Summer 2018

The Serving Supervisor: Supervisor Servant Leadership as a Protective Factor for Counseling Residents’ Burnout and Secondary Traumatic Stress

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THE SERVING SUPERVISOR: SUPERVISOR SERVANT LEADERSHIP AS A PROTECTIVE FACTOR FOR COUNSELING RESIDENTS’ BURNOUT AND SECONDARY TRAUMATIC STRESS

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Of the Requirements for the Degree

Doctor of Philosophy

by

Colleen M. L. Grunhaus

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THE SERVING SUPERVISOR

THE SERVING SUPERVISOR: SUPERVISOR SERVANT LEADERSHIP AS A PROTECTIVE FACTOR FOR COUNSELING RESIDENTS’ BURNOUT AND SECONDARY TRAUMATIC STRESS

by

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ABSTRACT

According to Stamm (2010), variables in counselors’ work environment, personal environment, and client environment precipitate the development of compassion fatigue. Compassion fatigue, which comprises secondary traumatic stress and burnout, is an occupational hazard for counselors, and new counselors are especially vulnerable. A supervisory style that exhibits servant leadership traits may provide necessary support and counteract compassion fatigue symptoms for counseling residents. Servant leadership shares many philosophical assumptions of the counseling profession and addresses the administrative challenges many clinical supervisors face today (Evans, Wright, Murphy, & Maki, 2016). A sample of 241 counseling residents participated in the study and completed several instruments. Data were analyzed with two structural equation models to identify the impact of the perceived servant leadership traits of supervisors on counseling residents’ compassion fatigue, burnout, and secondary traumatic stress with other relevant predictors. Limitations, avenues for future research, and implications for counselor education and supervision are discussed.

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The Serving Supervisor: Supervisor Servant Leadership as a Protective Factor for Counseling Residents’ Burnout and Secondary Traumatic Stress
CHAPTER ONE

Introduction

Novice counselors are at greater risk to experience compassion fatigue than their more experienced counterparts (Thompson, Amatea, & Thompson, 2014); and the supervisory context may ameliorate or exacerbate these symptoms (Knudsen, Roman, & Abraham, 2013). Unfortunately, supervisors may be ill-equipped for understanding and supporting the unique experiences of counseling residents or newly graduated counselors. Only 52% of state licensing boards require training for supervisors (Evans, Wright, Murphy, & Maki, 2016) even though an estimated 95% of experienced licensed counselors eventually become supervisors (Bernard & Goodyear, 2014). The empowering and supportive approach of servant leadership may enhance clinical supervision and, in conjunction with other known protective factors, decrease the compassion fatigue of counseling residents.

Counseling Residents at Risk

Besides inexperience, counseling residents’ developmental stage and beginning employment position often place them at further risk for developing compassion fatigue. McNeill and Stoltenberg (2016) asserted that recently-graduated counselors’ developmental stage is marked by a deepened awareness and empathy for the client’s affective and cognitive states and presents a risk of enmeshment in the client’s experience. Counselors with a high capacity for empathic engagement are more likely to experience compassion fatigue, as they have difficulty distinguishing between the client’s
emotional crises and their own (Ludick & Figley, 2017). Unlicensed, newly graduated counselors also often launch their careers in high-acuity and demanding work positions, whereas more experienced counselors have advanced to less stressful and more positive working conditions (Thompson et al., 2014). Supervisors of counseling residents provide support and monitor supervisees for the development of compassion fatigue, which encompasses both secondary traumatic stress (STS) and burnout (Adams, Figley, & Boscarino, 2008).

Precipitating Events

Recent events have resulted in increased workloads for counselors and have threatened counselor wellness. After the recession in 2007 to 2009, mental health funding in the United States (US) was cut by 4.35 billion dollars (National Alliance on Mental Illness [NAMI], 2015). Shortly after, the US experienced high-profile tragedies, such as the shootings in Newtown, Connecticut in 2012 and the suicide of Robin Williams in 2014 that resulted in increased public awareness of mental illness and demand for mental health services (NAMI, 2015). In the wake of these tragedies, some states have made efforts to increase mental health spending, but few have come close to recovering from the massive cuts experienced during the recession (NAMI, 2015). These events have resulted in provider layoffs, longer waitlists, higher caseloads, and overall, fewer counselors to do more work with less resources (NAMI, 2015). To compensate for losses, many public-sector agencies have begun requesting that employees meet quotas for billable services (Morse, Salyers, Rollins, Monroe-DeVita, & Pfhaler, 2012). These increased demands and responsibilities, coupled with heightened acuity, have left providers more susceptible to STS and burnout.
Introduction to the Current Study

The study tested an adapted model of Stamm’s (2010) model of professional quality of life, which hypothesized that compassion fatigue arises in the context of the work environment, personal environment, and client environment. The problem is further complicated by the challenges supervisors encounter in adequately meeting the needs of compassion-fatigued supervisees. Chapter one describes the problem of compassion fatigue including the detrimental effects of burnout and STS on counselor welfare, on client care, and on the organization. I then reviewed the prevailing approaches to studying compassion fatigue and provide justification for the proposed study, which includes the scarcely investigated construct of servant leadership. The second chapter reviews the current literature on compassion fatigue that provides the basis of several variables of the proposed study and also exposes the gaps in the current literature. Chapter three explicates the methodology for the proposed study to include the sampling method, data collection procedure, instrumentation, and data analyses. Chapter four presents the results of the study and chapter five discusses the implications for counseling practice, supervision, education, and future research.

The Problem of Compassion Fatigue

Adams, Boscarino and Figley (2006) concluded that compassion fatigue is best measured by burnout and STS, which are distinct constructs that have unique effects on counselor well-being. Scholars often study STS and burnout separately, and the literature on compassion fatigue, burnout, and STS often uses conflicting operational definitions, which creates challenges for interpreting results and conducting future studies. For example, compassion fatigue and STS are often used synonymously in the literature (e.g.,
Eastwood & Ecklund, 2008; Galek, Flannelly, Greene, & Kudler, 2011; McKim & Smith, 2013). Also, Adams and colleagues (2008) operationally defined compassion fatigue as “the formal caregiver’s reduced capacity or interest in being empathic” (p. 103); however, the Compassion Fatigue Scale (Figley, 2002), contains two subscales: STS and burnout; and does not measure empathic capacity. Further research is needed to statistically clarify the construct of compassion fatigue in relation to burnout and STS, both of which have deleterious effects on counselor well-being, effectiveness with clients, and decision to remain in the field.

**Counselor Well-Being**

High caseloads, lack of decision-making power, low support, and poor training are antecedents to burnout (Morse et al., 2012). This workplace hazard has been linked to various physical and mental health problems in employees in a variety of occupations, including mental health. In a study with 591 social workers, Acker (2010) found a positive correlation between burnout and various physical health problems including gastroenteritis and flu-like symptoms. Burnout has also been linked to substance use disorders in health professionals (Pedersen, Sørensen, Bruun, Christensen, & Vedsted, 2016).

STS includes the same symptom cluster of posttraumatic stress disorder (PTSD) found in the DSM-5; however, counselors experience the traumatic event indirectly through exposure to clients’ traumatic material (Adams et al., 2008). Symptoms include avoidance of stimuli associated with clients’ trauma and even clients themselves (Bride, 2007). Other symptoms of STS include negative mood, re-experiencing the client’s trauma, client-related nightmares, emotional numbing, and hypervigilance (Bride, Smith
Hatcher, & Humble, 2009). STS may also affect clinicians’ beliefs about intimacy, trust, and personal safety (Tehrani, 2007). Branson, Weigand, and Keller (2014) found a relationship between STS, diminished sexual desire, and an increase in sexual disorders.

**Compassion Fatigue and Client Welfare**

The *ACA Code of Ethics* recommends counselors engage in revitalizing self-care activities to “best meet their professional responsibilities” (p. 8) and avoid impairment (American Counseling Association [ACA], 2014, §C Introduction). Counselor impairment has detrimental effects on client welfare. Landrum, Knight, and Flynn (2010) determined employee burnout significantly predicted low client participation and engagement in treatment. Burnout is also significantly correlated with unhelpful and rejecting feelings among nurses towards patients (Holmqvist & Jeanneau, 2006). Counselors experiencing compassion fatigue may also provide less effective services. Craig and Sprang (2010) found evidenced-based practices to be inversely correlated with compassion fatigue.

STS is also associated with poor constructive communication patterns including withdrawal from work when demands are high and avoiding interactions with clients (Robinson-Keilig, 2014). Similarly, Bride and colleagues (2009) found 36% of participants avoided traumatized clients occasionally, often, or very often. Avoiding clients transgresses foundational principles of counseling such as fidelity, beneficence, and non-maleficence (Forester-Miller & Davis, 2016). Avoiding clients also injures therapeutic effectiveness as “it is hard to imagine the salutary effects of [therapeutic] alliance, such as the sense of safety, of openness to disclosure, and of support for exploration, without the steadfastness of abounding presence” (Schneider, 2015, p. 303).
The serving supervisor

Counselor STS is a hazard not only to counselors, but also to those in their care and the counseling profession.

**Organizational Costs**

In addition to undermining counselor wellness and client care, compassion fatigue may take a toll on organizational well-being. Organizations are living systems that “have needs similar to those required by individuals in order to be empathetic and healthy” (Tehrani, 2013, p. 264). Considering the detrimental impact of compassion fatigue on counselor well-being and client care, compassion fatigue has been unsurprisingly linked to withdrawal behaviors. These include increased use of sick leave (Toppinen-Tanner, Ojajärvi, Väänänen, Kalimo, & Jäppinen, 2005), turnover, and absences (Morse et al., 2012). Also, STS predicts low occupational commitment (Bride & Kintzle, 2011), and burnout is associated with job dissatisfaction (Scanlan, & Still, 2013).

In a study examining turnover in community mental health organizations in 42 randomly selected US cities, Bukach, Ejaz, Dawson, and Gitter (2017) found organizations lost 26% of their mental health staff to turnover annually. Organizations minimally spend 30% of a therapist’s annual salary in advertisement and training to replace one therapist who ends employment (Seldon, 2010). Intangible costs include increased stress among employees left behind and reduced morale (Morse et al., 2012). Compassion fatigue’s adverse effects negatively impact counselor retention, further impact the limited resources and high demands of mental health agencies, and perpetuate a destructive cycle to which new counselors are introduced.

**Supervision Inadequacies**
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Counseling residents are newly graduated counselors who are still under supervision and working towards licensure. Their status necessitates frequent interaction with one or more supervisors. According to Tromski-Klingshirn and Davis (2007) about half of counseling residents receive supervision from a supervisor fulfilling the roles of clinical and administrative supervisor simultaneously and the other half have one clinical and one administrative supervisor. Administrative supervisors are responsible for the “efficiency of the delivery of counseling services” (Association of Counselor Education and Supervision [ACES], 2011, p. 1) and the enforcement of organizational policy (Franco, 2015). Clinical supervisors provide support and education “to improve the application of counseling theory and technique directly with clients” (ACES, 2011, p. 1). Most clinical and administrative supervisors of counseling residents are not formally trained (Glossoff, Durham, & Whittaker, 2011) even though 95% of licensed counselors eventually serve as a supervisor (Bernard & Goodyear, 2014) and The Best Practices in Clinical Supervision (ACES, 2011) provides extensive guidelines for clinical supervisors. A mere 52% of state licensing boards require supervisors to receive formalized supervisory training prior to supervising counseling residents (Evans et al., 2016).

Rosenberg and Pace (2006) found marriage and family counselors in community mental health agencies who are bogged down by productivity standards exhibit more symptoms of burnout than marriage and family counselors in private practice. Supervisors in these community mental health settings are more likely to serve in dual roles and represent the demands of the agency by serving as enforcers of organizational policy (Franco, 2015; Kreider, 2014). Evans and colleagues (2016) asserted dual-role and ill-prepared supervisors must juggle multiple responsibilities and perspectives, which
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leads to a diminished capacity to provide quality supervision. In these ways, supervisors may inadvertently contribute to a fatiguing work environment (Kreider, 2014).

**Current Approaches**

The deleterious effects of compassion fatigue are far reaching and affect the work environment, personal environment, and client environment. Past research has focused on the development of risk and protective factors. Based on this research, scholars introduced multiple approaches to supporting counselors in these three environmental spheres.

**Personal Environment**

Counselors’ personal characteristics and practices impact their clinical work. Several studies have identified experience to be negatively related to compassion fatigue (Craig & Sprang, 2010; Finklestein, Stein, Greene, Bronstein, & Solomon, 2015; Robinson-Keilig, 2014; Thompson et al., 2014). Similarly, young counselors are more likely to experience compassion fatigue than more seasoned professionals (Bober & Regehr, 2006; Bonach & Heckert 2012; Craig and Sprang, 2010; Galek et al., 2011). Female counselors also may be more likely to experience STS than male counselors, but gender may not impact burnout (Hensel, Ruiz, Finney, & Dewa, 2015; Thompson et al., 2014). Furthermore, in a recent meta-analysis, Hensel and colleagues (2015) found strong effect sizes for counselor STS among survivors of trauma, especially among survivors of sexual or childhood trauma when working with clients around similar issues. Several researchers have also identified the practice of personal self-care strategies as necessary for counselor sustainment (Hernandez, Engstrom, & Gangsei, 2010; Hernandez-Wolfe, Killian, Engstrom, & Gangsei, 2015; Killian, 2008; Moore, Perry, Bledsoe, & Robinson,
2011). Although individual factors are important to be aware of, they cannot be severed from the combined impact of the client and work environments on counselor well-being.

**Client Environment**

Past researchers have also identified various correlates of compassion fatigue related to client interactions. According to Adams and colleagues (2008), compassion fatigue is a result of working with traumatized clients. Unsurprisingly, research consistently indicates that hours spent working with traumatized clients has a positive relationship with STS symptoms, but not necessarily burnout (Bober & Regehr, 2006; Galek et al., 2011). On the other hand, burnout is associated with the magnitude of caseload size. Counselors serving a high caseload exhibit greater symptoms of burnout (Acker & Lawrence, 2009; Knudsen, Ducharme, & Roman, 2006).

**Work Environment**

The work environment encompasses a multitude of workplace factors. Thompson and colleagues (2014) investigated mental health counselors’ perceptions of their working conditions, which included their appraisal of financial compensation, hour flexibility, coworker relationships, clinical preparedness, job tasks, organizational climate, quality of supervision, and fairness in administrative decision-making. The authors found that the counselors’ perceptions of these working conditions positively predicted compassion fatigue.

In their exhaustive review of burnout literature, Morse and colleagues (2012) concluded that the work environment was a greater contributor to worker burnout than any other factor. For example, scholars have identified that counselors working in community mental health environments experience greater burnout than counselors in
outpatient or inpatient environments (Franco, 2015; Lent & Schwartz, 2012). Role stress is a procedural demand and is defined as the “negative perceptions that organizational expectations are incompatible with workers’ expectations about the job behaviors and autonomy” (Acker, 2008, p. 297). Role stress can predict counselor burnout (Kirk-Brown & Wallace, 2004; Wallace, Lee, & Lee, 2010).

Several researchers also identified supervision to be an important buffer for burnout and STS in the workplace. Knudsen and colleagues (2013) determined that the quality of supervision strengthens substance abuse counselors’ commitment to their occupation, which prevents emotional exhaustion. Supervisor support is negatively correlated with burnout (Gibson, Grey, & Hastings, 2009); and Sterner (2009) found Supervisor Working Alliance (SWA) combined with workplace satisfaction provide a buffer against counselor work stress.

Deficiencies of Past Studies

The extensive research conducted on compassion fatigue centers around various risk and protective factors in counselors’ personal, client, and work environments. Over the past three decades a proliferation of research on compassion fatigue has emerged, yet gaps still exist. Research specifically with counselors is sparse and there is no known study on counseling residents and compassion fatigue. Similarly, there are few studies utilizing structural equation modeling (SEM) that allow for a multivariate analysis of compassion fatigue. Compassion fatigue manifests in the complexity of counselors’ work, client, and personal environments, and a multivariate technique such as SEM is helpful for analyzing the interaction of various observed and latent variables simultaneously while allowing for measurement error (Keith, 2015). Finally, very little
research has examined formal leadership models in counseling supervision and there is no known study identifying the impact of servant-leadership traits of supervisors in relation to supervisees’ compassion fatigue.

Counseling Residents

Although studies on compassion fatigue, burnout, and STS are ubiquitous, there is no known study surveying the compassion fatigue of counseling residents specifically. During their graduate program, counselors-in-training may receive more support than residents as they are afforded a site supervisor as well as a program supervisor, and they interact with peers and counselor educators regularly. However, upon graduation and commencement of their counseling career, counseling residents experience a dramatic decline in supportive resources provided by the insulation of academia and an increase in counseling responsibilities. Considering compassion fatigue is associated with inexperience (Bober & Regehr, 2006; Craig & Sprang, 2010; Finklestein et al., 2015; Galek et al., 2011; Robinson-Keilig, 2014), more research is needed to determine how to better support this vulnerable population.

Supervision Gaps

The Council for Accreditation of Counseling and Related Educational Programs (CACREP; 2016) standards address counselor self-care as an ethical obligation (Standard F.1) and have recently obligated counseling programs to educate students regarding the provision of competent services to victims of trauma. However, the standards lack specific language regarding the vicarious effects trauma services may have on the counselor. Similarly, ACES’ (2011) Best Practices in Supervision does not advise supervisors to monitor supervisees’ self-care practices or provide training on the risk of
secondary trauma and burnout. Counselors-in-training receive minimal training on coping with the occupational hazards of counseling during their CACREP education, and then post-graduation, counseling residents may receive supervision that neglects the topic entirely. Also, even though the quality of supervision has been identified as a protective or risk factor for counselors, a dearth of research exists exploring supervisory interventions to promote supervisee wellness (Knudsen et al., 2013). More research is needed on the specific supervisory factors that contribute to the amelioration of compassion fatigue.

Evans and colleagues (2016) recognized that supervisors often are challenged to meet the dual-role obligations as clinical and administrative supervisors. Tromski-Klingshirn and Davis (2007) found that about half of counseling residents surveyed receive supervision from a dual-role supervisor. Many supervisors serving in an administrative role have not received formal clinical supervision training (Evans et al., 2016), and therefore, may be ill-equipped to support counseling residents who are vulnerable to compassion fatigue. As supervisors are increasingly fulfilling managerial roles in the oversight of clinical services, counselors should explore the relevance of leadership models currently being implemented in disciplines beyond the field of counseling (Evans et al., 2016). Servant leadership is one such model that may prevent follower burnout (Babaku, Yavas, & Ashill, 2011; Upadyaya, Vartiainen, & Salmela-Aro, 2016), increase trust in leaders (Senjaya & Pekerti, 2010), and improver follower psychological safety (Schaubroeck, Lam & Peng, 2011). The servant leadership traits of supervisors may have positive effects on counseling resident compassion fatigue.

**Purpose and Significance of the Study**
The purpose of this cross-sectional study was to investigate the power of the work environment, personal environment, and client environment to predict compassion fatigue when the personal environment is represented by professional self-care, gender, and survivor status; the client environment is represented by percent of trauma cases and size of caseload; and the work environment is represented by role ambiguity, role conflict, and perceived servant leadership traits of supervisors. The current study primarily explored the following research questions: (a) Does the perceived servant leadership of supervisors negatively predict compassion fatigue of counseling residents? (b) Does the perceived servant leadership of supervisors negatively predict the counselor burnout of counseling residents? (c) Does the perceived servant leadership of supervisors negatively predict the secondary traumatic stress of counseling residents? (d) Does the perceived servant leadership of female supervisors and the perceived servant leadership of male supervisors differ significantly? These questions and others were embedded in two structural equation models. The models that depict all research questions and hypotheses can be viewed in Figure 6 and Figure 7 in Chapter 3.

Although previous studies have focused on predictors of compassion fatigue that may be categorized by the work, personal, or client environment, only a small number of studies have explored these predictors simultaneously (e.g., Galek et al., 2011; Thompson et al., 2014) despite the mounting evidence that compassion fatigue is a systemic problem (Hernandez et al., 2010; Morse et al., 2011; Stamm, 2010). A study that examines the experience of counseling residents may inform changes in counseling education programs that may better prepare students for the residency experience. Furthermore, this is a pioneer study examining the impact of servant leadership traits on compassion fatigue in
the field of counseling. Evans and colleagues (2016) have called for the integration of leadership models such as servant leadership into clinical supervision; this study reflects a crucial response that may impact supervision style to increase counselor sustainment and retention.

**Definition of Terms**

**Compassion Fatigue:** Compassion Fatigue is “a state of exhaustion and dysfunction – biologically, psychologically, and socially – as a result of prolonged exposure to compassion stress” (Figley, 1995, p. 253). Adams and colleagues (2008) determined that compassion fatigue includes at least two components: STS and burnout.

**Secondary Traumatic Stress:** STS is prompted by vicarious exposure to traumatic material through interaction with traumatized clients and results in symptoms mirroring the diagnostic profile of PTSD (Adams et al., 2008).

**Burnout:** Burnout is often the result of sustained interaction with demanding work and interpersonal situations (Adams et al., 2006). Burnout is also the “failure to perform clinical tasks appropriately because of personal discouragement, apathy toward system stress, and emotional/physical drain” (Lee et al., 2007, p. 143).

**Personal Environment:** The personal environment is an aspect of the theoretical model of professional quality of life (Stamm, 2010). The personal environment refers to the unique experiences, resources, practices, and identity of the helping professional. In this study, the personal environment is measured by professional self-care, gender, and survivor status.

**Client Environment:** The client environment is another aspect of the theoretical model of professional quality of life (Stamm, 2010). The client environment refers to the
characteristics of the client population served and the counselor’s level of trauma exposure. In this study, the client environment is measured by the number of weekly direct client hours (Caseload) and the number of weekly direct trauma counseling hours (Trauma Clients).

Work Environment: The work environment is the third environment that impacts the development of compassion fatigue according to the theoretical model of professional quality of life (Stamm, 2010). The work environment encompasses organizational factors and supervision factors. In this study, the work environment is represented by servant leadership, role ambiguity, and role conflict.

Servant Leadership: Servant leadership was coined by Greenleaf (1977) as a style of leadership marked by service, humility, and vision. Servant leaders are distinguished by conceptual skills, empowerment of followers, helping subordinates grow and succeed, care for personal concerns of supervisees, sacrificing their own needs to put followers’ needs first, ethical behavior, and care for providing valuable services to the larger community (Liden, Wayne, Zhao, & Henderson, 2008).

Role Conflict: Role conflict occurs when counselors receive conflicting messages and expectations from multiple sources (Culbreth, Scarborough, Banks-Johnson, & Solomon, 2005).

Role Ambiguity: Role ambiguity arises when expectations of responsibilities and performance are not clearly communicated (Culbreth et al., 2005).

Summary

This chapter introduced the problem of compassion fatigue with special attention paid to counseling residents. Risk and protective factors in counselors’ work, personal,
and client contexts impact the intensity of compassion fatigue symptoms. The presence or 
lack of quality supervision is a particular concern for counseling residents as they 
frequently interact with their supervisor in their work environment. Many supervisors fill 
the dual-roles of administrative and clinical supervisor, roles for which they may have 
received no formal education (Evans et al., 2016). Considering supervision is a 
significant predictor for supervisee compassion fatigue (Knudsen et al., 2006), 
incorporating an administrative leadership model such as servant leadership to the 
supervisor’s style of clinical supervision may be beneficial. This study incorporates 
servant leadership as a predictor of counseling residents’ compassion fatigue among other 
predictors in the work, personal, and client environment. This style of supervision has 
been shown to reduce burnout (Babakus et al., 2011; Upadyaya et al., 2016) and turnover 
(Babakus et al., 2011) in disciplines outside of counseling. However, the current study is 
first study to examine the impact of servant leadership on the compassion fatigue of 
counseling residents. The next chapter will provide a thorough review of the literature 
pertinent to the proposed study.
CHAPTER TWO

Literature Review

According to Stamm’s (2010) theoretical model of professional quality of life, compassion fatigue arises in the context of the personal environment, client environment, and work environment. Stamm’s model, which remains statistically unconfirmed, also includes compassion satisfaction (the positive outcomes of helping) as an outcome of these three environments (Stamm, 2010). The personal, client, and work contexts converge and provide protective or risk factors for counselors. This chapter reviews current literature related to these protective and risk factors.

Personal Environment

The personal environment includes unique characteristics and practices of individual counselors. Compassion fatigue researchers have identified counselor age, length of counseling experience, gender, and personal history of trauma as personal factors that affect the development of compassion fatigue. Personal self-care practices also can protect against the development of compassion fatigue.

Counselor Age

Younger helping professionals such as counselors are at greater risk for developing compassion fatigue more frequently than older therapists (Bober & Regehr, 2006; Craig and Sprang, 2010; Galek et al., 2011). Bonach and Heckert (2012) recruited a convenience sample of 257 child abuse forensic interviewers to identify organizational and personal correlates of STS. Participants completed measures of organizational
satisfaction, social support, demographic variables, and the Secondary Traumatic Stress Scale (STSS; Bride, Robinson, Yegidis, & Figley, 2004). Bonach and Heckert (2012) analyzed the data with a multiple regression analysis and age was a significant negative predictor for STS. The convenience sample utilized in this study limits generalizability and the participants’ experiences may not be easily generalized to counselors. However, this study further confirms the negative relationship between age and STS and supports the advancement of further research on this relationship among younger clinicians.

