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# Wellness, Professional Quality of Life, and Career-Sustaining Behaviors: What Keeps Us Well?

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A sample of 506 professional counselors who were members of the American Counseling Association completed measures of professional quality of life, career-sustaining behaviors (CSBs), and wellness. Significant differences were found both within the sample based on caseload characteristics and between the participants and available norm groups. Counselors with high wellness scores engaged in more CSBs and reported higher positive professional quality of life factors (compassion satisfaction). Implications for counselors, counselor training, and research are discussed.

The fact that impaired counselors are more likely to harm clients has been established (Lawson, Venart, Hazler, & Kottler, 2007); similarly, well counselors are more likely to help clients become more well (Hill, 2004; Witmer & Granello, 2005; Witmer & Young, 1996). Although few studies have examined wellness among counselors, the emerging literature suggests that counselor educators (Wester, Trepal, & Myers, 2009), counseling students (Myers & Sweeney, 2004; Roach & Young, 2007; Smith, Robinson, & Young, 2008), and professional counselors (Lawson, 2007; Mobley, 2003) all face challenges to optimal well-being. Lawson and Venart (2005) observed that counselors may be more vulnerable to mental and emotional disorders than are members of the general population; therefore, they underscored the need to better understand both the risk factors for impairment and the strategies for helping counselors be more resilient and thus more well. The need to better understand wellness among counselors was further underscored by Meyer and Ponton (2006), who observed that "resiliency in counselors is not an accident. Rather it is the cumulative effect of counselors' healthy decision making" (p. 200).

Various authors have suggested strategies for helping counselors make healthy decisions (e.g., Good, Khairallah, & Mintz, 2009; Meyer & Ponton, 2006) as a means of enhancing both personal wellness and professional quality of life (e.g., Cummins, Massey, & Jones, 2007; Venart, Vassos, & Pitcher-Heft, 2007). Most of these suggestions are based on what is known about wellness from both theoretical (e.g., Myers & Sweeney, 2004, 2005a) and empirical perspectives (Myers & Sweeney, 2005a, 2008) rather than on literature that links factors such as compassion fatigue, compassion satisfaction, and burnout, all of which affect professional quality of life (Sprang, Clark, & Whitt-Woosley, 2007). What counselors may do to enhance their professional quality of life, or the extent to which counselors engage in career-sustaining behaviors (CSBs; Stevanovic & Rupert, 2004), and how this affects their wellness have not been examined. Next, we present a brief summary of the literature on three main variables related to counselor wellness to provide a context for better understanding the study and meaning of the results.

## Wellness

Witmer and Sweeney (1992) and Myers, Sweeney, and Witmer (2000) reviewed literature from multiple disciplines to determine empirical correlates of health, quality of life, and longevity. Seventeen characteristics were identified and presented in a hypothetical Wheel of Wellness (Sweeney & Witmer, 1991), which served as the basis for initial studies of wellness from a counseling perspective. The expected relationships among wellness components were not supported in later studies, and a new model, the Indivisible Self Model of Wellness (IS-Wel), emerged as an evidence-based paradigm for understanding the multidimensional nature of holistic well-being (Myers & Sweeney, 2004, 2008). Based in structural equation modeling, the IS-Wel incorporates a three-level factor structure with a single higher order Wellness factor (i.e., the indivisible self), five second-order factors, and the original 17 wellness components grouped within the five factors.

Within the IS-Wel model, wellness is defined as "a way of life oriented toward optimal health and well-being, in which body, mind, and spirit are integrated by the individual to live life more fully within the human and natural community" (Myers et al., 2000, p. 252). The multifaceted, multidimensional wellness construct is consistent with a developmental, preventive orientation that has been identified as the hallmark of the counseling profession (Sweeney, 2001) and has been applied in multiple studies of wellness across populations and settings of interest to professional counselors (see Myers & Sweeney, 2008, for a review of wellness studies). Of interest here are studies involving counseling students and professionals, all of which have used the Five Factor Wellness Inventory

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(5F-Wel; Myers & Sweeney, 2004, 2005b) to assess wellness in the dimensions of the IS-Wel model.

Wellness of counseling students has been examined in several studies. Myers and Sweeney (2004) found higher levels of wellness among counseling students than among students in other majors. Roach (2005) found that counseling students exposed to courses in wellness had higher wellness scores, and Smith et al. (2008) found a statistically significant negative relationship between level of psychological disturbance and wellness for counseling students.

Mobley (2003) studied wellness in a sample of 289 male practicing professional counselors, specifically in relation to gender role conflict (GRC) and counselor training. He found that male professional counselors experienced both less GRC and greater wellness than did other groups of men; however, GRC did not predict wellness. Neither variable was related to accreditation status of training programs.

