Analyses

One sample univariate *t*-tests were conducted to examine whether there were statistically significant differences between the ProQOL scores of college mental health counselors and the established norms published in the *Concise ProQOL Manual* (Stamm, 2010). Multivariate analysis of variance (MANOVA) was performed to examine for effects and interactions between and among the categorical variables. MANOVA is an efficient way to examine whether or not independent variables relate to patterns of response on the dependent variables (Carey, 1998).

Statistical Assumptions

1. MANOVA assumes that the independent variables are categorical and the dependent variables are measured on a continuous scale. These assumptions were met. The three independent variables are categorical with two or more groups for each (gender: male/female; age: younger/older; years of experience: less experienced, moderately experienced, highly experienced). The dependent variables are taken from the ProQOL and

measured as interval variables on a continuous scale. The ProQOL is a continuous rating scale since there is an underlying measurement continuum.

2. The assumption of independence of observations was met as each participant fell into only one of each of the three categories with no participant being in more than one group of each category. In the study, participants self-identified as male or female. Counselors' reported age and years of experience were considered independent, categorical variables. The participant's age placed them in one of two possible categories: (a) younger or (b) older. The number of years of experience working as a mental health counselor placed them in one of three possible categories: (a) less experienced, (b) moderately experienced, or (c) highly experienced. Participant classifications were determined by the self-report of participants. Categories for age and years of work experience variables were guided by the classifications provided in the *Concise ProQOL Manual* (Stamm, 2010). See Chapter 3 of the study for full description of how these categories were operationally defined.
3. The absence of multicollinearity assumption is met. Prior to conducting MANOVA, Pearson correlations were performed between all of the dependent variables to test the MANOVA assumption that the dependent variables would be correlated with each other in the moderate range (Meyers, Gamst, & Guarino, 2006). Table 5 shows that the values for all of the dependent variables in the study are below $r = .90$, which indicates that there are no relationships between them that are too strongly correlated (Tabachnick, Fidell, & Ullman, 2007). Table 6 shows the values for the independent variables in the study are also below $r = .90$.

Table 5

Correlation Matrix for the Dependent Variables

	CS	BO	STS	M	SD
CS	1			50.18	9.77
BO	-.65	1		49.82	9.85
STS	-.37	.60	1	49.74	9.64

N = 236; CS = Compassion Satisfaction, BO = Burnout, STS = Secondary Traumatic Stress

Table 6

Correlation Matrix for the Independent Variables

	Gender	Age	Years of Experience
Gender	1		
Age	.16	1	
Years of Experience	.13	.69	1

N = 236

Additional Pearson correlations were performed to test for presence of multicollinearity between each of the dependent variables and the independent variables. A review of Tables 7, 8, and 9 shows an absence of multicollinearity as all correlations across the dependent variables are below $r = .90$. The value inflation factor (VIF) indicates the degree to which the standard errors are inflated due to the levels of collinearity. The more the VIF increases, the less reliable the regression results are. In general, the rule is that a VIF greater than 10 indicates high correlation (Belsley, Kuh, & Welsch, 1980) and cause for concern. Some researchers have suggested that a more conservative level of 2.5 or above is appropriate (Allison, 2012). For this study, each of the independent variables had a VIF (gender = 1.03,

age = 1.91, years of experience = 1.90) lower than both of the recommended indicator values for multicollinearity.

Table 7

Correlation Matrix for Compassion Satisfaction and the Independent Variables

	CS	Gender	Age	YoE	M	SD	VIF
CS	1				50.18	9.78	
Gender	.01	1					1.03
Age	.14	.16	1				1.91
YoE	.12	.13	.69	1			1.90

N = 236; CS = compassion satisfaction; YoE = years of experience

Table 8

Correlation Matrix for Burnout and the Independent Variables

	BO	Gender	Age	YoE	M	SD	VIF
BO	1				49.82	9.85	
Gender	.02	1					1.03
Age	-.02	.16	1				1.91
YoE	.04	.13	.69	1			1.90

N = 236; BO = burnout; YoE = years of experience

Table 9

Correlation Matrix for Secondary Traumatic Stress and the Independent Variables

	STS	Gender	Age	YoE	M	SD	VIF
STS	1				49.74	9.64	
Gender	-.12	1					1.03
Age	-.04	.16	1				1.91

Jarque-Bera omnibus test of normality (Jarque & Bera, 1987) indicates that all of the dependent variables meet the normality assumption at the univariate level: compassion satisfaction ($p = .0857$), burnout ($p = .2788$) and secondary traumatic stress ($p = .0454$). The assumption of multivariate normality of the dependent variables is met as indicated by results of Srivastava's tests (Srivastava, 1984) of multivariate skew (4.9853, $df = 3.0$, p -value = .1729) and multivariate kurtosis (2.9376, -.3388, p -value = .7348).

5. There is homogeneity of variance-covariance matrices. Box's M tests the null hypothesis that the observed covariance matrices of the dependent variables are equal across groups. The Box's M value of 44.246 was associated with a p value of .843, which is interpreted as non-significant based on the guideline of $p = .005$ (Huberty & Petoskey, 2000). Therefore, the covariance matrices across the groups were assumed to be equal for the purposes of the MANOVA. In addition, follow-up univariate tests met the homogeneity of variances assumption. The Levene's test of equality of error variances yielded non-significant p values at the univariate level: compassion satisfaction $F(9, 225) = 1.13$, $p = 0.34$), burnout $F(9, 225) = 1.22$, $p = 0.28$), and secondary traumatic stress $F(9, 225) = 1.19$, $p = 0.30$). Therefore, equal variance across groups is assumed.
6. The linearity assumption is met. Examination of the scatterplots for all of the dependent variables (ProQOL subscales: compassion satisfaction, burnout, and secondary traumatic stress) yielded very clearly delineated linear patterns. See Figure 7 for scatterplots.

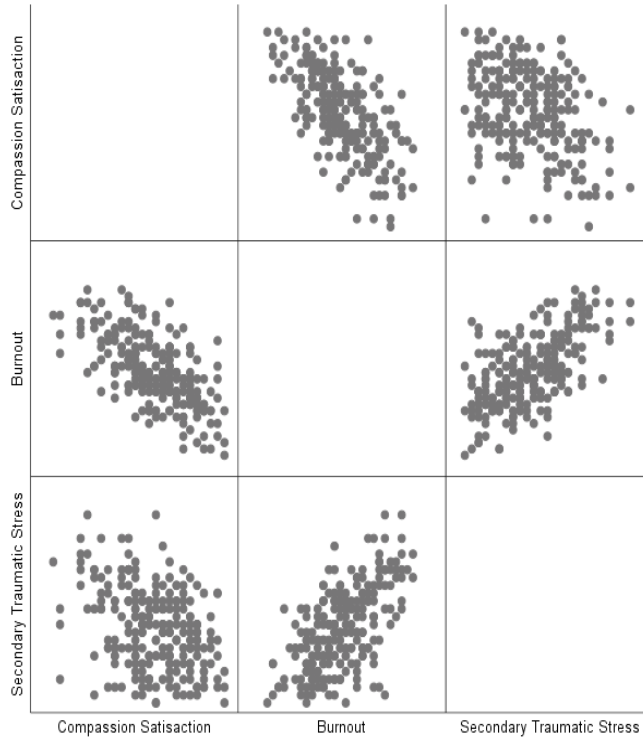


Figure 7. Linearity among dependent variables (Scatterplot)

Results of Research Hypotheses

For the first research question, one-sample univariate *t*-tests were conducted to determine whether there were any statistically significant differences between college mental health counselors' mean scores on each of the ProQOL subscales (compassion satisfaction, burnout, and secondary traumatic stress) and the corresponding, established means found in the ProQOL manual. According to *The Concise ProQOL Manual* (Stamm, 2010), the mean scores and standard deviations for all three ProQOL subscales (compassion satisfaction, burnout, secondary traumatic stress) are the same ($M = 50$, $SD = 10$). The mean scores and standard deviations of the sample population were examined against the ProQOL norms at the 0.05 level of significance.

RQ1: *Do U.S. college mental health counselors exhibit statistically significant differences in their mean scores on the ProQOL subscales for compassion satisfaction, burnout, and secondary traumatic stress from the established means (M = 50) published in The Concise ProQOL Manual (Stamm, 2010)?*

RH1: It was hypothesized that counselors would exhibit statistically significant differences in their mean scores on the ProQOL subscales for compassion satisfaction, burnout, and secondary traumatic stress from the established means (M = 50) published in *The Concise ProQOL Manual* (Stamm, 2010). Results of analysis found no statistically significant differences between counselors' mean scores and the established ProQOL means. See sub-hypotheses RH1a, RH1b, and RH1c for results of statistical tests for each of the ProQOL subscales.

RH1a: It was hypothesized that counselors would exhibit a statistically significant higher mean score on the compassion satisfaction subscale than the established mean (M = 50). However, analysis found no statistically significant difference between counselors' mean score on the compassion satisfaction subscale and the established ProQOL mean: (one-sample $t_{(235)} = 1.7, p > .05$).

RH1b: It was hypothesized that counselors would exhibit a statistically significant higher mean score on the burnout subscale than the established mean (M = 50). However, analysis found no statistically significant difference between counselors' mean score on the burnout subscale and the established ProQOL mean: (one-sample $t_{(235)} = .91, p > .05$).

RH1c: It was hypothesized that counselors would exhibit a statistically significant higher mean score on the secondary traumatic stress subscale than the established mean (M = 50). Result of statistical analysis found no statistically significant difference between counselors' mean

score on the secondary traumatic stress subscale and the established ProQOL mean: (one-sample $t_{(237)} = -1.68, p > .05$).

See Table 11 below for a listing of the established means and standard deviations for the compassion satisfaction, burnout, and secondary traumatic stress subscales published in *The Concise ProQOL Manual* (Stamm, 2010). U.S. college mental health counselors' mean scores and standard deviations for each of the subscales are also presented to illustrate that there were no statistically significant differences exhibited between counselors' mean scores and the established means of the instrument.