Counselor Experience

Thompson and colleagues (2014) explored the impact of multiple work and personal variables on the compassion fatigue of counselors. Thompson and colleagues recruited a sample of 213 counselors, which included both licensed counselors and counselors working towards licensure status. The Perceived Working Conditions Scale was developed for this study and measured the appraisal of financial compensation, hour flexibility, coworker relationships, clinical preparedness, job tasks, organizational climate, quality of supervision, and fairness in administrative decision-making (Thompson et al., 2014). Thompson and colleagues (2014) also used the brief COPE Inventory (Carver, 1997) to measure various coping strategies, the Mindful Attention Awareness Scale, Trait Version (MAAS; Brown & Ryan, 2003), and the Professional Quality of Life Scale 5 (ProQOL, Stamm, 2010). Thompson and colleagues (2014) also assessed the length of time in the field and gender. The authors investigated bivariate relationships between variables through correlations and ran multiple regressions to predict counselor compassion fatigue. Results indicated that years of experience was significantly related to burnout ($r = -.219$) and STS ($r = -.186$; Thompson et al., 2014).
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However, years of experience did not significantly contribute to a multiple regression model predicting counselor compassion fatigue that included positive perceptions of working conditions (Thompson et al., 2014). This study did not include a detailed examination of the differences in experience with compassion fatigue between licensed counselors and unlicensed residents in counseling. Also, the study included a measure that had not yet been validated. Nevertheless, the study evidences the negative correlation between experience and compassion fatigue.

Robinson-Keilig (2014) studied the relationship of STS and interpersonal functioning by selecting 320 licensed mental health therapists who completed the STSS (Bride et al., 2004). Using correlations, Robinson-Keilig (2014) found young and inexperienced mental health therapists were more likely to endorse symptoms of STSS than their older, more experienced, counterparts (Robinson-Keilig, 2014). An alpha level of .01 appears to be used for all correlations; however, STSS was used in 10 correlations. The author does not cite using a Bonferroni correction, which would have been necessary with one variable being used in multiple correlations (Kiess & Green, 2009). However, the negative relationship between experience and STS reflects similar findings from other studies (Craig & Sprang, 2010; Finklestein et al., 2015). Inexperienced counselors need support and monitoring to prevent the development of compassion fatigue.

Counselor Gender

Gender may play a role in the severity of compassion fatigue symptoms. In a study with hospital chaplains, women endorsed significantly fewer symptoms of burnout than men (Galek et al., 2011). Most quantitative studies have found being female to result in heightened levels of STS (Adams et al., 2008; Robinson-Keilig, 2014; Thompson et
al., 2014). However, one qualitative study found female participants to more frequently report resilient attributes in their work with traumatized clients (Lamb & Cogan, 2016). Although this qualitative finding cannot be generalized to the larger population of therapists, it may suggest that symptoms of STS do not necessarily preclude the experience of resilience.

Ivicic and Motta (2017) investigated the impact of multiple variables on STS and recruited 88 mental health professionals that included counselors, psychologists, and social workers who worked with traumatized clients. Participants completed a demographic questionnaire, the Secondary Trauma Scale (Motta, Hafeez, Sciancalepore, & Diaz, 2001), the Life Events Checklist (Blake et al., 1995), the Job Satisfaction Survey (Spector, 1985), and a Supervision scale. Ivicic and Motta (2017) also assessed participants with the Modified Stroop Procedure, which includes providing participants with neutral or trauma-related words written on index cards. Participants were then assessed on how quickly they can name the color of the words. Ivicic and Motta ran a multiple hierarchical regression analysis to identify which variables significantly predicted STS. The authors determined that life events (personal trauma) and gender significantly predicted STS with more females experiencing STS than males (Ivicic & Motta, 2017). This study contributes that female counselors may experience greater STS than male counselors; however, 80% of the sample was female, and the experiences of males may not be adequately represented in this study.

**Personal Trauma History**

Therapists with a personal history of trauma are at greater risk for STS, but not necessarily burnout (Dunkley & Whelan, 2006; Van Hook & Rothenberg, 2009). One
participant in a recent qualitative study stated that listening to the traumatic experiences of clients sometimes triggered memories of personal trauma (Hernandez-Wolfe et al., 2015). Some counselors may be motivated in their work by their survivor status. In a recent study, 106 counselors working with domestic and sexual abuse victims participated in a study examining counselor motivations (Jenkins, Mitchell, Baird, Whitfield, & Meyer, 2011). Participants responded to two open-ended questions that probed underlying motivations for working with trauma victims. They also completed the Traumatic Symptom Inventory (TSI) Life Events Questionnaire (Pearlman, 1996) to assess trauma history, the Compassion Fatigue self-test for psychotherapists (CFST; Figley & Stamm, 1996), the Traumatic Symptom Inventory Belief Scale, Revision L (TSI-BS; Pearlman, 1996), the Maslach Burnout Inventory (MBI; Maslach, 1996), and the Symptom Checklist-90 Revised (SCL-90-R). The qualitative responses were coded for common themes and filtered into categories of motivating factors (Jenkins et al., 2011). The authors ran point biserial correlations between the measures and motivating factors. The results indicated that counselors motivated by survivor status were more likely to report STS symptoms ($r_{pb}=.40$) and were more likely to experience positive personal changes as a result of their work with victims (Jenkins et al., 2011). A limitation of this study is its use of an older compassion fatigue measure that incorporates questions regarding personal trauma history within the measure. More research is needed regarding the impact of personal trauma history on counselors’ experiences with compassion fatigue.

**Self-Care**
Another study examined the impact of various self-care and coping strategies on the compassion fatigue of mental health counselors (Thompson et al., 2014). Thompson and colleagues (2014) utilized the transactional stress and coping perspective to determine the relationship between impact of counselor gender, years of experience, view of working conditions, and personal coping strategies on compassion fatigue. The authors recruited 213 mental health counselors and conducted several multiple regression analyses to predict burnout and STS. Maladaptive coping positively predicted STS and mindfulness negatively predicted STS (Thompson et al., 2014). Mindfulness and emotion-focused coping negatively predicted burnout; and problem-focused and maladaptive coping positively predicted burnout (Thompson et al., 2014). This study identified that various forms of coping can prevent or exacerbate compassion fatigue; however, the convenience sampling method limits the generalizability of the results.

Individualized self-care practices cannot be detached from contextual factors such as clinical workload and work social support that may promote or hinder healthy personal practices. Although research has substantiated the benefits of personal self-care practices, these are often ineffectual in an unsupportive agency environment or supervisory relationship (Morse et al., 2012). Similarly, Knight (2013) has argued for supervisors to normalize compassion fatigue reactions and promote self-care as an important professional obligation. When agencies do not openly promote self-care, therapists are less likely to discuss concerns about compassion fatigue with colleagues and supervisors (Sansbury, Graves, & Scott, 2015). Because residents in counseling are a vulnerable population, further research is needed on how supervisors contribute to counselor sustainment.
Client Environment

The client environment refers to the characteristics and quantity of clients treated by counselors. Bober and Regehr (2006) found significantly higher symptoms of STS among counselors treating victims of domestic violence, child physical abuse, child sexual abuse, sexual violence, and torture. The hours per week counselors served traumatized clients was also correlated with symptoms of STS, especially thought intrusion (Bober & Regehr, 2006). Similar to other findings, Bober and Regehr (2006) found STS to be negatively correlated with age and experience. A limitation of the study is the use of the Impact of Events Scale (Zilberg, Weiss, & Horowitz, 1982), which measures symptoms of PTSD and may not capture the vicarious nature of STS. However, because the symptoms of STS are the same as PTSD, the study does provide evidence that working with traumatized clients contributes to the experience of STS.

Additionally, McKim and Smith-Adcock (2014) investigated the relationship between workplace and individual variables on trauma counselors’ compassion fatigue. Participants in the study included 98 trauma counselors who completed the ProQOL (Stamm, 2005), the Psychologist’s Burnout Inventory (PBI; Ackerley, Burnell, Holder, & Kurdek, 1988), the Stressful Life Experiences—Short Form (Stamm, 1997), and various demographic variables including secondary exposure to trauma, contact hours with traumatized clients, and years working as a counselor (McKim & Smith-Adcock, 2014). McKim and Smith-Adcock (2014) conducted a stepwise method regression analysis and determined that lack of control over work activities, over-involvement with clients, and secondary exposure (time spent with traumatized clients) significantly contributed to a model that accounted for 26% of the variance in compassion fatigue. The population
examined in this study included members of trauma counseling organizations that provide training and resources for its members. These counselors may have greater trauma training than the general counseling population, which may affect their level of compassion fatigue.

Also, Knight (2010) found that inexperienced counselors who frequently worked with aggressive clients reported high levels of STS. Few beginning counselors have control over their caseload assignments, including who they will see and the percentage of trauma clients they interact with. Through case assignment, supervisors play an important role in limiting supervisees’ exposure to traumatic material. Future research with inexperienced counselors should explore this supervisory role in mitigating compassion fatigue symptoms.

Caseload size contributes to burnout because of the exhausting nature of a high workload. In a study exploring organizational demands for counselors in agencies with high turnover, Knight, Becan, and Flynn (2012) randomly selected 312 counselors from nine states and compared counselors with higher caseloads to those with lower caseloads. Individuals with higher caseloads reported significantly more work-related stress (Knight et al., 2012). Knight and colleagues (2012) found this outcome through analyzing the data with an independent t-test; however, the authors did not specify what constituted a high or low caseload. Also, the construct of work-related stress may differ from burnout. Nevertheless, other studies have corroborated the positive correlation between caseload size and burnout (Acker & Lawrence, 2009; Knudsen et al., 2006).

Work Environment
The third environmental context counselors can expect to encounter stressors or protective factors is in the work environment. Work environment and type of work setting can have harmful effects on counselors’ well-being. In a study with 143 counseling residents, Tromski-Klingshirn and Davis (2007) found that 56% of the sample worked in an outpatient community counseling center, 28% provided alcohol/drug counseling, 15% engaged in private practice, 9% were school counselors, 7% worked in hospitals, 3% engaged in residential counseling, 3% worked in employee assistant programs, and 2% worked in corrections. Rosenberg and Pace (2006) found that participants working in private practice reported significantly lower emotional exhaustion than those employed in community mental health and school settings. Individuals in community mental health agencies also indicated significantly higher depersonalization than individuals working in private practice and in school settings (Rosenberg & Pace, 2006).

New counselors may prefer to engage in a less-stressful private practice position but may lack the skills required to be successful in this arena. Private practice employment requires self-sufficiency, entrepreneur skills, business savvy, an established network, the financial freedom to maintain stability through the early stages of building a practice, and the ability to pay for the required clinical supervision (Cunningham, 2010). Few newly graduated counselors are likely to reflect these qualities.

Newly graduated counselors pursuing employment in an agency setting may also encounter other challenges. According to King (2007), new counselors face employment obstacles such as a dearth of counseling jobs available and employer preferences related to licensure status and experience requirements. As a result, new counselors may accept
employment in job settings that are incongruent with their preferences. According to Cunningham (2010), counselors who work in job settings that have values that are incompatible with their own ideals may suffer greater burnout. This, combined with the inherently fatiguing nature of counseling in agency settings, necessitates greater streams of support for counseling residents to maintain wellness and retain employment.

The work environment encompasses many facets of the organizational culture. However, role stress and supervision are factors that impact counselor compassion fatigue and are of current interest to this study. This section will summarize these contributions and will introduce the integration of servant leadership into clinical supervision as a strategy that addresses supervisee well-being and the multi-faceted roles of modern supervisors.

**Role Stress**

The word *role* represents the job responsibilities and expectations an organization or supervisor may place on a counselor (Culbreth et al., 2005). The construct of role stress consists of role conflict and role ambiguity (Coll & Freeman, 1997). Role conflict occurs when counselors receive conflicting messages and expectations from multiple sources (Culbreth et al., 2005). A counselor may experience role conflict when agency policy conflicts with counseling ethical codes, or when a clinical supervisor provides a direction for treatment that conflicts with an administrative supervisor’s advisement. Role ambiguity arises when expectations of responsibilities and performance are not clearly communicated (Culbreth et al., 2005). Role ambiguity may occur when counselors are not informed of agency policy and procedural expectations.
Role stress and burnout. Wallace, Lee, and Lee (2010) recruited a sample of 232 substance abuse counselors to identify if coping strategies mediated or moderated the relationship between job stress and burnout. Participants completed the Job Stress Scale (Caplan, Cobb, French, Van Harrison, & Pinneau, 1975), which assessed workload, role conflict, and role ambiguity. Participants also completed the Brief COPE inventory (Carver, 1997) and the Counselor Burnout Inventory (Lee et al., 2007). Wallace and colleagues (2010) analyzed the relationships among all variables through multiple regression and correlation analyses. Wallace and colleagues found that role conflict and role ambiguity positively predicted counselor burnout. Also, the coping strategies of self-distraction and behavior disengagement mediated the relationship between burnout and the job stress variables of role conflict, role ambiguity, and workload (Wallace et al., 2010). The results of this study explored statistical moderation and mediation, and therefore cannot determine causality. However, the study identifies that counselors do experience role stress in their work, and role stress predicts burnout.

Role stress and STS. Dagan, Ben Porat, and Itzhaky (2016) studied the impact of multiple factors including role stress on the development of STS with child protection social workers. Participants included 255 social workers who completed the Secondary Traumatic Stress Scale (STSS; Bride et al., 2004), the Traumatic Experience Questionnaire (Nijenhuis, Van Der Hart, & Vanderlinden, 1996), and a background questionnaire. Participants also completed a measure of role stress, a measure of the effectiveness of supervision, and a measure of mastery that assessed the participants’ sense of control over their environment (Dagan et al., 2016). The researchers examined relationships between variables through Pearson correlational analyses and multiple
regression analysis. The results indicated that years of work experience, survivor status, and role stress significantly predicted STS (Dagan et al., 2016). Effectiveness of supervision and social support were not significant predictors; however, they both had significant negative correlations with STS (Dagan et al., 2016). Dagan and colleagues (2016) also found inexperience and survivor status negatively predicted STS. This study was conducted with child protection social workers and, therefore, may not be generalizable to the experience of counselors. Also, the measure of role stress utilized was not a previously validated measure. However, it does suggest that role stress may positively impact the development of STS in helping professionals. The results also further elucidate the risk factors of survivor status and inexperience.

**Supervision**

Supervision is a protective resource for counseling residents. Researchers have identified level of supervisory working alliance, quality of supervision, and service-oriented supervision as important negative correlates of compassion fatigue. Even though supervision is a potential resource for counseling residents, supervisors in agency settings today may be overburdened with multiple responsibilities. Supervisors in agency settings often serve in multiple roles that can detract from the creation of a positive work environment (Killmer & Cook, 2014).

**Supervisor working alliance (SWA).** Bernard and Goodyear (2014) considered the SWA to be important for supervisee professional development. A strong SWA may also promote counselor wellness. Sterner (2009) hypothesized that the quality of SWA would have a positive relationship with counseling supervisee work satisfaction and a negative relationship with work-related stress. Sterner further ventured that supervisee
work setting, caseload, perceptions of supervisory rapport, and supervisor focus on client
needs would correlate with supervisee intrinsic and extrinsic work satisfaction, role
ambiguity, role boundary, and role overload. Sterner recruited 71 counselors who
completed the following measures: Supervisory Working Alliance Inventory-Trainee
(Efstation, Patton & Kardash, 1990), Minnesota Satisfaction Questionnaire-Short Form
(Weiss, Dawis, England, & Lofquist, 1967), Occupational Stress Inventory-Revised
(Osipow, 1998), and a demographic questionnaire designed by the author.

Sterner (2009) computed two Pearson correlations and detected significantly
higher intrinsic and extrinsic work satisfaction when supervisees perceived a strong SWA
with their supervisors \((r = .60, p < .001)\). Furthermore, high levels of work-related stress
were associated with poor SWAs. Sterner (2009) also analyzed two sets of variables
(supervision/setting and satisfaction/work stress) through a canonical correlation. The
supervision/setting represented counseling setting, client focus in supervision, and
rapport with supervisor, whereas the satisfaction/work stress represented intrinsic and
extrinsic satisfaction, role ambiguity, role boundary, and role overload (Sterner, 2009).
The canonical correlation was \(.68 (p < .001)\) and suggested that as satisfaction with
counseling setting and SWA increases, supervisees experience less work stress and
increased work satisfaction (Sterner, 2009). Although the sample size was small and the
response rate was only 20\%, this study does highlight the multivariate impact on
counselor work stress and satisfaction, and underscores the important role the SWA plays
in counselor well-being.

**Supervision quality.** Knudsen and colleagues (2006) hypothesized that the
quality of supervision would influence counselors’ perception of job autonomy and
workplace justice, which in turn, would influence counselor burnout (specifically emotional exhaustion) and counselor turnover intention. Knudsen and colleagues obtained a sample of 1,001 substance abuse counselors who completed the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1981) and five scales created for this study to measure the quality of clinical supervision, procedural justice, distributive justice, turnover intention, and job autonomy. The proposed model was analyzed via SEM. The researchers first tested the direct relationships between clinical supervision and the two outcome variables: burnout and turnover intention (Knudsen et al., 2006). Having found a good fit with this preliminary analysis, Knudsen and colleagues (2006) then analyzed the mediation model and again found that the model was a good fit for the data (CFI = .956, RMSEA = .037; see Figure 1). With the exception of the MBI, all instruments utilized in the study were not validated, and therefore may not be measuring the intended constructs. Also, the instrument developed to assess quality of supervision does not capture all facets of supervision. For instance, Knudsen and colleagues (2006) did not assess emotional support, but instead focused on the supervisor’s ability to empower the supervisee to address work-related problems. A study with a more sophisticated conceptualization of beneficial supervisory attributes may be able to detect a more complete picture of the impact of clinical supervision on counselor compassion fatigue. A model investigating both aspects of compassion fatigue as outcome variables will also be able to capture a comprehensive model of counselor wellness.

The findings of this study have implications for aspects of supervision that may best protect counselor welfare and promote commitment to the field of counseling. Supervision that empowers counselors to practice independent decision making and
supervision that implements just policies may develop counselors’ perceived job autonomy and workplace justice. These practices also reflect recommendations in the field of counselor supervision. According to ACES (2011), the ethical supervisor “encourages supervisee autonomy when appropriate” and adheres to “ethical codes and guidelines…and models of ethical behavior” (Standard 11.b.vii and Standard 7a). Future research should continue to explore the impact of supervisory styles that promote counselors’ perceived autonomy and justice on counselor burnout and STS.

Figure 1. SEM of emotional exhaustion and turnover intention (Knudsen et al., 2006, p. 393).

**Supervision and service.** In an ethnographic account of residential supervisors’ experiences, McCrea and Bulanda (2008) explored the values and practices of supervisors in countering supervisee compassion fatigue in a challenging mental health environment. McCrea and Bulanda sampled supervisors from 81 residential care programs and 18 supervisors agreed to participate. The semi-structured interviews focused on the subjects’ beliefs about what constitutes a good supervisor and their strengths, goals, challenges, and values (McCrea & Bulanda, 2008). Two researchers analyzed and coded the data for thematic findings and the interrater reliability was 100%
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(McCrea & Bulanda, 2008). Data inclusion was limited to what was supported by current research on preventing compassion fatigue (McCrea & Bulanda, 2008).

McCrea and Bulanda (2008) found an overarching theme of compassion towards supervisees. The supervisors expressed this compassion by providing education and training and by seeking to develop thriving and supportive teams (McCrea & Bulanda, 2008), which are all known correlates of combating compassion fatigue (e.g., Craig & Sprang, 2010; Dreison, White, Bauer, Salyers, & McGuire, 2015; Wachter Morris & Barrio Minton, 2012). Supervisors shared power with their supervisees by soliciting feedback and incorporating supervisee suggestions into clinical practice (McCrea & Bulanda, 2008). The supervisors also supported the staff through acts of service, which included “‘being willing to help with day-to-day operations regardless of status’ and ‘doing things below [the supervisors]’” (McCrea & Bulanda, 2008, p. 243).

The researchers did not implement recommended validity methods such as triangulation of data, member checking, clarifying researcher bias, or an external auditor (Creswell, 2014). However, because the authors used compassion fatigue research as a guide to winnow data, the findings imply that service-oriented supervision may be a protective factor for compassion fatigue and warrants further inquiry. Because qualitative results cannot be generalized beyond the sample, further quantitative research is needed to understand the impact of service-oriented supervision on employee well-being, especially in the midst of the challenges posed in mental health agencies.

**Dual-role supervision.** Supervisors in agency settings often serve in clinical and administrative roles with supervisees. The *Best Practices in Supervision* (ACES, 2011) standards specify the necessity for clinical supervisors to follow a formal model of
supervision to address the professional development and welfare of the supervisee and the clinical needs of supervisees’ caseload (Standard 12c). Similarly, the *ACA Code of Ethics* specifies that counselor supervisors “have knowledge of supervision models” (ACA, 2014, § F, Introduction). Even so, according to Evans and colleagues (2016), only 52% of state licensing boards require supervisors to receive formalized clinical supervision training. Administrative supervision requires the supervisor to assist the supervisee in fulfilling the mission and priorities of the agency or organization (Killmer & Cook, 2014). ACES (2011) instructs clinical supervisors to coordinate with other supervisors including administrative supervisors and identify any conflicts (Standard 11c). However, ACES (2011) does not provide best practice guidelines for administrative supervision other than distinguishing it from the duties of clinical supervisors (Standard 11b).

About half of clinical supervisors serve in an administrative supervision capacity (Tromski-Klingshirn & Davis, 2007); however, formal models of supervision do not address the intricacies of administrative supervision responsibilities. Dual-role supervision inevitably impacts the supervisory relationships and supervisors must manage the sometimes-conflicting demands these roles present (Killmer & Cook, 2014). Tromski-Klingshirn (2006) also cautioned that dual-role supervision provides many opportunities for role conflict and role ambiguity for supervisees, and therefore, places supervisees at risk for compassion fatigue.

Tromski-Klingshirn and Davis (2007) conducted an exploratory study to investigate counselors’ experiences and the prevalence of dual-role supervisors. A sample of 143 counseling residents completed the Clinical Supervision Questionnaire (CSQ),
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which was created for the study and measures the “extent and nature of clinical supervision” (Tromski-Klingshirn & Davis, 2007, p. 298). Participants also completed the Supervision Questionnaire (SQ; Ladany, Hill, Corbett, & Nutt, 1996) and responded to questions regarding work setting, demographic details, type of supervision, length of supervision relationship, supervisory roles, and questions assessing attitudes regarding dual-role supervision (Tromski-Klingshirn & Davis, 2007).

Tromski-Klingshirn and Davis (2007) conducted two 3-way analyses of variance (ANOVA). The first ANOVA tested the main and interaction effects of the clinical supervisor role (dual or clinical only) × supervisee gender × supervisor gender. The second ANOVA analyzed the main and interaction effects of the role of clinical supervisor × supervisee counseling setting × treatment focus of setting (mental health or substance abuse). Content analysis was also conducted on narrative responses (Tromski-Klingshirn & Davis, 2007). About half of respondents \( n = 70 \) had a dual-role supervisor (Tromski-Klingshirn & Davis, 2007). Although most of the supervisees did not view the dual-role as problematic, 18% of supervisees expressed concern with the multiple roles (Tromski-Klingshirn, & Davis, 2007). Supervisees expressed fears of retaliation and fears regarding how disclosures of countertransference may affect employment status (Tromski-Klingshirn & Davis, 2007). Also, some respondents stated that dual-role supervisors may use supervisee disclosures to build a case against other employees, which affected their level of trust in their supervisor (Tromski-Klingshirn & Davis, 2007). This study illuminated the prevalent practice of dual-role supervision and supervisee opinions of dual-role supervision. The study indicated that although many supervisees find dual-role supervision acceptable, dual-role supervision does pose a
hazard for some supervisees. The study also required participants to provide the first name and last initial of their supervisor. This may have resulted in participants providing more socially desirable responses.

Supervisors also may experience conflict of interest posed by engaging in multiple levels of oversight. A recent qualitative study investigated clinical supervisor value conflicts and determined that balancing administrative and clinical duties poses a challenge for many supervisors (Veach et al., 2012). Supervisors reported feeling forced to implement undesirable agency policies with their supervisees and admitted experiencing greater preoccupation with performance issues such as paperwork and direct service quota than supervisee welfare or professional development (Veach et al., 2012). A supervisory relationship centered around the enforcement of agency policies and accomplishment of agency goals may inhibit the development of a warm and genuine supervision relationship necessary for effective supervision (Veach et al., 2012). Furthermore, this enforcement-centered supervision style may dampen the protective benefits supervision usually provides for supervisee welfare. By allowing administrative goals to conflict with supervisee needs, supervisors may inadvertently contribute to an environment that promotes rather than ameliorates compassion fatigue by engaging in an unsupportive leadership style (Kreider, 2014).

Despite the difficulties and conflicts of interest that may arise in dual-role supervision, the practice is prevalent and is likely to continue due to budget constraints (Tromski-Klingshirn, 2006). Administrative and dual-role supervisors are often overburdened with multiple responsibilities that lead to “confusing and inconsistent training experiences for [supervisees]” (Evans et al., 2016, p. 3). Evans and colleagues (2016)
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recommended integrating leadership models into the provision of supervision services as a structured solution to improve the supervisory services provided to counseling supervisees. Formal leadership models are well-equipped to confront the challenges of administrative and organizational encumberments, and therefore, can address the array of responsibilities counseling supervisors may encounter.

**Servant Leadership**

Formal leadership styles are ubiquitous research topics in organizational literature beyond the field of counseling (Evans et al., 2016). However, Evans and colleagues (2016) only recently broached the discussion of formal leadership styles in counseling literature by stating, “the benefits of infusing leadership models into counseling supervision are numerous because this is a cost-effective solution to addressing the lack of formalized training to supervisors” (p. 5). Evans and colleagues suggested that servant leadership may be a beneficial model to weld with clinical supervision in the field of counseling.

Servant leadership was coined by Greenleaf (1977) as a style of leadership marked by service, humility, and vision. According to Babakus and colleagues (2011), a servant leader strives to bring out the best in followers, serves as a role model, and provides necessary resources for follower success. Furthermore, servant leaders are distinguished by relational power, promoting follower autonomy, ethical practices, and modeling of service-oriented leadership to be emulated by followers (Barbuto & Wheeler, 2006). According to Liden, Wayne, Zhao, and Henderson (2008), servant leadership has seven dimensions: conceptual skills, empowerment, helping subordinates
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grow and succeed, putting subordinates first, ethical behavior, emotional healing, and creating value for the community.