Wester et al. (2009) examined wellness among 180 counselor educators and found higher levels of wellness in their sample when compared with Myers, Mobley, and Booth (2003) study of counseling students. Higher levels of perceived stress and more children were inversely correlated with wellness. Differences among academic ranks were noted, with assistant professors reporting lower levels of Coping Self wellness, specifically Realistic Beliefs. A follow-up qualitative study is in process, which includes intentional interviews with approximately 15 counselor educators, to further explore the meaning of wellness in this population and how wellness affects factors related to personal and professional quality of life.

## Professional Quality of Life

Figley (1995) and Maslach (2003a) have observed that there is a cost to caring for helping professionals, and that cost can be conceptualized in various ways. Frequently, the risks that counselors face to their professional quality of life are described as burnout, compassion fatigue, and vicarious traumatization. Professional quality of life incorporates significant risks (burnout, compassion fatigue) inherent in the work that counselors do as well as the payoffs (compassion satisfaction).

Counselors have long understood that burnout is a potential risk inherent in the counseling profession. Freudenberg and Richelson (1980) offered an early definition of burnout as "a state of fatigue or frustration brought about by devotion to a cause, way of life, or relationship that failed to produce the expected reward" (p. 13). Since that time, research into burnout, specifically as it is experienced by counselors and helping professionals, has refined the definition. Maslach (2003b) described burnout as consisting of three dimensions: exhaustion (including emotional), cynicism, and decreased sense of efficacy. Burnout is a long-term degradation of these dimensions caused, in part, by the chronic strain that results from insufficient resources and excessive demands or incongruence between individuals and the work they do. The result of burnout can manifest physically and emotionally and often results in counselors who do not leave the field but who cannot adequately serve their clients any longer.

Stamm (1997) noted that the controversy is not whether secondary trauma exists among counselors as much as what it should be called. In terms of professional quality of life, the focus is on compassion fatigue, which is the product of bearing witness to the suffering of others, and results in a reduced ability or capacity to be present with clients, feelings of powerlessness, isolation, and confusion (Figley, 2002). Factors that contribute to compassion fatigue include poor counselor self-care, the counselor's own unresolved trauma, inability or unwillingness to control work stressors, and a lack of satisfaction from one's work (Figley, 1995). Figley (1995) also noted that compassion fatigue is characterized by emotional and physical exhaustion, a tendency to withdraw, reluctance to discuss the problem, high levels of stress, and irritability often expressed outside of the workplace.

The third aspect of professional quality of life is compassion satisfaction, which Stamm (2005) described simply as "the pleasure you derive from being able to do your work well" (p. 5). This often overlooked component is seen as the balance to compassion fatigue. In fact, Figley and Stamm (1996) noted that the key to preventing compassion fatigue lies in counselors detecting and reinforcing the sense of satisfaction they derive from working with clients. To remain effective and vital in their work, counselors must be able to recognize and find joy in their ability to help others.

Research across these areas has provided counselors with information regarding the professional quality of life of clinicians, both trauma specialists and generalists. Recent studies of professional quality of life have included samples of mental health providers, including trauma workers (Larsen & Stamm, 2008), child care workers (Eastwood & Ecklund, 2008), and international aid workers in Darfur (Musa & Hamid, 2008). In each of these studies, professional quality of life was assessed using the Professional Quality of Life scale (ProQOL; Stamm, 2005), which assesses burnout, compassion fatigue, and compassion satisfaction.

With a national sample chosen at random, Lawson (2007) found that counselors scored significantly better (lower on the Burnout and Compassion Fatigue subscales, higher on the Compassion Satisfaction subscale) on the ProQOL than did the normed group, which included therapists, teachers, nurses, child protective care workers, school personnel, and humanitarian aid workers. Across the 501 counselors who responded, 5.2% scored above the cut point (28) for Burnout, and 10.8% of participants scored above the cut point (17) for Compassion Fatigue. Similarly, 14.2% of counselors scored below the cut point (32) for Compassion Satisfaction, suggesting either that they are no longer deriving satisfaction from their work or that they find satisfaction elsewhere.

Sprang et al. (2007) examined the professional quality of life of more than 1,100 mental health providers in one south-

ern state. In this group, the mean Compassion Fatigue score was lower than that of the national sample, with 13.2% of the respondent pool scoring above the suggested cutoff. Similarly, on the Burnout subscale, these providers scored better than did the national sample, with 13.0% scoring above the cutoff on the Burnout subscale. Finally, providers were more satisfied in their work, scoring slightly higher on the Compassion Satisfaction subscale than did the national sample, with almost half (48.7%) scoring above the cutoff of 41. The authors suggested that the higher scores of mental health providers could be related to steps taken among these professionals to reduce stress and sustain life and work (career) satisfaction.