Table 11

Comparison of Mean Scores on the ProQOL CS, BO, and STS Subscales

	ProQOL CS	ProQOL BO	ProQOL STS	Counselor CS	Counselor BO	Counselor STS
N	1187	1187	1187	236	236	236
M	50	50	50	50.18	49.82	49.74
SD	10	10	10	9.78	9.85	9.64

CS = compassion satisfaction; BO = burnout; STS = secondary traumatic stress

For research questions 2 - 8, multivariate analysis of variance (MANOVA) was the statistical procedure used to investigate possible relationships between the three dependent variables (counselor's ProQOL scores on the compassion satisfaction, burnout, and secondary traumatic stress subscales) and the three independent variables in a 2 x 2 x 3 factorial design: counselor's gender (male or female), age (younger or older), and of years of experience (less experienced, moderately experienced, and highly experienced).

Research questions 2, 3, and 4 were focused on the main effects of the categorical variables by examining whether counselor's ProQOL scores showed statistically significant differences

between gender groups, between age groups, or between years of experience groups. Analyses for question 2, 3, and 4 were computed using the MANOVA procedure in IBM SPSS Version 25 with $\alpha = .05$.

Research questions 5, 6, and 7 were investigations of possible interaction effects among the categorical variables by examining whether there were significant differences in counselor's ProQOL scores based on the grouping of these variables: gender by age, gender by years of experience, and age by years of experience. Research question 8 was focused on possible interaction effects by examining whether there were significant differences in counselor's ProQOL scores when all categorial variable groups were considered together: gender by age by years of experience. Analyses for questions 5 - 8 were computed using the MANOVA procedure in IBM SPSS Version 25 with $\alpha = .05$.

RQ2: *Do male and female college mental health counselors in the U.S. exhibit statistically significant differences in their scores on the ProQOL subscales for compassion satisfaction, burnout, and secondary traumatic stress?*

RH2: For the second research question, it was hypothesized that there would be statistically significant differences between male and female counselors and their mean scores on the ProQOL subscales for compassion satisfaction, burnout and secondary traumatic stress. Results from a multivariate analysis of variance across the three dependent variables found no statistically significant differences between male and female college mental health counselors and their scores on the ProQOL subscales for compassion satisfaction, burnout, and secondary traumatic stress: $F(3, 232) = 2.381, p = .070$. Mean scores on the ProQOL subscales between gender groups are shown in Table 12.

Table 12

Mean Scores on the ProQOL Subscales Between Gender Groups

Dependent Variable	M	SD
Compassion Satisfaction Subscale		
Female	50.12	9.88
Male	50.41	9.43
Burnout Subscale		
Female	49.71	9.84
Male	50.29	10.01
Secondary Traumatic Stress Subscale		
Female	50.30	9.55
Male	47.43	9.79

Female (N = 190); Male (N = 46)

RQ3: *Do U.S. college mental health counselors exhibit statistically significant differences in their scores on the ProQOL subscales of compassion satisfaction, burnout, and secondary traumatic stress based on age?*

RH3: For the third research question, it was hypothesized that counselors' mean scores on the ProQOL subscales would exhibit statistically significant differences between age categories. In Table 13, counselor's mean scores on the ProQOL subscales are presented according to age categories. Examination of MANOVA results found no statistically significant differences among counselors' mean scores on the ProQOL subscales of compassion satisfaction, burnout, and secondary traumatic stress based on age: $F(3, 232) = 2.413, p = .067$.

Table 13

Mean Scores on the ProQOL Subscales Between Age Categories

Dependent Variable	M	SD
Compassion Satisfaction Subscale		
Younger (18 – 40)	48.78	10.02
Older (41 and up)	51.49	9.39
Burnout Subscale		
Younger (18 – 40)	49.99	9.85
Older (41 and up)	49.66	9.89
Secondary Traumatic Stress Subscale		
Younger (18 – 40)	50.12	10.15
Older (41 and up)	49.39	9.17

Younger (N = 114); Older = (N = 122)

RQ4: *Do U.S. college mental health counselors exhibit statistically significant differences in their scores on the ProQOL subscales of compassion satisfaction, burnout, and secondary traumatic stress and different levels of work experience?*

RH4: For the fourth research question, it was hypothesized that counselor’s mean scores on the ProQOL subscales would exhibit statistically significant differences across levels of work experience. A review of MANOVA results found no statistically significant differences among counselors’ mean scores on the ProQOL subscales of compassion satisfaction, burnout, and secondary traumatic stress based on years of work experience: $F(6, 462) = 2.161, p = .046$. Scores on the ProQOL subscales across the three years of experience groupings are depicted below in Table 14.

Table 14

Mean Scores on the ProQOL Subscales Across Years of Experience Groups

Dependent Variable	M	SD
Compassion Satisfaction Subscale		
Less Experienced (1-8 years)	49.25	10.19
Moderately Experienced (9-17 years)	49.14	9.50
Highly Experienced (18 or more years)	52.10	9.48
Burnout Subscale		
Less Experienced (1-8 years)	49.06	9.68
Moderately Experienced (9-17 years)	50.32	10.25
Highly Experienced (18 or more years)	50.05	9.69
Secondary Traumatic Stress Subscale		
Less Experienced (1-8 years)	49.98	9.35
Moderately Experienced (9-17 years)	50.36	10.18
Highly Experienced (18 or more years)	48.91	9.43

Less Experienced (N = 76); Moderately Experienced (N = 80); Highly Experienced (N= 80)

RQ5: *Is there an interaction between the gender and age of U.S. college mental health counselors as it relates to their scores on the ProQOL subscales of compassion satisfaction, burnout, and secondary traumatic stress?*

RH5: For the fifth research question, it was hypothesized that there is an interaction between gender and age that, when considered together, has an effect on counselor’s mean ProQOL scores. A three-way MANOVA found no statistically significant interaction between gender and age of U.S. college mental health counselors as it relates to their scores on the

ProQOL subscales for compassion satisfaction, burnout, and secondary traumatic stress: $F(3, 223) = 1.698, p = .168$.

RQ6: *Is there an interaction between the gender and years of experience of U.S. college mental health counselors as it relates to their scores on the ProQOL subscales of compassion satisfaction, burnout, and secondary traumatic stress?*

RH6: For the sixth research question, it was hypothesized that there is an interaction between counselors' gender and years of experience that has a statistically significant effect on their mean ProQOL scores. As was hypothesized, there is an interaction between counselors' gender and years of experience as it relates to their mean scores on the ProQOL subscales. A three-way MANOVA was conducted and the result was significant: $F(6, 456) = 2.237, p = .039$; Wilks' $\Lambda = .944$. The finding indicates that the statistically significant difference in ProQOL scores is a composite result of counselor's gender and years of experience. This means that years of experience has an effect on ProQOL scores that differ between male and female counselors. Post-hoc tests were conducted in an effort to determine where the statistically significant differences lie (i.e., which specific independent variable level significantly differs from another). A Tukey HSD test for multiple comparisons on the years of work experience groups was done and results were found to be non-significant ($\alpha = .05$) for the compassion satisfaction ($p = .142$), burnout ($p = .709$), and secondary traumatic stress ($p = .607$) subscales.

A subsequent examination of the descriptive statistics of counselors' mean ProQOL scores across gender and years of experience groups, as seen below in Table 15, reveals that there is an interaction that accounts for a statistically significant difference in scores on the secondary traumatic stress subscale. Less experienced (< than 9 years) female

counselors scored higher (51.36) on the secondary traumatic stress subscale than less experienced (< than 9 years) male counselors (42.61).

Table 15

Mean Scores on the ProQOL Subscales Across Gender and Years of Experience Groups

Dependent Variable		M	SD	N
Compassion Satisfaction Subscale				
Female	Less Experienced (< 9 years)	49.48	10.50	64
	Moderately Experienced (9 -17 years)	49.36	9.67	69
	Highly Experienced (> 17 years)	51.77	9.38	57
Male	Less Experienced (< 9 years)	48.02	8.65	12
	Moderately Experienced (9 -17 years)	47.77	8.65	11
	Highly Experienced (> 17 years)	52.92	9.86	23
Burnout Subscale				
Female	Less Experienced (< 9 years)	48.78	9.70	64
	Moderately Experienced (9 -17 years)	50.36	10.30	69
	Highly Experienced (> 17 years)	49.96	9.49	57
Male	Less Experienced (< 9 years)	50.59	9.77	12
	Moderately Experienced (9 -17 years)	50.05	10.40	11
	Highly Experienced (> 17 years)	50.26	10.40	23
Secondary Traumatic Stress Subscale				
Female	Less Experienced (< 9 years)	51.36	8.75	64
	Moderately Experienced (9 -17 years)	50.67	10.53	69
	Highly Experienced (> 17 years)	48.68	9.11	57

Male	Less Experienced (< 9 years)	42.61	9.35	12
	Moderately Experienced (9 -17 years)	48.41	7.74	11
	Highly Experienced (> 17 years)	49.47	10.37	23

The profile plot depicted below in Figure 8 illustrates the difference in estimated marginal means on the ProQOL secondary traumatic stress subscale between the counselor gender and years of experience groups.

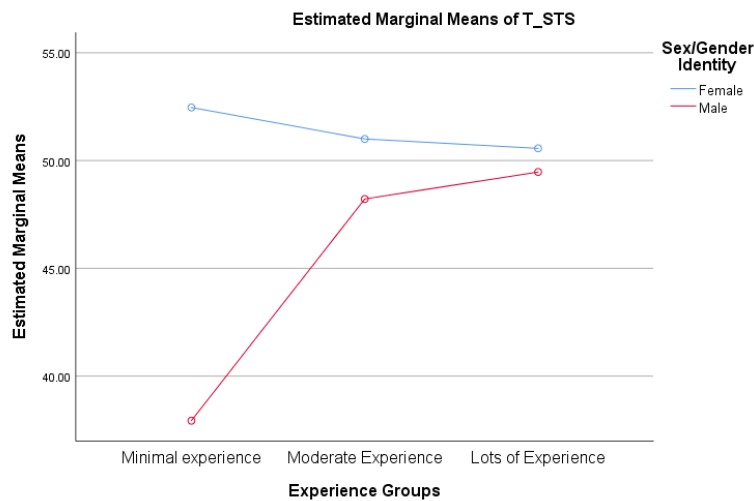


Figure 8. Estimated marginal mean differences in ProQOL scores between gender and years of experience groups on the Secondary Traumatic Stress subscale (Profile plot)

RQ7: *Is there an interaction between the age and years of experience of U.S. college mental health counselors as it relates to their scores on the ProQOL subscales of compassion satisfaction, burnout, and secondary traumatic stress?*

RH7: For the seventh research question, it was hypothesized that there is an interaction between counselors' age and years of experience that has an effect on their ProQOL scores. A three-way MANOVA found no statistically significant interactions between counselors' age and years of experience groups as it relates to their scores on the ProQOL subscales for

compassion satisfaction, burnout, and secondary traumatic stress: $F(6, 446) = .236, p = .965$.