Servant leadership is a style of leadership that closely reflects counseling philosophy and principles. Greenleaf and Spears (2002) indicated that servant leaders work to develop caring and supporting relationships with subordinates. This corresponds with the necessity of counseling supervisors to develop a “supervisory working alliance that is collaborative and egalitarian” (ACES, 2011, Standard 1.c.i.). Also, servant leaders value the empowerment and development of followers to reach their goals (Ehrhart, 2004). Similarly, counseling supervisors “meet the professional development needs of supervisees while protecting client welfare” (ACES, 2011). Additionally, servant leaders value ethical behavior and interact openly and fairly with others (Liden et al., 2008). Counseling supervisors must adhere to applicable counseling ethical codes and promote open and candid interaction with all professional relationships (ACES, 2011, Standard 5.b.ix and Standard 11.c.ii). Servant leadership has also been effective in increasing followers’ advocacy initiatives (Liden et al., 2008). Counseling supervisors likewise encourage “supervisees to infuse diversity and advocacy considerations in their work with clients” (ACES, 2011, Standard 6.b.).

Servant leadership has been found to improve the supervisory relationship and prevent burnout in followers. Specifically, servant leadership is associated with a more trusting and open supervisory relationship (Chatbury, Beaty, & Kriek, 2011; Senjaya & Pekerti, 2010), reduced employee turnover (Babakus et al., 2011), increased employee job satisfaction (Mayer, Bardes, & Piccolo, 2008), and increased employee psychological safety (Schaubroeck et al., 2011). Furthermore, employees who perceive servant
leadership traits in their supervisors are significantly less likely to experience burnout (Babakus et al., 2011; Upadyaya et al., 2016). This indicates that integrating a servant leadership style with clinical supervision in the field of counseling may promote counseling residents’ well-being.

**Conceptual skills.** Servant leaders are interpersonally savvy, but they are also equipped with conceptual skills to maintain an effective business. Conceptual skills refer to the leader’s ability to effectively solve work-related problems (Liden et al., 2008). Liden and colleagues (2008), also indicated that conceptual skills refer to servant leaders’ knowledge of current tasks and utilization of this knowledge to “effectively support and assist others, especially immediate followers” (p. 162). For counselors, conceptual skills include selection of interventions, identification of crucial clinical themes, and overall cognitive abilities (Usher & Borders, 1993). Clinical supervisors often utilize conceptual skills to support supervisees in developing these skills in session with clients.

**Empowerment.** The second dimension of servant leadership is empowerment. Empowerment refers to servant leaders’ encouragement and facilitation of immediate followers and assisting them in identifying solutions to work-related problems (Liden et al., 2008). Lack of Empowerment within organizational structure has been linked to burnout in numerous studies (Ayala Calvo & Garía, 2017; Meng et al., 2015; Orgambídez-Ramos, Borrego-Alés, Vázquez-Aguado, March-Amegual, 2017). An additional precipitant of burnout is having insufficient resources to complete tasks (Morse et al., 2012). Servant leaders empower others through verbal processing and through providing necessary resources for followers to solve their own problems.
Putting subordinates first. Next, servant leaders’ service-oriented approach to leadership includes placing the needs of followers above the needs of the leader. Servant leaders verbalize that their priority includes meeting the needs of followers (Liden et al., 2008). In addition, servant leaders support this through action by interrupting their work to help subordinates solve their problems (Liden et al., 2008).

Helping subordinates grow and succeed. Servant leaders invest in followers and intend to develop long-term relationships with them (Liden et al., 2008). Servant leaders show a genuine care for their followers’ career goals and foster their “development by providing support and mentoring” (Liden et al., 2008, p. 162). Magnuson, Norem, and Wilcoxon (2002) found that professional growth may protect against burnout.

Ethical behavior. The ethical behavior of supervisors has a positive impact on supervisees. According to Liden and colleagues (2008), servant leaders have candid, honest, and fair interactions with others, including followers. This is one reason why servant leadership fosters trust in followers (Senjaya & Pekerti, 2010). Having a trusting relationship allows supervisees to disclose stressful work experiences in supervision, gain support when needed, and disclose the effects of counseling on personal wellness (Bernard & Goodyear, 2014).

Emotional healing. Liden and colleagues (2008) define emotional healing as servant leaders’ sensitivity to the personal needs of others, especially subordinates. According to Bernard and Goodyear (2014), the goal of supervision is to facilitate supervisees’ professional and personal growth. Supervisors that show empathy and concern for supervisees’ professional and personal concerns may have a positive impact
on supervisees’ wellness. Harrison and Westwood (2009) found that “relationally healing supervision” (p. 212) may alleviate STS.

**Creating value for the community.** Servant leaders provide service and concern for the organization and for followers. They also are concerned with positively impacting the surrounding community (Liden et al., 2008). Counseling services exist to benefit the mental health needs of the surrounding community. Supervisors who are in touch with the needs of the community and concerned with providing services that meet these needs may initiate specific counseling services that target these needs. Counselors engaged in services that are valued by clients may experience increased wellness. Substance abuse counselors who have a clear sense of mission were less likely to experience burnout than those with a poor sense of mission (Garner, Knight, & Simpson, 2007).

**Servant Leadership and Burnout**

Upadyaya and colleagues (2016) investigated whether servant leadership, self-efficacy, and resilience would increase work engagement and life satisfaction, which they hypothesized would then decrease burnout and depressive symptoms through a cross-lagged survey design study. Participants included 1,415 employees of a water chemistry organization, a network service provider, and a public-sector administration (Upadyaya et al., 2016). Participants completed the Utrecht Work Engagement Scale (Schaufeli, Bakker, & Salanova, 2006), the Bergen Burnout Inventory (Salmela-Aro, Näätänen, & Nurmi, 2004), a measure of depression symptoms frequency, the Satisfaction with Life Scale (Diener, Emmons, Larsen, & Griffin, 1985), the Servant Leadership Survey (Van Dierendonck & Nuijten, 2011), and a measure of work-related self-efficacy beliefs (Scholz, Doña, Sud, & Schwarzer, 2002).
Upadyaya and colleagues (2016) tested the hypothesis through SEM and after setting non-significant paths to zero, the researchers found a good fit for the data (RMSEA = 0.02). The results of the study indicated that servant leadership predicted burnout, life satisfaction, and work engagement, which predicted burnout, depression, and life satisfaction (Upadyaya et al., 2016; Figure 2). The results of this study highlight the need for holistic approaches to worker well-being, as professional distress can impact life satisfaction and mental health symptoms. Considering the relationship found between servant leadership and burnout, one component of compassion fatigue, in industrial organizations, further research into servant leadership’s impact on compassion fatigue is warranted in mental health organizations.

Figure 2. “Cross-lagged Associations between work engagement and burnout, and life satisfaction and depressive symptoms” (Upadyaya et al., 2016, p. 105) *p < 0.05; **p < 0.01; ***p < 0.001.

Another recent study investigated servant leadership’s impact on burnout and leader trust in hospital employees. Participants included 711 members of the general nursing staff of two large hospitals in Italy (Bobbio & Manganelli, 2015). Participants completed the Servant Leadership Survey (Van Dierendonck & Nuijten, 2011), the Survey of Perceived Organizational Support (Eisenberger, Huntington, Hutchinson, & Sowa, 1986), the Organizational Trust Inventory (Vidotto, Vicentini, Argentero, &
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Bromiley, 2008), the Italian version of the Maslach Burnout Inventory-General Survey (Borgogni, Armandi, Consiglio, & Petitta, 2005), and intention to leave the organization was measured by three items used in previous studies (Bobbio & Manganelli, 2015). Using SEM, the researchers determined a model with acceptable fit (RMSEA = .06) and found servant leadership to be correlated with perceived organizational support (Bobbio & Manganelli, 2015; Figure 3). Servant leadership positively predicted leader trust, which negatively predicted emotional exhaustion, personal accomplishment, and cynicism (Bobbio & Manganelli, 2015). Cynicism predicted intention to leave (Bobbio & Manganelli, 2015).

![Figure 3. SEM of Intention to Leave Antecedents (Bobbio & Manganelli, 2015). The first coefficient refers to sample 1 and the second coefficient refers to sample 2; all paths shown are significant (Bobbio & Manganelli, 2015, p. 1188).](image)

Although the above study may be limited by self-selection bias, common method variance, and social desirability bias as are all studies reliant on self-report measures, the results support the hypothesis that servant leadership provides a buffer against follower burnout. The study could be improved by selecting a wider range of agency settings.
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Also, a study that focuses on counseling residents who have frequent interaction with a supervisor could identify if servant leadership impacts burnout in the counseling field.

**Servant Leadership and STS**

Servant leadership’s relationship to STS has not yet been investigated in any discipline. However, evidence exists that suggests servant leadership may be beneficial in addressing or preventing STS symptoms in supervisees. Followers who perceive servant leadership traits in their supervisors experience a greater sense of trust (Bobbio & Manganelli, 2015; Senjaya & Pekerti, 2010) and psychological safety (Schaubroek et al., 2011). Also, emotional healing is a facet of servant leadership that may provide a buffer for supervisee STS.

**Trust.** Senjaya and Pekerti (2010) hypothesized that servant leadership would significantly predict follower trust in a convenience sample of 555 teaching faculty and staff in two educational institutions in Indonesia (Senjaya & Pekerti, 2010). Participants completed the Servant Leadership Behavior scale (Sendjaya, Sarros, & Santora, 2008) and a six-item scale measuring follower loyalty to leader developed by Podsakoff, MacKenzie, Moorman, and Fetter (1990). Senjaya and Pekerti (2010) analyzed the data by regressing follower trust on a 6-factor measure of servant leadership. Results indicated that servant leadership significantly predicted follower trust and accounted for 26% of the variance (Senjaya & Pekerti, 2010).

This study was conducted in Indonesia and a collectivist cultural bias may prevent generalization to other cultures. Also, the convenience sample from two educational institutions affects the generalizability of the results to populations beyond the sample. However, the results do indicate that servant leadership may support follower trust.
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Considering supervisees who lack trust in their clinical supervisors are much less likely to discuss the ways they are impacted by their counseling (Bernard & Goodyear, 2014) and supervisees who are reluctant to talk with their supervisors are at greater risk for compassion fatigue (Knight, 2010), servant leadership may be a supervisory approach that facilitates trust and counters compassion fatigue in supervisees.

**Psychological safety.** Counselors who experience STS may lack psychological safety. Branson and colleagues (2014) found that supervisees who displayed higher symptoms of STS experienced a diminished sense of physical and emotional safety. Pulido (2012) also determined that counselors who experienced STS had a disruption in cognitive schemas related to trust and psychological safety. Zerubavel and O’Dougherty Wright (2012) recommended that clinical supervisors cultivate an environment of safety with supervisees in order to promote resilience and posttraumatic growth. Supervisors who employ a servant leadership style may create this safe environment to ameliorate STS symptoms.

Schaubroeck and colleagues (2011) hypothesized that servant leadership would optimize psychological safety among subordinates, which would drive team performance. Psychologically safe individuals are “able to show and employ one’s self without fear of negative consequences of self-image, status, or career” (Kahn, 1990, p. 708). Participants included 999 employees of banks in Hong Kong and the United States (Schaubroeck et al., 2011). Participants completed a measure of trust developed for the study (Schaubroeck et al., 2011). Psychological safety was measured with 7 items from a psychological safety scale developed by Edmonson (1999). Participants also completed the Transformational Leadership Scale (Podsakoff et al., 1990) and the Servant...
Leadership Scale (SLS; Liden et al., 2008). Finally, supervisors completed a measure of team performance (Schaubroeck et al., 2011). The mediation model was tested with SEM and the model fit indices suggested a good fit to the data, which indicates that servant leadership’s influence on psychological safety is mediated by affective trust (see Figure 4). Schaubroeck and colleagues (2011) also utilized hierarchical regression to identify the simultaneous impact of leadership style on team performance. Servant leadership accounted for an additional 10% of the variance in team performance beyond transformational leadership. This study selected participants from the same multinational bank, which may limit generalizability beyond the study. Also, causality cannot be confirmed due to the cross-sectional design of the study. However, the results indicate that a servant leadership style may optimize follower psychological safety and trust.

*Figure 4.* Model of servant leadership’s relationship to psychological safety as mediated by affect based trust (Schaubroeck et al., 2011, p. 866).

**Emotional healing.** Liden and colleagues (2008) identified emotional healing as a dimension of the servant leadership construct. Emotional healing is “the act of showing sensitivity to others’ personal concerns” (Liden et al., 2008, p. 162). Harrison and Westwood (2009) selected a purposive sample of trauma therapists with a minimum of
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10 years of experience and who self-identified as managing well in their work with clients to identify protective practices of trauma therapists. A total of 6 individuals participated in a three-phase interview process. The first phase included structured interviews to obtain demographic and work experience information, the second phase included semi-structured interviews focused on how participants self-sustain in their work with traumatized clients, and the third phase of interviews took place after data analysis to member-check findings (Harrison & Westwood, 2009). The first author analyzed the data through a narrative content analysis, coded emergent themes, and then sent the coded transcripts to a peer review committee for validity purposes (Harrison & Westwood, 2009).

Harrison and Westwood (2009) identified nine thematic findings. One theme, “relationally healing supervision” (p. 212) was identified as a protective factor for STS. Participants indicated that supervision was experienced as relationally healing when supervisees felt free to discuss STS reactions (Harrison & Westwood, 2009). Supervision counteracted feelings of isolation and shame provoked by STS (Harrison & Westwood, 2009). Although the results of this qualitative study cannot be generalized to a larger audience, the study suggests that when emotional healing exists in a supervisory relationship, supervisees may enjoy diminished STS.

Servant Leadership and Gender

Traditional leadership styles encompass agentic behaviors that demonstrate an assertive, competitive, and results-oriented approach to leadership (Hogue, 2016). These agentic qualities that are normatively expected of leaders also correspond with traits most frequently prescribed to the masculine gender role (Eagly & Carli, 2007). Communal
behaviors that prioritize group cohesion, teamwork, and consensus-building correlate with behaviors associated with the female gender role (Eagly & Carli, 2007). Women may experience gender-bias when seeking leadership positions because of the seemingly contradictory nature of traditional leadership attributes and the socially-constructed feminine gender role (Hogue, 2016). However, modern leadership styles incorporate communal and agentic leadership attributes and focus on the importance of relationship building and investing in followers (Hogue, 2016). Servant leadership incorporates both communal and agentic leadership qualities.

Barbuto and Gifford (2010) recruited a sample of 75 leaders and 388 raters, which formed 368 leader-follower dyads. Leaders completed a demographic questionnaire and the raters completed the Servant Leadership Questionnaire (Barbuto & Wheeler, 2006) and the Multifactor Leadership Questionnaire (Avolio & Bass, 2002). A multivariate analysis of variance (MANOVA) was conducted to identify between-group differences in supervisee ratings of male and female leaders on five dimensions of servant leadership and three dimensions of leader satisfaction (Barbuto & Gifford, 2010). All null hypotheses were accepted and no significant differences were found in perceived servant leadership traits or satisfaction with leadership for male or female leaders (Barbuto & Gifford, 2010). The results of this study indicated that both women and men can display communal and agentic qualities of leadership, and gender did not affect supervisee perception of servant leadership traits. This study incorporated a majority of female leaders and results may vary in a sample with more evenly distributed genders (Barbuto & Gifford, 2010).

Gaps in Current Research
This chapter provided an overview of current research regarding protective and risk factors for compassion fatigue as a dual-dimensional construct, as well as describing current research on burnout and STS independently. These protective and risk factors exist in counselors’ personal, client, and work environment. When considered holistically, these arenas form a comprehensive picture of the multi-systemic impact on counselor compassion fatigue.

Sufficient literature indicates that young age and inexperience are risk factors for burnout and STS (e.g., Bober & Regehr, 2006; Craig & Sprang, 2010; Galek et al., 2011; Robinson-Keilig, 2014). However, much of the current compassion fatigue research focuses on the general population of practicing therapists, but a dearth of research exists that focuses solely on counselors in residency. These unlicensed counselors have less support than pre-graduated counselors, and increased vulnerability than more experienced counselors. Protective factors for compassion fatigue in this population warrant further investigation. Considering the frequent interaction supervisees have with their clinical supervisors, supervision is an appropriate avenue of intervention.

Supervisors can shield supervisees from compassion fatigue through high quality supervision (Knudsen et al., 2006), a positive working alliance (Sterner, 2009), and service-oriented supervision (McCrea & Bulanda, 2008). However, out of necessity due to budget constraints, supervisors are often forced to engage in administrative and clinical roles simultaneously (Tromski-Klingshirn, 2007), which may lead to inconsistent supervisory interactions (Evans et al., 2016). Current supervisory models do not adequately address the functions of administrative and dual-role supervision. Incorporating a formal leadership model that addresses the challenges of administrative
supervision without betraying the foundational principles of the field of counseling may address the challenges that counseling resident supervisors face and may simultaneously promote counselor wellness. Evans and colleagues (2016) advocated for the inclusion of servant leadership in counselor supervision because of the congruency of its philosophical underpinnings to counseling tenets and its ability to address administrative obligations while providing sufficient support to supervisees.

Significance of Study

In the current study, I hypothesized the power of servant leadership would predict burnout and STS with counseling residents in a model based on Stamm’s (2010) theoretical model of professional quality of life. The personal environment was measured by professional self-care strategies, personal history of trauma, and gender, as these are potent individual factors contributing to compassion fatigue development. The client environment included caseload size and amount of trauma clients served because workload significantly contributes to burnout (Knight et al., 2012) and level of trauma exposure influences severity of STS (Galek et al., 2011). Role ambiguity, role conflict, and the servant leadership qualities of supervisors represented the counselors’ work environment. Hypothetically, servant leadership was thought to be a significant contributor to a model predicting compassion fatigue and a model predicting burnout and STS as separate constructs in the context of other relevant environmental factors.

Servant leadership has significantly negatively predicted burnout in disciplines beyond the scope of the counseling profession (e.g., Babakus et al., 2011; Bobbio & Maganelli, 2015; Hunter et al., 2013; Upadyaya et al., 2016) and warrants further inquiry in the field of mental health. Furthermore, servant leadership may enhance psychological
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safety (Schaubroeck et al., 2011), a trusting relationship (Senjaya & Pekerti, 2010), and emotional healing (Liden et al., 2008). These are all qualities that set the stage for STS recovery and prevention (e.g., Branson et al., 2014; Harrison & Westwood, 2009; Knight, 2010; Pulido, 2012; Zerubavel & O’Dougherty Wright, 2012). Servant Leadership is an appropriate leadership style to weld with clinical supervision for the support and empowerment of supervisees, and for the prevention of compassion fatigue in the context of other work, individual, and client factors. The following chapter describes the methodology for the current study.
CHAPTER THREE

The previous chapters introduced the problem of compassion fatigue, burnout, and STS specifically with new counselors and provided a literature review of the various protective and risk factors associated with burnout. These factors initiate the onset of symptoms in the context of the counselor’s personal, client, and work contexts. The previous chapter also introduced the current study, which investigated the influence of perceived servant leadership supervision in the context of other known variables on counseling residents’ compassion fatigue, burnout, and STS. This third chapter proposes the methodology for the study including the purpose statement, the study design, the population and sampling method, instruments, data analysis method, data interpretation, and ethical considerations.

Statement of Purpose

The purpose of the study was to determine the appropriateness of two modified models of the professional quality of life model as created by Stamm (2010) that implies compassion fatigue arises in the context of the personal, work, and client environments of the mental health professional (see Figures 6 and 7). The proposed models included several variables to represent counselors’ personal, client, and work environments. Counselor self-care practices, survivor status, and counselor gender represented the counselor’s personal environment. Trauma clients and caseload magnitude represented the client environment. Role ambiguity, role conflict, and perceived servant leadership traits of the participants’ supervisors represented the work environment. Compassion
fatigue was hypothesized to be the only endogenous latent outcome variable in the Hypothesized Compassion Fatigue Short (CF-S) model (Figure 6), and burnout and STS were hypothesized as two separate endogenous outcome latent variables in the Hypothesized Counselor Burnout Inventory (CBI)/STSS model (Figure 7). This study added to the current literature on compassion fatigue by statistically clarifying the complex relationships between the personal, client, and work environments, and their relative impact on counseling residents’ burnout and STS. Also, this study attempted to expand the theoretical conceptualization of compassion fatigue by comparing the latent variable of compassion fatigue (Hypothesized CF-S model, Figure 6) with a model that conceptualizes STS and burnout as two separate latent constructs (Hypothesized CBI/STSS model, Figure 7).

Furthermore, this was the first study to investigate the impact of servant leadership on compassion fatigue and STS, and the first study to explore the servant leadership construct in the field of counseling. Also, this study added to the literature by examining the changing landscape of clinical supervision, which may include administrative and clinical responsibilities. Results of this study may inform supervisory practices and could potentially influence administrative policies and procedures that affect counselor compassion fatigue.

**Study Design**

The method selected for this study was a cross-sectional survey design, administered to a sample of participants at one point in time. The basic purpose of survey research is to collect data pertaining to identified characteristics from a sample representing a target population, and then, after analyzing this data, generalize the results
to the target population (Creswell, 2014). This method was appropriate for this study because it is an expedient method for collecting quantitative data on a small group that can be used to make inferences about the represented larger population (Groves & Fowler, 2009).

The survey was entered into Qualtrics and distributed to identified participants meeting inclusion criteria through an online format. There are various advantages and disadvantages to online survey distribution. Online surveys have a quick turn-around time, are cost-effective, and are convenient and appropriate for populations with easy internet access (Sue & Ritter, 2012). A low response rate may be a risk of the online survey method. This can result in a nonprobability sample, which makes generalizing to a target population more difficult (Sue & Ritter, 2012). However, according to Sue and Ritter (2012), nonprobability samples can be appropriate for exploratory studies. Since this study was the first study to examine perceived servant leadership in counseling, this study was exploratory in nature and provided preliminary evidence for future research. Therefore, an online survey-disbursement method was implemented.

**Population and Sample**

The target population for this study included counseling residents in Florida. In this state, counseling residents are referred to as Registered Mental Health Counseling Interns and Registered Marriage and Family Interns and collectively as registered interns. Inclusion criteria included masters-level, unlicensed, and post-graduate counselors currently providing direct counseling services and accruing supervised counseling hours for eventual licensure. These individuals were selected for further study because new counselors are at greater risk for compassion fatigue (Bober & Regehr, 2006; Knight,
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2010; Thompson et al., 2014) and they are required to be under regular clinical supervision. This ensured that each participant had a supervisor to evaluate for servant leadership traits. Also, the Florida Board of Counseling had a full published list of registered interns’ contact information available for research purposes. The purpose of the list was to display all registered interns that were registered with the Florida Board of Counseling with an approved supervisor and were accruing experience hours for licensure.

There were 5,706 registered mental health counseling interns in the state of Florida and 1179 registered marriage and family therapist interns for a total of 6,885 registered interns. Of these interns, 5,842 registered interns had published email addresses available and 126 of these registered interns were accruing hours towards both licenses. Emails were sent to 5,716 addresses and 218 of these emails could not be successfully delivered. Therefore, the survey was successfully emailed to 5,498 registered interns. The Florida Board of Counseling does not collect demographic information on registered interns. However, Tromski-Klingshirn and Davis (2007) collected a sample of counseling residents (N=143) and concluded that participants were primarily female (76%) and Caucasian (95%). I conducted two power analyses to calculate the needed sample size for both hypothesized models with a desired effect size of 50%, statistical power level of 80%, and a probability level of 0.05. The Hypothesized CF-S model (Figure 6) has 6 observed variables and 3 latent variables, and the recommended minimum sample size was 400 participants. The Hypothesized CBI/STSS model (Figure 7) had 6 observed variables and 4 latent variables, and the recommended minimum sample size was 538 participants. A minimum of a 9.2% response rate was
required to obtain the recommended sample size. In order to incentivize participation, individuals were directed to an external website where they had the option to enter their contact information to be entered into a raffle to win one of four amazon gift cards. Their contact information was not associated with their survey response.

Use of Theory

The study’s model was adapted from Stamm’s (2010) model of professional quality of life that depicts three environmental spheres that contribute to compassion fatigue and compassion satisfaction (see Figure 5). The current study altered this model by delineating specific variables to represent the work, client, and personal environments. Role stress and servant leadership represented the work environment. Client environment comprised the percentage of trauma clients and magnitude of caseload. Survivor status, gender, and self-care strategies represented the personal environment. As an exploratory study, the proposed model also looked only at compassion fatigue, burnout, and STS as outcome variables rather than including compassion satisfaction or variables beyond compassion fatigue.

Measures

The number of indicators included in the study was informed by a variety of factors. Although prior research identified a plethora of protective and risk factors to affect clinician compassion fatigue, I included only those variables that best represented the personal, client, and work environment and that adequately tested the study’s hypotheses based on the theoretical constraints and the specific population of counselors. Scale development standards and subject burden were also considered in the selection of variables and instruments. Because this survey resulted in 128 items for participants to
complete, four items to check attention were distributed evenly throughout the instrument sections of the survey. The following will overview the data collected on the survey and how variables were measured.

![Diagram](image)

*Figure 5. The Professional Quality of Life. This model depicts Stamm's (2010) hypothetical model of compassion fatigue development.*

**Demographics**

Participants first responded to study-inclusion questions that probed licensure status, current involvement in direct services, and regular interaction with a supervisor. A general set of demographic and background questions was also included to assess respondents’ individual characteristics and professional background (see Appendix B). Individual characteristics included gender, race/ethnicity, and age. Professional history consisted of the length of counseling experience, hours of trauma training received, and current agency setting. I also asked participants to indicate whether they attended a CACREP-accredited counseling program.

**Work Environment**
In the current study, exogenous work environment variables included role ambiguity, role conflict, and perceived servant leadership traits of the participants’ supervisors. Role ambiguity and role conflict are included as work environmental variables as these are stressors in counselors’ work environments (Coll & Freeman, 1997; Kirk-Brown & Wallace, 2004; Wallace et al., 2010). Also, counseling residents have either multiple supervisors or dual-role supervisors. Both of these supervisory arrangements provide ample opportunity for role conflict or role ambiguity in supervisees (Evans et al., 2016).