## CSBs

CSBs are those personal and professional activities that counselors participate in which help them to extend, enhance, and more fully enjoy their work experiences (Brodie, 1982). Kramen-Kahn and Hansen (1998) noted that counselors need to be aware of the hazards and rewards of the work that they do and be vigilant about incorporating CSBs into their daily practice. This is particularly true for professionals who do not have control (or a sense of control) over hazards (e.g., economic and workload uncertainty) or who are vulnerable in other ways.

Stevanovic and Rupert (2004) found that psychologists who were more satisfied in their work also rated the value of 10 specific CSBs higher than did less satisfied psychologists: vary work responsibilities, use positive self-talk, maintain balance between personal and professional lives, spend time with partner/family, take regular vacations, maintain professional identity, turn to spiritual beliefs, participate in continuing education programs, read literature to keep up to date, and maintain sense of control over work responsibilities. The authors noted the importance of finding balance between personal and professional work to remaining effective as a clinician and that the CSBs that are most valued reflect that striving for balance.

Rupert and Kent (2007) examined the effect of work setting and gender on CSBs in a sample of 595 psychologists. Consistent with previous findings, they found that maintaining a sense of humor, maintaining self-awareness, maintaining balance between professional and personal lives, maintaining professional identity/values, and spending time with spouse/partner/family were among the top CSBs (Stevanovic & Rupert, 2004). Significant differences were discovered in that women endorsed more CSBs overall and rated 15 specific CSBs higher than men did. The authors cautioned that there may be a tendency for women to endorse more CSBs generally, but the strengths of their findings suggest that women are more "inclined to use relational or support-seeking strategies and to recognize the importance of self-awareness" (Rupert & Kent, 2007, p. 93).

Lawson (2007) examined the CSBs of 501 counselors in a national sample. Four of the five strategies endorsed by counselors were the same as for psychologists in previous studies. The top five strategies endorsed by counselors were the following: maintain sense of humor, spend time with partner/family, maintain balance between professional and personal lives, maintain self-awareness, and maintain sense of control over work responsibilities. The author also compared the CSBs of highly satisfied and less satisfied counselors and identified 14 CSBs that were rated higher and one variable that was rated lower (i.e., use substances to relax) by more satisfied counselors. It is interesting that Lawson also found that counselors who practiced more CSBs were less likely to experience burnout than were those who endorsed fewer CSBs.

## Method

The present study was undertaken to address gaps in the literature concerning counselor wellness in relation to professional quality of life and CSBs through the following research questions: (a) What are the levels of wellness, professional quality of life factors (compassion satisfaction, burnout, compassion fatigue), and CSBs among professional counselors? (b) Are there differences in these three variables for professional counselors when compared with the normed samples in allied professions or based on caseload variables? and (c) What are the relationships between wellness, professional quality of life factors, and CSBs among professional counselors?

### Participants and Procedure

The names and addresses of 1,000 members of the American Counseling Association (ACA) were selected at random and contacted by U.S. mail, following Dillman's (2000) tailored design method. The first author sent a presurvey letter introducing the purpose of the survey, followed by the initial survey packets 2 days later. After 1 week, participants who had not responded received a reminder postcard, and 10 days later, those who had still not responded received a second survey packet. A small number ($n$ = 22) of packets were returned undeliverable, or the participant responded indicating that he or she would not be appropriate for the survey (e.g., had retired, did not provide counseling), resulting in 978 potential respondents. A usable sample of 506 surveys was obtained, resulting in a response rate of 51.7%.

### Measures

The survey packet included three paper-and-pencil assessments and a demographic questionnaire. The demographic questionnaire was designed for this study to gather general demographic information and other information that may relate to counselor wellness. The instruments were the 5F-Wel, the ProQOL (specifically Revision III), and the Career-Sustaining Behaviors Questionnaire (CSBQ; Stevanovic & Rupert, 2004).

*5F-Wel.* The 5F-Wel was developed through structural equation modeling and measures the components of wellness in the IS-Wel model. Scores are included for overall or Total

Wellness, five second-order wellness factors (Essential Self, Social Self, Creative Self, Physical Self, and Coping Self), and 17 discrete wellness factors. The instrument includes 91 items scored using a 4-point Likert-type scale, 73 of which are scored on the five second-order factors and the remaining items on four context scales. Scores are sums of mean item responses recalculated to place each scale on a common metric with a range of 25 to 100. Only participants' total scores and five second-order factor scores were used in this study.

Smith et al. (2008) administered the 5F-Wel to a sample of counseling students and found no relationship between wellness and social desirability. Myers and Sweeney (2008) reported the results of multiple studies establishing convergent and divergent validity for the 5F-Wel scales. They also reported alpha coefficients for a heterogeneous sample including undergraduate and graduate students and a general adult population ranging from .89 for the Coping Self scale to .96 for the Creative Self and Social Self scales, and .98 for Total Wellness. The current sample yielded the following internal consistency coefficients: Total Wellness (.94), Essential Self (.83), Social Self (.84), Creative Self (.86), Physical Self (.88), and Coping Self (.87).