RQ8: *Is there an interaction between the gender, age, and years of experience of U.S. college mental health counselors as it relates to their scores on the ProQOL subscales of compassion satisfaction, burnout, and secondary traumatic stress?*

RH8: For the eighth research question, it was hypothesized that there is an interaction among counselors' gender, age and years of experience that has a statistically significant effect on their ProQOL scores when considered together. A multivariate analysis of variance found no statistically significant interaction between gender, age, and years of experience groups among U.S. college mental health counselors as it relates to their scores on the ProQOL subscales for compassion satisfaction, burnout, and secondary traumatic stress: $F(3, 223) = .813, p = .488$.

Summary

The purpose of the study was to examine the professional quality of life of U.S. college mental health counselors and investigate whether gender, age and years of work experience have a statistically significant effect on their reported levels of compassion satisfaction, burnout, and secondary traumatic stress. The chapter provided a summary of the data collected from a survey of 236 mental health counselors working with students at colleges and universities in the United States. It is crucial for leaders in higher education to be better informed about the challenges facing the mental health counselors whom they rely on to address the current campus mental health crisis. As such, the chapter provided descriptive data about U.S. college mental health counselors, their occupational environments, and work-related experiences. Some of the data collected from the demographic questionnaire did not factor into statistical analyses for the study. However, these

inquiries were intentional as the information submitted by college mental health counselors lends insight to the work they do and provides context for the purpose of the study.

The results of the study show that U.S. college mental health counselors indicate average potential for compassion satisfaction and average risk for developing burnout and secondary traumatic stress. There were no statistically significant differences between U.S. college mental health counselors' mean ProQOL scores for compassion satisfaction, burnout, or secondary traumatic stress and the established means of the ProQOL scale. U.S. college mental health counselors in this study indicated mean ProQOL scores that were statistically similar between gender groups, between age groups, and between years of experience groups. There was no interaction between U.S. college mental health counselor's gender and age that had a statistically significant effect on scores for any of the ProQOL subscales. There was no interaction between U.S. college mental health counselor's age and years of work experience that had a statistically significant effect on scores for any of the ProQOL subscales. There were no interactions among counselor's gender, age, and years of experience that had a statistically significant effect on their ProQOL scores when these demographic variables were considered together. There was a statistically significant interaction between U.S. college mental health counselors' gender and years or work experience: Less experienced (< 9 years) female college mental health counselors indicated higher risk for developing secondary traumatic stress than less experienced (< 9 years) male college mental health counselors.

The results from the collected data provide a current snapshot of U.S. college mental health counselors, their occupational environments, their work-related experiences, and their self-reported levels of compassion satisfaction, burnout, and secondary traumatic stress. The next

chapter provides a summary of the study, conclusions and implications based on the results of the study, and recommendations for education leaders and researchers to consider.

CHAPTER 5: SUMMARY, CONCLUSIONS, AND IMPLICATIONS

Summary of Study

This chapter contains a summary of the study and analyses of the data. The chapter begins with a restatement of the problem, followed by a review of the procedures used in the study. Next, a summary of the descriptive statistics for the sample population is provided. Then, each of the specific research hypotheses are listed for review. This is followed by conclusions drawn from the statistical analyses for each of the research hypotheses which are grounded in the data-based results of the study. Next, the implications of the research are presented and inferences drawn from the results of the study are discussed. Based on the results of the study, several recommendations for practice related to improving the professional quality of life of U.S. college mental health counselors are offered. Finally, recommendations for further research examining the professional quality of life of college mental health counselors are presented.

Statement of the Problem

Campus mental health issues are a serious concern for higher education administrators, faculty, staff, students, and parents. Highly publicized reports of mass shootings, sexual assaults, and student suicides at campuses across the United States support the evidence that there is a campus mental health crisis. Increasing numbers of students are seeking assistance at campus counseling centers and many have severe mental health problems. Counseling centers are overwhelmed by service demands and many do not have the resources needed to effectively provide students the help they need.

College mental health counselors are essential to institutional support, intervention, and management of student mental health concerns. Helping students can generate a pleasurable sense of compassion satisfaction for many college mental health counselors. However, they are

constantly exposed to student reports of trauma which puts counselors at risk for developing burnout and secondary traumatic stress. These negative psychological reactions can adversely affect the counselor's psychological health and the quality of work they do. To the best of my knowledge, there are no previous research studies that have examined U.S. college mental health counselors and their professional quality of life.

Statement of the Procedures

The study was conducted via an anonymous, on-line survey of U.S. college mental health counselors during the entire month of October 2018. The final sample consisted of 236 mental health counselors employed at U.S. institutions affiliated with the Association for University and College Counseling Center Directors. Instruments consisted of a demographic questionnaire and the Professional Quality of Life Scale (ProQOL). Descriptive statistics were compiled from data collected in the demographic questionnaire which provides a snapshot of U.S. college mental health counselors' work-related experience. Inferential statistics were used to examine whether there were statistically significant differences between counselors' mean scores on the ProQOL subscales of compassion satisfaction, burnout, and secondary traumatic stress and the established norms of the instrument. Multivariate analysis of variance (MANOVA) was used to examine for possible differences between counselors' ProQOL scores and the demographics of gender, age, and years of work experience.

Summary of the Descriptive Statistics of the Sample Population

This section provides a brief summary of the demographic data collected from the U.S. college mental health counselors who participated in the study. The data for counselors' gender, age, and years of work experience are presented first as these are the independent variables in the study. Among the 236 counselors, 81% identified as female and 19% as male. Counselors ranged

in age from 25 to 76 years old with a mean age of 43 years ($M = 43.39$, $SD = 10.84$). The mean years of work experience for counselors in the study was 15 ($M = 14.47$, $SD = 9.42$).

Data shows counselors in the study are mostly employed at 4-year public universities (50%), 4-year private colleges (22%), and 4-year private universities (17%). Reported campus enrollments range from a low of 200 students to a high of 65,000. It is worth noting that 66% ($N = 155$) of all counselors in the study reported working at institutions with a student enrollment of 15,000 or less and only 3% ($N = 6$) of these counselors reported a student enrollment of 15,000. Colleges and universities with enrollments between 5,000 and 15,000 are considered medium-sized campuses (Velasco, 2018). Further examination of enrollment data shows that 36% ($N = 85$) of all counselors in the study reported student enrollment to be less than 5,000 and 21% ($N = 49$) of *these* counselors reported student enrollment to be 2,000 or less. Colleges and universities with enrollments of less than 5,000 are considered small campuses (Hyman & Jacobs, 2010; Velasco, 2018). Possible implications related to campus enrollment size will be discussed in the next section.

Counselors' level of education was nearly evenly divided as 47% reported to hold a master's degree and 53% a doctorate. This result is consistent with the literature that counseling centers have historically been staffed with doctoral level mental health counselors (Stone, Vespia, & Kanz, 2000) but smaller counseling centers have been hiring more master's level mental health counselors (Vespia, 2007).

Thirty-three percent participants (33%) reported that they provide counseling services to 5 students each work day ($M = 5.31$, $SD = 2.98$), 17% counsel 6 students each work day, and 17% counsel 4 students each work day. These results support the literature regarding high student

demand for counseling services. In a typical 5-day work week, this generally equates to counselors seeing 25 students per week; 100 each month.

College mental health counselors were asked to estimate the frequency of 8 trauma-related experiences reported by the students whom they counseled in the past five working days.

Student reports of suicidal ideation were prevalent as 98% of all study participants counseled at least one student who reported experiencing suicidal ideation. Only five participants in the study indicated that none of the students they counseled reported suicidal ideation. Nearly half (49%) of the participants counseled at least 1 and as many as 5 students who reported suicidal ideation; 39% counseled between 6 and 10 students who reported suicidal ideation. The majority of participants (64%) counseled at least 1 and as many as 5 students who reported having attempted suicide. This data supports the extant literature regarding the prevalence of suicidal ideation among college students (National Council on Disability, 2017) and corroborates results that identify suicide as the second leading cause of death among college students (Eiser, 2011).

A high percentage of participants (77%) counseled between 1 and 5 students who reported having engaged in nonsuicidal self-injury. There were numerous student accounts of sexual trauma as 66% of participants counseled at least 1 and as many as 5 students who reported that they had been raped or sexually assaulted and 61% of participants counseled between 1 and 5 students who had experienced unwanted touching of a sexual nature by another. Participants in the study counseled at least 1 and as many as 5 students who reported that they had: been the victim of a physical assault (43% of the participants), been verbally assaulted by another person (58% of participants), experienced the death of someone they knew (73% of participants). Some of the data collected from participants in the study support the results of the 2018 Center for Collegiate Mental Health report which shows that college students disclosed an increase in non-suicidal self-injury

for the eighth year in a row; an increase in unwanted sexual contact(s) or experience(s) for the fifth year in a row; and an increase in harassing, controlling, and/or abusive behavior from another person for the fifth year in a row (Center for Collegiate Mental Health, 2018) .

Finally, 61% of the college mental health counselors in the study reported that work-related stress had resulted in taking time off for personal mental health reasons and 64% reported that they have considered quitting their job as a college mental health counselor due to work-related stress. The 2018 Association for University and College Counseling Center Directors Annual Survey reported that 51.8% of counseling centers had one or more counseling center positions turnover between July 1, 2017 and June 30, 2018. Low salaries and problematic center work conditions were cited as significant factors in the reported counselor turnover (LeViness et al., 2018). The current study was conducted during the month of October 2018, four months after the 2018 AUCCCD report period ended. The 2018 AUCCCD report supports results in the literature that many campus counseling centers lack the needed resources to meet student demand for services (Baker, 2015; Flatt, 2013; Gallagher, 2015; Kadambi et al., 2010; Kitzrow, 2009; Locke et al., 2016; Much, Wagener, & Hellenbrand, 2009; Shelesky et al., 2016; Smith et al., 2007; Stone et al., 2000; Watkins, Hunt, & Eisenberg, 2012; Xiao et al., 2017).