**Role stress.** Role ambiguity and role conflict are measured by the widely used and well-validated Role-Stress Scale (RSS; Rizzo, House, & Lirtzman, 1970). The 14-item measure has two subscales: role conflict and role ambiguity. The role conflict scale has 8 items (e.g., *I work under incompatible guidelines and policies*) and the role ambiguity scale has 6 items (e.g., *I feel uncertain about how much authority I have*). Respondents rated their level of agreement to statements on a 7-point Likert scale from very false to very true. Rizzo and colleagues (1970) identified the two-factor model by using an orthogonal varimax rotation and found a .25 intercorrelation between the two scales, which indicates two somewhat independent subscales. As a result, these scales will be utilized as two observed exogenous variables in both the Hypothesized CF-S model and the Hypothesized CBI-STSS model (see Figures 6 and 7).

Gonzalez-Roma and Lloret (1998) found an internal reliability (Cronbach’s alpha) of 0.82 for the role ambiguity scale and 0.85 for the role conflict scale. Rizzo and colleagues (1970) validated the role conflict and role ambiguity scales by finding correlations between both scales with leadership and organizational characteristics. Both
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scales also had moderate correlations with job satisfaction (Rizzo et al., 1970). Acker and Lawrence (2009) also found higher burnout, role conflict, and role ambiguity scores among mental health professionals who had lower self-perceived competence.

**Servant leadership.** Perceived servant leadership of supervisors was measured by the SLS (Liden, Wayne, Zhao, & Henderson, 2008). Permission to use and modify the scale in this study was obtained through personal correspondence with the scale developers. One modification was made to the original scale: the word *manager* was replaced by *supervisor*. According to Liden and colleagues (2008), the six subscales have good internal consistency and include conceptual skills (α = .86; e.g., *My supervisor can tell if something work-related is going wrong*), empowering (α = .90; e.g., *My supervisor gives me the responsibility to make important decisions about my job*), helping subordinates grow and succeed (α = .90; e.g., *My supervisor makes my career development a priority*), putting subordinates first (α = .91; e.g., *My supervisor seems to care more about my success than his/her own*), behaving ethically (α = .90; e.g., *My supervisor holds high ethical standards*), emotional healing (α = .89; e.g., *I would seek help from my supervisor if I had a personal problem*), and creating value for the community (α = .89; e.g., *My supervisor emphasizes the importance of giving back to the community*).

Liden and colleagues (2008) established face validity by reviewing extant scales and created 85 questions based on these scales and existing servant leadership literature. This original scale was given to 283 undergraduate students and an EFA with oblique rotation revealed a 7-factor structure. Liden and colleagues then eliminated items based on factor loadings and internal consistency estimates without individual items. The
measure was then given again to 182 employees and the researchers analyzed the data using CFA, which confirmed the original 7-factor structure (Liden et al., 2008). The SLS moderately correlated with transformational leadership ($r = .43$), which demonstrated convergent validity (Liden et al., 2008). The scale’s moderate correlation with organizational commitment established predictive validity. (Liden et al., 2008).

Respondents in the current study completed the SLS for the supervisor they consider to be their immediate supervisor and the person they “report to” (Liden et al., 2008, p. 166). Respondents were also asked if the evaluated supervisor is both their clinical and administrative supervisor (dual-role), their administrative supervisor only, their clinical supervisor outside the workplace setting, or their clinical supervisor within the workplace setting. Respondents also indicated the supervisor’s gender. The SLS was represented in the Hypothesized CF-S model (Figure 6) and the Hypothesized CBI/STSS model (Figure 7) as a seven-factor latent exogenous latent variable.

**Client Environment**

The variables representing the client environment included magnitude of caseload and trauma exposure. In previous studies caseload was measured by the number of cases currently being treated by the respondent (Acker & Lawrence, 2009; Knight et al., 2012). However, some counselors may carry a lower caseload but see their clients more frequently than clients with higher caseloads. In order to have an accurate assessment of workload, caseload size was determined by the hours per week the respondent spends counseling clients. To assess counselors’ exposure to traumatized clients, participants estimated the number of hours per week they serve traumatized clients. These items were based on strategies reported in a recent meta-analysis (Hensel et al., 2015).
Personal Environment

The personal environment of the counselor was represented by gender, survivor status of personal trauma, and professional self-care practices. Survivor status was assessed through a single question because using a dichotomous variable to assess survivor status has been successful in previous studies (e.g., Branson et al., 2014). Also, one question decreased the number of survey items requiring a response and may have minimized subject burden. The following question that was used in the current study is from the Comprehensive Organizational Health Assessment (COHA; Potter et al., 2016):

Have you ever experienced a traumatic event in your life? (Examples of traumatic events include, but are not limited to: Domestic violence, sexual assault, incest, sudden loss of a child, physical abuse, torture, fire, war veteran, and others).

In the current study, survivor status was hypothesized to mediate the relationship between counselor gender and STS. In prior research, women and survivors of trauma were more likely to experience STS (Hensel et al., 2015). Hypothetically, gender has an indirect relationship with STS because women are statistically more likely to experience a personal trauma or PTSD (Hensel et al., 2015).

The participants also completed the Professional Self-Care Scale (PSCS; Dorociak, Rupert, Bryant, & Zahnisser, 2017). I contacted Katie Dorociak to obtain permission to use the PSCS. This scale included five subscales with acceptable internal reliability: professional support (α = .83; e.g., I cultivate professional relationships with my colleagues), professional development (α = .80; e.g., I take part in work-related social and community events), life balance (α = .81; e.g., I spend time with family or friends), cognitive strategies (α = .72; e.g., I try to be aware of my feelings and needs), and daily
balance (α = .70; e.g., I take breaks throughout the workday). Participants rated each item on a Likert scale from 1 (never) to 7 (almost always).

The factors were identified by running multiple principle axis factorings with an oblique, promax rotation and all factors were intercorrelated (Dorociak et al., 2017). All factors had significant correlations with the Perceived Stress Scale (Cohen, Kamarck, & Mermelstein, 1983) and the Maslach Burnout Inventory Human Services Survey (MBI-HSS; Maslach et al., 1996), which established convergent and discriminant validity. The factors also had significant correlations with the Satisfaction with Life Scale (Diener et al., 1985), which established predictive validity (Dorociak et al., 2017). The PSCS was depicted in the Hypothesized CF-S model (Figure 6) and the Hypothesized CBI/STSS model (Figure 7) as a five-factor exogenous latent variable.

**Compassion Fatigue**

Compassion fatigue is an endogenous latent variable in the first proposed model. Compassion fatigue was measured by the Compassion Fatigue Short Scale (CF-Short; Adams et al., 2006). Permission to use the scale in this study was obtained through personal correspondence with the scale developers. The sample used to test the psychometric properties of the scale included social workers who worked with the victims of the September 11, 2001 terror attacks.

Respondents were asked to read each item and to rate how frequently they experience the item on a 10-point Likert scale (rarely/never = 1 to very often = 10). Adams and colleagues (2006) ran a principle components analysis (PCA) with orthogonal, varimax rotation to identify two factors: STS (e.g., troubling dreams similar to clients) and burnout (e.g., thoughts about not achieving goals). Adams and colleagues
(2006) found that the subscale and the combined measure had good reliability with a Cronbach’s alpha of .90 for the burnout scale (8 items), an alpha of .80 for the STS scale (5 items), and an alpha of .90 for the combined scale (13 items).

To establish discriminant validity, the scale was correlated with a general measure of psychological distress \( (r=.49) \) and negative life events \( (r=.23) \), showing that although the constructs are related, compassion fatigue is distinguished from general psychological distress (Adams et al., 2006). The CF-Short Scale also predicted psychological distress well when controlling for demographic variables and psychological resources (Adams et al., 2006). According to Adams and colleagues (2006), the CF-Short Scale can be used with a total score or as two separate scores (burnout and STS). In the Hypothesized CF-S model, compassion fatigue was conceptualized as an endogenous latent variable (Figure 6).

In the Adams and colleagues (2006) validation study, the STS subscale did not correlate with the level of trauma exposure the participants experienced or the participants’ level of involvement in counseling serves for survivors of the terrorist attacks of 9/11. This was unexpected because in past research, the level of trauma exposure was associated with higher levels of STS. Also, the burnout of the CF-Short Scale shares 12% variance in common with the MBI-HSS, which is a common measure of burnout. This suggests that the two scales are measuring different conceptualizations of burnout. As a result, I used two alternate measures of STS and burnout as latent endogenous variables in the Hypothesized CBI/STSS model (see Figure 7).

**Secondary Traumatic Stress**
In the Hypothesized CBI/STSS model (Figure 7), the STSS (Bride et al., 2004) was hypothesized to measure STS as a three-factor endogenous latent variable. Bride and colleagues (2004) operationalized the construct of STS as intrusion, avoidance, and arousal symptoms resulting from secondary exposure to trauma, and created items for the STSS based off the DSM-IV criteria for PTSD. A sample of 500 social workers completed the 65-item measure. Items were deleted based on the item-total correlation and the resulting reliability coefficients if various items were deleted. This was done until 50 items remained. Then the 50-item measure was administered to 200 social workers and items were deleted using the same method until 17 items remained (Bride et al., 2004). Next, a CFA was conducted and confirmed the theorized three-dimensional factor structure.

Then, Bride and colleagues (2004) administered the 17-item measure to 660 social workers and a CFA again yielded acceptable fit (RMSEA=.069). Also, the internal reliability was adequate for the full STSS ($\alpha = .93$), the intrusion subscale ($\alpha = .80$), the avoidance subscale ($\alpha = .87$), and the arousal subscale ($\alpha = .83$). Convergent validity was determined through significant positive correlations among the total scale and all subscales with the extent of client trauma exposure, the frequency of interaction with trauma clients, anxiety symptoms, and depression symptoms (Bride et al., 2004).

In the current study, participants rated how frequently they experienced each item over the past 7 days. Example items of the STSS included *My heart started pounding when I thought about my work with clients* (Intrusion Subscale), *I felt emotionally numb* (Avoidance Subscale), and *I had trouble sleeping* (Arousal Subscale). Participants rated each item on a 5-point Likert scale ranging from *never* (1) to *very often* (5).
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Burnout

In the Hypothesized CBI/STS model (Figure 7), burnout was measured by the Counselor Burnout Inventory (CBI; Lee et al., 2007). This instrument was designed to assess the level of burnout among counselors, which made the measure an appropriate measure of burnout for this study. Lee and colleagues (2007) recruited a sample of 275 professional counselors and a second sample of 132 professional counselors. Items were based off of items from the MBI-HSS (Maslach & Jackson, 1981). Participants completed the 40-item scale, a measure of job satisfaction, and a measure of self-esteem. Lee and colleagues (2007) conducted an EFA with the first sample and reduced the scale length to 20 items and identified 5 intercorrelated factors: Exhaustion, Negative Work Environment (NWE), Devaluing the Client (DC), Incompetence, and Deterioration in Personal Life (DPL). Lee and colleagues then administered the 20-item scale to the second sample and the resulting data were analyzed using CFA, which yielded a good fit. The Cronbach’s alphas for the subscales of the final 20-item scale ranged from .73-.85, and .88 overall (Lee et al., 2007).

Example items of the CBI include *Due to my job as a counselor I feel tired most of the time* (Exhaustion Subscale), *I feel frustrated with the system in my workplace* (Negative Work Environment Subscale), *I have become callous toward clients* (DC Subscale), *I am not confident in my counseling skills* (Competence Subscale), and *I feel like I do not have enough time to engage in personal interests* (DPL Subscale; Lee et al., 2007). Participants rated each item on a 5-point Likert scale ranging from *never true* (1) to *always true* (5). Lee and colleagues (2007) found convergent validation for the CBI through positive correlations with the MBI-HSS. Also, the CBI is negatively correlated
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with job satisfaction and self-esteem, which provides criterion-related validity (Lee et al., 2007). The CBI measured burnout as a latent endogenous variable in the Hypothesized CBI/STSS model (see Figure 7).

Research Questions and Hypotheses

Figures 6 and 7 depict the various hypotheses embedded in two structural equation models. The models are differentiated solely by the outcome variables. In the Hypothesized CF-S model, compassion fatigue as measured by the CF-Short Scale is the only latent endogenous variable (Figure 6). In the Hypothesized CBI/STSS model, the CF-S was not used. Instead, STS as measured by the STSS and burnout as measured by the CBI were latent outcome endogenous variables in the second model (Figure 7).

Although there are others, the four primary research questions investigated in the study are (a) Does the perceived servant leadership of supervisors negatively predict compassion fatigue of counseling residents? (b) Does the perceived servant leadership of supervisors negatively predict the counselor burnout of counseling residents? (c) Does the perceived servant leadership of supervisors negatively predict the STS of counseling residents? (d) Does the perceived servant leadership of female supervisors and the perceived servant leadership of male supervisors differ significantly? These primary research questions were analyzed in a multivariate SEM analysis that included hypotheses and research questions for each parameter depicted in the Hypothesized CF-S model and the Hypothesized CBI/STSS model (Figures 6 and 7). All research questions and hypotheses are justified and presented below and summarized at the end of the chapter.

Servant Leadership
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The latent variable of servant leadership as measured by the valid and reliable SLS (Liden et al., 2008) has not yet been studied with counselors or in the field of mental health. However, in previous studies servant leadership traits of supervisors have negatively predicted burnout (e.g., Babakus et al., 2011; Bobbio & Maganelli, 2015; Hunter et al., 2013; Upadyaya et al., 2016). This will be the first study to examine servant leadership’s relationship with STS. According to Weymes (2003), servant leaders who build positive relationships with followers provide emotional stability for organizations, and Barbuto and Wheeler (2006) asserted that servant leaders support the healing process in followers. The healing and stabilizing role servant leaders play with counseling residents is expected to be a protective factor for STS in counseling residents.

Therefore, in answer to the first primary research question (Does the perceived servant leadership of supervisors negatively predict compassion fatigue of counseling residents?), the servant leadership of supervisors will negatively predict the compassion fatigue of counseling residents in the Hypothesized CF-S model (hypothesis 1; see Figure 6). In answer to the second primary research question (Does the perceived servant leadership of supervisors negatively predict the counselor burnout of counseling residents?), servant leadership traits of supervisors will negatively predict counselor burnout in the Hypothesized CBI/STSS model (hypothesis 2; see Figure 7). In answer to the third primary research question (Does the perceived servant leadership of supervisors negatively predict the STS of counseling residents?), the servant leadership of supervisors will negatively predict the STS of counseling residents in the Hypothesized CBI/STSS model (hypothesis 3; see Figure 7).
**Servant leadership and gender.** Servant leadership gender is not featured in the proposed models because it will not be analyzed with SEM. Eagly and Carli (2003) concluded that the inclusion of communal aspects of leadership into the construct of servant leadership may advantage women who may be more likely to display communal behaviors in leadership roles. However, Barbuto and Gifford (2010) asked followers to rate their supervisors on servant leadership behaviors and used the Servant Leadership Questionnaire (Barbuto & Wheeler, 2006). Barbuto and Gifford (2010) found no difference between men and women’s scores on any of the scales. This study utilized the SLS (Liden et al., 2008), which has not been used to investigate the impact of supervisor gender on followers’ perceptions of servant leadership traits. In answer to the fourth primary research question (Does the perceived servant leadership of female supervisors and the perceived servant leadership of male supervisors differ significantly?), I predicted that there would be no significant difference in servant leadership scores between men and women (hypothesis 4) based on the conclusions by Barbuto and Gifford (2010).

**Role Stress**

Various research studies have identified role conflict (e.g., Coll & Freeman, 1997; Kirk-Brown & Wallace, 2004) and role ambiguity (e.g., Acker, 2011; Wallace, Lee, & Lee, 2010) as positive predictors of burnout in counselors. Dagan and colleagues (2016) also found that both role conflict and role ambiguity contributed to STS in child protection workers. Role conflict was hypothesized to positively predict the CF-S in the Hypothesized CF-S model (hypothesis 5). Role conflict also was hypothesized to positively predict the CBI (hypothesis 6) and the STSS (hypothesis 7) in the Hypothesized CBI/STSS model. Role ambiguity was hypothesized to positively predict
compassion fatigue in the Hypothesized CF-S model (hypothesis 8) and burnout (hypothesis 9) and STS (hypothesis 10) in the Hypothesized CBI/STSS model. These relationships are depicted in Figures 6 and 7.

**Counselor Self-Care**

Counselor self-care was measured by the valid and reliable PSCS (Dorociak et al., 2017) and was a latent, exogenous variable in both hypothesized models. Positive self-care practice is an established protective factor for compassion fatigue, burnout, and STS (e.g., Killian, 2008; Thompson et al., 2014). Therefore, this construct was hypothesized to negatively predict compassion fatigue in the Hypothesized CF-S model (hypothesis 11; see Figure 6), and burnout (hypothesis 12) and STS (hypothesis 13) in the Hypothesized CBI/STSS model (see Figure 7).

**Caseload and Trauma Exposure**

The frequency of direct hours with clients was measured by the participants’ caseload size. Caseload size is associated with high levels of burnout (Acker & Lawrence, 2009; Knudsen et al., 2006). Because burnout was a subscale of compassion fatigue, caseload size was hypothesized to positively predict compassion fatigue in the Hypothesized CF-S model (hypothesis 14; see Figure 6). Caseload size was expected to positively predict burnout in the Hypothesized CBI/STSS model (hypothesis 15; see Figure 7). Based on previous research, caseload size was expected to have no relationship with STS in either hypothesized model (Knight, 2010).

On the other hand, the amount of trauma cases that counselors serve has a direct positive relationship with STS (Bride et al., 2009). The hypothesized models reflected the established research, and frequency of interaction with trauma clients was hypothesized
to positively predict compassion fatigue in the Hypothesized CF-S model (hypothesis 16; see Figure 6). Frequency of interaction with trauma clients was expected to positively predict STS in the Hypothesized CBI/STSS model (hypothesis 17; see Figure 7).

**Survivor Status and Counselor Gender**

Counselors’ personal trauma experience can increase the likelihood of experiencing STS in their work (Dunkley & Whelan, 2006; Van Hook & Rothenberg, 2009). Some studies have also indicated that being female predicts greater STS, but not burnout (Adams et al., 2008; Robinson-Keilig, 2014). According to Hensel and colleagues (2015), women are more likely to survive a traumatic experience and to develop PTSD than men. From the evidence of research, gender’s effect on compassion fatigue was hypothesized to be mediated by Survivor Status in the Hypothesized CF-S model. Similarly, gender’s impact on STS was expected to be mediated by Survivor Status in the Hypothesized CBI/STSS model. I hypothesized that female counseling residents would be more likely to be survivors of traumatic events in the Hypothesized CF-S model (hypothesis 18; Figure 6) and the Hypothesized CBI/STSS model (hypothesis 19; Figure 7). I also hypothesized that survivors of traumatic events would experience greater compassion fatigue in the Hypothesized CF-S model (hypothesis 20; Figure 6) and STS in the Hypothesized CBI/STSS model (hypothesis 21; Figure 7).

**Burnout and STS**

A recent meta-analysis concluded that burnout and STS are strongly related constructs (Cieslak et al., 2013). Based on a literature review of 41 studies, Cieslak and colleagues (2013) found that burnout and STS have a 49% overlap of shared variance. The first model conceptualized the two constructs as subscales of the latent construct,
compassion fatigue (see figure 6). In the second model, STS and burnout are separate latent variables. Burnout and STS were expected to correlate in the Hypothesized CBI/STSS model (hypothesis 22, see Figure 7).

**Two Model Comparison**

The two models were compared to determine which had a better model fit. The models only differed in the outcome variables, so differences between the two models could be explained by the relationships between the three outcome variables. It is expected that the Hypothesized CBI/STSS model will have a better model fit than the Hypothesized CF-S model because the compassion fatigue variable was a just identified variable with no degrees of freedom (hypothesis 23). Low degrees of freedom can result in diminished power, which makes estimating models more challenging (Wolf, Harrington, Clark, & Miller, 2013).
Figure 6. Proposed CF-S model. This is the first model to be utilized in the proposed study with compassion fatigue as an endogenous outcome variable analyzed with SEM.
Figure 7. Proposed CBI/STSS model. This is the second model in the proposed study with burnout and STS as endogenous outcome variables analyzed with SEM.
Summary of Hypothesized Models’ Research Questions and Hypotheses

Does the perceived servant leadership of supervisors negatively predict compassion fatigue of counseling residents?

Hypothesis 1 (SLS $\rightarrow$ CF-S). In the Hypothesized CF-S model, servant leadership as measured by the SLS will negatively predict compassion fatigue as measured by the CF-S.

Does the perceived servant leadership of supervisors negatively predict the burnout of counseling residents?

Hypothesis 2 (SLS $\rightarrow$ CBI). In the Hypothesized CBI/STSS model, servant leadership as measured by the SLS will negatively predict the latent variable of counselor burnout as measured by the CBI.

Does the perceived servant leadership of supervisors negatively predict the STS of counseling residents?

Hypothesis 3 (SLS $\rightarrow$ STSS). In the Hypothesized CBI/STSS model, servant leadership will negatively predict STS as measured by the STSS.

Does the perceived servant leadership of female supervisors and the perceived servant leadership of male supervisors differ significantly?

Hypothesis 4 (SLS female supervisors $=$ SLS male supervisors). There will be no significant difference between the means of the perceived servant leadership traits of male supervisors and female supervisors as evaluated by counseling residents.

Does role conflict positively predict compassion fatigue?
Hypothesis 5 (Role Conflict $\rightarrow$ CF-S). In the Hypothesized CF-S model, role conflict as measured by the Role Conflict subscale of the RSS will positively predict compassion fatigue as measured by the CF-S.

Does role conflict positively predict burnout?

Hypothesis 6 (Role Conflict $\rightarrow$ CBI). In the Hypothesized CBI/STSS model, role conflict as measured by the Role Conflict subscale of the RSS will positively predict burnout as measured by the CBI.

Does role conflict positively predict STS?

Hypothesis 7 (Role Conflict $\rightarrow$ STSS). In the Hypothesized CBI/STSS model, role conflict as measured by the Role Conflict subscale of the RSS will positively predict STS as measured by the STSS.

Does role ambiguity positively predict compassion fatigue?

Hypothesis 8 (Role Ambiguity $\rightarrow$ CF-S). In the Hypothesized CF-S model, role ambiguity as measured by the Role Ambiguity subscale of the RSS will positively predict compassion fatigue CF-S.

Does role ambiguity positively predict burnout?

Hypothesis 9 (Role Ambiguity $\rightarrow$ CBI). In the Hypothesized CBI/STSS model, role ambiguity as measured by the Role Ambiguity subscale of the RSS will positively predict burnout as measured by the CBI.

Does role ambiguity positively predict STS?

Hypothesis 10 (Role Ambiguity $\rightarrow$ STSS). In the Hypothesized CBI/STSS model, role ambiguity as measured by the Role Ambiguity subscale of the RSS will positively predict STS as measured by the STSS.
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Does professional self-care negatively predict compassion fatigue?

**Hypothesis 11 (PSCS → CF-S).** In the Hypothesized CF-S model, professional self-care as measured by the PSCS will negatively predict compassion fatigue as measured by the CF-S.

Does professional self-care negatively predict burnout?

**Hypothesis 12 (PSCS → CBI).** In the Hypothesized CBI/STSS model, professional self-care as measured by the PSCS will negatively predict burnout as measured by the CBI.

Does professional self-care negatively predict STS?

**Hypothesis 13 (PSCS → STSS).** In the Hypothesized CBI/STSS model, professional self-care as measured by the PSCS will negatively predict STS as measured by the STSS.

Does frequency of client interaction positively predict compassion fatigue?

**Hypothesis 14 (Caseload → CF-S).** In the Hypothesized CF-S model, the frequency of client interaction as represented by the variable Caseload will positively predict compassion fatigue as measured by the CF-S.

Does frequency of client interaction positively predict burnout?

**Hypothesis 15 (Caseload → CBI).** In the Hypothesized CBI/STSS model, the frequency of client interaction as represented by the variable Caseload will positively predict burnout as measured by the CBI.

Does frequency of trauma client interaction positively predict compassion fatigue?
Hypothesis 16 (Trauma Clients → CF-S). In the Hypothesized CF-S model, the frequency of trauma client interaction as represented by the variable Trauma Clients will positively predict compassion fatigue as measured by the CF-S.

Does frequency of trauma client interaction positively predict STS?

Hypothesis 17 (Trauma Clients → STSS). In the Hypothesized CBI/STSS model, the frequency of trauma client interaction as represented by the variable Trauma Clients will positively predict STS as measured by the STSS.

Are female counseling residents more likely to be survivors of trauma?

Hypothesis 18 (Gender → Survivor Status). In the Hypothesized CF-S model, female counseling residents will be more likely to be survivors of a traumatic event as represented by the variable Survivor Status.

Hypothesis 19 (Gender → Survivor Status). In the Hypothesized CBI/STSS model, female counseling residents will be more likely to be survivors of a traumatic event as represented by the variable Survivor Status.

Do survivors of traumatic events experience greater compassion fatigue than non-survivors?

Hypothesis 20 (Survivor Status → CF-S). In the Hypothesized CF-S model, survivors of trauma as represented by the variable Survivor Status will experience greater compassion fatigue as measured by the CF-S.

Do survivors of traumatic events experience greater STS than non-survivors?

Hypothesis 21 (Survivor Status → STS). In the Hypothesized CBI/STSS model, survivors of trauma as represented by the variable Survivor Status will experience greater STS as measured by the STSS.
Are STS and burnout correlated?

**Hypothesis 22 (STSS ↔ CBI).** In the Hypothesized CBI/STSS model, STS as measured by the STSS, and burnout as measured by the CBI are correlated endogenous outcome variables.

Does the Final CBI/STSS Model have a better model fit than the Final CF-S Model?

