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Keeping Ourselves Well: Strategies for Promoting and Maintaining Counselor Wellness

PAIGE N. CUMMINS
LINDA MASSEY
ANITA JONES

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This article describes challenges to wellness that counselors face when working with clients. Autobiographical reflections are used to illustrate the personal nature of some of these challenges and how this affects counselor effectiveness and wellness. Additionally, assessment measures and theoretical models for promoting and maintaining wellness are presented.

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A common utterance from counselors in their practice with clients is the statement "You need to make sure to take care of yourself, eat well, get good sleep, and reduce your stress." Like doctors, however, counselors often are remiss in taking their own advice about wellness. Often, we counselors believe we can handle it and that we do not need to be concerned with our own wellness because it does not affect our professional practice. In our daily work, we encounter clients who have tremendous pain. We are their sounding boards and reflectors of feelings. The essence of counseling is to consistently summon the energy to engage with another human's emotions while at the same time balancing our own personal experiences and challenges outside of the job. Jeffrey Kottler described his challenges of providing good client care while feeling distressed as follows: "There isn't a day that goes by that I don't feel impaired in some way, hopefully not to the point that I hurt others, but at least to the point that my levels of competence are diminished" (Kottler & Hazler, 1996, p. 100). Even prominent historical figures in the field of counseling, such as Carl Rogers, described having difficulty with managing self-care and client care: "I have always been better at caring for and looking after others than I have in caring for myself" (Rogers, 1995, p. 80).

This article highlights some of the challenges that counselors face in identifying and maintaining their own wellness, as well as some strategies and resources for assessing one's own wellness. Throughout the article,

Paige N. Cummins and Linda Massey, Department of Human Resources, East Central University; Anita Jones, Department of Allied Health, College of Southern Idaho, and Department of Health and Human Services, University of Phoenix. Anita Jones is now in Family Court Services, Fifth Judicial District, Twin Falls, Idaho. Correspondence concerning this article should be addressed to Paige N. Cummins, Department of Human Resources, Box K-5, East Central University, Ada, OK 74826 (e-mail: pcummins@ecok.edu).

the third author (Anita Jones), a counselor and a member of the American Counseling Association's Task Force on Exemplary Practices for Promoting Wellness for Counselors, shares her personal story of life's challenges, her path to recovery, and the effect such experiences had on her work as a counselor. She begins as follows:

Working as a clinical supervisor for a residential treatment center came with tremendous stress. Crisis calls came in 24 hours, 7 days per week. There was daily responsibility of staff and ancillary personnel. I taught at a local junior college and made public presentations. In addition, I had the personal stressors that are part of my life's journey. My elderly mother shared our home. We had taken physical custody of a little boy whose mother was an addict with mental illness, which added complexities to our already busy lifestyle. Our youngest adult son had been diagnosed 3 years earlier with schizophrenia. Counselors who work with schizophrenic clients and their families know about the challenges and disruption to any family this illness brings. Life was unpredictable, but manageable. I had a strong supportive partner, a terrific supervisor, good friends, and family who made themselves available. (A. Jones)

Even with a good support system and adequate supervision, it is well known that counselors are vulnerable to distress because of the nature of the work that they do. However, many counselors may not realize that their own relationships and state of mental health can make them vulnerable. A study (Sherman & Thelen, 1998) of 522 practicing psychologists indicates that half reported relationship problems and that work with traumatized clients was related to their own experiences of distress or impairment. In a similar study (Pope, Tabachnick, & Keith-Spiegel, 1987), 60% of practicing psychologists surveyed indicated that they very often worked while under distress. In the decade since the 1996 special issue of the *Journal of Humanistic Education and Development* (now called the *Journal of Humanistic Counseling, Education and Development*) addressed counselor impairment, the counseling profession has seen a shift in focus from merely identifying and responding to counselor impairment to promoting counselor wellness as a preventative measure. Although this shift is important in terms of the prevention of impairment, it is imperative that counselors continue to be vigilant about identifying experiences and factors that tax their ability to maintain physical and emotional wellness.