The Specific Research Hypotheses

RH1: U.S. college mental health counselors exhibit statistically significant differences in their mean scores on the ProQOL subscales for compassion satisfaction, burnout, and secondary traumatic stress from the established means ($M = 50$) published in *The Concise ProQOL Manual* (Stamm, 2010).

- RH1a: U.S. college mental health counselors exhibit a statistically significant higher mean score on the compassion satisfaction subscale than the established mean ($M = 50$) published in *The Concise ProQOL Manual* (Stamm, 2010).
- RH1b: U.S. college mental health counselors exhibit a statistically significant higher mean score on the burnout subscale than the established mean ($M = 50$) published in *The Concise ProQOL Manual* (Stamm, 2010).
- RH1c: U.S. college mental health counselors exhibit a statistically significant higher mean score on the secondary traumatic stress subscale than the established mean ($M = 50$) published in *The Concise ProQOL Manual* (Stamm, 2010).
- RH2: There are statistically significant differences between male and female U.S. college mental health counselors and their mean scores on the ProQOL subscales for compassion satisfaction, burnout, and secondary traumatic stress.
- RH3: There are statistically significant differences among U.S. college mental health counselors and their mean scores on the ProQOL subscales of compassion satisfaction, burnout, and secondary traumatic stress based on age.
- RH4: There are statistically significant differences among U.S. college mental health counselors and their mean scores on the ProQOL subscales of compassion satisfaction, burnout, and secondary traumatic stress and different levels of work experience.
- RH5: There is an interaction between the gender and age of U.S. college mental health counselors as it relates to their mean scores on the ProQOL subscales for compassion satisfaction, burnout, and secondary traumatic stress.

RH6: There is an interaction between the gender and years of experience of U.S. college mental health counselors as it relates to their mean scores on the ProQOL subscales for compassion satisfaction, burnout, and secondary traumatic stress.

RH7: There is an interaction between the age and years of experience of U.S. college mental health counselors as it relates to their mean scores on the ProQOL subscales for compassion satisfaction, burnout, and secondary traumatic stress.

RH8: There is an interaction between the gender, age, and years of experience of U.S. college mental health counselors as it relates to their mean scores on the ProQOL subscales for compassion satisfaction, burnout, and secondary traumatic stress.

Conclusions

For RH1, it was hypothesized that U.S. college mental health counselors would exhibit statistically significant differences in their mean scores on the ProQOL subscales for compassion satisfaction, burnout, and secondary traumatic stress from the established means ($M = 50$) published in *The Concise ProQOL Manual* (Stamm, 2010). Analyses revealed no significant differences.

For RH1a, it was hypothesized that U.S. college mental health counselors would indicate a statistically significant higher mean score on the compassion satisfaction subscale than the established mean. This hypothesis was based on review of the literature which indicates that those in helping professions such as mental health counseling tend to be altruistic and compassionate individuals who experience a high sense of compassion satisfaction from assisting others (Alkema, Linton, & Davies, 2008; Ansari & Lodhia, 2013; Bride & Figley, 2007; Koren, 2016; Radey & Figley, 2007; Sacco & Copel, 2017; Swank et al., 2013). The results reveal that there was no statistically significant difference. U.S. college mental health counselors' score ($M = 50.18$) on the

compassion satisfaction subscale was similar to the established mean ($M = 50$) of the ProQOL. According to guidelines published in *The Concise ProQOL Manual* (Stamm, 2010), scores in the average range indicate that U.S. college mental health counselors in the study derive a moderate degree of satisfaction related to their ability to be an effective caregiver and indicate average potential for compassion satisfaction.

For RH1b, it was hypothesized that U.S. college mental health counselors would indicate a statistically significant higher mean score on the burnout subscale than the established mean. This hypothesis was guided by the literature review which finds that many college mental health counselors are currently overwhelmed by work demands because the counseling centers they work in lack the necessary resources to meet the needs of a growing number of students with severe mental health problems (Baker, 2015; Flatt, 2013; Gallagher, 2015; Kadambi et al., 2010; Kitzrow, 2009; Locke et al., 2016; Much et al., 2009; Shelesky et al., 2016; Smith et al., 2007; Stone et al., 2000; Watkins et al., 2012; Xiao et al., 2017). The results reveal that there was no statistically significant difference. U.S. college mental health counselors' score ($M = 49.82$) on the burnout subscale was similar to the established mean ($M = 50$) of the ProQOL. U.S. college mental health counselors in the study are at average risk for developing burnout.

For RH1c, it was hypothesized that U.S. college mental health counselors would indicate a statistically significant higher mean score on the secondary traumatic stress subscale than the established mean. The development of secondary traumatic stress among helping professionals is rare, but it does occur (Stamm, 2010). Because of the proliferation of students with significant mental health problems seeking counseling services and highly publicized reports of violence, suicide, and sexual assault on U.S. college campuses, it was hypothesized that counselors would exhibit a higher than average score on the secondary traumatic stress subscale. However, there was

no statistically significant difference. U.S. college mental health counselors' score ($M = 49.74$) on the secondary traumatic stress subscale was similar to the established mean ($M = 50$) of the ProQOL. U.S. college mental health counselors in the study indicate average risk for developing secondary traumatic stress.

Research questions 2, 3, and 4 examined whether counselors' ProQOL scores indicated statistically significant differences between gender groups, between age groups, and between years of experience groups. As cited in chapter two of this study, some previous research studies using the ProQOL have found scoring differences among these demographic groups. For example, female mental health providers have shown to be at greater risk than male mental health providers for developing secondary traumatic stress (Baum, 2016; Sprang et al., 2007), younger trauma therapists and nurses have indicated higher levels of burnout than older trauma therapists and nurses (Craig & Sprang, 2010; Kelly, Runge, & Spencer, 2015), and social work students working in field placements at the beginning of their professional careers have indicated high potential for compassion satisfaction and average risk for secondary traumatic stress and burnout (Harr & Moore, 2011)

For RH2, RH3, and RH4, it was hypothesized that counselor's ProQOL scores would indicate statistically significant differences between gender groups, between age groups, and between years of experience groups, respectively. Analyses for research questions 2, 3, and 4 were computed using MANOVA with an alpha of .05 and found no statistically significant differences between gender groups, between age groups, or between years of experience groups as it relates to their mean scores on the ProQOL subscales for compassion satisfaction, burnout, and secondary traumatic stress. This means that the U.S. college mental health counselors in this study exhibited

mean ProQOL scores that were statistically similar between gender groups, between age groups, and between years of experience groups.

Research question 5 examined whether there is an interaction between college mental health counselors' gender and age that relates to their scores on the ProQOL subscales for compassion satisfaction, burnout, and secondary traumatic stress. For RH5, it was hypothesized that there is a statistically significant interaction between counselors' gender and age that relates to their ProQOL scores. This hypothesis was guided by another previously cited study (Van Hook & Rothenberg, 2009), in which ProQOL scores for female and younger child welfare workers indicated higher risk for developing burnout and secondary traumatic stress. However, in the current study, the results of a three-way MANOVA found no statistically significant interaction between U.S. college mental health counselors' gender and age that relates to their ProQOL scores.

Research Question 6 examined whether there is an interaction between college mental health counselors' gender and years of work experience that relates to scores on the ProQOL subscales for compassion satisfaction, burnout, and secondary traumatic stress. For RH6, it was hypothesized that there is a statistically significant interaction between counselors' gender and years of work experience that relates to their ProQOL scores. The hypothesis was also guided by the study on child welfare workers (Van Hook & Rothenberg, 2009) which found that female and younger workers are at higher risk for developing burnout and secondary traumatic stress.

As was hypothesized, there is a statistically significant interaction between counselors' gender and years of work experience that relates to their ProQOL scores. The result of a three-way MANOVA was significant: $F(6, 456) = 2.237, p = .039$; Wilks' $\Lambda = .944$. Less experienced (< than 9 years) female counselors scored higher ($M = 51.36$) on the secondary traumatic stress subscale than less experienced (< than 9 years) male counselors ($M = 42.61$). Scores on the

secondary traumatic stress subscale for less experienced college mental health counselors of both genders indicate average risk for developing secondary traumatic stress. However, the less experienced female counselors scored higher than the less experienced male counselors to a statistically significant degree. This result supports the results of previous research studies using the ProQOL that female mental health professionals are at greater risk for developing secondary traumatic stress than male mental health professionals (Baum, 2016; Sprang et al., 2007).

Research Question 7 examined whether there is an interaction between college mental health counselors' age and years of work experience that relates to their scores on the ProQOL subscales for compassion satisfaction, burnout, and secondary traumatic stress. For RH7, it was hypothesized that there is a statistically significant interaction between counselors' age and years of work experience that relates to their ProQOL scores. The hypothesis for RH7 was guided by previous research studies which found younger helping professionals to be at greater risk for burnout (Craig & Sprang, 2010; Kelly et al., 2015) and the literature review regarding the current campus mental health crisis. Heavy workloads with increasing numbers of students who have severe mental health problems, acts of campus violence and sexual assault, and student suicides could have a statistically significant effect on younger, less experienced college mental health counselors' scores on the ProQOL subscales for burnout and secondary traumatic stress. However, the results of a three-way MANOVA found no statistically significant interaction between U.S. college mental health counselors' age and years of work experience that relates to their scores for any of the ProQOL subscales.

Research question 8 investigated for possible interactions by examining whether there were significant differences in counselors' scores on the ProQOL subscales for compassion satisfaction, burnout, and secondary traumatic stress when all categorical variable groups were considered

together: gender by age by years of experience. I was unable to find any previous ProQOL studies that tested for interactions involving these three variables with mental health professionals. For RH8, it was hypothesized that there is a statistically significant interaction among counselors' gender, age, and years of experience that relates to their ProQOL scores when considered together. A three-way MANOVA was conducted and no statistically significant differences between scores on any of ProQOL subscales were found.

Implications

This section contains the implications of the study. Based on the literature review, the study supports the evidence that there is a national campus mental health crisis and that further research is needed to examine the extent to which college mental health counselors are being affected by it. The current study differs from previous research involving college mental health counselors in three important ways:

1. There are no previous studies that examine the professional quality of life of college mental health counselors at the national level.
2. The study provides higher education leaders and policy-makers a description of the college mental health counselors whom they rely on to manage the current campus mental health crisis.
3. The study fills a gap in the research on the specialized field of college mental health counseling.