**Hypothesis 23 (Final CF-S Model < Final CBI/STSS Model).** The Hypothesized CBI/STSS model will have a better model fit than the Hypothesized CF-S model because the compassion fatigue variable is a just identified variable with no degrees of freedom.

**Data Analysis and Interpretation**

I first conducted CFAs to identify if all measurement models (CBI, STSS, CF-S, SLS, RSS) fit the data as originally theorized by the instrument designers. Then, I analyzed the descriptive statistics of all variables utilized in the structural equation models including measures of central tendency, standard deviations, minimum and maximum values, and measures of kurtosis and skewness in order to identify any abnormalities in the data. I then analyzed the bivariate relationships between individual variables through correlations to identify expected directionality of relationships and assess strength of correlation among predictors and outcome variables. I then tested the theoretical models through SEM. SEM is a multivariate technique that tests whether the data support a theoretical model through various fit indices. SEM has multiple advantages including the ability to model the complex relationships between both latent and observed variables, and it accounts for measurement error, which is often ignored in other traditional techniques (Welch, 2010).
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Testing the Models Separately

In this study, I used IBM SPSS and the add-on program, AMOS 21 (Arbuckle, 2012), for CFA and SEM analyses to determine the impact of supervisor servant leadership on counseling residents’ compassion fatigue, burnout, and STS in the presence of other relevant variables. I determined model fit through assessment of several fit measurements. I did not report the chi-square goodness of fit result because the chi square test is affected by sample size, so even if this was significant I relied on other model fit indices. I determined the model was an acceptable fit if the CMIN/df was less than 2 (Schumacker & Lomax, 2004). Also, an acceptable fit was evidenced by an RMSEA below .08 and a good fit was indicated by a RMSEA below .05 (Awang, 2012). In addition, a Tucker-Lewis Index (TLI) and a Comparative Fit Index of 0.9 or above was considered a good-fitting model. The CMIN/df, RMSEA, CFI, and TLI were interpreted and reported for CFAs and all iterations of both structural equation models.

Comparing the Two Models

The two non-nested models were compared by analyzing the Akaike Information Criterion (AIC), Bayesian Information Criterion (BIC), and the Expected Cross-Validation Index (ECVI). The better-fit was determined by the model that had the smaller fit index. Because the models differed by endogenous latent variables (CF-Short, CBI, STSS), the relationships between these variables were explored to include the amount of shared variance.

Servant Leader Gender

I also determined if the ratings of counseling residents’ male and female supervisors differed significantly. I will conduct seven t-tests for each subscale of the
SLS. I implemented a Bonferroni correction by dividing the 0.05 alpha level by seven and setting the new alpha level at 0.007. This protected against a Type I error.

**Ethical Considerations**

Various precautions were taken to ensure ethical research practices. Permission to conduct this study was submitted to and approved by the William & Mary Education Institutional Review Board (IRB). I also took necessary precautions to protect respondents from any harm. Participants who completed the survey read the informed consent and voluntarily agreed or declined to participate. I informed participants of the purpose of the study, the voluntary nature of their participation, and their right to discontinue the survey at any time. Also, participants were informed of the confidential nature of the study. To ensure protection of participants’ confidential information, all participants were assigned an identification number and all identifying information was removed from their response. Although risks of participation in the study were expected to be minimal, participants were given a list of counseling referral sources if they wanted to address compassion fatigue symptoms in counseling. The complete IRB and informed consent are located in Appendix A.

**Assumptions and Limitations**

Although this method was assumed to be rigorous, various limitations were present in this research study. First, I chose a convenient sample because this is a hard to reach population. However, non-random sampling, such as purposive sampling, has limitations in its ability to represent a target population and compromises the generalizability of the results. Also, some individuals who were invited to take the survey
did not participate. This self-selection may affect results if individuals who chose to participate differ in some systematic way from those who chose not to participate.

The measurement method also may produce some limitations. All variables present in this study were assessed with instrumentation involving Likert scales, which may produce a common method variance. This refers to variance attributed to the measurement method, rather than the variables the instruments intend to measure (Podsakoff, MacKenzie, Lee, & Podsakoff, 2003). As counselors, participants may be aware of theoretical origins of compassion fatigue and have assumptions about relationships between variables. When respondents have an assumption about how items should relate, it can affect responses in systematic ways; this is known as illusory correlations (Podsakoff et al., 2003).

Summary

This chapter summarized the methodology of the current study, which analyzed the power of the work environment, client environment, and personal environment of counseling residents to predict compassion fatigue, burnout, and STS through a SEM design. The method was considered to be a strong and rigorous approach to test the study’s hypotheses. The following chapter presents the results of all analyses.
CHAPTER FOUR

Results

The previous chapter provided a summary of the methods used to examine the impact of a servant leadership supervisory style on counseling residents’ compassion fatigue in the context of other relevant variables in the counselors’ work environment, client environment, and personal environment. This chapter provides the results generated from these methods. I first tested the measurement models used in the structural equation models through various CFAs. I then reported the descriptive statistics for variables incorporated in the structural equation models. Finally, I tested all hypotheses embedded in the structural equation models and reported results yielded to answer the following research questions.

Research Questions and Hypotheses

Four primary research questions guided the zetetic approach of this study: (a) Does the perceived servant leadership of supervisors negatively predict compassion fatigue of counseling residents? (b) Does the perceived servant leadership of supervisors negatively predict the counselor burnout of counseling residents? (c) Does the perceived servant leadership of supervisors negatively predict the secondary traumatic stress (STS) of counseling residents? (d) Does the perceived servant leadership of female supervisors and the perceived servant leadership of male supervisors differ significantly?

I hypothesized that the perceived servant leadership traits of supervisors negatively predicted the compassion fatigue, counselor burnout, and STS of counseling
residents. I also predicted that there would be no significant difference on any of the servant leadership subscales based on the gender of supervisor as rated by counselors. I tested several other hypotheses as depicted in Figures 54 and 55 and explicated later in the chapter.

Participants

I sent the survey of instruments through email to 5,498 registered interns and a total of 393 respondents accessed and began the survey on Qualtrics for a response rate of 7.15%. Inclusion criteria included post-masters and pre-licensure practicing counselors; therefore, 80 respondents were eliminated who answered yes to the question, *Are you currently a licensed counselor?*, and another 17 respondents were eliminated who answered no to the question *Are you currently providing direct counseling services?*. I then eliminated 41 cases that neglected to complete fifty percent or more of at least one instrument. Next, nine respondents’ data were not used because they failed at least one attention item. Three cases were deleted that completed all instruments but did not identify current caseload, number of trauma clients seen, the experience of a traumatic event and/or gender, because these were variables present in the structural equation models. In addition, one individual identified as transgender and another individual selected *other* for gender. Because only one person endorsed each category and cannot adequately represent a group, the data from these respondents were also not used. Therefore, a total of 241 counseling resident respondents had usable data. This was less than the sample size of 538 participants that was needed according to the a priori power analysis. Large sample size is often required for models to converge appropriately and an insufficient sample size can diminish the statistical power needed to determine accurate
relationships in the data (Wolf et al., 2013). Therefore, results should be interpreted with caution because lowered statistical power increases the likelihood of making a Type II error or failing to reject a null hypothesis when it is false (Cohen, 1988).

Participants were predominantly female ($n = 209$, 86.72%) and about half of participants identified their race or ethnicity as White ($n = 131$, 54.36%; see Table 1). As expected, the participants’ age ($M = 37.93$, $SD = 11.76$) and experience ($M = 4.74$, $SD = 4.22$) were significantly positively skewed with medians of 33 years of age and 3 years of experience (see Figures 8 and 9). Participants worked in a variety of settings with the highest frequencies being community mental health outpatient ($n = 92$, 38.17%), private practice ($n = 38$, 15.80%), and residential/psychiatric inpatient settings ($n = 31$, 12.85%; see Table 2). Most participants also graduated from a counseling program that was accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP; $n = 158$, 65.6%). Seventy-two percent ($n = 174$) of the sample indicated they had experienced a traumatic event in their lives, which is close to the national average of 70% (The Sidran Traumatic Stress Institute, 2016).
Table 1

**Race and Ethnicity of Participants**

<table>
<thead>
<tr>
<th>Race/Usual Hispanic Identification</th>
<th>n</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>131</td>
<td>54.36</td>
</tr>
<tr>
<td>Black or African American</td>
<td>38</td>
<td>15.77</td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td>1</td>
<td>0.41</td>
</tr>
<tr>
<td>Asian</td>
<td>3</td>
<td>1.24</td>
</tr>
<tr>
<td>Native Hawaiian or Pacific Islander</td>
<td>1</td>
<td>0.41</td>
</tr>
<tr>
<td>Hispanic, Latino, or Spanish</td>
<td>53</td>
<td>22.00</td>
</tr>
<tr>
<td>Middle Eastern or North African</td>
<td>2</td>
<td>0.83</td>
</tr>
<tr>
<td>2 or More Races</td>
<td>12</td>
<td>4.98</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>241</td>
<td>100</td>
</tr>
</tbody>
</table>

*Note.* This table displays the sample participants’ race and ethnicity (*N* = 241).

Table 2

**Work Environment of Participants**

<table>
<thead>
<tr>
<th>Environment</th>
<th>n</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Practice</td>
<td>38</td>
<td>15.77</td>
</tr>
<tr>
<td>Community Mental Health Outpatient</td>
<td>92</td>
<td>38.17</td>
</tr>
<tr>
<td>Intensive In-Home</td>
<td>13</td>
<td>5.39</td>
</tr>
<tr>
<td>Residential/Psychiatric Inpatient</td>
<td>31</td>
<td>12.85</td>
</tr>
<tr>
<td>Higher Education Academic Setting</td>
<td>14</td>
<td>5.81</td>
</tr>
<tr>
<td>Corrections</td>
<td>8</td>
<td>3.32</td>
</tr>
<tr>
<td>Employee Assistant Program</td>
<td>1</td>
<td>0.41</td>
</tr>
<tr>
<td>K-12</td>
<td>9</td>
<td>3.73</td>
</tr>
<tr>
<td>Other</td>
<td>35</td>
<td>14.52</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>241</td>
<td>100</td>
</tr>
</tbody>
</table>

*Note.* This table displays the frequencies and percentages of participants’ agency settings, *n* = number in sample (*N* = 241).
Figure 8. Distribution of participants’ ages. This histogram illustrates the positively skewed ages of the sample \( (N = 241; \text{Md} = 33) \).

Figure 9. Years of experience of participants. Participants' experience level was positively skewed \( (N = 241; \text{Md} = 3) \).
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Confirmation and Exploration of Measurement Models

Prior to analyzing measurement models, I identified and replaced missing values. One case was missing an observation for item 7 of the RSS and one case was missing an observation for item 8 of the CF-S scale. I replaced these missing items with linear interpolation. Then, I conducted CFAs on all measurement models (STSS, CBI, CF-S, RSS, PSCS, and SLS).

The Purpose of CFA

The proposed SEM models are comprised of several latent variables whose fit should be assessed before proceeding to the larger SEM models. Confirmation of the measurement models allows for the checking of the instrument properties before bringing any misspecifications into the larger model. In instances where the measurement model is not confirmed, the larger model may be modified to reflect the indicated structure of the data. The purpose of CFA is to test a theoretical construct (Warren, 2013). As such, CFA is confirmatory rather than exploratory in nature (Keith, 2015). When testing the measurement models, I maintained an awareness of the theory-testing purpose of CFA and made sure that modifications and preservations were theory-based.

Process for Model Determination

For each CFA I conducted, I first tested a first-order model with the specific number of factors that were identified/suggested by the instrument designers and/or theory. At this first step, I checked that each item loaded on the intended factor, determined if any modifications were needed based on the modification indices, and identified the number of factors that best fit the data while maintaining theoretical coherence. I also ensured that the factors were correlated because this is an assumption in
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a second-order measurement model. I qualified correlation strength by the magnitude of the correlation coefficient as distinguished by Evans (1996; see Table 3). Each CFA iteration was evaluated by the model fit indices. When multiple first-order models had acceptable fits, I conducted a chi-square difference test. This test is a way to compare nested models and determine the better-fitting model. The chi square value of the larger model is subtracted from the chi-square value of the smaller model. If the chi-square difference value was greater than the chi-square critical value at a significance level of 0.05 and degrees of freedom equal to the difference between the degrees of freedom of the two models, than I concluded that the more complex (i.e., larger) model was significantly better than the first. When there was no significant difference, the simpler (i.e., smaller) model was preferred.

Once an acceptable fit was found through the above process with first-order models, I then tested the second-order model that was congruent with theory and that included the number of factors identified in the first-order CFA iterations. If the second-order model had acceptable fit according to goodness of fit criteria and aligned with theoretical implications, I favored the second-order hierarchical model over previous iterations. The only exception to this was the RSS because role conflict and role ambiguity are theorized to be separate but related observed variables (Rizzo et al., 1970). The final model determined from this process was used in the subsequent SEM analyses.
Table 3

Strength of Correlations According to Evans (1996)

<table>
<thead>
<tr>
<th></th>
<th>Very Weak</th>
<th>Weak</th>
<th>Moderate</th>
<th>Strong</th>
<th>Very Strong</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive correlations</td>
<td>( r = .00 - .19 )</td>
<td>( r = .20 - .39 )</td>
<td>( r = .40 - .59 )</td>
<td>( r = .60 - .79 )</td>
<td>( r = .80 - 1.00 )</td>
</tr>
<tr>
<td>Negative correlations</td>
<td>( r = .00 - -.19 )</td>
<td>( r = -.20 - -.39 )</td>
<td>( r = -.40 - -.59 )</td>
<td>( r = -.60 - -.79 )</td>
<td>( r = -.80 - 1.00 )</td>
</tr>
</tbody>
</table>

*Note.* Magnitude of \( r \) values assumes statistical significance.

Modification Indices

Throughout the above process, I looked at large modification indices to identify recommended alterations that would improve model fit. According to Whittaker (2011), a modification index should only be considered if it is at least 3.84 (the critical value of \( \chi^2 \) at a \( p \) value of .05). Others recommend modification values over 100 (Little, 2013). Due to the disagreement in the field of what constitutes a large modification index, I considered a modification index to be large if it was over 25. A large modification index alone is not sufficient for model alteration. I altered the model based on modification indices only if the suggestions made sound and obvious theoretical sense (Little, 2013).

Goodness of Fit

The various fit indices were interpreted to determine adequate fitting models. I considered CFAs to be a good fit if the CMIN/df was less than 2 (Schumacker & Lomax, 2004), the RMSEA was below .08 (Awang, 2012), and the TLI and CFI were 0.9 or greater. However, these values are approximate recommendations and rules of thumbs (Dimitrov, 2010) rather than strict cut-off scores. A strict adherence to these rules of thumb can increase the risk of a Type II error, the rejection of an acceptable model.
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(Marsh, Hua, & Wen, 2004). Therefore, I chose to accept models that are close to these recommendations.

**STSS**

Bride and colleagues (2004) developed and confirmed the three-factor model of the STSS through CFA. These three factors include avoidance, arousal, and intrusion. Ting, Jacobson, Sands, Bride, and Harrington (2005) also utilized CFA to confirm the factor structure of the STSS and the items loaded on appropriate factors, and these factors had very strong intercorrelations with each other ($r = .96 – 1.00$). Due to these very strong correlations, the authors tested a one-factor model and then a second-order model. The one-factor model yielded a better and more parsimonious model fit (Ting et al., 2005). Both Bride and colleagues (2004) and Ting and colleagues (2005) theorized that avoidance, arousal, and intrusion are all symptoms evidencing the construct of STS. Therefore, my goal in utilizing CFA with the STSS was to eventually confirm a three-factor, second-order measurement model because this was the theorized manifestation of the latent variable.

**First-order iterations.** Prior to testing the second-order model, I first tested a three-factor first-order model (Figure 10). I took this step to confirm that each item loaded on the identified factor as theorized, to identify if any modifications were needed to strengthen the model fit, to determine the best number of factors to adequately represent the data, and to ensure that all factors were appropriately correlated. I estimated 37 parameters for this model. All path estimates were significant and loaded on the intended factors. The model fit indices approached a reasonable fit according to fit criteria ($\text{CMIN/df} = 2.86$, $\text{TLI} = .86$, $\text{CFI} = .88$, $\text{RMSEA} = .09$). One modification index
was over 25 for a suggested correlation between the residuals associated with items 10 (*I thought about my work with clients when I didn’t intend to*) and 11 (*I had trouble concentrating*). This suggestion had a clear theoretical implication. These items are most likely associated with a unique and unmeasured latent variable related to concentration and attention. In addition, they are consecutive items, which may have contributed to participants endorsing similar responses for both items.

**Two-factor model.** The three factors had strong intercorrelations (Intrusion-Avoidance: \(r = .83, p < .001\); Avoidance-Arousal: \(r = .99, p < .001\); Intrusion-Arousal: \(r = .86, p < .001\)). The near perfect correlation between Avoidance and Arousal indicated that the two factors are measuring the same phenomenon. As a result, I modified the model by combining these two factors into one latent variable and I correlated the errors of items 11 and 10. I then retested the two-factor model (Figure 11). All estimates were significant, and the two factors were strongly correlated \((r = 0.84)\). The model fit indices suggested a model that, with the exception of the CMIN/df, was close to an acceptable model \((\text{CMIN}/df = 2.60, \text{CFI} = 0.89, \text{TLI} = .88, \text{RMSEA} = .08)\). No modification indices were over 25.
I conducted a chi-square difference test to determine if the three-factor or the two-factor was the better-fitting model. The three-factor model had 37 parameters and the two-factor model had 36 parameters. The chi-square difference value ($\Delta \chi^2 = -27.35$) was
not greater than the chi-square critical value of 3.84 at one degree of freedom. Therefore, the simpler model (the two-factor model) was the better-fitting model.

**One-factor model.** Because of the strong correlation between the two factors, and Ting and colleagues’ (2005) finding that a one-factor model was the best fit, I chose to also test a one-factor model. I maintained the correlation between the residuals of items 10 and 11 and tested a first-order one-factor model (Figure 12). The RMSEA and the CFI had fit indices that were close to an acceptable fit (CMIN = 2.93, TLI = 0.85, CFI = 0.87, RMSEA = 0.09). I utilized a chi-square difference test to determine the better fitting model between the one-factor model and the two-factor model. The two-factor model had 36 parameters and the one-factor model had 35 factors. The chi-square difference value ($\Delta\chi^2 = 42.18$) was greater than the chi-square critical value of 3.84 at one degree of freedom and a $p$ value of 0.05. Therefore, the more complex model (the two-factor model) was the better-fitting model.

**Second-order iteration.** Because the two-factor model was the preferred model and STSS is theorized to be a latent variable, I maintained the two-factors and tested a second-order model (Figure 13). The two-factor second-order model was unidentified when it was first calculated. When a latent variable has only two indicators, it may need further constraints to be identified (Keith, 2015). Keith (2015) recommended setting both regression weights of the two indicators to one. I set both paths to one in order to have an identifiable model. The model successfully ran but the model fit indices were the same as the model fit indices for the first-order two-factor model (CMIN/df = 2.60, CFI = 0.89, TLI = .88, RMSEA = .08). It is important to note that this occurred because of the extra constraints imposed on the model. When models have many degrees of freedom and a
large sample size, there is sufficient power to accurately assess model fit (Keith, 2015). The newly specified two-factor, second-order model had no degrees of freedom and could not accurately be estimated beyond the first-order model. Because the second-order model could not be specified, I chose to utilize a first-order model. The two-factor, first-order model was the best fit; however, the two correlated observed variables do not represent the theoretical concept of STS as a parsimonious construct. Even though the two-factor model was a statistically significantly better fit than the one-factor model, the one-factor model reflected the holistic and parsimonious nature of STS. Also, the two constructs had a very strong correlation ($r = 0.82$), which suggested that the two factors are very similar concepts. The one-factor STSS was utilized in the Revised CBI/STSS model (Figure 66) and had good internal consistency ($\alpha = 0.92$).
Figure 11. First-order two-factor STSS model. This figure depicts the second CFA for STSS with two strongly correlated factors.
Figure 12. One-factor STSS CFA. This figure depicts a one-factor modification to the STSS CFA.
Lee and colleagues (2007) utilized EFA to develop the CBI and CFA to confirm a five-factor first-order structure. Lee and colleagues (2007) also theorized that these five factors evidenced the underlying latent variable of counselor burnout. This implied a
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theorized five-factor second-order measurement model of counselor burnout. Prior to testing the second-order model, I first tested the first-order five-factor model through CFA to confirm that items loaded on appropriate factors, identify if the correct number of factors was specified, determine if further modifications were indicated, and to ensure that the factors were appropriately correlated.

**First order model.** Through CFA, I confirmed the first-order five-factor model (Figure 14). The model fit summary indicated an acceptable fit ($\text{CMIN/df} = 1.88$, $\text{TLI} = .95$, $\text{CFI} = 0.96$, $\text{RMSEA} = .06$) with all items loaded on the appropriate factors and all factors were correlated. One modification index was over the threshold of 25. The modification index of 40.73 with a parameter change of 0.83 suggested a correlation between the errors associated with items 7 (*I feel negative energy from my supervisor*) and 8 (*I am treated unfairly in my workplace*). These items vary from the other items on the NWE subscale because they are related to negative interpersonal interactions as opposed to environment factors in the workplace. I modeled this correlation and reran the model (Figure 15). In the revised model, all correlations and paths were significant. The model fit indices showed a good fit ($\text{CMIN/df} = 1.61$, $\text{TLI} = 0.96$, $\text{CFI} 0.97$, $\text{RMSEA} = 0.05$), and no modification indices were above 25.

**Second-order model.** I maintained the residual correlation and then tested the five-factor second-order model to confirm the counselor burnout latent variable (Figure 16). The model fit indices indicated an acceptable fit to the data ($\text{CMIN/df} = 1.69$, $\text{TLI} = 0.96$, $\text{CFI} = 0.97$, $\text{RMSEA} = 0.05$). All estimates were significant, and no modification indices were above 25. This second-order, five-factor model had an acceptable model fit and it was theoretically appropriate. Good internal consistency was found for the
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incompetence (α = 0.86), NWE (α = 0.88), DPL (α = 0.86), and DC (α = 0.83) subscales; and excellent internal consistency for the exhaustion subscale (α = 0.94). I chose to use the second-order model in the subsequent SEM analyses.
Figure 114. First iteration of CBI CFA. This is the first attempt to confirm the five-factors of the CBI.
Figure 15. Five-factor first-order CFA of the CBI. This figure depicts the confirmed five-factor fit of the CBI with an error correlation on the NWE subscale.
Figure 16. CBI hierarchical measurement model. The figure illustrates the second-order five-factor CBI measurement model utilized in the structural equation model.
Figure 17. SLS seven-factor measurement model. This figure depicts the first-order 7 factor model of servant leadership according to Liden et al. (2006) and their corresponding items.
SLS

I then confirmed the measurement model of the SLS. Liden and colleagues (2008) confirmed the first-order seven factors of the SLS through CFA. In addition, Liden and colleagues compared the seven-factor model to other model iterations (six-factor, three-factor, and one-factor models); however, the seven-factor model was significantly better than all the others. I first tested the first-order, seven-factor model to ensure that the items load on the theorized factors, to confirm the number of factors, to determine if modifications were necessary, and to ensure that all factors correlated as theorized (Figure 17).

**First order model.** The results indicated strong correlations among all factors. Model fit indices overall indicated an acceptable fit ($\text{CMIN/df} = 2.48$, $\text{TLI} = 0.91$, $\text{CFI} = 0.92$, $\text{RMSEA} = 0.08$). Four modification indices were over 25, and all suggested error correlations. I did not implement these correlations because none of the suggested changes corresponded with sound theoretical implications. I also tested a six-factor model that had the helping factor and emotional healing factor combined because of the high correlation between the factors ($r = 0.94$, $p < .001$; Figure 18). The model fit indices again, with the exception of the CMIN/df, suggested an acceptable fit ($\text{CMIN/df} = 2.56$, $\text{TLI} = 0.90$, $\text{CFI} = 0.91$, $\text{RMSEA} = 0.08$). I conducted a chi-square difference test and found that the test value chi-square difference (41.80) was greater than the chi-square critical value (12.59) with a difference of six degrees of freedom at a $p$ value of 0.05. This indicated a significant difference between the models and the more complex model (the seven-factor model) was the better fitting model.
**Second order model.** The first-order CFAs resulted in the confirmation of a seven-factor model. These factors were correlated as expected and had items that loaded on the appropriate factors. The seven factors are theorized to be mutually affected by the underlying construct of servant leadership. This was modeled through the use of a second-order hierarchical model (Figure 19). I tested the second-order seven-factor model to confirm the latent variable of servant leadership causing the manifestation of the seven-factors (Figure 19). This model overall had an acceptable fit (CMIN/df= 2.46, TLI = 0.91, CFI = 0.92, 0.08). Because this model was an acceptable fit and theoretically sound, I used the hierarchical SLS model as originally hypothesized in the subsequent SEM analyses. Subscale internal consistency was acceptable (Empowerment, $\alpha = 0.79$), good (Conceptual Skills, $\alpha = 0.95$; Putting Subordinates First, $\alpha = .88$; Emotional Healing, $\alpha = 0.87$), and excellent (Helping Subordinates Grow and Succeed, $\alpha = 0.92$; Ethical Behavior, $\alpha = 0.93$; Creating Value for the Community, $\alpha = 0.90$).
Figure 18. Six-factor SLS model. In this model the helping factor and emotional healing factors have been combined due to the very strong correlation.
Figure 19. Second-order SLS model. This figure depicts the second-order, seven-factor CFA.
I then conducted a CFA for the CF-S measurement model. Boscarino and colleagues (2004) utilized an EFA in the construction of the scale, rather than a CFA. Compassion fatigue is theorized to be one construct consisting of two components: burnout and STS (Boscarino et al., 2004). Both aspects are distinct but related aspects of counselor wellness. Part of the intention of the study is to identify if these two components should be conceptualized as separate constructs or two factors of the same latent variable. The aim of the CFA of the CF-S is to confirm the two-factor second-order measurement model for use in the subsequent SEM analysis.