Since 1996, research has more clearly identified factors that affect counselor wellness and that make us as counselors more vulnerable to distress. From the research, it appears that there are important factors to consider at the personal level, the counselor-client relationship level, and the work level (Deutsch, 1985; Figley, 1999; Sherman & Thelen, 1998; Skovholt, 2001).

IMPACT OF COUNSELOR LIFE EVENTS, CLIENT TRAUMA, AND WORK ENVIRONMENT

Contrary to what many counselors believe, we are not immune to the effects of personal life events or to the impact of our work with often traumatized

populations. Deutsch (1985) examined the question of whether therapists maintain positive mental health and the influence of personal factors on their work. In Deutsch's study of 294 therapists, she found that more than three fourths reported experiencing relationship difficulties and that 47% of all of the therapists surveyed had at some time in their lives sought therapy for relationship problems. More than half of the therapists surveyed reported experiencing depression in their lives, with only one fourth reporting having received therapy for depression. Another study by Sherman and Thelen (1998) supports the findings of Deutsch. Their survey of 522 therapists found that life events such as relationship problems or major personal illness or injury caused counselors to feel significant distress. Specifically, Sherman and Thelen found that therapists tend to feel less satisfied in their personal lives when dealing with stressful life events. This dissatisfaction can affect counselors' satisfaction with work, resulting in cancelled, late, and missed therapy sessions; a reduced ability to be empathic; and an inability to meet the basic requirements of the job.

Personal Vulnerability to Distress

A personal history of trauma, unresolved personal issues, and life stressors significantly influence counselors' ability to manage stress (Figley, 2002; Valent, 1995; Yassen, 1993). Counselors who have previously or are currently experiencing trauma are at high risk for developing compassion fatigue and job burnout (Pearlman & Mac Ian, 1995). Yassen (1993) suggested that counselors who are abuse survivors may have difficulty setting boundaries with clients, which may increase their vulnerability to impairment.

Cognitive coping ability and personality characteristics also appear to affect how counselors react to stress (Skovholt, 2001). A counselor who has difficulty analyzing and responding to ambiguous situations with his or her clients is more likely to experience stress and anxiety. Counselor personality "hardiness" also appears to be an important factor that may mediate vulnerability to stress (Figley, 2002). Hardiness is a cognitive framework in which the counselor (a) feels in control, (b) has commitment to the work, and (c) sees change as a challenge (King, King, Fairbank, Keane, & Adams, 1998). Counselors who do not exhibit this personality factor may develop a skewed worldview or may have their commitment and response to change affected. However, as the following quote illustrates, counselors who exhibit hardiness may find that this personality factor serves as a buffer that prevents the development of distress.

I would have described myself as having a "hardy" personality. The concept of wellness for myself was totally about staying healthy enough to continue performing my "to do" tasks. Taking care of me included an occasional pedicure or spending a full day without taking the car out of the garage. Even vacations were planned with an estimated time of arrival—fit as much fun as you could into the amount of time allotted and quickly return to work. I didn't become tired easily and appeared to be able to withstand high levels of stress without negative consequences. (A. Jones)

Hardiness notwithstanding, for many counselors, the vulnerability to distress is exacerbated by that fact that often they are working with individuals who have experienced traumatic life events. The cumulative effect of working with clients who have experienced trauma is that the work may result in counselors' developing vicarious traumatization or secondary traumatic stress (STS; Figley, 1995; Pearlman & Saakvitne, 1995). The reality of counseling is that all counselors are doing trauma work with clients. Current research suggests that 36% of clients seen for counseling are trauma survivors (Lawson, 2007). Counselors may work with a variety of clients, from clients who have been traumatized by world events such as 9/11 to clients who are experiencing life-changing events such as cancer. When counselors who work with clients who have been traumatized repeatedly listen to and empathically respond to their stories, a negative transformation of self may occur (Saakvitne, Gamble, Pearlman, & Lev, 2000). This negative transformation may also manifest as a transformed view of the world as an unsafe place (Pearlman & Saakvitne, 1995). Counselors experiencing STS may also have intrusive thoughts or images and avoid reminders of a client's trauma (Cerney, 1995). In addition, counselors with STS may experience symptoms of hypervigilance, difficulty sleeping, irritability, and avoidance of being emotionally available to clients (Salston & Figley, 2003).