*CSBQ.* The CSBQ includes 34 items scored on a 7-point Likert-type scale, which participants use to rate specific strategies for their importance in helping the counselor function effectively and maintain a positive attitude in their professional role. The CSBQ include items such as "maintain sense of control over work responsibilities," "maintain self-awareness/self-monitoring," "maintain balance between professional and personal lives," and "receive regular clinical supervision." Scores are calculated as mean item responses. The CSBQ has moderate internal consistency, with the Cronbach's alpha for the total score reported at .71 (Kramen-Kahn & Hansen, 1998). The Cronbach's alpha for our sample was .89.

*ProQOL.* The ProQOL includes 30 items designed to measures three dimensions of professional quality of life: compassion satisfaction, burnout, and compassion fatigue/vicarious traumatization. Respondents report the frequency of specific experiences on a scale of 0 (*never*) to 5 (*very often*). Stamm (2005) reported alpha reliabilities for the three subscales for a sample of 463 as follows: Compassion Satisfaction (.87), Burnout (.72), and Compassion Fatigue (.80). The current sample yielded the following internal consistency coefficients: Compassion Satisfaction (.84), Burnout (.78), and Compassion Fatigue (.80). The construct validity of the ProQOL has been well established in the literature given that the subscale intercorrelations are relatively low, suggesting that the subscales measure three distinct constructs.

### Statistical Analyses

Descriptive statistics were computed to identify the general level of wellness, professional quality of life factors, CSBs, and participant characteristics (e.g., demographic and caseload variables). Analyses of variance (ANOVAs) and *t* tests were computed to identify statistically significant differences in the means between groups based on select variables, and correlational analyses were used to identify relationships among variables. The assumptions of linearity and homoscedasticity for the correlational analyses were met, and the assumptions for homogeneity in the ANOVAs were met. We also followed the example of Stamm (2005) in using the top and bottom quartiles to compare the factors of interest. This method is a type of extreme groups analysis and allows for the comparison of groups of individuals who scored in the extreme on one measure of interest (Preacher, Rucker, MacCallum, & Nicewander, 2005). SPSS (Version 17 for Windows) was used to perform all analyses, and we selected the .01 confidence level for the statistical analyses.

## Results

### Demographic Description of Participants

Consistent with other studies of counselors (e.g., Myers et al., 2003), most participants were female (78.8%) and their primary cultural background was Caucasian (89.1%). A minority were African American (5.5%), Asian/Pacific Islander (2.6%), Hispanic (1.8%), and Native American (1.0%). In addition, 4.0% reported that they were biracial. The mean age of participants was 49.9 years ($SD$ = 11.1).

Counselors had been working an average of 13.6 years ($SD$ = 9.4). Most of the counselors indicated that a master's degree was their highest degree earned (72.9%), followed by those holding a doctorate (e.g., PhD, PsyD; 19.1%), those with a specialist degree (7.5%), and those with a professional degree (e.g., MD, JD; 0.4%). (Percentages in this section may not equal 100% because of rounding.) More than two thirds (69.1%) reported that they were licensed as a professional counselor (or their state's equivalent). A plurality of these counselors were working in private practice (39.3%), followed by community mental health agencies (23.5%), K–12 schools (20.6%), college or university settings (11.7%), and hospital or residential settings (4.9%). Approximately half (46.3%) indicated that they worked in a suburban area, 33.7% in an urban area, and 19.9% in a rural locale.

### Caseload Variables

Caseload variables, including the size of counselors' caseloads, the percentage of clients who are suicidal or self-injurious, and the percentage of clients who are trauma survivors, are useful in interpreting counselor responses to wellness and impairment questions. Counselors reported a mean of 123 ($SD$ = 1,017.90) clients on their typical caseload. This figure seems remarkably high, and it seems that counselors in some educational settings occasionally reported the entire number of students who are assigned to them as their active caseload rather than those who are seen in the counseling relationship on an ongoing basis. In an effort to control for this discrepancy, we excluded those caseloads of more than 200 clients (the

point at which a setting other than an educational institution appeared), which resulted in a mean of 30.86 ($SD$ = 33.70) clients on a typical caseload.

Counselors reported that, on average, 35.0% of clients on their caseloads were survivors of some sort of trauma, which was defined as including sexual abuse, domestic violence, victims of crime, and the like. Similarly, 15.5% of clients on these counselors' active caseloads were reported to be actively or regularly suicidal, self-injurious, or otherwise a danger to themselves or others.