**First-order model.** I first modeled a first-order correlated two-factor model (Figure 20) to ensure the appropriate items loaded on the intended factor, determine the number of factors reflected in the data, and identify if the factors are strongly correlated. The first-order two-factor model had an inadequate fit (CMIN/df= 3.69, TLI = 0.88, CFI = 0.90, RMSEA = 0.11). Only one modification index was above 25. This suggested a correlation between the errors associated with items 11 (*I feel I am unsuccessful at separating work from my personal life*) and 12 (*I am losing sleep over a client’s traumatic experiences*). I did not identify an underlying theoretical origin to explain the correlated errors, and I did not model the correlation.
Figure 20. First-order two-factor CF-S CFA. This figure depicts the CF-S CFA as two correlated latent variables.
Exploratory factor analysis. Because I was unable to confirm an acceptable factor structure through first-order CFA, I utilized EFA to explore the underlying structure of the CF-S data. The goal of EFA is to obtain simple structure and identify the fewest factors that explain the most variance (Henson & Roberts, 2006). I considered Thurston’s (1947) criteria for determining the achievement of simple structure:

a. Each item should contain at least one loading that is zero on at least one factor.

b. Each factor should contain at least the number of zero loadings as there are factors.

c. All pairs of factors should have variables with significant loadings on one factor and zero loadings on the other.

d. All pairs of factors should have a large portion of zero loadings on each factor.

e. All pairs of factors should have minimal complex loadings.

According to these rules of thumb, some factor loadings should be zero under various conditions. I considered a zero loading to lie between -0.10 and +0.10 (Gorsuch, 1983). In addition, criteria c requires significant loadings on a factor when other factors have loadings that approach zero. I considered a factor loading to be significant if it was 0.30 or above (Kline, 2002). Thurston’s last rule of thumb also recommended minimal complex loadings. I considered loadings to be complex when the same item had a loading of 0.30 or higher on more than one factor.

The number of factors to extract is a critical decision influencing future analyses. Due to equivocal practices in reporting procedures, Henson and Roberts (2006) suggested using multiple methods for determining the number of factors to be extracted in EFA. I
considered Kaiser’s rule by observing which factors had eigenvalues over 1 (Kaiser, 1960). I also interpreted the scree plot and observed the elbow on the graph. I also wanted to extract the number of factors that would explain at least 60% of the variance while not sacrificing parsimony and interpretability (Hair, 2014). In addition, the matrix needed to have simple structure according to Thurston’s rules of thumb, be theoretically sound, and have at least three items per factor.

I conducted a principal axis factoring with a varimax rotation as previously implemented by Boscarino and colleagues (2004). This resulted in two factors that had eigenvalues over one and accounted for 61.73% of the variance. The scree plot (Figure 21) shows an elbow bend after three factors. The third factor has an eigenvalue just under one (0.96); because this was close to one, I extracted three factors with the same extraction and rotation method. Both the two-factor and the three-factor extractions had multiple complex loadings (cross-loadings). I then utilized a promax rotation to extract three factors because oblique rotations allow factors to correlate.

The three-factor solution resulted in one factor with three variables, one of which was a complex loading (Table 4). Also, the third factor was not theoretically sound as it could not be theoretically distinguished from the second factor with the items related to STS. I limited the extraction to two factors with a promax rotation. This resulted in a simple structure that had theoretical significance and accounted for 61.73% of the variance (Table 5). Item 11 (I feel I am unsuccessful at separating work from my personal life) loaded on the STS factor; however, this item was originally attributed to the burnout subscale. The content of the item relates to the intrusive nature of STS. All other items
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loaded on their respective factors. I named the factors, Job Burnout (JB) Revised and STS Revised.

Figure 21. CF-S EFA scree plot. This figure depicts an elbow bend after the third variable.

Table 4

<table>
<thead>
<tr>
<th>Item</th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>CF_1</td>
<td>.748</td>
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<tr>
<td>CF_2</td>
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<td>CF_3</td>
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<td>CF_4</td>
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</tr>
<tr>
<td>CF_9</td>
<td>.683</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CF_10</td>
<td>.368</td>
<td>.513</td>
<td></td>
</tr>
<tr>
<td>CF_11</td>
<td></td>
<td>.579</td>
<td></td>
</tr>
<tr>
<td>CF_12</td>
<td></td>
<td>.564</td>
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</tr>
</tbody>
</table>
Note. Factor loadings of the CF-S scale after Principal Components Analysis with a varimax rotation and loadings under .35 suppressed.

Table 5
Two-Factor Rotated Component Matrix for CF-S

<table>
<thead>
<tr>
<th>Item</th>
<th>JB Revised</th>
<th>STS Revised</th>
</tr>
</thead>
<tbody>
<tr>
<td>CF_1</td>
<td>.788</td>
<td></td>
</tr>
<tr>
<td>CF_2</td>
<td>.785</td>
<td></td>
</tr>
<tr>
<td>CF_3</td>
<td></td>
<td>.732</td>
</tr>
<tr>
<td>CF_4</td>
<td>.703</td>
<td></td>
</tr>
<tr>
<td>CF_5</td>
<td></td>
<td>.748</td>
</tr>
<tr>
<td>CF_6</td>
<td>.840</td>
<td></td>
</tr>
<tr>
<td>CF_7</td>
<td>.746</td>
<td></td>
</tr>
<tr>
<td>CF_8</td>
<td></td>
<td>.569</td>
</tr>
<tr>
<td>CF_9</td>
<td>.709</td>
<td></td>
</tr>
<tr>
<td>CF_10</td>
<td></td>
<td>.734</td>
</tr>
<tr>
<td>CF_11</td>
<td>.318</td>
<td></td>
</tr>
<tr>
<td>CF_12</td>
<td></td>
<td>.723</td>
</tr>
<tr>
<td>CF_13</td>
<td>.853</td>
<td></td>
</tr>
</tbody>
</table>

Note. Factor loadings of the CF-S scale after a principal axis factoring with promax rotation; items suppressed below .30.

**Second-order CFA.** I then retested the new configuration of the CF-S model in a first order CFA (Figure 22) and hierarchical CFA (Figure 23). The first order consisted of the STS Revised latent variable and the JB Revised latent variable correlated with their corresponding items (Figure 22). The first order two-factor model resulted in a similar fit to the previous CFA (CMIN/df= 3.80, TLI = 0.87, CFI = 0.90, RMSEA = 0.11). I then conducted the second order hierarchical model (Figure 23). The model notes indicated
that the model was unidentified. When a hierarchical model has only two factors, it may be unidentified and require additional constraints to estimate the model (Keith, 2015). Keith (2015) suggested setting both latent variable indicator regression weights to one. I made this adjustment and the model fit indices for this adjusted model indicated the same fit indices as the first order (CMIN/df = 3.80, TLI = 0.87, CFI = 0.90, RMSEA = 0.11). The two-factor first-order model and the two-factor second-order model had the same degrees of freedom, chi-square value, and fit indices. This occurred because the additional constraints reduced the degrees of freedom, and therefore, power needed to accurately estimate a model fit beyond the first-order model (Keith, 2015). I chose to implement the CF-S as two separate but correlated constructs in the SEM analyses because burnout and STS are often investigated separately in the literature and treated as separate constructs. In addition, STS and burnout had a strong correlation (r = 0.63) and shared 40% of the variance but maintained 60% of unique variance. Internal consistency was excellent for the JB Revised (α = 0.91) and good for the STS Revised (α = 0.81).
Figure 22. Revised CF-S CFA. This model depicts the STS Revised and JB Revised latent variables correlated.
Figure 23. Hierarchical revised CF-S CFA. This model depicts a second-order CF-S revised CFA.
RSS

I next tested the two factors of the RSS scale. This scale was originally intended to assess role ambiguity and role conflict (Rizzo et al., 1970). These two factors are hypothesized to be two separate variables, rather than two aspects of the same construct. I then conducted a first-order CFA to confirm that the appropriate items loaded on the theorized factor.

The first originally generated item of the RSS (I have enough time to complete my work) was mistakenly incorporated into the survey rather than the appropriate first item (I know exactly how much authority I have). The item that was incorrectly used in this study was an eliminated item during the original scale-construction process (Rizzo et al., 1970). I implemented a first-order CFA to confirm a two-factor structure with the mistakenly included item on the Ambiguity scale because Rizzo and colleagues (1970) originally constructed the item for the Ambiguity scale (Figure 24). The CFA revealed that the model was an inadequate fit for the data (CMIN/df = 3.17, TLI = 0.87, CFI = 0.89, RMSEA = 0.09). Two modification indices were over 25 and both suggested correlations between errors. The first modification index suggested a correlation between the errors associated with items 6 (I know what my responsibilities are) and 9 (I know exactly what is expected of me). These items relate to the clarity of tasks and responsibilities; however other items on the Ambiguity scale correspond to the same theme, therefore, I determined it was not theoretically sound to correlate these errors. The second modification index suggested that items 1 (I have enough time to complete my work) and 4 (I know that I have divided my time properly) were correlated. These are the only two items on the scale that refer to time, and the two items may share an unmeasured latent variable related to
time management. I chose to correlate these errors (see Figure 25); and I reran the model. This resulted in an acceptable model fit with the exception of the CMIN/df (CMIN/df = 2.73, TLI = 0.90, CFI = 0.91, RMSEA = 0.08). The new model did not result in modification indices above 25.

I also tested the model without the incorrect item (Figure 25). This resulted in an acceptable fit for the data (CMIN/df = 2.52, TLI = 0.91, CFI = 0.93, RMSEA = 0.08) and no modification indices over 25. I compared this model with the first model that had the erroneously included item in it and correlated errors between items 1 and 4 (Figure 25). Table 6 illustrates the AIC, BIC, and ECVI values of both models. The model without the erroneous item is smaller on all indices and is the better fitting model.

Table 6

<table>
<thead>
<tr>
<th></th>
<th>AIC</th>
<th>BIC</th>
<th>ECVI</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st RSS Model</td>
<td>264.90</td>
<td>268.81</td>
<td>1.08</td>
</tr>
<tr>
<td>2nd RSS Model</td>
<td>215.36</td>
<td>218.63</td>
<td>0.88</td>
</tr>
</tbody>
</table>

*Note.* The first RSS model had an erroneously added item included and an error correlation. The second RSS model did not include this item.

Because role ambiguity and role conflict are theorized to be two separate observed variables, I did not test a second order model. I created a new variable named Ambiguity Revised to represent the Ambiguity scale without item one. I then used Ambiguity Revised and Role Conflict as separate, correlated, observed variables in both structural equation models (Figure 25). Good internal consistency was found for the Ambiguity Revised subscale (α = 0.81) and for the Role Conflict subscale (α = 0.88).
Figure 24. First RSS CFA. First iteration of the RSS.
Figure 25. RSS CFA with correlated errors. Two items related to time management had errors that correlated.
Figure 26. RSS CFA without first item. This figure depicts the RSS without the mistakenly used item; this conceptualization was used in both structural equation models.
Lastly, I ran a CFA to confirm the PSCS measurement model. Dorociak and colleagues (2017) tested multiple CFA models to include a one-factor unidimensional model, a bifactor model, a first-order, five-factor model, and a second-order model with five factors. The best fitting model was the second-order, five-factor model (Dorociak et al., 2017). I utilized CFA to confirm the five factors and the underlying construct of professional self-care theorized to affect the five-factor structure.

First-order model. First, I tested a first-order five-factor model to ensure that the items loaded on the appropriate factor, the five factors were the best number of factors for my dataset, and all factors were correlated as expected. I did this confirmation prior to testing the theoretical hierarchical model of professional self-care. The model fit index for the five-factor first-order model was an overall acceptable fitting model (CMIN/df = 2.72, TLI = 0.88, CFI = 0.90, RMSEA = 0.08; Figure 27). A modification index of 58.75 with a parameter change of 0.53 suggested a correlation between the errors associated with item 3 and 4. Brown (2015) asserted that correlating errors between indicators of a CFA may be justified if the items have shared method variance due to the wording of the items. Item 3 (I share work-related stressors with trusted colleagues) and item 4 (I share positive work-related experiences with colleagues) are similarly worded items. Therefore, I chose to correlate the errors between these two items (Figure 28). The results of the modified model improved the model fit (CMIN/df = 2.36, TLI = 0.91, CFI = 0.92, RMSEA = 0.07). I maintained the residual correlation in testing the hierarchical model.

Second-order model. I then conducted a CFA to test the five-factor second-order hierarchical measurement model (Figure 29). The model fit summary indicated that the
model was an overall adequately-fitting model (CMIN/df = 2.47, TLI = 0.90, CFI = 0.91, RMSEA = 0.08) and no theoretically relevant modification indices were above 25. This confirmed the five-factor second-order model that was theorized to correspond with the measurement model. I utilized this model (Figure 29) in subsequent SEM analyses. Good internal consistency was found for the Professional Support subscale (α = 0.88), the Professional Development subscale (α = 0.88), Life Balance subscale (α = 0.89), Cognitive Strategies (α = 0.85), and Daily Balance (α = 0.81).
Figure 27. PSCS five-factor first-order model. This figure depicts the five factors of the PSCS and the corresponding items.
Figure 28. PSCS first-order five-factor model with correlated errors. This figure depicts the correlation between items 3 and 4.
Figure 29. PSCS five-factor second-order model. This figure depicts the final model that was used in the SEM analyses.
Summary of CFA Results

I utilized CFA to confirm the measurement models of all instruments modeled in the SEM analyses. Confirming measurement model assumptions prior to SEM is important and prevents the inclusion of misspecifications in the structural equation models. The Hypothesized CF-S model (Figure 6) and the Hypothesized CBI/STSS model (Figure 7) included assumptions about the included measurement models. The preceding CFAs indicated that some of these measurement models stayed the same and some of the measurement models had alterations.

I successfully confirmed the second-order five-factor CBI that was depicted in the Hypothesized CBI/STSS model (Figure 7) and the same configuration was used in the subsequent SEM analyses as depicted in the Revised CBI/STSS model (Figure 55). The CBI is an endogenous latent variable. I also successfully confirmed the second-order seven-factor SLS, the second-order five-factor PSCS, and the first-order two-factor RSS that were depicted in the Hypothesized CF-S model (Figure 6) and the Hypothesized CBI/STSS model (Figure 7). These were identically specified in the Revised CF-S model (Figure 54) and the Revised CBI/STSS model (Figure 55). The SLS and the PSCS were used as exogenous latent variables. The Ambiguity Revised and Role Conflict scales were used as exogenous observed variables.

I attempted to confirm the second-order three-factor STSS that is depicted in the Hypothesized CBI/STSS model (Figure 7). However, through the course of analysis, a one-factor model was selected to represent STSS and this is now reflected in the Revised CBI/STSS model as an observed variable (Figure 55). I also attempted to confirm the second-order two-factor CF-S that is depicted in the Hypothesized CF-S model (Figure
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6). However, the two-factor hierarchical model was unable to be identified. The CF-S was not represented as an endogenous latent variable but as two endogenous observed variables: STS Revised and JB Revised. This new specification is reflected in the Revised CF-S model (Figure 54).

Descriptive Statistics

After new variables were computed from the preceding measurement model analyses, I analyzed the descriptive statistics on all variables that were used in the structural equation models. This included measures of central tendency, standard deviations, kurtosis, skewness, and range. I determined significant skewness or kurtosis by the standard error rule, which stipulates that significance occurs when the absolute value of the skewness or kurtosis statistic is greater than two times the standard error of skewness of kurtosis (Lomax & Hahs-Vaughn, 2012).

Outcome Variables

CF-S. Measures of central tendency, standard deviations, range, skewness, and kurtosis of the outcome variables used in the structural equation models can be found in Table 7. The STS Revised variable had a leptokurtic distribution and was significantly positively skewed. In addition, the JB Revised variable had a platykurtotic and positively skewed distribution. The distribution of the STS Revised and the JB Revised are depicted in Figures 30 and 31 respectively.
**Table 7**

*Descriptive Statistics of Outcome Variables*

<table>
<thead>
<tr>
<th>Outcome Variables</th>
<th>$M$</th>
<th>$Md$</th>
<th>$Mo$</th>
<th>$s$</th>
<th>Range</th>
<th>Skewness ($SE_s$)</th>
<th>Kurtosis ($SE_k$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>STS Revised</td>
<td>13.48</td>
<td>11</td>
<td>6</td>
<td>8.08</td>
<td>40</td>
<td>1.67 (0.16)</td>
<td>2.90 (31)</td>
</tr>
<tr>
<td>JB Revised</td>
<td>25.73</td>
<td>23</td>
<td>15</td>
<td>14.84</td>
<td>63</td>
<td>0.60 (0.16)</td>
<td>-0.57 (0.31)</td>
</tr>
<tr>
<td>STSS</td>
<td>34.39</td>
<td>32</td>
<td>21</td>
<td>11.37</td>
<td>49</td>
<td>0.49 (0.16)</td>
<td>-0.54 (0.31)</td>
</tr>
<tr>
<td>Exhaustion</td>
<td>14.53</td>
<td>13</td>
<td>4</td>
<td>7.48</td>
<td>24</td>
<td>0.27 (0.16)</td>
<td>-1.24 (0.31)</td>
</tr>
<tr>
<td>DC</td>
<td>6.01</td>
<td>5</td>
<td>4</td>
<td>3.16</td>
<td>19</td>
<td>2.41 (0.16)</td>
<td>7.69 (0.31)</td>
</tr>
<tr>
<td>NWE</td>
<td>12.93</td>
<td>13</td>
<td>4</td>
<td>6.52</td>
<td>24</td>
<td>0.38 (0.16)</td>
<td>-0.75 (0.31)</td>
</tr>
<tr>
<td>DPL</td>
<td>10.91</td>
<td>10</td>
<td>4</td>
<td>6.21</td>
<td>24</td>
<td>0.82 (0.16)</td>
<td>-0.90 (0.31)</td>
</tr>
<tr>
<td>Incompetence</td>
<td>11.67</td>
<td>11</td>
<td>7.00</td>
<td>5.26</td>
<td>24</td>
<td>0.89 (0.16)</td>
<td>0.33 (0.31)</td>
</tr>
</tbody>
</table>

*Note.* $N = 241$, $M =$ sample mean, $Md =$ median, $Mo =$ mode, $s =$ standard deviation, $SE_s =$ standard error of skewness, $SE_k =$ standard error of kurtosis, STS = secondary traumatic stress, JB = job burnout, STSS = Secondary Traumatic Stress Scale, DC = Devaluing of the Client, NWE = Negative Work Environment, DPL = Deterioration of Personal Life.

*Figure 30.* Distribution of STS Revised. This figure depicts the positively skewed and leptokurtic distribution of the STS Revised variable.
Figure 31. Distribution of JB Revised. This figure depicts the positively skewed and platykurtic distribution of the JB Revised variable.

CBI. The measures of central tendencies, standard deviations, range, skewness, and kurtosis of the five subscales of the CBI can be found in Table 7. The subscales of Exhaustion and NWE had significant platykurtic distributions (see Figures 32 and 33 respectively). The DC subscale had a leptokurtic distribution (see Figure 34). The subscales of DC, DPL, NWE, and Incompetence had significantly positively skewed distributions (see Figures 34, 35, 33, and 36 respectively).
Figure 32. Distribution of exhaustion subscale. This figure depicts the platykurtic distribution of the Exhaustion subscale.

Figure 33. Distribution of NWE subscale. This figure depicts the platykurtic and positively skewed distribution of the subscale.
Figure 34. Distribution of DC subscale. This figure depicts the leptokurtic and positively skewed distribution of the subscale.

Figure 35. Distribution of the DPL subscale. This figure depicts the positively skewed distribution of the subscale.
Figure 36. Distribution of Incompetence subscale. This figure depicts the positively skewed distribution of the subscale.

**STSS.** The measures of central tendencies, standard deviations, range, skewness, and of the one factor STSS can be found in Table 7. The STSS was significantly positively skewed and had a platykurtotic distribution. Depictions of this distribution can be found in Figure 37.

Figure 37. Distribution of STSS. This figure depicts the positively skewed and platykurtotic distribution of the STSS.
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Work Environment

The work environment included role ambiguity, role conflict, and servant leadership traits of counseling resident supervisors. Descriptive statistics related to measures of central tendency, standard deviation, range, skewness, and kurtosis can be found in Table 8. The Ambiguity Revised variable was not significantly skewed or kurtotic and approached a normal distribution (see Figure 38). The Role Conflict variable had a significantly positively skewed distribution (see Figure 39).

Table 8

<table>
<thead>
<tr>
<th>Work Environment Variables</th>
<th>M</th>
<th>Md</th>
<th>Mo</th>
<th>SD</th>
<th>Range</th>
<th>Skewness (SE_s)</th>
<th>Kurtosis (SE_k)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambiguity Revised</td>
<td>13.31</td>
<td>13.00</td>
<td>13.00</td>
<td>4.57</td>
<td>21.00</td>
<td>0.21 (0.16)</td>
<td>-0.49 (0.31)</td>
</tr>
<tr>
<td>Role Conflict</td>
<td>20.82</td>
<td>19.00</td>
<td>18.00</td>
<td>8.31</td>
<td>40.00</td>
<td>0.65 (0.16)</td>
<td>-0.02 (0.31)</td>
</tr>
<tr>
<td>Conceptual Skills</td>
<td>21.82</td>
<td>23.00</td>
<td>27.00</td>
<td>5.55</td>
<td>24.00</td>
<td>-1.14 (0.16)</td>
<td>0.84 (0.31)</td>
</tr>
<tr>
<td>Empowerment</td>
<td>21.17</td>
<td>22.00</td>
<td>24.00</td>
<td>4.98</td>
<td>24.00</td>
<td>-1.00 (0.16)</td>
<td>0.84 (0.31)</td>
</tr>
<tr>
<td>Helping Subordinates</td>
<td>20.87</td>
<td>23.00</td>
<td>28.00</td>
<td>6.66</td>
<td>24.00</td>
<td>-0.89 (0.16)</td>
<td>-0.35 (0.31)</td>
</tr>
<tr>
<td>Grow</td>
<td>16.08</td>
<td>16.00</td>
<td>16.00</td>
<td>6.29</td>
<td>24.00</td>
<td>-0.22 (0.16)</td>
<td>-0.68 (0.31)</td>
</tr>
<tr>
<td>Putting Subordinates</td>
<td>19.54</td>
<td>21.00</td>
<td>24.00</td>
<td>6.62</td>
<td>24.00</td>
<td>-0.68 (0.16)</td>
<td>-0.56 (0.31)</td>
</tr>
<tr>
<td>First</td>
<td>18.51</td>
<td>19.00</td>
<td>21.00</td>
<td>6.37</td>
<td>24.00</td>
<td>-0.52 (0.16)</td>
<td>-0.50 (0.31)</td>
</tr>
<tr>
<td>Creating Value for the Community</td>
<td>21.76</td>
<td>24.00</td>
<td>28.00</td>
<td>6.59</td>
<td>24.00</td>
<td>-1.15 (0.16)</td>
<td>-0.57 (0.31)</td>
</tr>
</tbody>
</table>

Note. N = 241, M = sample mean, Md = median, Mo = mode, SD = standard deviation, SE_s = standard error of skewness, SE_k = standard error of kurtosis
Figure 38. Distribution of Ambiguity Revised. This figure depicts the normal distribution of the Ambiguity Revised variable.

Figure 39. Distribution of Role Conflict. This figure depicts the significantly positively skewed distribution of the variable.

Servant leadership. Participants responded to the SLS by rating their supervisor on a variety of items. Participants evaluated dual-role supervisors \( (n = 85, 35.3\%) \), administrative supervisors \( (n = 67, 27.8\%) \), clinical supervisors within the workplace setting \( (n = 54, 22.4\%) \), or clinical supervisors outside the work setting \( (n = 35, 14.5\%) \).
Conceptual Skills and Empowerment subscales of the SLS had leptokurtic and negatively skewed distributions (see Figures 40 and 41). The Helping Subordinates Grow, Ethical Behavior, Creating Value for the Community and Emotional Healing subscales had significantly negatively skewed distributions (see Figures, 42, 43, 44, 45). The Putting Subordinates First subscale had a platykurtic distribution (see Figure 46).

*Figure 40.* Distribution of Conceptual Skills subscale. This figure depicts the leptokurtic and negatively skewed distribution of the subscale.
Figure 41. Distribution of Empowerment subscale. This figure depicts the leptokurtic and negatively skewed distribution of the subscale.

Figure 42. Distribution of Helping Subordinates Grow and Succeed subscale. This figure depicts the negatively skewed distribution of the subscale.
Figure 43. Distribution of Ethical Behavior subscale. This figure depicts the negatively skewed distribution of the subscale.

Figure 44. Distribution of Creating Value for the Community subscale. This figure depicts the negatively skewed distribution of the subscale.
Figure 45. Distribution of Emotional Healing subscale. This figure depicts the negatively skewed distribution of the subscale.

Figure 46. Distribution of Putting Subordinates First subscale. This figure depicts the platykurtic distribution of the subscale.

Client Environment

The client environment was measured by the hours per week counseling residents provided direct services to clients (represented by Caseload), and the hours per week counseling residents provided direct services to victims of trauma (represented by
Trauma Clients). The measures of central tendency, standard deviation, range, skewness, and kurtosis of these variables can be found in Table 9. Both variables are positively skewed (see Figures 47 and 48).