Skovholt, Grier, and Hanson (2001) described the following aspects of counseling that compound the challenge of working with traumatized clients: (a) clients' unsolvable problems that must be solved; (b) clients who appear to have resources but who continue to struggle even with help; (c) the frequent occurrence of a readiness gap between counselor and client; (d) counselors' inability to say no; (e) constant empathy, interpersonal sensitivity, and one-way caring that leave counselors emotionally depleted; (f) elusive measures of success; and (g) normative failure that requires counselors to accept the lack of success as a part of the job (pp. 169-170).

These constant emotional interactions with clients who are traumatized are a challenge. It requires the counselor to renew, restore, and come to the client with the resources and energy to be a catalyst for change. What happens when the counselor finds himself or herself in a personal crisis? Not just the occasional spilled coffee, flat tire, fender bender, broken limb, or even a change in career, but a major life-changing event can affect the counselor's ability to cope with his or her clients' traumas. Anita's story describes how a life-changing event can force a counselor to become detached, a distant observer, which then has an impact on that counselor's ability to "be there" or to respond empathically to clients. At that moment, all of a counselor's emotional resources are shifted to responding to that personal crisis.

In May 2003, I received a phone call, via satellite, from my husband informing me our 27-year-old son had drowned while on a white water rafting trip in the remote Frank Church wilderness area of Idaho. It seemed as if my life had shifted into slow motion. It began what was to be a 6-week saga for the search and recovery of our son's remains. As a counselor, and a behavioral science major, I began to note my reactions and behaviors as I responded to this news. (A. Jones)

When a counselor shifts emotional resources to attend to a personal crisis, this creates a deficit in the counseling relationship and ultimately one's ability to remain well. There are several relational factors that predispose counselors to experiencing distress and becoming ultimately unwell. Skovholt (2001) suggested that counselors are vulnerable to becoming ineffective counselors, in part, because of the very nature of the work. Counseling is a "high-touch" profession, and individuals in the high-touch fields must make a connection with and actively engage with clients. As a result, counselors are continually forced to engage and disengage during what Skovholt described as the "caring cycle" (p. 13). Counselors must repeatedly engage with clients via empathic attachment, become actively involved with them during the work of therapy, and then separate. According to Skovholt, this involves an attachment that is made from the counselor's vulnerable side, the part of the counselor that could be hurt in the process. Counselors cannot attach to clients with a wall of self-protection because this affects the quality of the attachment.

The ability to be empathic is a critical aspect of the caring cycle, and it is generally considered to be necessary for the foundation of a successful therapy relationship. Humanistic theorists such as Carl Rogers and Alfred Adler viewed empathy as a necessary and sufficient condition for change (Dinkmeyer, Pew, & Dinkmeyer, 1979; Rogers, 1959). Empathy is defined as a "process of feeling as if one were the other person" (Rogers, 1959, p. 210). Truax and Carkhuff (1967) described empathy as assuming the internal frame of another.

Furthermore, Rogers (1975) described empathy as a process involving three phases: empathic resonance, expressed empathy, and received empathy. This process model highlights the relational nature of empathy. An empathic counselor must not only sense a client's world but also be able to communicate that sensing to the client. This process requires a significant amount of skill and emotional energy, whereby the counselor must be emotionally available to the client.

If it is true that most counselors will have a career lasting 30 to 40 years (Skovholt, 2001), then counselors engage and disengage from the cycle of caring thousands of times. This process of repeated engagement and disengagement, Skovholt suggested, results in a diminished capacity to engage in the caring cycle in future therapeutic relationships. Because caring is such an essential quality of the therapeutic process, counselors' inability to care is "the most dangerous signal of burnout, ineffectiveness, and incompetence" (Skovholt, 2001, p. 12).