The purpose of the study was to examine the professional quality of life of U.S. college mental health counselors. Based on the literature review it was hypothesized that U.S. college mental health counselors would indicate higher than average scores on the ProQOL subscales for compassion satisfaction, burnout, and secondary traumatic stress subscales. However, counselors

in the study indicated average scores on all three subscales. This section begins with inferences drawn from the results of the study which offer possible reasons why the sample population of U.S. college mental health counselors did not score higher than the established average means as was hypothesized. This is followed by inferences drawn from some of the demographic findings of the study that support the need for further research with U.S. college mental health counselors.

The size of the sample population is an important variable to discuss. Although the sample size was adequate and met the statistical power requirements for the study with a power probability of 0.95, a much larger sample was desired. The more participants there are in a study, the more protected the results of the study are from random error which cannot be controlled (Emerson, 2015). An example of random error might be that mental health counselors at 20 colleges did not participate in the study because the directors at their institutions were out sick or on vacation and did not forward the study to the counseling staff. A larger sample size was also anticipated as there were 886 colleges and universities that were members of the Association for University and College Counseling Center Directors (AUCCCD) in 2018. In the 2018 AUCCCD survey, directors were asked if they were a one-person counseling center (i.e., the director is the only mental health counselor) and 96.3% (N = 548) reported that they are *not* the only mental health counselor on staff. Counseling center staffing numbers at AUCCCD institutions are either unknown because the question is not asked or unavailable to the public because they are not listed in the public version of the 2018 AUCCCD survey. However, the directors' response to the above question means that the majority of AUCCCD counseling centers have more than one mental health counselor on staff. There are some AUCCCD-member counseling centers that are one-person counseling centers. We know this because 3.7% (N = 21) of directors in the 2018 AUCCCD survey identified as such. The AUCCCD-member institution where I am employed as a mental health counselor, had a fall 2018

enrollment of 25,151 (UTEP fall enrollment increases for 20th consecutive year.2018). There are 8 mental health counselors on our staff. Pennsylvania State University, an AUCCCD-member institution, had a fall 2018 enrollment of 46,270 (Annual enrollment snapshot released, university sees slight decline, 2018). The Pennsylvania State University Counseling and Psychological Services website lists a “clinical staff” of 33. It is unknown whether any mental health counselors from the University of Texas at El Paso or Pennsylvania State University participated in the study and reference to these two institutions is not meant to imply participation in the current study. Also, the references to the enrollments at the University of Texas at El Paso and Pennsylvania State University are used to illustrate the wide spectrum of staff size at AUCCCD-member institutions. The population of AUCCCD college mental health counselors could number in the low thousands. The number of college mental health counselors at AUCCCD-member institutions is unknown which prevents the estimation of a response rate for the study.

A possible limitation of the study was the chosen sampling method, which effectively made AUCCCD counseling center directors the gatekeepers for access to the study. The number of prospective participants for the study relied on counseling center directors to forward the study to their counseling staff. Expectations that counseling center directors would forward the study were influenced by the published response rates for the 2016, 2017 and 2018 AUCCCD surveys. The response rate for AUCCCD directors was 65% for the 2016 survey, 63.4% for the 2017 survey and 61.2% for the 2018 survey. These response rates left the impression that many directors would choose to forward the study to their counseling staff since the majority of them responded to the AUCCCD survey in each of the past three years leading up to the study.

Because the study asks personal questions of a psychological nature, it was of paramount importance to assure the anonymity of directors, potential participants, and the institutions in

which they work. As such, there is no way to determine which of the directors nor how many of them forwarded the questionnaire to their counseling staff and how many did not. There is no way to determine how many directors forwarded the questionnaire to their counseling staff and counselors chose not to participate. Snowball sampling used with anonymous participants makes it impossible to determine the pattern of distribution of study materials. The main disadvantage of the snowball sampling method is that it usually makes determining possible sampling error impossible (Dudovskiy, 2016).

Surveys are often used in descriptive research to describe characteristics or behaviors of a sample population as they exist in present time. When posing questions of a personal nature, it is important to consider the questions being asked, who is being asked to respond to the questions, and the context in which the questions are being asked. Prospective participants for the study were asked to self-evaluate and self-report their current level of satisfaction with the work they do, the degree to which they feel burned out from the work they do, and the degree to which they feel traumatized by the work they do. College mental health counselors were asked to respond to these questions. As mental health professionals, some counselors may have been reluctant to participate in a survey that asks whether they are currently experiencing psychological stress reactions such as work-related burnout and secondary trauma. This may be especially true when the survey was given to them by their director, who is also a mental health professional. The rationale for designing the study to be completely anonymous was to minimize the possibility of a response bias. Although no identifying information was collected at any point in the study, it is possible that some counselors who completed the questionnaire may have felt pressure to respond to items on the burnout and secondary traumatic stress subscales in a manner that they believed their directors would approve of. A response bias of this type could have lowered counselors' mean scores on the

burnout and secondary traumatic subscales resulting in mean scores that reflect the established norms for the burnout and secondary traumatic stress subscales.

The demographic of institutional enrollment may have also had an effect on counselors' mean ProQOL scores. The majority of participants in the study (66%) reported that they provide counseling services at institutions with enrollments of 15,000 or less. When enrollment data was examined further, 36% of all participants provide counseling services at institutions with an enrollment of less than 5,000. Results of the study reported the sample population's mean scores on the ProQOL subscales for compassion satisfaction, burnout, and secondary traumatic stress. It is possible that enrollment size may have been a significant factor that shifted counselors' mean ProQOL scores towards the established ProQOL averages for each of the subscales. It would be reasonable to assume that large institutions with an enrollment greater than 15,000 also have greater numbers of students receiving counseling services than small institutions with an enrollment of less than 5,000. If higher enrollment correlates with a higher workload due to student demands for counseling services, there is less time for a counselor to complete a survey during the work day. If higher enrollment correlates with counseling more traumatized students on a daily basis, this would likely be reflected in a counselor's ProQOL scores. If lower enrollment correlates to counseling fewer traumatized students on a daily basis, this would likely be reflected in a counselor's ProQOL scores. The demographic of institutional enrollment may explain, in part, the average scores on the ProQOL subscales obtained from the sample population in the study.

Among the 236 college mental health counselors who participated in the study, 81% identified as female and 19% as male. This result was not surprising when considering the results from the 2018 AUCCCD survey which indicates that 74% of counseling center staff at AUCCCD

colleges and universities are female (LeViness et al., 2018). The sample population for the study also reflects the gender imbalance in the field of psychology which was discussed in chapter two.

In the study, the sample population of U.S. college mental health counselors' level of education was nearly evenly divided as 47% hold a master's degree and 53% a doctorate. The literature indicates counseling centers to be predominately staffed by those with doctoral degrees (Stone et al., 2000). However, it has also been reported that the number of college mental health counselors with a master's degree is growing, particularly in smaller college counseling centers (Vespia, 2007). A result in the current study seems to support the latter assertion as 36% of all participants in the study reported student enrollment at their college or university to be less than 5,000. As campus counseling centers with tight budgetary constraints struggle to meet increasing demand for counseling services, the percentage of lower-salaried master's-level mental health counselors at U.S. colleges and universities may continue to grow regardless of enrollment size.

Half of all the U.S. college mental health counselors in the study ($N = 119$) reported being employed at a 4-year public university, 22% at a 4-year private college, and 17% at a 4-year private university. In the 2018 AUCCCD survey, 37% of directors reported being employed at a 4-year public university, 16% at a 4-year private college, and 27% at a 4-year private university. The statistics for this demographic are not surprising as universities tend to have larger enrollments with students in need of campus counseling services and private schools tend to have well-funded mental health services where 30% of the student population is likely to visit (Mitchell et al., 2019).

Over thirty-two percent of mental health counselors (32.8%) reported that they provide counseling services to 5 students each work day ($M = 5.31$, $SD = 2.98$). This result was not surprising as it has been the expectation of my counseling center director since the mass shooting at Virginia Tech in 2007. The average of counseling at least 5 students each work day is also

reported by colleagues of mine who are mental health counselors working at various U.S. colleges and universities, some of which are AUCCCD-member institutions. The average of counseling 5 students per day is likely to increase as the number of students seeking campus counseling services also continues to increase. Waitlists for appointments are commonplace at many colleges and universities (LeViness et al., 2018).

U.S. college mental health counselors were asked to estimate the number of students they counseled who reported trauma-related experiences during the past five working days. Although the percentage of counselors who reported hearing 1-5 student disclosures of suicidal ideation may seem large (46%), it is far more alarming to consider that the percentage of counselors who reported hearing 1-5 student disclosures of suicide attempt was greater (64%). The literature review identifies suicide as the second most common cause of death among college students. Administrators, faculty, staff, and students at colleges and universities in the United States are likely to have heard about or known a student who committed suicide. College mental health counselors are tasked with helping the depressed and overwhelmed on a daily basis and most understand that the possibility of student suicide is an occupational hazard. And yet, they still come to work each day in an effort to prevent it from happening. Not every student who comes to the counseling center feels suicidal but at least 20% of those who died by suicide had sought help at campus counseling centers (Czyz, Horwitz, Eisenberg, Kramer, & King, 2013).

It is not surprising to know that 66% of college mental health counselors (N = 164) provided counseling services for at least 1 and as many as 5 students who reported that they had been the victim of a rape or sexual assault (anal, oral, or vaginal penetration by force) and 61% (N = 143) counseled between 1 and 5 students who had experienced unwanted touching of a sexual nature by another. The study was conducted during the month of October, a month that falls within

a four-month period referred to as the “red zone.” For college students, women in particular, the risk for sexual assault is highest during the “red zone” as more than 50% of college sexual assaults occur between August and November of each academic year (Dastagir, 2019).

The most surprising finding of the study was the percentage (64%) of U.S. college mental health counselors who have considered quitting their job due to work-related stress. I found this result to be in conflict with counselors’ mean scores on the burnout and secondary traumatic stress subscales which are interpreted as being at average risk for burnout and secondary traumatic stress. If the majority of the sample population in this study has considered quitting their job due to work-related stress, a good portion of them are in need of institutional support of some kind. Whether this support comes in the form of additional staff, specialized training in trauma work, or some other type of resource, is a decision that leaders in higher education must make.