Table 9

<table>
<thead>
<tr>
<th>Statistic</th>
<th>Caseload</th>
<th>Trauma Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>$\bar{x}$</td>
<td>13.31</td>
<td>13</td>
</tr>
<tr>
<td>$Md$</td>
<td>20.82</td>
<td>19</td>
</tr>
<tr>
<td>$Mo$</td>
<td>21.82</td>
<td>23</td>
</tr>
<tr>
<td>$s$</td>
<td>21.17</td>
<td>22</td>
</tr>
<tr>
<td>Range</td>
<td>20.87</td>
<td>23</td>
</tr>
<tr>
<td>Skewness ($SE_s$)</td>
<td>0.34 (0.16)</td>
<td>0.98 (0.16)</td>
</tr>
<tr>
<td>Kurtosis ($SE_k$)</td>
<td>-0.56 (0.31)</td>
<td>0.51 (0.31)</td>
</tr>
</tbody>
</table>

Note. N = 241, $M$ = sample mean, $Md$ = median, $Mo$ = mode, $SD$ = standard deviation, $SE_s$ = standard error of skewness, $SE_k$ = standard error of kurtosis

Figure 47. Distribution of Caseload. This figure depicts the positively skewed distribution of the Caseload variable.
Figure 48. Distribution of Trauma Clients. This figure depicts the positively skewed distribution of the variable.

**Personal Environment**

Next, I analyzed the descriptive statistics of the variables representing the personal environment of the counseling residents. This included the PSCS, survivor status, and gender. As previously noted, 86.7% of participants were female \((n = 209)\) and 13.3% of participants were male \((n = 32)\). In addition, 72.2% of participants experienced a traumatic event \((n = 174)\) and 27.8% \((n = 67)\) indicated they were not survivors of a traumatic event.

**PSCS.** The central tendency, standard deviation, range, skewness, and kurtosis of the PSCS subscales are found in Table 10. The Professional Support and Life Balance subscales had significantly negatively skewed distributions, and the Cognitive Strategies subscale had a platykurtic distribution (see Figures 49, 50, and 51 respectively). The Professional Development and Daily Balance subscales approached normal distributions (see Figures 52 and 53 respectively).
Table 10

*Descriptive Statistics of the PSCS*

<table>
<thead>
<tr>
<th>PSCS Subscales</th>
<th>$\bar{x}$</th>
<th>Md</th>
<th>Mo</th>
<th>$s$</th>
<th>Range</th>
<th>Skewness $(SE_{k})$</th>
<th>Kurtosis $(SE_{k})$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Support</td>
<td>25.59</td>
<td>26.00</td>
<td>26.00</td>
<td>5.76</td>
<td>28.00</td>
<td>-0.47 (0.16)</td>
<td>0.17 (0.31)</td>
</tr>
<tr>
<td>Professional Development</td>
<td>22.88</td>
<td>23.00</td>
<td>22.00</td>
<td>6.14</td>
<td>27.00</td>
<td>-0.07 (0.16)</td>
<td>-0.41 (0.31)</td>
</tr>
<tr>
<td>Life Balance</td>
<td>21.80</td>
<td>23.00</td>
<td>24.00</td>
<td>4.57</td>
<td>20.00</td>
<td>-0.49 (0.16)</td>
<td>-0.50 (0.31)</td>
</tr>
<tr>
<td>Cognitive Strategies</td>
<td>23.20</td>
<td>23.00</td>
<td>28.00</td>
<td>3.62</td>
<td>16.00</td>
<td>-0.30 (0.16)</td>
<td>-0.68 (0.31)</td>
</tr>
<tr>
<td>Daily Balance</td>
<td>13.61</td>
<td>14.00</td>
<td>13.00</td>
<td>3.94</td>
<td>18.00</td>
<td>-0.14 (0.16)</td>
<td>-0.31 (0.31)</td>
</tr>
</tbody>
</table>

*Note.* $N = 241$, $\bar{x} =$ sample mean, $Md =$ median, $Mo =$ mode, $s =$ standard deviation, $SE_{k} =$ standard error of skewness, $SE_{k} =$ standard error of kurtosis

Figure 49. Distribution of Professional Support subscale. This figure depicts the negatively skewed distribution of the subscale.
Figure 50. Distribution of Life Balance subscale. This figure depicts the negatively skewed distribution of the subscale.

Figure 51. Distribution of Cognitive Strategies subscale. This figure depicts the platykurtic distribution of the subscale.
Figure 52. Distribution of Professional Development subscale. This figure depicts the normal distribution of professional development.

Figure 53. Distribution of Daily Balance subscale. This figure depicts the normal distribution of the subscale.

**Bivariate Relationships**

Next, I analyzed the bivariate relationships between all variables in the structural equation models starting with the correlations between predictors (subscales of the SLS and PSCS, Caseload, Trauma Clients, Ambiguity Revised, and Role Conflict).
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evaluated the strength of correlation by Evans and colleagues’ (1996) delineations as indicated by Table 11. Analyzing the bivariate relationships of predictor variables is important to detect possible collinearity issues that may arise during regressions or SEM. Multicollinearity is a problem when highly correlated predictor variables obscure the impact of individual variables on the outcome variables (Vatcheva, Lee, McCormick, & Rahbar, 2016). Correlations will be considered at risk for multicollinearity problems if they are strong or very strong ($r > .60$).

Table 11

<table>
<thead>
<tr>
<th></th>
<th>Very Weak</th>
<th>Weak</th>
<th>Moderate</th>
<th>Strong</th>
<th>Very Strong</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive correlations</td>
<td>$r = .00 - .19$</td>
<td>$r = .20 - .39$</td>
<td>$r = .40 - .59$</td>
<td>$r = .60 - .79$</td>
<td>$r = .80 - 1.00$</td>
</tr>
<tr>
<td>Negative correlations</td>
<td>$r = .00 - .19$</td>
<td>$r = -.20 - -.39$</td>
<td>$r = -.40 - -.59$</td>
<td>$r = -.60 - -.79$</td>
<td>$r = -.80 - -1.00$</td>
</tr>
</tbody>
</table>

*Note.* Magnitude of $r$ values assumes statistical significance.

Each variable was tested in 15 correlations with other predictor variables and 9 correlations with each outcome variable, for a total of 23 correlations. I implemented a Bonferroni correction to protect against alpha slippage and the risk of a Type I error. The new alpha level was 0.002. Table 12 displays the results of the correlations between all predictor variables. Trauma Clients and Caseload were strongly correlated ($r = 0.60, p < .002$). However, all other strong correlations were between the SLS factors.
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SLS and Outcome Variables

I then examined the bivariate relationships between all predictor variables with each outcome variable. Table 13 shows the bivariate relationships of each SLS subscale with the subscales of the CBI, JB Revised, STS Revised, and the one-factor STSS. Incompetence had a weak correlation with the Empowerment subscale but was not significantly correlated with any of the other subscales of the SLS. NWE had significant, negative, moderate correlations with the Conceptual Skills, Empowerment, Putting Subordinates First, Ethical Behavior, Emotional Healing, and Creating Value for the Community subscales; and a significant, negative, strong correlation with Helping Subordinates Grow and Succeed ($r = -.60$, $p < .002$). DPL was weakly correlated with Empowerment. DC had weak correlations with Empowerment, Helping Subordinates Grow and Succeed, and Emotional Healing. Exhaustion had weak to moderate correlations with all subscales of the SLS. STSS had weak correlations with all of the subscales of the SLS except CS. STS Revised was not significantly correlated with any of the SLS subscales. JB Revised was weakly correlated with all SLS subscales.
The five subscales of the PSCS had weak to moderate significant correlations with most of the outcome variables (Table 14). Professional Support had weak correlations with incompetence, STSS, and JB Revised; and very weak correlations with DPL and DC subscales. Professional Development had weak to moderate negative correlations with STSS Revised and JB Revised.
correlations with all outcome variables. Life Balance had weak correlations with most of the outcome variables, a very weak correlation with NWE, and a moderate correlation with Exhaustion ($r = -0.40, p < .002$). Cognitive Strategies had very weak to weak significant negative correlations with all outcome variables except STS Revised. Daily Balance was significantly negatively correlated with all outcome variables. DPL and Exhaustion were moderately correlated with Daily Balance.

**Observed Variables and Outcome Variables**

I also tested the bivariate relationships of the outcome variables with Role Conflict, Ambiguity Revised, Caseload, and Trauma Clients (Table 15). The Role Conflict scale had a strong positive correlation with NWE, and weak to moderate relationships with all other outcome variables except Incompetence. Ambiguity Revised also had significant positive correlations with all outcome variables including moderate correlations with NWE ($r = 0.58, p < .002$), DPL ($r = 0.44, p < .002$), Exhaustion ($r = 0.50, p < .002$), STSS ($r = 0.43, p < .002$), and JB Revised ($r = 0.48, p < .002$). Caseload had a very weak positive correlation with DPL ($r = 0.17, p < .002$). Trauma Clients was weakly correlated with NWE ($r = 0.22, p < .002$) and very weakly correlated with DPL ($r = 0.19, p < .002$). Trauma Clients was surprisingly not correlated with the STS Revised or the STSS.
Table 15

<table>
<thead>
<tr>
<th></th>
<th>Role Conflict</th>
<th>Ambiguity Revised</th>
<th>Caseload</th>
<th>Trauma Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incompetence</td>
<td>.14</td>
<td>.24*</td>
<td>.05</td>
<td>.05</td>
</tr>
<tr>
<td>NWE</td>
<td>.67*</td>
<td>.58*</td>
<td>.18</td>
<td>.22*</td>
</tr>
<tr>
<td>DPL</td>
<td>.41*</td>
<td>.44*</td>
<td>.17*</td>
<td>.19*</td>
</tr>
<tr>
<td>DC</td>
<td>.26*</td>
<td>.29*</td>
<td>.02</td>
<td>-.05</td>
</tr>
<tr>
<td>Exhaustion</td>
<td>.47*</td>
<td>.50*</td>
<td>.17</td>
<td>.14</td>
</tr>
<tr>
<td>STSS</td>
<td>.45*</td>
<td>.43*</td>
<td>.08</td>
<td>.10</td>
</tr>
<tr>
<td>STS Revised</td>
<td>.37*</td>
<td>.33*</td>
<td>.13</td>
<td>.17</td>
</tr>
<tr>
<td>JB Revised</td>
<td>.49*</td>
<td>.48*</td>
<td>.11</td>
<td>.09</td>
</tr>
</tbody>
</table>

*Note. * indicates significance at the .002 level. NWE = Negative Work Environment, DPL = Deterioration in Personal Life, DC = Devaluing the Client.

Gender and STS

I also analyzed the bivariate relationships of the categorical variables, gender and survivor status, with STS Revised and STSS. In order to avoid alpha slippage and increased risk of a Type I error, I chose to only test the impact of gender and survivor status on variables measuring STS in the structural equation models. The STS measures were selected for these analyses because I hypothesized that gender would have an indirect effect on STS and survivor status would have a direct effect on STS in both structural equation models. In addition, I conducted a chi-square to identify if men or women were significantly more likely to endorse the experience of a traumatic event to discern the bivariate relationship between gender and survivor status.

First, I utilized two independent t-tests to test the difference between men and women’s experiences with STS. Then I conducted two different independent t-tests to determine if survivors and non-survivors differed in their experience with STS. I completed a total of four t-tests and each variable was used two times in the analyses.
Utilizing a Bonferroni correction, I altered the p value from 0.05 to 0.025. In the first set of t-tests, men and women did not differ significantly on either the STS Revised or the STSS (Table 16).

**Survivor status and STS.** I conducted two independent t-tests to identify if survivors of traumatic events experienced STS significantly differently from those who had not experienced a traumatic event. A summary of these findings and prior predictions of significance are displayed in Table 17. The Levene’s test was significant for STS Revised, which indicates that the assumption of equal variance was violated. SPSS adjusted the t value and df for the unequal variances, and the t-test for STS Revised was significant at the 0.025 level. Survivors of traumatic events \((M = 14.20, SD = 8.63)\) were significantly more likely to endorse higher levels of STS than those who had not experienced a traumatic event \((M = 11.61, SD = 6.10)\). The Cohen’s \(d\) for this t-test was 0.35. According to Cohen (1988), an effect size of \(d = 0.2\) can be considered a small effect size and \(d = 0.5\) is a medium effect size. A Cohen’s \(d\) of 0.35 is between a small and medium effect size. The mean of the survivor group lies at the 64th percentile of the non-survivor group, and about 76% of the survivor distribution overlaps with the non-survivor distribution.
Gender and survivor status. Of the male participants, 62.5% indicated they had experienced a traumatic event ($n = 20$) and 37.5% reported no experience of a traumatic event ($n = 12$). Similarly, most female participants endorsed the experience of a traumatic event ($n = 154, 73.7\%$). I conducted a chi-square test of independence to determine if women were significantly more likely to experience a traumatic event than men as predicted by the a priori hypothesis. The chi square test of independence indicated the men and women did not differ significantly in how frequently they endorsed the experience of a traumatic event ($\chi^2 = 1.73, p = 0.19$). The result of this test indicated that survivor status did not moderate a relationship between gender and STS.

Revised Models

Due to the change in some of the measurement models, the original SEM models needed to be altered along with some of the some of the specific hypotheses relating to the research questions. The CF-S scale is no longer a latent variable in the CF-S revised model; instead, the two subscales of the CF-S scale (JB Revised and STS Revised) are two observed endogenous and correlated variables. The direction of predicted
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relationships for the CF-S model are modeled after the CBI/STSS predictions. Also, the Ambiguity subscale of the RSS is represented by a revised variable (Ambiguity Revised) to account for the missing item. Rather than using the STSS as a latent variable in the CBI/STSS model, I used this as a one-factor, observed, endogenous variable. The new revised structural equation models that were tested in this study can be found in Figure 54 (Revised CF-S model) and Figure 55 (Revised CBI/STSS model).

I also calculated a post hoc power analysis for both models. The a priori power analysis indicated a minimum sample size requirement of 538 participants. With a sample size of 241, an effect size of 0.10, and an alpha level of 0.05, the Revised CF-S model (Figure 54) had a power level of 0.29. With the same sample size, effect size, and alpha level, the Revised CBI/STSS model (Figure 55) had a power level of 0.16. This small sample size and diminished power may affect the ability of the models to converge appropriately and accurately estimate relationships in the data (Wolf et al., 2013). Results should be interpreted with caution because diminished power can increase vulnerability for making a Type II error (Cohen, 1988). The following are the revised hypotheses tested in this study and illustrated in Figures 54 and 55.
Figure 54. Revised CF-S model. This figure illustrates the CF-S structural equation model that includes the revised variables and tests the study's hypotheses.
Figure 5.5. Revised CBI/STSS model. This figure depicts the newly revised CBI/STSS structural equation model that was tested in the study and includes newly revised variables.
Summary of Revised Model Research Questions

Does the perceived servant leadership of supervisors negatively predict the burnout of counseling residents?

Hypothesis 1a (SLS $\rightarrow$ JB Revised). In the Revised CF-S model, servant leadership as measured by the SLS will negatively predict burnout as measured by the JB Revised.

Hypothesis 2 (SLS $\rightarrow$ CBI). In the Revised CBI/STSS model, servant leadership as measured by the SLS will negatively predict burnout as measured by the CBI.

Does the perceived servant leadership of supervisors negatively predict the STS of counseling residents?

Hypothesis 1b (SLS $\rightarrow$ STS Revised). In the Revised CF-S model, servant leadership as measured by the SLS will negatively predict STS as measured by the STS Revised.

Hypothesis 3 (SLS $\rightarrow$ STSS). In the Revised CBI/STSS model, servant leadership as measured by the SLS will negatively predict STS as measured by the one-factor STSS.

Does the perceived servant leadership of female supervisors and the perceived servant leadership of male supervisors differ significantly?

Hypothesis 4 (SLS female supervisors $=$ SLS male supervisors). There will be no significant difference between the means of the perceived servant leadership traits of male supervisors and female supervisors as measured by the SLS and as evaluated by counseling residents.

Does role conflict positively predict burnout?
Hypothesis 5a (Role Conflict → JB Revised). In the Revised CF-S model, role conflict as measured by the Role Conflict subscale of the RSS will positively predict burnout as measured by JB Revised.

Hypothesis 6 (Role Conflict → CBI). In the Revised CBI/STSS model, role conflict as measured by the Role Conflict subscale of the RSS will positively predict burnout as measured by the CBI.

Does role conflict positively predict STS?

Hypothesis 5b (Role Conflict → STS Revised). In the Revised CF-S model, role conflict as measured by the Role Conflict subscale of the RSS will positively predict STS as measured by the STS Revised.

Hypothesis 7 (Role Conflict → STSS). In the Revised CBI/STSS model, role conflict as measured by the Role Conflict subscale of the RSS will positively predict STS as measured by the one-factor STSS.

Does role ambiguity positively predict burnout?

Hypothesis 8a (Ambiguity Revised → JB Revised). In the Revised CF-S model, role ambiguity as measured by the Ambiguity Revised (modified subscale of the RSS) will positively predict burnout as measured by the JB Revised.

Hypothesis 9 (Ambiguity Revised → CBI). In the Revised CBI/STSS model, role ambiguity as measured by the Ambiguity Revised will positively predict burnout as measured by the CBI.

Does role ambiguity positively predict STS?
**Hypothesis 8b (Ambiguity Revised → STS Revised).** In the Revised CF-S model, role ambiguity as measured by the Ambiguity Revised will positively predict STS Revised.

**Hypothesis 10 (Ambiguity Revised → STSS).** In the Revised CBI/STSS, role ambiguity as measured by the Ambiguity Revised will positively predict STS as measured the one-factor STSS.

**Does professional self-care negatively predict burnout?**

**Hypothesis 11a (PSCS → JB Revised).** In the Revised CF-S model, professional self-care of counselors as measured by the PSCS will negatively predict burnout as measured by the JB Revised.

**Hypothesis 12 (PSCS → CBI).** In the Revised CBI/STSS model, professional self-care as measured by the PSCS will negatively predict burnout as measured by the CBI.

**Does professional self-care negatively predict STS?**

**Hypothesis 11b (PSCS → STS Revised).** In the Revised CF-S model, professional self-care as measured by the PSCS will negatively predict STS as measured by the STS Revised.

**Hypothesis 13 (PSCS → STSS).** In the Revised CBI/STSS model, professional self-care as measured by the PSCS will negatively predict STS the STS as measured by the one-factor STSS.

**Does frequency of client interaction positively predict burnout?**
Hypothesis 14 (Caseload → JB Revised). In the Revised CF-S model, the frequency of client interaction as represented by the variable, Caseload, will positively predict burnout as measured by the JB Revised.

Hypothesis 15 (Caseload → CBI). In the Revised CBI/STSS model, the frequency of client interaction as represented by the variable, Caseload, will positively predict burnout as measured by the CBI.

Does frequency of trauma client interaction positively predict STS?

Hypothesis 16 (Trauma Clients → STS Revised). In the Revised CF-S model, the frequency of trauma client interaction as represented by the variable, Trauma Clients, will positively predict STS as measured by the STS Revised.

Hypothesis 17 (Trauma Clients → STSS). In the Revised CBI/STSS model, the frequency of trauma client interaction as represented by the variable, Trauma Clients, will positively predict STS as measured by the one-factor STSS.

Are female counseling residents more likely to be survivors of trauma?

Hypothesis 18 (Gender → Survivor Status). In the Revised CF-S model, female counseling residents will be more likely to be survivors of a traumatic event.

Hypothesis 19 (Gender → Survivor Status). In the Revised CBI/STSS model, female counseling residents will be more likely to be survivors of a traumatic event as measured by survivor status.

Do survivors of traumatic events experience greater STS than non-survivors?

Hypothesis 20 (Survivor Status → STS Revised). In the Revised CF-S model, individuals who are survivors of traumatic events, as represented by the variable of survivor status, will endorse higher levels of STS as measured by the STS Revised.
Hypothesis 21 (Survivor Status → STSS). In the Revised CBI/STSS model, survivors of traumatic events, as represented by the variable of survivor status, will endorse higher levels of STS as measured by the one-factor STSS.

Are STS and burnout correlated?

Hypothesis 22a (STS Revised ↔ JB Revised). In the Revised CF-S model, STS as measured by the STS Revised and burnout as measured by the JB Revised will be correlated. As these outcome variables are predicted by several of the same exogenous variables, this correlation is implied rather than graphically shown.

Hypothesis 22b (STSS ↔ CBI). In the Revised CBI/STSS model, STS as measured by the STSS, and burnout as measured by the CBI are correlated endogenous outcome variables. As these outcome variables are predicted by several of the same exogenous variables, this correlation is implied rather than graphically shown.

Does the Final CBI/STSS Model have a better model fit than the Final CF-S Model?

Hypothesis 23 (Final CF-S Model < Final CBI/STSS Model). The Hypothesized CBI/STSS model was originally predicted to be a better fitting model than the Hypothesized CF-S model due to the CF-S having only two subscales and zero degrees of freedom. However, the CF-S has now become two observed variables rather than a two-factor latent variable. Nevertheless, the Revised CBI/STSS model will be a better fitting model than the Revised CF-S model because the CBI was designed specifically for counselors and is a good-fitting measurement model, and the questions of the STSS relate specifically to the symptoms of PTSD, which is the operational definition of STSS.
Structural Equation Models

Using SEM, I tested both the Revised CF-S model and the Revised CBI/STSS model. A model was considered to have a good fit if the CMIN/df was less than 2 (Schumacker & Lomax, 2004), the RMSEA was below .08 (Awang, 2012), and the TLI and CFI were equal to or greater than 0.90. Because these indices are recommendations rather than strict cut-off scores, I also considered models with fit indices close to these recommendations as adequately fitting models.

I utilized a developmental approach to SEM by first attempting to confirm the hypothesized models and then making model alterations as suggested by the modification indices. I incorporated modification indices only if the index was above 25 and the alteration had theoretical significance in accordance with best practices (Silvia & MacCullum, 1988). When all modifications based on modification indices were exhausted, I deleted nonsignificant paths.

CF-S Structural Equation Model

I tested the CF-S model through SEM using the SPSS add-on program AMOS 21 (Arbuckle, 2012). Because the CF-S was unable to be identified through CFA as a latent variable, the JB Revised and STS Revised variables were utilized as separate observed endogenous variables. The results of the first iteration of the CF-S structural equation model indicated an inadequate fit (CMIN/df = 3.77, TLI = 0.78, CFI = 0.81, RMSEA = .11; Figure 56). Five modification indices were over 25. The first index of 86.49 with an estimated parameter change of 55.99 recommended a correlation between Caseload and Trauma Clients. Both variables required participants to rate the number of hours they spend seeing clients. Participants with higher caseloads would presumably have more
opportunity to interact with traumatized clients. This alteration was accepted as theoretically plausible. I modeled the correlation and tested the new model (Figure 57).

Figure 56. First iteration of the Revised CF-S model. This figure shows the first CF-S model testing.
Figure 57. Second iteration of the Revised CF-S model. The second iteration of the CF-S incorporated a correlation between Caseload and Trauma Clients.
Second iteration of the CF-S model. After a correlation between Caseload and Trauma Clients was modeled, I retested the model. The fit indices showed an improved but inadequate fit (CMIN/df = 3.14, TLI = 0.83, CFI = 0.85, RMSEA = 0.09). Three large modification indices involved the interaction of JB Revised and STS revised. One modification index of 54.59 with a parameter change of 39.41 was related to the residuals associated with JB Revised and STS Revised. This correlation may be due to an extraneous latent variable that had not been specified in the model, such as compassion fatigue (Landis, Edwards, & Cortina, 2009). However, in this dataset, the CFA for CF-S indicated that compassion fatigue as a latent variable did not exist in the dataset. A modification index of 40.62 with an estimated parameter change of 0.60 suggested a prediction from STS Revised to JB Revised; and another modification index of 36.62 with an estimated parameter change of 0.20 suggested a path from JB Revised to STS Revised. The prediction of STS by burnout was supported by theory. Shoji and colleagues (2015) conducted a longitudinal study examining the directional relationship between STS and burnout with mental health providers. Participants with symptoms of burnout at the first point of assessment were more likely to develop STS at a 6-month follow up. I chose to implement the prediction of the STS Revised by the JB Revised because this had theoretical support. I modeled the pathway and reran the new model (Figure 58).
Figure 58. Third iteration of the Revised CF-S model. This model incorporated a prediction of the STS Revised by the JB Revised.
Third iteration of the CF-S model. In the third iteration of the CF-S model, the model fit indices improved (CMIN/df = 2.78, TLI = 0.86, CFI = 0.88, RMSEA = 0.09). The largest modification index was a modification index of 33.90 with an estimated parameter change of 3.13 and recommended a correlation between the PSCS and the Ambiguity Revised. All of the ambiguity items are reverse scored and describe an individual who has a sense of clarity and organization in the workplace. Individuals who are regularly engaged in professional self-care may have greater tolerance for ambiguity (Bohecker, Wathen, Wells, Salazar, & Vereen, 2014). As this has theoretical credence, I chose to implement this modification (Figure 59).
Figure 59. Fourth iteration of the Revised CF-S. This model incorporated a correlation between Ambiguity Revised and the PSCS.
Fourth iteration of CF-S model. Figure 59 depicts the fourth iteration of the CF-S model with a correlation between Ambiguity Revised and the PSCS. The model fit indices for this model showed an improvement in model fit (CMIN/df = 2.56, TLI = 0.87, CFI = 0.89, RMSEA = 0.08). All modification indices were under 25.
Figure 60. Final CF-S model. This final model has nonsignificant paths removed.
Final iteration of CF-S model. According to the model estimates, several specified paths were nonsignificant. Servant leadership did not significantly predict burnout. Caseload did not significantly predict burnout. Gender did not significantly predict survivor status. Trauma Clients did not significantly predict STS. The PSCS did not significantly predict STS. Ambiguity Revised did not significantly predict STS. I removed the nonsignificant paths and reran the model (Figure 60). The model had fit indices very close to the recommended goodness of fit indices, which indicated an adequate fit (CMIN/df = 2.51, TLI = 0.88, CFI = 0.89, RMSEA = 0.08). Modification indices were all below 25, and all estimates were significant. Notably, the sign of the regression coefficient between SLS and STS had switched from negative to positive. This may be a sign of multicollinearity in the model (Grewal, Cote, & Baumgartner, 2004).

Table 18 summarizes the iterations of the CF-S model.