Another aspect of the counseling relationship that makes counselors vulnerable to becoming distressed is the two-way nature of the counseling relationship. Figley (1995) described compassion fatigue as "the unsuccessful, maladaptive psychological and social stress responses of Rescue-Caretaking"

(p. 26). As a result of the counselor's inability to rescue or take care of the client, feelings of depletion, self-concern, resentment, neglect, and rejection occur. When the counselor's level of empathic response or concern and exposure to the suffering of clients is prolonged, this exposure results in residual stress (Figley, 1999).

This residual stress leads to traumatic memories or thoughts, life disruption, and performance problems. More specifically, this compassion stress or fatigue leads to problems in the therapeutic relationship. Counselors who are experiencing compassion stress or fatigue will often fail to recognize or will deny client traumas, experience fragmented attention, or exhibit a lack of empathy. In addition, compassion-fatigued counselors may intellectualize, dehumanize, and/or preemptively diagnose their clients (Figley, 2002). Ultimately, this leads clients to accommodate for the deficits in the counselor-client relationship, whereby the helpee in effect becomes the helper, creating enmeshment in the counselor-client relationship.

The Work Environment

Whereas traumatic stress and compassion fatigue impair counselor effectiveness, a counselor can experience job burnout without experiencing impairment in his or her work with clients (Salston & Figley, 2003). Job burnout is described as a "syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment" (Maslach & Jackson, 1986, p. 1). Burnout affects counselors' effectiveness not only in the work that they do but also in their work relationships. Figley (2002) further described burnout as an "emotional numbing" (p. 1437). It is suggested that environmental factors that contribute to job burnout in counselors include (a) the amount and type of work counselors do, (b) overabundance of distressing cases, and (c) too much overtime (Raphael, Meldrum, & Donald, 1993). Counselors who are experiencing burnout are often in work environments that are not supportive of counselor wellness and that leave them isolated and disconnected. Research suggests that this is especially true of counselors who work in rural areas (Valent, 1995). Supervision is often inadequate for counselors in these settings, which leaves them without an outlet for expending their stress and frustration. Time management may also be an issue that results in job stress for counselors because many agencies are understaffed and require that counselors serve clients in a large service area. Ultimately, burned-out counselors are likely to leave the field because they have few resources within the work environment to help them manage and ameliorate stress.

When a wellness action plan is developed, prevention should be the primary focus. In order for counselors to prevent burnout or compassion fatigue, they will need to use various resources, such as self-awareness assessment tools, effective supervision, and reflection on their own issues. Ongoing personal assessment is not only helpful but also imperative if a counselor is to avoid the pitfalls of distress. Prevention begins with self-

awareness and knowledge of how we counselors react to stress. A recent study indicates that approximately 11% of all counselors experience signs of compassion fatigue or vicarious traumatization (Lawson, 2007) and should examine their beliefs about their work and discuss their feelings with a supervisor or peer (Stamm & Figley, 1999).

One avenue that Skovholt (2001) addressed in regard to self-assessment is making sure that there is a balance of caring for others and caring for self. Counselors experience the normal day-to-day stress and strain that living in a complex world brings. A few of these stressors are time and money pressures, multiple-role demands, and high workplace expectations. The cumulative effect of these pressures results in a series of stress-related problems. Many counselors believe, however, that their needs should come second to everyone else's. When counselors do not tend to their own needs, there will be consequences personally and professionally. Counselors must be able to check for signs of stress or concern in their physical, emotional, social, spiritual, and intellectual experience, which may be early warning signs of a problem. Because the practitioner works in a highly stressful environment, there must be a constant awareness of and obligation to self-monitor and to engage in self-nurturing activities. The counselor should check for physical, emotional, social, spiritual, and intellectual signs that there is a problem. Early warning signs of insufficient self-care could be episodes of forgetfulness and inattention (Skovholt, 2001). More serious signs of possible insufficient self-care are episodes of irritability or emotional exhaustion, chronic fatigue, feelings of loneliness or isolation, episodes of anxiety, episodes of depression, and frequent headaches, to name a few (Skovholt, 2001). However, counselors should make a point to understand how they react to stress and to understand the signs that they personally need to watch for in their own behavior. In addition, counselors need to learn how to nurture themselves during these stressful times. Skovholt indicated that we counselors need to "acknowledge that what is good for others is good for ourselves" (p. 148).