### Research Question 1

The 5F-Wel Total Wellness score and five factor scores were significantly higher than the scores of the normed sample. All differences were significant at $p < .01$, with medium to large effect sizes. Scores for the 5F-Wel are shown in Table 1. Mean scores on Total Wellness ranged from 78.11 ($SD$ = 14.94) for Physical Self to 92.50 ($SD$ = 8.98) for Social Self. Variability among scores as assessed by the standard deviations was greatest for Physical Self and lowest for Creative Self and Total Wellness. Table 1 also includes mean scores for the ProQOL subscales.

The highest and lowest rated CSBs are shown in Table 2. These behaviors were indicated as the most important for helping participants function effectively and maintain a positive attitude. The top eight strategies had a mean greater than 6.00 on the 7-point scale: spend time with partner/family (6.52), maintain sense of humor (6.45), maintain balance between professional and personal lives (6.42), maintain self-awareness (6.38), reflect on positive experiences (6.16), engage in quiet leisure activities (6.15), try to maintain objectivity about clients (6.14), and maintain professional identity (6.05). The strategies with the lowest endorsement from counselors were discuss work frustrations with spouse/partner/family (4.96), engage in formal relaxation activities (4.90), receive regular clinical supervision (4.45), participate in personal therapy (4.17), discuss work frustrations with friends (4.08), participate in peer support groups (3.72), and use substances to relax (1.53).

**TABLE 1**

**Levels of Wellness and Professional Quality of Life Among Professional Counselors**

| | Total | | Norm Group Comparison | | | | |
|---|---|---|---|---|---|---|---|
| Variable | *M* | *SD* | *M* | *SD* | *t* | *p* | *d* |
| 5F-Wel[a] | | | | | | | |
| Creative Self | 84.96 | 7.95 | 77.80 | 12.99 | 12.06 | < .001* | .67 |
| Coping Self | 80.13 | 9.49 | 72.36 | 10.63 | 15.53 | < .001* | .77 |
| Social Self | 92.50 | 8.98 | 84.06 | 17.82 | 10.45 | < .001* | .60 |
| Essential Self | 87.04 | 9.46 | 78.90 | 16.15 | 11.05 | < .001* | .62 |
| Physical Self | 78.11 | 14.94 | 70.98 | 17.00 | 8.93 | < .001* | .45 |
| Total Wellness | 84.05 | 7.45 | 76.22 | 12.51 | 13.71 | < .001* | .76 |
| ProQOL[b] | | | | | | | |
| Compassion Satisfaction | 40.53 | 5.57 | 37.00 | 7.30 | 8.04 | < .001* | .54 |
| Burnout | 19.93 | 5.96 | 22.00 | 6.80 | 4.73 | < .001* | .32 |
| Compassion Fatigue | 10.32 | 5.98 | 13.00 | 6.30 | 6.33 | < .001* | .44 |

*Note.* 5F-Wel = Five Factor Wellness Inventory; ProQOL = Professional Quality of Life Scale.
[a]$df$ = 3837. [b]$df$ = 967.
*$p < .01$.

**TABLE 2**

**Highest and Lowest Rated Career-Sustaining Behaviors Among Counselors**

| Career-Sustaining Behavior | *M* | *SD* |
|---|---|---|
| Spend time with partner/family | 6.52 | 0.97 |
| Maintain sense of humor | 6.45 | 0.90 |
| Maintain balance between professional and personal lives | 6.42 | 0.95 |
| Maintain self-awareness | 6.38 | 0.95 |
| Reflect on positive experiences | 6.16 | 1.05 |
| Engage in quiet leisure activities | 6.15 | 1.10 |
| Try to maintain objectivity about clients | 6.14 | 1.06 |
| Maintain professional identity | 6.05 | 1.07 |
| Discuss work frustrations with spouse/partner/family | 4.96 | 1.61 |
| Engage in formal relaxation activities | 4.90 | 1.65 |
| Receive regular clinical supervision | 4.45 | 2.05 |
| Participate in personal therapy | 4.17 | 1.83 |
| Discuss work frustrations with friends | 4.08 | 1.79 |
| Participate in peer support groups | 3.72 | 1.95 |
| Use substances to relax | 1.53 | 1.10 |

### Research Question 2

*Wellness.* Differences in the 5F-Wel scores based on several caseload variables were statistically significant, but the low effect sizes suggest that those differences are less relevant in practical terms. Counselors who worked in private practice ($n$ = 191, $M$ = 85.58, $SD$ = 6.90) also scored higher on the 5F-Wel than did counselors who worked in K–12 school ($n$ = 100, $M$ = 83.10, $SD$ = 7.75) and community agency settings ($n$ = 114, $M$ = 82.36, $SD$ = 7.50), $F(4, 481) = 4.11$, $p = .003$, $\eta^2 = .03$. One caseload variable was found to be negatively correlated with the 5F-Wel scores. Specifically, counselors who scored higher on the 5F-Wel tended to have a lower percentage of high-risk clients (actively or regularly dangerous to self or others; $r = -.19$, $p < .001$, $r^2 = .03$).