Recommendations for Practice

The following recommendations are based on the results of the current study which examined the professional quality of life of U.S. college mental health counselors. As such, these recommendations are limited to what has been learned from the literature review and the self-report data submitted by U.S. college mental health counselors. Recommendations are intended to promote institutional support for college mental health counselors by nurturing a sense of compassion satisfaction within them and minimizing their risks for developing burnout and secondary traumatic stress. Some counseling center directors may have already integrated these recommendations into the management of their counseling center. This would not be surprising as counseling center directors are the professionals who are best informed about the challenges that they and their counseling staff must contend with in the provision of campus counseling services. Some institutions may have already integrated these recommendations to adapt to campus mental

health needs. Nevertheless, these recommendations may be helpful to leaders in higher education who may not be aware of the work-related experience of college mental health counselors. The findings of the study may serve as the "voice" from those on the front lines of the current campus mental health crisis.

Based on the literature review and the results of the study, it is recommended that U.S. colleges and universities hire more mental health counselors. According to the 2018 Association for University and College Counseling Center Directors survey, 43.3% of counseling centers gained counseling staff positions (LeViness et al., 2018). This is an encouraging statistic that suggests that higher education administrators are responding to the current campus mental health crisis. The biggest obstacle to increasing staff is the cost of doing so. Higher education budgets are shrinking and administrators are faced with decisions regarding the distribution of financial resources. High enrollment and high student utilization rates at the campus counseling center are two important factors that can legitimize institutional spending to increase counseling staff.

The International Accreditation of Counseling Services (IACS) (2019) recommends a counselor to student ratio of at least 1:1500. The IACS identifies the likely consequences when the ratio increases beyond this recommendation: a) longer wait lists for students who seek counseling services, b) increased difficulty providing services to students with severe mental health problems as the time needed to manage these student's needs is greater and leaves other students on the waitlist c) liability risks to the counseling center and the institution increase, d) support for the academic success of students is decreased, e) counselors are less available to engage in campus outreach efforts because the counseling center staff is overwhelmed by student service demand (International Accreditation of Counseling Services, 2019).

Colleges and universities might increase counseling staff in a cost-effective manner by hiring experienced and skilled master's-level mental health counselors as opposed to hiring equally experienced and skilled doctoral-level mental health counselors. The difference in salary between these two job candidates is likely to be significant. This is merely a recommendation to consider if cost is a prohibitive factor in the expansion of the campus counseling staff. This is not meant to suggest that one mental health counselor is preferable over another based solely on one's level of education. Also, there are many factors that must be considered if expanding the counseling staff is possible. What are the mental health needs of the student population? Is there a large demand for specific types of psychological testing that only psychologists can do? Does the counseling center have an APA-accredited training program that requires staffing with doctoral-level psychologists? Does the counseling center need more counselors, regardless of the type of degree, in order to mitigate the risks associated with student mental health problems? How big is the counseling center's budget? Is salary commensurate with experience?

Higher education leaders should consider conducting a survey regarding mental health concerns within their campus communities. A user-friendly survey that is accessible to mobile devices is well-suited to students who are rarely without their cellphones. This type of survey can provide insights regarding the most concerning campus mental health issues. The American College Health Association has created the National College Health Assessment (NCHA). The NCHA is a survey that enables institutions to collect data about a variety of student health issues and includes questions about student mental health. The American College Health Association promotes the NCHA as a nationally-recognized research survey that is available at a low-cost (American College Health Association, 2019).

College counseling center directors should discuss the importance of professional quality of life with their counseling staff. Some directors may suggest that counselors take the ProQOL survey on their own—for the counselor’s own self-interests. It is of critical importance to stress that this recommendation is for directors to *suggest—not instruct*—their counseling staff to consider taking the ProQOL on their own. Counseling center directors who introduce the ProQOL to their staff must be familiar with the survey and be prepared to answer questions about it. The ProQOL is designed for helping professionals to self-evaluate their professional quality of life. It is not a diagnostic measure of any kind. If directors suggest that counselors consider taking the ProQOL, they should also advise that there will not be further inquiry regarding counselor’s individual results. In order for ProQOL scores to be valid and useful to counseling staff, there cannot not be any form of persuasion or pressure for counselors to take the survey. Counseling center directors should make clear that the ProQOL is not a diagnostic measure of any kind and offer to consult with members of the counseling staff if there are questions about the ProQOL.

Higher education administrators must be aware of the mental health concerns on their campuses. Regular administrative meetings related to campus mental health, safety, and risk management should include the counseling center director in order to keep administrators informed of campus mental health concerns. It is recommended that colleges and universities have suicide prevention programs and bystander intervention programs that are available to all interested students, staff, faculty, and administrators. These programs should be available to any employee who wants to attend during work hours without penalty. The programs must be widely advertised and promoted through campus news organizations, campus billboards and websites, residence life bulletins, new student orientation sessions, and departmental meetings. Both of these programs should be offered several times during the academic year to better meet the scheduling

needs of the campus community. Suicide prevention and bystander intervention programs must be easy to learn and practical for use by any member of the campus community. These types of programs are not intended to train people to become mental health counselors, they are intended to normalize conversations about well-being and safety. The general formula is to: a) ask people if they are feeling alright if they appear to be troubled, b) encourage people to seek help if they are troubled, and c) refer them to the campus counseling center or someone else who can help if they are in need of assistance. College mental health counselors cannot be in all places at all times, especially when service demands are high. A motivated campus community that is trained to intervene when trouble is apparent can better prevent tragic situations from developing.

Colleges and universities that provide the availability of free mental health counseling to their employees demonstrate an institutional investment in the well-being of employees and the entire campus community. An employee assistance program (EAP) is a work-based, counseling program that institutions can contract with to provide confidential counseling services to their employees as a cost-free work benefit. Employee assistance programs provide short-term counseling and referral services done by off-campus mental health counselors in the community. Employees can seek counseling for personal or work-related issues at no cost. It is recommended that higher education administrators enlist the services of an EAP as a part of their institution's risk-management strategy. Mentally healthy employees are likely to be more productive and engaged employees. Having access to an EAP can improve a college mental health counselor's professional quality of life. Who can help the helpers? The employee assistance program.

When campus mental health emergencies occur, colleges and universities must have an established policy regarding the transportation of students with severe mental health problems to medical facilities in the surrounding community. For example, if a student comes to the campus

counseling center and reports that he or she is going to commit suicide, there has to be a plan in place that involves transporting the student to an outside medical facility for evaluation. When a student is in eminent danger, transporting the student to a nearby medical facility requires the assistance of the campus police department. If mental health counselors lack the necessary institutional support in such cases, they are burdened with the uncertainty of what can or will be done when faced with an emergency situation. Problematic work conditions such as these can contribute to higher risk for occupational burnout.

The results of the study found that U.S. college mental health counselors indicate average risk for developing burnout or secondary traumatic stress. However, 64% of participants in the study reported that they have considered quitting their job as a college mental health counselor due to work-related stress. Administrators in higher education need to show that they value the college mental health counselors who are entrusted to manage the mental health needs of the campus community. In light of the current campus mental health crisis, it is recommended that administrators demonstrate institutional commitment to the ongoing professional development and well-being of college mental health counselors in several ways:

- Arrange for a specialist in trauma therapy to conduct an in-house training workshop for the counseling staff and cover the expense. This would convey that the administration understands the difficult nature of the work counselors do and demonstrates a willingness to assist them in doing their jobs effectively. This is a risk-management strategy that benefits students and mental health counselors.
- Cover the costs of counselors' licensing renewal fees and continuing education credits. If hiring another counselor is not possible, covering the costs associated with licensing fees and continuing education classes is likely to be significantly less than the annual salary of

hiring one additional mental health counselor. Although the size of the counseling staff might be the determining factor in the financial feasibility of this recommendation, it is one that is worth considering. A gesture of this kind demonstrates that administrators value mental health counselors and want to retain their services.

- Visit the campus counseling center at least once during the academic year. Meet the counseling staff and acknowledge the importance of the work they do. All too often, discussions about campus counseling centers and the mental health counselors who work within them, occur in the aftermath of a campus tragedy. These discussions usually involve concerns regarding campus mental health services and institutional liability for the tragedy. Let mental health counselors know that they are a valuable asset as opposed to a scrutinized liability.
- At least once during the academic year, arrange for a medical professional from the campus health center to provide counselors a workshop on general health matters that should be attended to on a regular basis. It may be appropriate to ensure that special attention is given to the healthcare needs of women as the literature review and results of the study indicate that women are the majority in college counseling centers.
- Provide mental health counselors with free access to the campus gymnasium. This could motivate counselors to engage in physical exercise, which is an essential component of effective stress management.
- Create a national roster of mental health counselors employed at colleges and universities in the United States. For example, the AUCCCD could, conceivably, create a national Listserv of mental health counselors employed at their AUCCCD-member colleges and universities. Such a Listserv could facilitate, among other things, the ability to share the

latest trauma-therapy techniques, creative ways to engage the campus community in suicide prevention, or ways to maintain a personal and professional orientation towards self-care. An AUCCCD counselor's Listserv would also enable the AUCCCD to conduct voluntary surveys of their mental health counselors and distribute prizes for participation.

Recommendations for Future Research

- The results of the study may have been very different with a larger sample population. Future studies examining the professional quality of life of U.S. college mental health counselors should focus on recruiting a larger number of participants through a variety of alternate sources such as higher education conferences, professional counseling organizations, and counseling workshops. Additionally, a future ProQOL study might gain more participants if there was an incentive to participate. Typically, this involves telling prospective participants that completing a survey enters them into a drawing to win a gift card or some other type of prize. For the current study, the confidentiality of participants was of the utmost importance. The distribution of incentives to the “winners” would have resulted in a breach of confidentiality of some type as the “winners” would have had to be notified. This would have been an unacceptable compromise to the study design. Furthermore, there was no research budget available to purchase incentives for the study.
- With a large enough sample size, a future ProQOL study might examine for differences between college mental health counselors' ProQOL scores based on the type of institutions in which they work (i.e., community colleges, public colleges and universities, private colleges and universities). Similarly, it would be worthwhile to conduct a ProQOL study that examines for differences between college mental health counselors' ProQOL scores based on the enrollment size of the institutions in which they work (i.e., small, medium,

and large enrollments). A future ProQOL study with a focus on mental health counselors who work at colleges and universities with large enrollments that exceed 15,000 students could be relevant to the results of the current study. Such a study could reveal ProQOL scores that differ from the established means to a statistically significant degree.