The effects of secondary and vicarious traumatization also affect relationships with colleagues and work performance (Figley, 2002). Increased conflict at work and absenteeism are common behaviors exhibited by counselors with STS. Vicarious traumatization and STS set the stage for counselors to become unwell and could contribute to the experience of job burnout.

Whether assessment occurs through self-assessment, formal assessment tools, or ongoing dialogue between supervisor and supervisee, it is important to be aware of the necessity of periodically assessing counselor wellness. Recurrent experiences of traumatic events may compound and result in a state of being unwell without the counselor realizing it. A counselor experiencing burnout may not realize that a change in wellness has occurred.

Our lives were beginning to settle back to a routine. The "hardiness" was returning to me. There was some anxiety as we planned for our first Christmas holiday without our [eldest] son. There were so many things to look forward to. Early one stormy December morning, we received a call from our [youngest] son. We had anticipated

this call as they were expecting their second child. Our son was tearful; the baby was in crisis. He had a diaphragmatic hernia, and the condition was critical. On January 7, just 6 months after losing my son, Von, I lost my precious grandson, Skylar Von. I was trudging down life's road, experiencing another traumatic loss. (A. Jones)

Recognitions of Traumatic Stress

It is common for people who have experienced traumatic situations to have very strong emotional reactions. According to the American Psychological Association (1998),

it is important to remember that there is not one 'standard' pattern of reaction to the extreme stress of traumatic experiences. Some people respond immediately, while others have a delayed reaction—sometimes months or even years later. . . . Some have adverse effects for a long period of time, while others recover quite quickly. A number of factors tend to affect the length of time for recovery, including:

- The degree and intensity of the loss. . . .
- A person's general ability to cope with emotionally challenging emotions. . . .
- Other stressful events preceding the traumatic experience.

(How Do People Respond Differently Over Time? section)

Effective Supervision

Dialogue between supervisor and supervisee should be an ongoing and integral part of the wellness plan. This wellness focus in clinical supervision is an added way of assessing and monitoring for prevention purposes. Good supervision requires a level of trust much like that required in a counselor–client relationship. The supervisor will use direct teaching and modeling in this relationship to help the supervisee refine his or her counseling skills. In addition, the supervisor may provide an atmosphere and environment of caring and support, which helps with the pervasive anxiety that many beginning practitioners experience (Skovholt, 2001). The supervisor is in a position to be able to help the supervisee to become more reflective in his or her approach to wellness and to determine the effect of multiple traumatic life events. As Anita's story highlights, adequate supervision is necessary to identify and intervene when trauma begins to affect the counselor's work:

I was mindful of the need to address my personal feelings. What I had not anticipated was how difficult it would be and the amount of emotional commitment and energy required responding to people who reached out to me. My Rogerian style began to buckle under the emotional stress. Not only did I find it difficult to listen, I was having problems empathizing. I did not have the energy to emotionally interact with my clients and their issues. I struggled with recognition that some of my clients' issues were "significant." I found myself resisting responding to clients with statements like "Suck it up! Things could be lots worse! Stop whining!" My patience was short. I caught myself on several occasions on the verge of self-disclosure with clients, knowing very well that I had not yet resolved my own distress. I tried to remind myself that my clients' problems were real and important to them. (A. Jones)

Supervisors who are aware of the impact that personal life events may have on counselors' work can develop, with their supervisees, a plan of wellness before events occur. This will allow counselors to practice wellness behaviors while they are in a well state, increasing the likelihood the plan will be used when a personal crisis occurs.

THE WELLNESS PLAN

There are several factors that should be included in a counselor wellness plan. Specific components of a counselor wellness plan are addressed in other articles in this special issue; however, some general areas are discussed here.