*Professional quality of life.* Scores on all three ProQOL subscales in our sample compared favorably with those of the sample on which the instrument was originally normed (see Table 1; Stamm, 2005). Counselors in our sample scored significantly higher on the Compassion Satisfaction subscale than did the normed sample, $t(967) = 8.76$, $p < .01$, $d = .54$. On the Burnout subscale, counselors in our sample scored significantly lower than did the normed sample, $t(967) = 10.59$, $p < .01$, $d = .32$. Likewise, the score for our sample on the Compassion Fatigue subscale was significantly lower than the published score on that subscale, $t(967) = 7.01$, $p < .01$, $d = .44$.

Our analysis revealed a relationship between some of the ProQOL subscale scores and counseling setting and caseload variables. Counselors who worked in private practice ($n$ = 191, $M$ = 42.13, $SD$ = 4.46) scored higher on the Compassion Satisfaction subscale than did counselors working in K–12

school ($n$ = 100, $M$ = 40.06, $SD$ = 5.08), college or university ($n$ = 57, $M$ = 39.58, $SD$ = 6.50), or community agency settings ($n$ = 114, $M$ = 38.91, $SD$ = 6.64), $F(4, 481) = 7.82$, $p < .001$, $\eta^2 = .06$. Counselors in private practice ($M$ = 17.21, $SD$ = 5.17) also scored lower on the Burnout subscale than did counselors working in community agency ($M$ = 20.43, $SD$ = 6.39) and K–12 school settings ($M$ = 19.98, $SD$ = 6.20), $F(4, 481) = 7.28$, $p < .001$, $\eta^2 = .06$. Although these findings were statistically significant, effect size was very modest.

There were also differences in the ProQOL subscale scores based on caseload variables. A positive correlation was noted between the percentage of clients on a counselor's caseload who were trauma survivors and the Burnout subscale ($r$ = .14, $p$ = .002, $r^2$ = .02). Similarly, we found that there was a positive relationship between the percentage of high-risk clients and scores on the Burnout subscale ($r$ = .20, $p < .001$, $r^2$ = .04) and a negative relationship between the percentage of high-risk clients and scores on the Compassion Satisfaction subscale ($r = -.18$, $p < .001$, $r^2$ = .03).

The ProQOL manual (Stamm, 2005) provides cutoff scores for each of the three subscales. These scores were set by the scale's author at the 75th percentile for the normed groups and offer some idea of how many counselors scored in areas that may be cause for concern. In our sample, 8.9% of counselors scored below the cut point (32) for the Compassion Satisfaction subscale, suggesting that they are either no longer deriving satisfaction from their work or that they find satisfaction elsewhere. In addition, 6.1% of counselors scored above the cut point (28) for the Burnout subscale. If this score reflects a persistent state for those counselors, they are at higher risk for burnout and may be experiencing difficulty with their work responsibilities and feeling hopeless or ineffective as counselors. Finally, 10.3% of participants scored above the cut point (17) for the Compassion Fatigue subscale. Elevated scores in this area suggest a higher risk for vicarious traumatization or compassion fatigue, which may result in an inability to develop empathy for clients or even trauma-related symptomatology.

### Research Question 3

One interesting, but not altogether surprising, finding emerged with regard to how the scores on the ProQOL and the 5F-Wel related to one another. Scores on the 5F-Wel were significantly correlated with scores on the ProQOL, with Total Wellness and Compassion Satisfaction positively correlated ($r$ = .57, $p < .001$, $r^2$ = .32), and Total Wellness scores negatively correlated with both Burnout ($r = -.58$, $p < .001$, $r^2$ = .34) and Compassion Fatigue ($r = -.37$, $p < .001$, $r^2$ = .14). Following the model that Stamm (2005) used, we compared those individuals in the top and bottom quartiles of 5F-Wel scores. Only one of the 143 counselors (0.7%) in the top quartile on the 5F-Wel scored below the cut point score for Compassion Satisfaction, four counselors (2.8%) scored above the cut point for Compassion Fatigue, and no counselors in the top quartile on the 5F-Wel scored above the cut point for Burnout. The converse was true as well. Among counselors who scored in the lower quartile on the 5F-Wel, 28.6% scored below the cut point for Compassion Satisfaction, 26.9% scored above the cut point for Compassion Fatigue, and 16.8% scored above the cut point for Burnout.