- A future study that examines the professional quality of life of mental health counselors who work at Ivy League institutions could be valuable. The Ivy League institutions are grounded in a campus culture of intense competition and high expectations. The pressure to be “the best” can be overwhelming for many students. As previously cited in the literature review, student suicides have been prevalent at several Ivy League institutions. A 2018 report evaluated the student mental health leave of absence policies of the eight Ivy League institutions (Hayman, 2018). Each of the institutions were scored on 15 indicators, including policies related to students going on leave, the details of the leave itself and the process of returning from the leave. None of the eight Ivy League institutions received a passing grade. The report suggested that institutions can force a student to take a mental health leave of absence in order to protect the student and others, but some may also do so to avoid the possibility of the institution being found legally responsible for students who die by suicide (Suh, 2019). If a depressed and suicidal Ivy League student is considering seeking campus counseling services, their decision may be influenced by the possibility that they could be forced to take a mental health leave of absence. Reference to the aforementioned report is not intended to disparage any efforts by the Ivy League institutions to address campus mental health concerns. Student suicides are not a tragedy confined to the Ivy League. A future ProQOL study with mental health counselors at Ivy

League institutions might reveal how this type of higher education environment affects the mental health counselors who work within them.

- Finally, a future study of college mental health counselors that includes the collection of qualitative data in addition to the use of the ProQOL scale could provide additional insights regarding the occupational challenges of being a college mental health counselor. Such a study could help explain why the participants in the current study indicated average risk for developing burnout and secondary traumatic stress while the majority of them (64%) also indicated that they have considered quitting their job as a college mental health counselor due to work-related stress.

Summary

There is a national campus mental health crisis and it has captured the attention of higher education administrators, faculty, staff, students, and parents. Increasing numbers of students are seeking assistance at campus counseling centers and many have severe mental health problems. Counseling centers are overwhelmed by service demands and many do not have the resources needed to effectively provide students the help they need. College mental health counselors are essential to the management of student mental health concerns. Helping students generates a pleasurable sense of compassion satisfaction for many college mental health counselors. However, they are constantly exposed to student reports of trauma which puts counselors at risk for developing burnout and secondary traumatic stress.

To the best of my knowledge, the study is the first to examine the professional quality of life of U.S. college mental health counselors. An online survey comprised of a demographic questionnaire and the Professional Quality of Life Scale (ProQOL) was sent out to counseling center directors on the Association for University and College Counseling Center Directors

Listserv. The directors were asked to forward the study to the members of their counseling staff and advised that all directors, mental health counselors, and the institutions in which they work would remain anonymous. A total of 236 U.S. college mental health counselors participated in the study which was conducted during the month of October in 2018.

Among the 236 college mental health counselors who participated in the study, 81% identified as female and 19% as male. Counselors ranged in age from 25 to 76 years old with a mean age of 43 years. The average years of work experience was 15. Most of the counselors in the study are employed at 4-year public universities (50%), 4-year private colleges (22%), and 4-year private universities (17%). Reported campus enrollments ranged from a low of 200 students to a high of 65,000. It is worth noting that 66% of all counselors in the study reported working at institutions with a student enrollment of 15,000 or less. Further examination of enrollment data showed that 36% of all counselors in the study reported student enrollment to be less than 5,000 and 21% of these counselors reported student enrollment to be 2,000 or less. Counselors' level of education was nearly evenly divided as 47% hold a master's degree and 53% a doctorate.

Thirty-three percent of counselors (33%) reported that they provide counseling services to 5 students each work day. In a typical 5-day work week, this equates to 25 students per week; 100 each month. College mental health counselors were asked to estimate the frequency of 8 trauma-related experiences reported by the students whom they counseled in the past five working days. Student reports of suicidal ideation were prevalent as 98% of participants in the study counseled at least one student who reported experiencing suicidal ideation; only five participants in the study indicated that none of the students they counseled reported suicidal ideation. Nearly half (49%) of the participants counseled at least 1 and as many as 5 students who reported suicidal ideation; 39% counseled between 6 and 10 students who reported suicidal ideation. The majority of participants

(64%) counseled at least 1 and as many as 5 students who reportedly attempted suicide. A high percentage of participants (77%) counseled between 1 and 5 students who engaged in nonsuicidal self-injury. There were numerous student accounts of sexual trauma as 66% of participants counseled at least 1 and as many as 5 students who reported that they had been raped or sexually assaulted and 61% of participants counseled between 1 and 5 students who had experienced unwanted touching of a sexual nature by another. Participants in the study counseled at least 1 and as many as 5 students who reported that they had been the victim of a physical assault (43% of the participants), had been verbally assaulted by another person (58% of participants), had experienced the death of someone they knew (73% of participants). The data supports the findings of the 2018 Center for Collegiate Mental Health report which found that college students disclosed an increase in non-suicidal self-injury for the eighth year in a row; an increase in unwanted sexual contact(s) or experience(s) for the fifth year in a row; and an increase in harassing, controlling, and/or abusive behavior from another person for the fifth year in a row (Center for Collegiate Mental Health, 2018).

Sixty-one percent (61%) of the college mental health counselors in the study reported that work-related stress had resulted in taking time off for personal mental health reasons and 64% reported that they have considered quitting their job as a college mental health counselor due to work-related stress. In the 2018 Association for University and College Counseling Center Directors Annual Survey, directors reported that 51.8% of counseling centers had one or more counseling center positions turnover between July 1, 2017 and June 30, 2018. Low salaries and problematic center work conditions were cited as significant factors in the reported counselor turnover (LeViness et al., 2018).

The results from testing of the research hypotheses can be summed up by the following:

1. In terms of professional quality of life, college mental health counselors' mean ProQOL scores are interpreted as: average potential for compassion fatigue, average risk for developing burnout, and average risk for developing secondary traumatic stress. There were no statistically significant differences between college mental health counselors' mean scores on the ProQOL subscales for compassion satisfaction, burnout, secondary traumatic stress and the established norms found in *The Concise ProQOL Manual* (Stamm, 2010) .
2. There were no statistically significant differences in college mental health counselors' mean ProQOL scores between gender groups, between age groups, or between years of experience groups.
3. There was no statistically significant interaction between college mental health counselors' gender and age as it relates to their scores on any of the ProQOL subscales. There was no statistically significant interaction between college mental health counselors' age and years of work experience as it relates to their scores on any of the ProQOL subscales. There were no interactions among counselor's gender, age, and years of experience that had a statistically significant effect on their ProQOL scores when these demographic variables were considered together. There is an interaction between college mental health counselors' gender and years of work experience that accounts for a statistically significant difference in scores on the ProQOL subscale for secondary traumatic stress. Female counselors with less than 9 years of experience scored higher on the secondary traumatic stress subscale than male counselors with less than 9 years of experience.

Although the results of the study can be valuable to leaders in higher education, a review of the limitations of the study is warranted. There are three main limitations of the study and all three relate to factors that may have had a significant effect on the study results. First, the method of recruitment for the study did not facilitate direct access to all mental health counselors at AUCCCD-member institutions. The use of a snowball sampling method makes it impossible to determine possible sampling errors or to make statistical inferences about the population of AUCCCD college mental health counselors based on the obtained sample. Second, due to the personal nature of the inquiries made in the study, the anonymity of directors, participants, and institutions was built into the research design to facilitate and encourage a mental health counselor's decision to participate in the study. Despite this, the possibility of response bias exists due to the sensitive nature of asking mental health counselors to self-report burnout or secondary traumatic stress reactions. Third, the number of mental health counselors at AUCCCD-member institutions is unknown which prevents the estimation of a response rate to the study.

Statistical analyses of U.S. college mental health counselors' ProQOL scores indicate average potential for compassion satisfaction and average risk for risk for developing burnout and secondary traumatic stress. However, findings of the demographic questionnaire suggest that U.S. college mental health counselors may be at higher than average risk for burnout and secondary traumatic stress as they report heavy workloads with traumatized students and many (64%) have considered quitting their job due to work-related stress.

Higher education leaders must constantly strive to better ensure that campus mental health concerns are managed in ways that protect all members of the campus community. College mental health counselors are indispensable to these efforts and must be shown institutional support in order for them to do their work effectively and efficiently. Leaders in higher education can

demonstrate institutional support for college mental health counselors and recommendations have been provided for consideration.

One Final Note:

The struggle itself toward the heights is enough to fill a man's heart. One must imagine Sisyphus happy.

- Albert Camus, Le Mythe de Sisyphe, 1942

Sisyphus was a figure of Greek mythology who defied the gods and put Death in chains so that no human would have to die. Death broke free of the chains and Sisyphus was caught. Seemingly doomed, Sisyphus devised a strategy and managed to escape. He subsequently eluded Death on many occasions, but was ultimately captured. Because Sisyphus had managed to repeatedly cheat Death, the gods condemned him to push a boulder up a steep mountain for eternity. Each time Sisyphus pushed the boulder to the top of the mountain, the boulder would roll back down to the bottom and he would have to begin again. And so, he did: pushing the boulder to the top of the mountain once again, only to have it roll to the bottom again. And then he would begin again. The outcome was known to him and yet, Sisyphus continued.

There are many interpretations to the Myth of Sisyphus, and many allude to the absurdity of finding happiness in a seemingly unachievable task. In the context of the study, I liken Sisyphus to the college mental health counselors who find meaning, purpose, and satisfaction in their efforts to help students elude hopelessness and death. Pushing the boulder up the mountain is the strategy—a metaphor for the counseling process. It is a difficult and precarious task, but the struggle is meaningful. Reaching the height of the mountain represents an outcome in which counselors help students continue with their lives with a more hopeful orientation. The boulder rolling to the bottom of the mountain represents the fact that there is, inevitably, another student waiting for assistance in navigating the fears and desperations inherent of the human condition.

And so, they begin again because there is meaning in the work and there is happiness in doing the work.