A wellness plan should include aspects that address both personal and professional wellness. Personal self-care, according to Skovholt et al. (2001), should address all areas of a counselor's personal life, including the physical, spiritual, emotional, and social. It is suggested that counselors work to reduce the number of one-way caring relationships they are maintaining. These types of relationships tax the counselor both emotionally and socially. Maintaining nurturing and challenging connections with family, friends, and social groups is also key. Personal therapy is encouraged to allow for self-reflection and insight, ultimately improving counselor resiliency and sense of well-being.

Professional self-care is maintained through the work environment. Skovholt et al. (2001) described key factors to addressing professional self-care. One strategy they recommended is defining success with clients as being knowledgeable and skillful in the counselor-client relationship rather than focusing on whether clients improve. Increasing self-understanding and reducing the need for validation from clients as to counselors' own needs are critical to keeping the counselor-client relationship professional. Creating a "professional greenhouse at work" (Skovholt, 2001, p. 174) means finding or developing a work environment that encourages growth with leadership and supervision that promote wellness and self-care. Mentorship and having fun at work are seen as key elements of an effective self-care work environment. Finally, minimizing professional loss by acknowledging that a lack of closure and concrete evidence of success are a part of the job helps to keep those events in perspective and not tied to a counselor's worth as a professional.

ASSESSMENT INSTRUMENTS

In addition to behaviorally monitoring oneself and enlisting the assistance of a supervisor in monitoring wellness, there are various instruments that could be used in the self-assessment or supervision process. Some instruments that might be selected for use in the assessment process are the Wellness Evaluation of Lifestyle Inventory (WEL; Myers & Sweeney,

2005), the F.A.M.I.L.Y. Self-Care Assessment Inventory (Eckstein, 2001), the Professional Quality of Life Scale (Stamm & Figley, 1999), and the Stress Reaction Inventory (Yassen, 1995).

WEL

The WEL is a paper-and-pencil measure of wellness based on the Wheel of Wellness model developed by Sweeney and Witmer (1991). The WEL assessment tool looks at the 16 dimensions of healthy functioning represented in the current Wheel of Wellness model. In order to more fully understand the WEL instrument, one must first understand the concept of the Wheel of Wellness model. The model is grounded in counseling theory and takes a holistic point of view when dealing with wellness (Myers & Sweeney, 2005). This holistic point of view stresses the idea that individuals are seen as a combination of parts that work together as a "whole." More specifically, the WEL is based on Adler's (1927/1954) concept that the mind, body, and spirit are inseparable, whereby one aspect of self affects the others. Specifically, Adler related the aforementioned elements of the self to the three basic life tasks of work, friendship, and love. Furthermore, Mosak and Dreikurs (1967) identified self and spirit as being critical components of Adler's model, and these components have also been incorporated into the WEL (Myers & Sweeney, 2005).

In the original Wheel of Wellness model (Sweeney & Witmer, 1991), spirituality is at the core of the Wheel, and work and love and friendship are portrayed as the rims of the Wheel. The spokes of the wheel model include the following eight components: (a) sense of worth, (b) sense of control, (c) realistic beliefs, (d) spontaneous and emotional response, (e) intellectual stimulation, (f) problem solving and creativity, (g) sense of humor, and (h) physical fitness and nutrition. Wellness or healthy functioning is seen as a developmental continuum, and if there is a deficit in any of the areas, it affects the other components in negative ways. As Myers, Sweeney, and Witmer (2000) conducted further research and study, their model evolved into a three-dimensional model of wellness. Spirituality remains the core of the Wheel of Wellness and is believed to be the most important characteristic of healthy individuals. However, the spokes of the wheel have become 12 subtasks of self-direction that include sense of worth, sense of control, realistic beliefs, emotional awareness and coping, problem solving and creativity, sense of humor, nutrition, exercise, self-care, stress management, gender identity, and cultural identity. Friendship, love, and work and leisure are still viewed as life tasks that are basically met or not met through these self-direction subtasks. In addition, the three-dimensional model of the Wheel of Wellness hypothesizes a dynamic interaction between the individual and a variety of life forces. These life forces could include such areas as family, community, education, religion, government, and business, among others. In addition, global events, whether natural, such as floods, or human, such as wars, are seen as having an impact on the individual (Myers & Sweeney, 2005).