We also compared the use and importance of CSBs between counselors who scored in the highest and lowest quartiles on the 5F-Wel (see Table 3). Using the Total Wellness score, we compared the responses of the upper and lower quartile on the

**TABLE 3**

**Career-Sustaining Behavior Differences by Wellness Quartiles**

| | High Wellness | | Low Wellness | | High–Low Group Differences | | |
|---|---|---|---|---|---|---|---|
| Career-Sustaining Behavior | *M* | *SD* | *M* | *SD* | *M* Difference | *F*(1, 260) | *p* |
| Turn to spiritual beliefs | 6.21 | 1.39 | 4.90 | 1.89 | 1.31 | 41.29 | .001* |
| Engage in physical activities | 6.42 | 0.92 | 5.19 | 1.49 | 1.23 | 66.20 | .001* |
| Engage in formal relaxation activities | 5.54 | 1.55 | 4.39 | 1.70 | 1.15 | 32.60 | .001* |
| Use positive self-talk | 6.15 | 1.30 | 5.24 | 1.59 | 0.91 | 26.07 | .001* |
| Participate in peer support groups | 4.09 | 2.05 | 3.21 | 1.80 | 0.88 | 13.33 | .001* |
| Spend time alone in self-reflection | 6.17 | 1.14 | 5.34 | 1.47 | 0.83 | 27.05 | .001* |
| Vary work responsibilities | 5.88 | 1.17 | 5.14 | 1.37 | 0.74 | 22.04 | .001* |
| Participate in personal therapy | 4.59 | 1.85 | 3.90 | 1.86 | 0.69 | 8.95 | .003* |
| Participate in continuing education | 6.27 | 0.98 | 5.62 | 1.17 | 0.65 | 22.45 | .001* |
| Spend time with friends | 6.16 | 1.07 | 5.53 | 1.33 | 0.63 | 18.24 | .001* |
| Maintain self-awareness | 6.68 | 0.72 | 6.08 | 1.07 | 0.60 | 28.62 | .001* |
| Reflect on positive experiences | 6.43 | 0.92 | 5.86 | 1.14 | 0.57 | 20.02 | .001* |
| Engage in quiet leisure activities | 6.42 | 0.98 | 5.86 | 1.21 | 0.56 | 17.16 | .001* |
| Maintain balance between professional and personal life | 6.75 | 0.51 | 6.19 | 0.99 | 0.56 | 34.33 | .001* |
| Take regular vacations | 6.10 | 1.25 | 5.55 | 1.53 | 0.55 | 10.32 | .001* |
| Maintain regular contact with referral networks | 5.25 | 1.38 | 4.72 | 1.43 | 0.53 | 9.33 | .002* |
| Maintain professional identity | 6.34 | 8.73 | 5.82 | 1.18 | 0.52 | 16.76 | .001* |
| Limit time spent with clients | 5.59 | 1.29 | 5.07 | 1.44 | 0.52 | 9.46 | .002* |
| Spend time with partner/family | 6.73 | 0.71 | 6.28 | 1.09 | 0.45 | 16.11 | .001* |

*$p < .01$.

34 CSBQ items to determine which CSBs were practiced by counselors who had higher wellness scores. This comparison revealed that counselors with higher 5F-Wel scores rated the importance of 19 strategies significantly higher than did counselors with lower 5F-Wel scores. Although the differences were statistically significant, the effect size for the differences was modest for all the variables, with eta-squared values ranging from a low of .03 (maintain regular contact with referral networks) to a high of .20 (engage in physical activities).

## Discussion

The research we have undertaken brings together three strands of counselor performance (what counselors do to remain vital, how well they are, and their professional quality of life) for the first time. The sample of professional counselors was diverse in terms of numerous demographic and caseload variables and different in important ways from norm groups for the measures used. Perhaps most important, relationships between the three variables studied and differences between subgroups of participants have implications for counselor training and renewal to avoid burnout and maintain a high quality of life and work satisfaction and overall wellness.

As a group, our participants were largely Caucasian, female, and in midlife. They were highly educated and licensed to practice, and two out of three worked in private practice and mental health settings as opposed to schools. They tended to have large and high-risk caseloads, with one third of clients being survivors of trauma. Yet, as a group, our participants reported greater wellness than did previous populations studied, along with higher positive professional quality of life factors (compassion satisfaction) and lower negative factors (compassion fatigue and burnout), perhaps because of the large number of CSBs reported. At the same time, a variety of issues emerged that suggest the need for professional counselors to attend to factors that will help prevent burnout and maintain work and life wellness.

### Wellness

A few of the caseload characteristics are interesting to explore, and perhaps the most meaningful was that where one works seems to have some impact on how well one is. Counselors in private practice scored higher on the 5F-Wel than did those in school or community agency settings. Whether this is due to policies and constraints of institutional settings cannot be determined from the current data; however, further study of the factors underlying the current finding could be useful as a foundation for helping counselors learn to cope with environmental factors in their work settings that contribute to lower levels of wellness.