As the drafting of this dissertation drew to a close, a prominent figure in college mental healthcare died by suicide at the age of 52. Dr. Gegory Eells helped shape the way U.S. colleges and universities currently assist students in need of support. Dr. Eells was six months into his new job as director of Counseling and Psychological Services at the University of Pennsylvania. In an interview with the *Philadelphia Inquirer*, Dr. Eell's mother said that prior to his death her son told her that he found the new job to be more demanding than he had anticipated and that he missed his wife and three children back in Ithaca, New York (Snyder & Gantz, 2019). Dr. Eells had been the director of Counseling and Psychological Services at Cornell University in Ithaca for 15 years. Prior to that, Dr. Eells had been the director of Student Counseling Services at the University of Southern Mississippi. Dr. Eells was a nationally recognized expert in the field of college student mental health. He served as president of the Association for University and College Counseling Center Directors from 2007 to 2009 and won the AUCCCD Lifetime Achievement Award in 2012. He was chair of the Mental Health Section of the American College Health Association in 2014. Dr. Eells, thank you for your service. I choose to imagine you being happy as you have bettered the lives of countless others. You will be missed.

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APPENDIX A

REQUEST FOR PARTICIPATION

On Mon, Oct 1, 2018 at 1:16 PM Sneed, Brian <bjsneed@utep.edu> wrote:
Dear fellow AUCCCD Counseling Center Directors,

A member of my counseling staff is pursuing his doctorate at the University of Texas at El Paso. He is an LPC with 12 years of counseling in my department and is doing a research study on mental health counselors at colleges and universities in the United States.

We know that more students are coming to our counseling centers and many of these students present with severe psychological problems. With increased service demands, insufficient staffing and tight departmental budgets, our counselors are stressed by the work they do hour after hour, day after day, week after week, and so on.

There is a lack of research examining the work experience of college mental health counselors. This study seeks to learn more about college counselors as they are the first point of contact for most campus mental health concerns and are exposed to student reports of distress and trauma on a daily basis.

Please look at this very brief (8-10 minute) survey and consider forwarding it to your counseling staff. The study has IRB approval to collect all data via an anonymous survey link.

The survey is open from 10/1/18 through 10/31/18. The principal investigator has asked that I resend this email to the Listserv every Monday during the month of October in the hopes of obtaining a representative sample size.

Thank you for your consideration and have a great semester,

Brian Sneed

Follow this link to the Survey: [College Mental Health Counselors ProQOL](https://utep.qualtrics.com/jfe/form/SV_6xmbNG4TXT6MOzP)

Or copy and paste the URL below into your internet browser:
https://utep.qualtrics.com/jfe/form/SV_6xmbNG4TXT6MOzP

Follow the link to opt out of future emails:
\${1://OptOutLink?d=Click here to unsubscribe}

Brian Sneed, Ph.D.
Director
Office: 915-747-5302 / Fax: 915-747-5393
Email: bjsneed@utep.edu

Counseling and Psychological Services
202 Union West Building
500 W. University Ave. El Paso TX 79968-0602

APPENDIX B

INFORMED CONSENT

THE PROFESSIONAL QUALITY OF LIFE OF U.S. COLLEGE MENTAL HEALTH COUNSELORS: USING THE PROFESSIONAL QUALITY OF LIFE SCALE TO EXAMINE COMPASSION SATISFACTION, BURNOUT, AND SECONDARY TRAUMATIC STRESS

You are invited to participate in this research study examining the work experience of mental health counselors at colleges and universities in the United States, which is largely unexplored in the research literature. As the first point of contact for most campus mental health concerns, you are a valuable resource for the students you serve and the institutions of higher education that rely on your professional skills and abilities. In this online survey, you will first be asked to provide demographic information such as sex/gender identity, degree type, age, and years of counseling experience. Questions on this survey will also inquire about stress-related work concerns. Next, you will be asked to complete the Professional Quality of Life Scale – Version 5 (ProQOL) (Stamm, 2010). Professional Quality of Life is a term that refers to the quality of our work lives. The ProQOL Scale is used to examine one's professional quality of life across three dimensions: compassion satisfaction, burnout, and secondary traumatic stress. “The ProQOL is the most commonly used measure of the positive and negative effects of working with people who have experienced extremely stressful events” (Stamm, 2010, p.12). “The most important aspect about interpreting the ProQOL is that it is not a diagnostic test” (Stamm, p. 18). Simply stated, it is practical to think of the ProQOL as a "thermometer" used to take the "temperature" of a helping professional. All responses submitted to this survey are completely anonymous. No identifying information pertaining to a participant or the college/university in which they work will be collected at any time. Although this survey has been forwarded to you by the

administrator of your counseling center, no one (including your counseling center director) will have any knowledge of who participates in this study. No names or email addresses are identified as all responses to this survey will be collected using Qualtrics software with an anonymous survey link enabled. All participants in this study must be at least 18 years of age, hold a master's or doctorate, and be licensed to practice mental health counseling. Your participation in this study is completely voluntary. You have the right to withdraw at any point during the study, for any reason, and without any prejudice. There are no foreseeable risks to you resulting from participation in this study. There is no compensation to you for participating in this study. There is no cost to you for participating in this study. This survey should take you approximately 10 minutes to complete. This survey will be open from 10/1/18 until 10/31/18 with weekly reminders to participate. If you would like to contact the Principal Investigator in the study to discuss this research, please e-mail Jeffrey Kuroiwa M.Ed., LPC at the University of Texas at El Paso: jkuroiwa@utep.edu

By clicking the button below, you acknowledge that you are at least 18 years of age, you hold a master's or doctorate, you are currently licensed to practice mental health counseling, you work at a college or university in the United States, your participation in the study is voluntary, and you are aware that you may choose to terminate your participation in the study at any time and for any reason without penalty. Please note that this survey will be best displayed on a laptop or desktop computer. Some features may be less compatible for use on a mobile device.

APPENDIX C

DEMOGRAPHIC QUESTIONNAIRE

1. What is your Sex/Gender Identity?

Female

Male

2. What is your age in years?

3. How many years of experience do you have as a mental health counselor?

4. Highest Postgraduate Degree Earned:

Master's

Doctorate

5. I am employed at a:

Community College

Four-Year Public College

Four-Year Public University

Four-Year Private College

Four-Year Private University

Other

6. What is the approximate enrollment at your place of work?

7. On average, how many students do you provide direct, face-to-face counseling services to each work day?

8. Thinking about the past five days of work, estimate the number of students you counseled who reported:

_____Suicidal attempt

_____Suicidal ideation

_____Nonsuicidal, self-injurious behavior (e.g., cutting, burning, stabbing, hitting)

_____Unwanted touching of a sexual nature by another

_____Rape or sexual assault (anal, oral, or vaginal assault by force)

_____Physical assault by another

_____Verbal assault by another

_____Death of someone important to them

9. Has work-related stress ever resulted in taking time off for personal mental health reasons (to include calling in sick as a "mental health day")?

_____No

_____Yes

10. Have you ever considered quitting your job as a mental health counselor due to work-related stress?

No

Yes

APPENDIX D

PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)

COMPASSION SATISFACTION AND COMPASSION FATIGUE (PROQOL) VERSION 5 (2009)

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

	1=Never	2=Rarely	3=Sometimes	4=Often	5=Very Often
_____ 1.					
_____ 2.					
_____ 3.					
_____ 4.					
_____ 5.					
_____ 6.					
_____ 7.					
_____ 8.					
_____ 9.					
_____ 10.					
_____ 11.					
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_____ 26.					
_____ 27.					
_____ 28.					
_____ 29.					
_____ 30.					

© B. Hudnall Stamm, 2009-2012. Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL). www.proqol.org. This test may be freely copied as long as (a) author is credited, (b) no changes are made, and (c) it is not sold. Those interested in using the test should visit www.proqol.org to verify that the copy they are using is the most current version of the test.

APPENDIX E

NOTIFICATION OF IRB APPROVAL



THE UNIVERSITY OF TEXAS AT EL PASO
Office of the Vice President for Research and Sponsored Projects
Institutional Review Board
El Paso, Texas 79968-0587
phone: 915 747-8841 fax: 915 747-5931

FWA No: 00001224

DATE: July 26, 2018

TO: Jeffrey Kuroiwa, M.Ed.

FROM: University of Texas at El Paso IRB

STUDY TITLE: [1291435-1] The Professional Quality of Life of U.S. College Mental Health Counselors: Using the Professional Quality of Life Scale to Examine Compassion Satisfaction, Burnout, and Secondary Traumatic Stress

IRB REFERENCE #: College of Education

SUBMISSION TYPE: New Project

ACTION: DETERMINATION OF EXEMPT STATUS

DECISION DATE: July 26, 2018

REVIEW CATEGORY: 45 CFR 46.101(b)(2)

Thank you for your submission of New Project materials for this research study. University of Texas at El Paso IRB has determined this project is EXEMPT FROM IRB REVIEW according to federal regulations.

Exempt protocols do not need to be renewed. Please note that it is the Principal Investigator's responsibility to resubmit the proposal for review if there are any modifications made to the originally submitted proposal. This review is required in order to determine if "Exemption" status remains.

We will put a copy of this correspondence on file in our office.

If you have any questions, please contact the IRB Office at (915) 747-8841 or irb.orsp@utep.edu. Please include your study title and reference number in all correspondence with this office.

cc:

CURRICULUM VITA

Jeffrey Yoichi Kuroiwa earned his Bachelor of Arts in Psychology from UTEP in 1993. In 1998, he earned his Master of Education in Guidance and Counseling from UTEP. In 2014, he joined the UTEP doctoral program in Educational Leadership and Administration.

Dr. Kuroiwa has worked in the field of mental health since 1992 and has extensive experience as a mental health counselor in psychiatric hospitals, employee assistance programs, and educational environments. He has provided counseling services to children, adolescents, adults, and geriatric patients and gained a practice-based knowledge of life challenges spanning these pivotal stages of human growth and development. Throughout his career as a mental health counselor, Dr. Kuroiwa has done numerous presentations, workshops, and training sessions in the El Paso community, hospital settings, and educational environments.

In 2006, Dr. Kuroiwa returned to UTEP and joined the staff at the Counseling and Psychological Services department. During thirteen years of service with the UTEP Division of Student Affairs, Dr. Kuroiwa has worked with the diverse palate of gender identity, age, race, ethnicity, religion, sexual orientation, socio-economic status and academic discipline that represents the 21st century campus community. Dr. Kuroiwa intends to continue working in the field of higher education as the work is personally fulfilling and meaningful for him.

Dr. Kuroiwa's dissertation, "A Fist Step: Analyzing The Professional Quality of Life of U.S. College Mental Health Counselors" was supervised by Dr. Eduardo Arellano.

Contact Information: jkuroiwa@utep.edu

This dissertation was typed by Jeffrey Yoichi Kuroiwa