Factor analyses of the WEL database and the previous Wheel of Wellness model have resulted in the current model proposed by Myers and Sweeney (2005): the Indivisible Self Model of Wellness. Myers and Sweeney described the new model as an "evidence based model of wellness with a holistic foundation" (p. 269). This model is based on a universal first-order dimension of wellness, which indicates a holistic dimension of wellness that cannot be deconstructed. This serves as a foundation to five second-order factors: (a) Essential Self, (b) Social Self, (c) Creative Self, (d) Physical Self, and (e) Coping Self. These factors constitute the Indivisible Self. Each of the aforementioned factors is composed of third-order factors. The Essential Self consists of spirituality, self-care, gender identity, and cultural identity; the Social Self consists of friendship and love; the Creative Self consists of the components of thinking, emotions, control, positive humor, and work; the Physical Self involves exercise and nutrition; and, finally, the Coping Self involves realistic beliefs, stress management, self-worth, and leisure. All of the selves must be considered in a total estimation of wellness. The selves are also assessed in consideration of local, global, and chronometrical contexts. These contexts are composed of family, work, and world environments. Chronometrical context recognizes that people change over time and in important ways (Myers & Sweeney, 2005, p. 275). The Indivisible Self Model of Wellness supposes that wellness choices made early have an impact on an individual's state of wellness in later life.

The Indivisible Self Model of Wellness has resulted in the development of a new assessment measure, the 5F Wellness Inventory (Myers & Sweeney, 2005). The 5F Wellness Inventory enables the counselor to "engage the clients in meaningful dialogue about the value of wellness to them, as well as ways to enhance their wellness" (Hattie, Myers, & Sweeney, 2004, p. 363). In this way, supervisors may also engage their supervisees in a dialogue to reinforce the importance of keeping oneself healthy when working with others. The 5F Wellness Inventory as an assessment tool has been successfully used as a practical way of promoting positive well-being.

F.A.M.I.L.Y. Self-Care Assessment Inventory

The F.A.M.I.L.Y. Self-Care Assessment Inventory, developed by Eckstein (2001), provides an assessment tool that counselors may use to assess health factors related to self-care. The instrument gives counselors some indication of how effective their self-care behavior is. The F.A.M.I.L.Y. Self-Care Assessment Inventory is composed of six subscales that assess self-care behavior: Fitness, Adaptability, Moving Through Loss, Independence, Longevity, and Your Motivation. All of these subscales are related to the areas of vulnerability discussed earlier. Fitness subscale strategies address the individual's ability to manage stress through physical fitness, social support, emotional support, mental focus, and spiritual faith. The Adaptability subscale assesses environmental demands that may potentially lead

to feelings of hopelessness. The Moving Through Loss subscale is used to ascertain an individual's movement through the process of grieving for losses in the areas of physical, emotional, spiritual, and mental domains. This subscale would be especially useful when working with counselors who have experienced trauma or grief events. The Independence subscale focuses on the resources that maintain intimacy, identity, and insight. Longevity is a subscale that provides information about the basic needs for caring for self in order to live more effectively. Finally, the Your Motivation subscale assesses why one would want to create a healthy balance. Low motivation may indicate that there is not an understanding or a belief that health and well-being are important (Eckstein, 2001). This instrument provides the counselor and supervisor a means to assess vulnerability to impairment and stress in a global way.

Professional Quality of Life Scale

The Professional Quality of Life Scale (ProQOL; Stamm, 2002) is an instrument that has replaced Figley's (1995) Compassion Fatigue Self-Test. The need for an updated test as well as a new name is due to the overall effort of the counseling profession to focus more on the professional quality of life rather than on the negative effects of caregiving. This paradigm shift is in an effort toward prevention rather than remediation. The ProQOL has been shortened from 66 items to 30 items and now consists of three subscales: Compassion Satisfaction, Burnout, and Compassion Fatigue/Secondary Trauma (Stamm, 2002).