### Professional Quality of Life

For our participants, positive aspects of professional quality of life seem related in some ways to caseload variables. Counselors with larger percentages of trauma survivors among their clients seemed to be more at risk for burnout, and those with more high-risk clients on their caseloads were at higher risk for burnout and garnered less satisfaction from their work. These findings are similar to those of Sprang et al. (2007), who, through a hierarchical regression analysis, found that gender, age, degree level, clinical experience, and percentage of clients with posttraumatic stress disorder (PTSD) accounted for 59% of the variance in the compassion satisfaction domain, 42% of the variance in the compassion fatigue domain, and 69% of the variance in the burnout domain. Specifically, mental health professionals who were female, were younger, had a higher educational degree, had less clinical experience, and had a higher percentage of clients with PTSD were more likely to score higher on the Burnout and Compassion Fatigue subscales and lower on the Compassion Satisfaction subscale. For these counselors, access to peer support and encouragement to engage in CSBs is important for career satisfaction. Although a variety of explanations could be offered for the higher compassion satisfaction and lower burnout and compassion fatigue for our participants compared with other mental health professionals, an important way to help explain these findings is to examine the CSBs practiced by professional counselors as compared with members of other professional groups.

### CSBs

Counselors practice specific CSBs that differ somewhat from the CSBs reportedly practiced by psychologists in Stevanovic and Rupert's (2004) study. Top CSBs shared by the two professional groups were as follows: spend time with partner/family, maintain sense of humor, maintain balance between professional and personal lives, and maintain professional identity. Specifically, the CSBs mentioned by counselors as among their top behaviors that were not rated highly by psychologists were the following: maintain self-awareness, reflect on positive experiences, engage in quiet leisure activities, and try to maintain objectivity about clients. Psychologists, in turn, rated some CSBs highly that were rated lower by counselors: use positive self-talk, take regular vacations, participate in continuing education programs, read literature to keep up to date, turn to spiritual beliefs, and maintain sense of control over work responsibilities. Many of these differences disappeared when contrasted groups were examined. For example, counselors with high levels of wellness rated turning to spiritual beliefs among their highest CSBs. Differences in professional training programs may help account for these differences.

Sampling limitations and the exploratory nature of this research need to be considered in the interpretation of the results of this study. Our sample of professional counselors was diverse in terms of both demographic and caseload variables, but lack of comparative data on national samples of professional counselors limits our discussion of the results. Because of the voluntary nature of reporting, ACA is unable to provide accurate demographic information for its full membership; therefore, the results of this study may be validly generalized

only to members of that association who report demographic information on their annual membership renewal forms. The small sample sizes for subgroups of participants, notably ethnic minority groups, did not allow valid within-group comparisons on some variables. Nevertheless, the strength of relationships among the variables and the high reliability of the scales are factors that support the validity of the findings.

## Implications

The difference in professional quality of life between counselors with high and low wellness levels in this study was quite strong, suggesting that, overall, greater wellness translates to dramatically improved professional quality of life. Even without taking caseload variables into account as risk factors, simply focusing on increasing holistic wellness offers the potential to help all counselors retain high compassion satisfaction and avoid burnout and compassion fatigue. Clearly, the types of counselor self-care suggested by Lawson (2007) are critical for professional and personal renewal and quality of life.

Counselor educators and counseling professionals responsible for preservice preparation and continuing education may find the results of this study useful for program planning. For example, wellness models such as the IS-Wel can be used to develop multidimensional interventions to help counselors increase their wellness in all areas. Although counselors recognize the interaction between work, personal relationships and activities, and spiritual issues, the benefits of using holistic wellness models include having a structured means of addressing these life components and their interaction to ensure that none are inadvertently ignored or de-emphasized.

Many of the CSBs mentioned earlier are also included in a wellness lifestyle, and an emphasis on all the CSBs could be useful to professionals seeking to maintain satisfaction in their work. At a minimum, including an assessment of CSBs in a wellness-focused workshop could help raise awareness among counselors of specific strategies that can increase their professional and personal quality of life. Using all three variables examined in this study offers the potential for achieving the consistent healthy decision making discussed by authors such as Meyer and Ponton (2006), who also reminded counselors that counselors as a whole tend to neglect their own self-care in favor of the services they provide to their clients.

Replication of the current findings with additional samples of professional counselors, counselors-in-training, and counselor educators would be useful to further explore the relationships among wellness, professional quality of life, and CSBs for subgroups in the counseling field. Larger samples of ethnic minorities and expanded demographics in terms of age and experience would add to the knowledge base in the field. Such research should be a priority because it will help counselors to create and sustain a healthy workforce in the face of increasing mental health challenges among their clients. A logical next step includes outcome studies to determine the kinds of interventions most useful and successful with professional counselors in all settings to enhance wellness over personal and professional life spans.

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