The Compassion Satisfaction subscale deals with the pleasure one derives from being able to work with others in a helping capacity. This subscale encompasses such components as work setting, interaction with colleagues, and being able to contribute to others in society. The Burnout subscale deals with feelings of hopelessness and frustrations associated with feelings of being ineffective in the workplace or with clients. High workload, nonsupportive work environment, and not seeing immediate results may be components of this subscale. The Compassion Fatigue/Secondary Trauma subscale is used to assess feelings regarding work-related, secondary exposure to stressful or traumatic events.

These three subscales do not yield a composite score, but rather each subscale is psychometrically unique and stands alone. However, there can be correlations between the three subscales. For instance, it is possible to have reported high scores on the Compassion Satisfaction subscale and high scores on the Compassion Fatigue/Secondary Trauma subscale, but it is highly unlikely to see high scores on the Compassion Satisfaction subscale along with high scores on the Burnout subscale. However, there does appear to be a high correlation between Burnout and Compassion Fatigue/Secondary Trauma subscale scores.

When using the ProQOL for self-assessment, the average subscale scores are useful references for possible intervention. The average scores for the

Compassion Satisfaction, Burnout, and Compassion Fatigue/Secondary Trauma subscales are 37, 23, and 13, respectively. Counselors scoring at or below 32 on the Compassion Satisfaction subscale are advised to examine how they feel about their work and possibly discuss their feelings with a trusted colleague. Similarly, counselors scoring at or above 28 on the Burnout subscale or 18 or above on the Compassion Fatigue/Secondary Trauma subscale should consider discussing the results with a trusted colleague in the event that further intervention is necessary.

Stress Reaction Inventory

Yassen (1995) offered another instrument that is effective in screening for counselor stress. The Stress Reaction Inventory assesses six wellness domains: physical, cognitive, emotional, spiritual, interpersonal, and behavioral. The inventory's simple checklist format provides a quick reference, which reflects some of the stressors that counselors may experience. In addition, this instrument enables the counselor to identify stress signals in a particular domain where they may need additional support. Symptoms of distress in the aforementioned six domains are listed, and the counselor is able to readily identify those they are experiencing. In addition, Yassen (1995) identified wellness strategies the counselor might want to use to alleviate those symptoms. Results from the Stress Reaction Inventory can then be used as a tool to begin a dialogue between supervisee and supervisor (or counseling peer).

For 6 weeks, we continued our effort to locate our son's remains. This required organization of weekly camping expeditions into a remote wilderness area. There was a 4-mile hike from the nearest vehicle access. Hindsight tells me that those opportunities to hike with friends and family who assisted in the search and the physical challenge added to the healing. I began to view the wilderness not as a wild, wicked, dangerous region which had taken my son away, but as a beautiful, calming, spiritual element (a perfect location to release his earthly life). (A. Jones)

CONCLUSION

It is imperative that counselors become aware of their vulnerability to distress and how to assess for and respond to it if it occurs. Because counselors are working with populations whose work affects them so directly, maintaining wellness and preventing impairment become critical to providing good care. In addition to client care, it is important that counselors take care of themselves to maintain a good quality of life so that they do not leave the field prematurely. We have included the story of the third author to illustrate both the challenges counselors face and examples of adaptive responses to those challenges.

In addition to personal factors, the literature suggests that the supportiveness of the work environment is a critical aspect in promoting the wellness of

counselors in the workplace. Counselors who work in an environment that includes interaction with colleagues, encourages regular self-care activities, and offers manageable caseloads of clients dealing with trauma are less likely to incur the negative aspects of the profession that could lead to burnout and a state of not being well. Proper supervision also appears important to providing a sense of checks and balances to detect counselor vulnerability to distress before the counselor's behavior becomes unethical or impairment occurs. Assessments discussed in this article offer supervisors tools to assess supervisee wellness so that appropriate interventions may be offered.

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