Table 18

<table>
<thead>
<tr>
<th>Iteration</th>
<th>Respecification</th>
<th>CMIN/df</th>
<th>TLI</th>
<th>CFI</th>
<th>RMSEA</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
<td>Original Model</td>
<td>3.77</td>
<td>0.78</td>
<td>0.81</td>
<td>0.11</td>
</tr>
<tr>
<td>Second</td>
<td>Caseload ↔ Trauma Clients</td>
<td>3.14</td>
<td>0.83</td>
<td>0.85</td>
<td>0.09</td>
</tr>
<tr>
<td>Third</td>
<td>JB Revised → STS Revised</td>
<td>2.78</td>
<td>0.86</td>
<td>0.88</td>
<td>0.09</td>
</tr>
<tr>
<td>Fourth</td>
<td>Ambiguity Revised ↔ PSCS</td>
<td>2.56</td>
<td>0.87</td>
<td>0.89</td>
<td>0.09</td>
</tr>
<tr>
<td>Fifth</td>
<td>Nonsignificant paths removed</td>
<td>2.51</td>
<td>0.88</td>
<td>0.89</td>
<td>0.08</td>
</tr>
</tbody>
</table>

Note. The fifth iteration represents the final CF-S model.

Analyses of the CBI/STSS Structural Equation Model

I then tested the CBI/STSS model through SEM (Figure 61). This model had counselor burnout as a latent endogenous outcome variable measured by the CBI, and STS as an observed endogenous outcome variable measured by the one-factor STSS (Figure 61). The results of the first iteration of the CBI/STSS model showed an
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inadequate fit (CMIN/df = 3.72, TLI = 0.75, CFI = 0.78, RMSEA = 0.11). The largest modification of 86.49 with an estimated parameter change of 55.99 was related to the correlation between Caseload and Trauma Clients as it was in the CF-S model. I modeled this modification and retested the model.
Figure 61. First iteration of the Revised CBI/STSS model. This figure depicts the first test of the CBI/STSS model.
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Second Iteration of the CBI/STSS Model

After modeling the correlation between Trauma Clients and Caseload (Figure 62), the new model resulted in an improved fit (CMIN/df = 3.30, TLI = 0.79, CFI = 0.82, RMSEA = 0.10). Three modification indices were above 25. These suggested a correlation between the residuals of the STSS and CBI, the prediction of the CBI by the STSS, or the prediction of the STSS by the CBI. The prediction of the STSS by the CBI had theoretical support. Shoji and colleagues (2015) conducted a longitudinal study that supported the unidirectional relationship of burnout’s prediction of STS. I incorporated this change in the CBI/STSS model and tested the new model.
Figure 62. Second iteration of the Revised CBI/STSS model. This figure depicts the addition of the correlation between Caseload and Trauma Clients.
Third Iteration of the CBI/STSS Model

The third iteration of the CBI/STSS model resulted in a further improved model fit (CMIN/df = 3.03, TLI = 0.82, CFI = 0.84, RMSEA = 0.09; Figure 63). Modification indices over 25 were generated for modifications that would add predictions from the latent variable of Servant Leadership and/or each of the subscales of the SLS to the NWE subscale of the CBI. Another modification index suggested a prediction of the residual associated with the NWE by the SLS. These are strong indications of shared variance between the SLS and the NWE subscale of the CBI and the specific variance of the NWE subscale. Two items of the NWE relate specifically to supervisors. This was identified in the CFA of the CBI when the residuals of these two items correlated. This explains why the SLS may have had a strong prediction of the residual of the NWE. However, supervisors impact the work environment. Supervisors may contribute to a negative and fatiguing atmosphere in the workplace (Kreider, 2014). According to Seldon (2010), employees often look to their direct supervisor to provide a positive working environment. This theoretical support and large modification indices indicate that the SLS positively predicts the NWE. In addition, moderate to strong bivariate relationships were identified between the subscales of the SLS and the subscale of the NWE. I chose to implement a prediction of the NWE subscale by the SLS. In addition, the SLS prediction of the CBI was nonsignificant, so this was removed.
Figure 63. Third iteration of the Revised CBI/STSS model. This model incorporated a prediction of the STSS by the CBI.
Fourth Iteration of the CBI/STSS Model

After modeling the SLS prediction of the NWE subscale, I tested the revised model (Figure 64). This model was a better fit, and the RMSEA showed an acceptable fit (CMIN/df = 2.70, TLI = 0.85, CFI = 0.86, RMSEA = 0.08). A modification index of 33.83 had an estimated parameter change of 3.15 and suggested a correlation between Ambiguity Revised and the PSCS. This occurred in the CF-S model as well and I found it to be theoretically plausible. I modeled this correlation and reran the model.
Figure 64. Fourth iteration of the Revised CBI/STSS model. This model removed the path between servant leadership and the CBI and added a prediction of the NWE subscale by the SLS.
Figure 65. Fifth iteration of the Revised CBI/STSS model. This model incorporates a correlation between Ambiguity Revised and the PSCS.
Fifth Iteration of the CBI/STSS Model

The model depicted in Figure 65 illustrates the fifth iteration of the CBI/STSS model. The model fit indices showed an improved model fit (CMIN/df = 2.55, TLI = 0.86, CFI = 0.88, RMSEA = 0.08). All modification indices were under 25. Multiple paths were nonsignificant. Caseload did not significantly predict burnout, gender did not significantly predict survivor status, Trauma Clients did not significantly predict the STSS, the PSCS did not significantly predict the STSS, Role Conflict did not significantly predict the STSS, and Ambiguity Revised did not significantly predict the STSS.
Figure 66. Final CBI/STSS model. This figure shows the final version of the CBI/STSS model with nonsignificant paths removed.
Sixth Iteration of the CBI/STSS Model

After removing nonsignificant paths, the model fit indices showed a similar fit to the previous iteration (CMIN/df = 2.52, TLI = 0.86, CFI = 0.88, RMSEA = 0.08). All estimates were significant, and all modification indices were under 25. The fit indices are close to the recommended fit requirements, and according to the RMSEA, the final iteration of the CBI/STSS model was an acceptable fit for the data. The final model is shown in Figure 66. Table 19 summarizes the iterations of the CBI/STSS model.

Table 19

<table>
<thead>
<tr>
<th>Iteration</th>
<th>Respecification</th>
<th>CMIN/df</th>
<th>TLI</th>
<th>CFI</th>
<th>RMSEA</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
<td>Original Model</td>
<td>3.72</td>
<td>0.75</td>
<td>0.78</td>
<td>0.11</td>
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<tr>
<td>Second</td>
<td>Caseload ↔ Trauma Clients</td>
<td>3.30</td>
<td>0.79</td>
<td>0.82</td>
<td>0.10</td>
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<tr>
<td>Third</td>
<td>CBI → STSS</td>
<td>3.03</td>
<td>0.82</td>
<td>0.84</td>
<td>0.09</td>
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<td>Fourth</td>
<td>SLS → NWE</td>
<td>2.70</td>
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<tr>
<td>Fifth</td>
<td>Ambiguity Revised ↔ PSCS</td>
<td>2.55</td>
<td>0.86</td>
<td>0.88</td>
<td>0.08</td>
</tr>
<tr>
<td>Sixth</td>
<td>Nonsignificant paths removed</td>
<td>2.52</td>
<td>0.86</td>
<td>0.88</td>
<td>0.08</td>
</tr>
</tbody>
</table>

*Note. NWE = Negative Work Environment. The sixth iteration represents the final CF-S model.*

Comparing the Two Models

The CF-S model and the CBI/STSS final models had the same variables that represented the personal, client, and work environments of the counseling resident. However, the outcome variables that measured counseling residents’ burnout and STS differed in each model. The CF-S model contained two observed endogenous variables: the JB Revised subscale and the STS Revised subscale of the CF-S. The CBI/STSS model had one latent endogenous variable (the CBI), and one observed endogenous variable of STS as measured by the STSS. To determine which final model is a better model, I analyzed the relationships between these differing variables, and then I compared the AIC, BIC, and ECVI between both models.
Relationship Between Outcome Variables

Multiple one-tailed Pearson’s product-moment correlations were run with the assumption that all variables are positively correlated. The variables representing burnout and STS were tested in nine correlations with predictor variables and seven correlations with other outcome variables, for a total of 16 correlations. I used a Bonferroni correction and set the alpha level to 0.003. The results indicated significant correlations between all variables (Table 20). All subscales of the CBI were more strongly correlated with the JB Revised variable than with the STS Revised variable, which indicates that the CBI has more shared variance with the measurement for burnout than with the measurement for STS. The STSS scale had strong correlations with both the STS Revised variable and the JB Revised variable; however, STSS shared more variance with JB Revised than STS Revised. This was surprising since the STSS scale assumedly measured the same phenomenon that the STS Revised measured.

Table 20

<table>
<thead>
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<td>.65*</td>
<td>.55*</td>
<td>.74*</td>
<td>.73*</td>
<td>.60*</td>
</tr>
</tbody>
</table>

* indicates significance at the .003 level. 1 = Incompetence, 2 = NWE, 3 = DPL, 4 = DC, 5 = Exhaustion, 6 = STSS, 7 = STS Revised, 8 = JB Revised

Comparison of Indices

Both the CF-S and the STSS/CBI models are non-nested models because they contain a subset of the same variables, but also had different variables. The AIC, BIC, and EVCI values can be found in Table 21. The CF-S model had smaller AIC, BIC, and
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ECVI values and is the better fitting model. This contradicted the expected hypothesis because the CBI/STSS model did not have a better model fit.

Table 21

<table>
<thead>
<tr>
<th></th>
<th>AIC</th>
<th>BIC</th>
<th>ECVI</th>
</tr>
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<tr>
<td>Final CF-S Model</td>
<td>505.74</td>
<td>652.11</td>
<td>2.11</td>
</tr>
<tr>
<td>Final CBI/STSS Model</td>
<td>729.81</td>
<td>904.05</td>
<td>3.04</td>
</tr>
</tbody>
</table>

Note. The CF-S model has smaller AIC, BIC, and ECVI values and is the better fitting model.

The Impact of Supervisor Gender on Perceived Servant Leadership

I hypothesized that counseling residents who had male supervisors (n = 59) would not differ significantly in their servant leadership ratings from the counseling residents who had female supervisors (n = 182). To identify if the perceived servant leadership traits of male and female supervisors differed significantly, I ran 7 independent samples t-tests. To protect against a Type I error, I utilized a Bonferroni correction by dividing the alpha level of .05 by 7 and set the new alpha level at .007. The mean of the Putting Subordinates First subscale was significantly higher for male (M = 18.20, SD = 6.73) supervisors than female (M = 15.39, SD = 6.00) supervisors (t[239] = 3.03, p < .007). This indicated that counseling residents rated the ability of male supervisors to put subordinates first more positively than female supervisors. The Cohen’s d for this result was 0.44. According to Cohen (1988), a medium effect size is 0.5, so an effect size of 0.44 is just under a medium effect size. The mean of the distribution for counseling residents who have male supervisors falls at about the 67th percentile of the distribution for counseling residents who have female supervisors. The results of the t-tests can be
found in Table 22. Counseling residents’ ratings of female or male supervisors did not
differ significantly on any other servant leadership subscale.

Table 22

<table>
<thead>
<tr>
<th>Servant Leadership Ratings of Male and Female Supervisors</th>
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<tbody>
<tr>
<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td>CS</td>
</tr>
<tr>
<td>Empowerment</td>
</tr>
<tr>
<td>Helping</td>
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<tr>
<td>PSF</td>
</tr>
<tr>
<td>EB</td>
</tr>
<tr>
<td>EH</td>
</tr>
<tr>
<td>CVC</td>
</tr>
</tbody>
</table>

Note. * indicates significance at the .007 level. CS = Conceptual Skills, PSF = Putting Subordinates
First, EB = Ethical Behavior, EH = Emotional Healing, CVC = Creating Value for the Community,
NWE = Negative Work Environment, DPL = Deterioration in Personal Life, DC = Devaluing the Client,
t = t value df = degrees of freedom, M = mean

Summary and Hypotheses Results

This study tested the theoretical professional quality of life model (Stamm, 2010),
which indicated that compassion fatigue arises in the context of the professional helper’s
work, individual, and client environments. Compassion fatigue was studied as two
separate constructs: burnout and STS, and in the context of two separate structural
equation models. The first model measured compassion fatigue with the CF-S and the
second model measured compassion fatigue with the CBI and the STSS as two separate
outcome variables. Professional self-care, gender, and survivor status represented the
personal environment in both models. The approximate number of hours spent providing
direct care (Caseload) and the approximate number of hours providing trauma-orienting
counseling services (Trauma Clients) represented the client environment. The RSS
measured role ambiguity and role conflict as two aspects of professionals’ work
environment. The servant leadership of counseling residents’ supervisors was a newly
studied construct in the counseling field and in the context of compassion fatigue, and
this phenomenon also represented another aspect of the work environment. Most hypotheses of the study were embedded within both models. Hypothesis conclusions are briefly summarized below and implications of results are discussed in the following chapter.

**Does the perceived servant leadership of supervisors negatively predict the burnout of counseling residents?**

**Hypothesis 1a (SLS → JB Revised).** In the Revised CF-S model, servant leadership as measured by the SLS will negatively predict burnout as measured by JB Revised.

**Hypothesis not supported.** The SLS did not significantly predict JB Revised in the Final CF-S model.

**Hypothesis 2 (SLS → CBI).** In the Revised CBI/STSS model, servant leadership as measured by the SLS will negatively predict burnout as measured by the CBI.

**Hypothesis partially supported.** The SLS was a significant, negative, moderate predictor of the NWE subscale of the CBI in the Final CBI/STSS model ($\beta = -0.46$).

**Does the perceived servant leadership of supervisors negatively predict the STS of counseling residents?**

**Hypothesis 1b (SLS → STS Revised).** In the Revised CF-S model, servant leadership as measured by the SLS will negatively predict STS as measured by the STS Revised.

**Hypothesis partially supported.** According to the Final CF-S model, the SLS was a weak, significant, positive predictor of STS Revised ($\beta = 0.15$). The sign of the
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prediction changed in the model from the bivariate relationship identified previously between these two variables. This indicates multicollinearity.

**Hypothesis 3 (SLS → STSS).** In the Revised CBI/STSS model, servant leadership as measured by the SLS will negatively predict STS as measured by the one-factor STSS.

**Hypothesis not supported.** The SLS did not significantly predict the STSS in the Final CBI/STSS model.

**Does the perceived servant leadership of female supervisors and the perceived servant leadership of male supervisors differ significantly?**

**Hypothesis 4 (SLS female supervisors = SLS male supervisors).** There will be no significant difference between the means of the perceived servant leadership traits of male supervisors and female supervisors as measured by the SLS and as evaluated by counseling residents.

**Hypothesis partially supported.** Counseling residents’ perception of the servant leadership of supervisors did not differ significantly on most of the SLS subscales. However, counseling residents rated male supervisors significantly higher on the Putting Subordinates First subscale of the SLS.

**Does role conflict positively predict burnout?**

**Hypothesis 5a (Role Conflict → JB Revised).** In the Revised CF-S model, role conflict as measured by the Role Conflict subscale of the RSS will positively predict burnout as measured by JB Revised.

**Hypothesis supported.** Role Conflict significantly and positively predicted the JB Revised in the Final CF-S model ($\beta = 0.37$).
Hypothesis 6 (Role Conflict → CBI). In the Revised CBI/STSS model, role conflict as measured by the Role Conflict subscale of the RSS will positively predict burnout as measured by the CBI.

Hypothesis supported. Role Conflict significantly and positively predicted the CBI ($\beta = 0.42$) in the Final CBI/STSS model.

Does role conflict positively predict role conflict STS?

Hypothesis 5b (Role Conflict → STS Revised). In the Revised CF-S model, role conflict as measured by the Role Conflict subscale of the RSS will positively predict STS as measured by the STS Revised.

Hypothesis supported. Role Conflict significantly and positively predicted the STS Revised in the Final CF-S model ($\beta = 0.37$).

Hypothesis 7 (Role Conflict → STSS). In the Revised CBI/STSS model, role conflict as measured by the Role Conflict subscale of the RSS will positively predict STS as measured by the one-factor STSS.

Hypothesis supported. Role Conflict significantly and positively predicted the STSS in the Final CBI/STSS model ($\beta = 0.38$).

Does role ambiguity positively predict burnout?

Hypothesis 8a (Ambiguity Revised → JB Revised). In the Revised CF-S model, role ambiguity as measured by the Ambiguity Revised (modified subscale of the RSS) will positively predict burnout as measured by the JB Revised.

Hypothesis supported. Ambiguity Revised significantly and positively predicted the JB Revised in the Final CF-S model ($\beta = 0.13$).
Hypothesis 9 (Ambiguity Revised → CBI). In the Revised CBI/STSS model, role ambiguity as measured by the Ambiguity Revised will positively predict burnout as measured by the CBI.

_Hypothesis supported_. Ambiguity Revised significantly and positively predicted the CBI in the Final CBI/STSS model ($\beta = 0.18$).

Does role ambiguity positively predict STS?

_Hypothesis 8b (Ambiguity Revised → STS Revised)_. In the Revised CF-S model, role ambiguity as measured by the Ambiguity Revised will positively predict STS Revised.

_Hypothesis not supported_. Ambiguity Revised did not significantly predict the STS Revised in the Final CF-S model.

_Hypothesis 10 (Ambiguity Revised → STSS)_. In the Revised CBI/STSS, role ambiguity as measured by the Ambiguity Revised will positively predict STS as measured the one-factor STSS.

_Hypothesis not supported_. Ambiguity Revised did not significantly predict the STSS in the Final CBI/STSS model.

Does professional self-care negatively predict burnout?

_Hypothesis 11a (PSCS → JB Revised)_. In the Revised CF-S model, professional self-care of counselors as measured by the PSCS will negatively predict burnout as measured by the JB Revised.

_Hypothesis supported_. PSCS significantly and negatively predicted the JB Revised in the Final CF-S model ($\beta = -0.40$).
Hypothesis 12 (PSCS → CBI). In the Revised CBI/STSS model, professional self-care as measured by the PSCS will negatively predict burnout as measured by the CBI.

*Hypothesis supported.* PSCS negatively and significantly predicted the CBI in the Final CBI/STSS model ($\beta = -0.38$).

**Does professional self-care negatively predict STS?**

Hypothesis 11b (PSCS → STS Revised). In the Revised CF-S model, professional self-care as measured by the PSCS will negatively predict STS as measured by the STS Revised.

*Hypothesis supported.* The PSCS negatively predicted the STS Revised in the Final CF-S model ($\beta = -0.28$).

Hypothesis 13 (PSCS → STSS). In the Revised CBI/STSS model, professional self-care as measured by the PSCS will negatively predict STS as measured by the one-factor STSS.

*Hypothesis supported.* The PSCS negatively predicted the STSS in the Final CBI/STSS model ($\beta = -0.42$).

**Does caseload positively predict burnout?**

Hypothesis 14 (Caseload → JB Revised). In the Revised CF-S model, the frequency of client interaction as represented by the variable, Caseload, will positively predict burnout as measured by the JB Revised.

*Hypothesis not supported.* Caseload was not a significant predictor of burnout as measured by JB Revised in the Final CF-S model.
Hypothesis 15 (Caseload → CBI). In the Revised CBI/STSS model, the frequency of client interaction as represented by the variable, Caseload, will positively predict burnout as measured by the CBI.

Hypothesis not supported. Caseload did not significantly predict counselor burnout as measured by the CBI in the Final CBI/STSS model.

Do the hours spent each week providing trauma-related counseling positively predict STS?

Hypothesis 16 (Trauma Clients → STS Revised). In the Revised CF-S model, the frequency of trauma client interaction as represented by the variable, Trauma Client, will positively predict STS as measured by the STS Revised.

Hypothesis not supported. Trauma Clients did not significantly predict the STS Revised in the Final CF-S model.

Hypothesis 17 (Trauma Clients → STSS). In the Revised CBI/STSS model, the frequency of trauma client interaction as represented by the variable, Trauma Clients, will positively predict STS as measured by the one-factor STSS.

Hypothesis not supported. Trauma Clients did not significantly predict the STS Revised in the Final CBI/STSS model.

Are female counseling residents more likely to be survivors of trauma?

Hypothesis 18 (Gender → Survivor Status). In the Revised CF-S model, female counseling residents will be more likely to be survivors of a traumatic event.

Hypothesis not supported. Gender did not significantly predict Survivor Status in the Final CF-S model.
Hypothesis 19 (Gender → Survivor Status). In the Revised CBI/STSS model, female counseling residents will be more likely to be survivors of a traumatic event as measured by survivor status.

Hypothesis not supported. Gender did not significantly predict Survivor Status in the Final CBI/STSS model.

Do survivors of traumatic events experience greater STS than non-survivors?

Hypothesis 20 (Survivor Status → STS Revised). In the Revised CF-S model, individuals who are survivors of traumatic events, as measured by the variable of survivor status, will experience greater STS as measured by the STS Revised.

Hypothesis supported. Survivor Status was a significant, weak, negative predictor of the STS Revised in the Final CF-S model ($\beta = -0.12$).

Hypothesis 21 (Survivor Status → STSS). In the Revised CBI/STSS model, survivors of traumatic events will endorse higher levels of STS as measured by the one-factor STSS.

Hypothesis supported. Survivor status significantly and weakly predicted STSS in the Final CBI/STSS model ($\beta = -0.11$).

Are STS and burnout positively correlated?

Hypothesis 22a (STS Revised ↔ JB Revised). In the Revised CF-S model, STS as measured by the STS Revised and burnout as measured by the JB Revised will be correlated. As these outcome variables are predicted by several of the same exogenous variables, this correlation is implied rather than graphically shown.

Hypothesis partially supported. In the Final CF-S model (Figure 60), the JB Revised significantly predicted the STS Revised ($\beta = 0.54$).
Hypothesis 22b (STSS ↔ CBI). In the Revised CBI/STSS model, STS as measured by the STSS, and burnout as measured by the CBI are correlated endogenous outcome variables. As these outcome variables are predicted by several of the same exogenous variables, this correlation is implied rather than graphically shown.

Hypothesis partially supported. In the Final CBI/STSS model (Figure 66), the CBI significantly predicted the STSS ($\beta = 0.74$).

Does the Final CBI/STSS Model have a better model fit than the Final CF-S Model?

Hypothesis 23 (CF-S Model < CBI/STSS Model). The Hypothesized CBI/STSS model was originally predicted to be a better fitting model than the Hypothesized CF-S model due to the CF-S having only two subscales and zero degrees of freedom. However, the CF-S has now become two observed variables rather than a two-factor latent variable. Nevertheless, the Revised CBI/STSS model will be a better fitting model than the Revised CF-S model because the CBI is specifically for counselors and is a good-fitting measurement model, and the questions of the STSS relate specifically to the symptoms of PTSD, which is the operational definition of STSS.

Hypothesis not supported. The Final CF-S model provided a better model fit than the Final CBI/STSS model.

This chapter provided the methods of analyses and the summary of statistical findings from this study. The following chapter explicates the significance of these findings for clinical practice and counselor training. Discussion of application, future research avenues, and limitations will follow.
CHAPTER FIVE

The purpose of this study was to explore the capability of the servant leadership of supervisors to predict the burnout and STS of counseling residents in a model based on Stamm’s (2010) professional quality of life model. This model posited that professional helpers experience compassion fatigue, or STS and burnout, as a result of stressors in the work, personal, and client environments. I hypothesized that the servant leadership traits of supervisors would be a relevant contributor to counselors’ work environments and would negatively predict the STS and burnout of counseling residents in a model with other relevant predictors in counseling residents’ work, personal, and client environments. This chapter further reviews the purpose and significance of the study and discusses the implications of the results for counselor education and supervision. In addition, limitations and avenues for future research are discussed.

Purpose and Significance of Study

This study included two modified models of the professional quality of life model (Stamm, 2010). The first model explored the construct of compassion fatigue as a latent variable underlying STS and burnout in the Hypothesized CF-S model (Figure 6). The second model included two separate outcome latent variables of burnout and STS in the Hypothesized CBI/STSS model (Figure 7). Varied definitions of compassion fatigue exist in the literature, which causes confusion for researchers to study the construct. A goal of the study was to further clarify the construct of compassion fatigue, and how this differed from the separate constructs of burnout and STS.
This study also included an exploration of the construct of servant leadership in the professional quality of life theoretical framework. This was the first study of servant leadership in the field of counseling and was a response to Evans and colleagues’ (2016) call for further research on the application of servant leadership in clinical supervision. Although servant leadership has been identified as a protective agent for burnout in other professions (e.g., Babakus et al., 2011; Bobbio & Maganelli, 2015; Hunter et al., 2013; Upadyaya et al., 2016), this study provided the first investigation of servant leadership as a negative predictor of STS. As an investigation of how servant leadership style impacts counseling residents, this study has implications for clinical supervision, supervisor preparation, and counselor education. Because compassion fatigue is a multidimensional construct, it was important to investigate servant leadership’s impact on the outcome variables in a model of other relevant variables in the counselors’ work, personal, and client environments.

The following primary research questions were proposed in the context of the Hypothesized CF-S model (Figure 6) and the Hypothesized CBI/STSS model (Figure 7): (a) Does the perceived servant leadership of supervisors negatively predict compassion fatigue of counseling residents? (b) Does the perceived servant leadership of supervisors negatively predict the counselor burnout of counseling residents? (c) Does the perceived servant leadership of supervisors negatively predict the STS of counseling residents? (d) Does the perceived servant leadership of female supervisors and the perceived servant leadership of male supervisors differ significantly? These primary questions were tested through SEM in the presence of other relevant research questions and hypotheses emerging from the Hypothesized CF-S model (Figure 6) and the Hypothesized CBI/STSS
model (Figure 7). Hypotheses were revised to account for the alterations that occurred during the CFAs of measurement models. These revised hypotheses were presented in chapter four and were embedded in the Revised CF-S model (Figure 54) and the Revised CBI/STSS model (Figure 55). The implications of results for all tested hypotheses and research questions will be discussed in this chapter.

**Compassion Fatigue**

The first primary research question (Does the perceived servant leadership of supervisors negatively predict compassion fatigue of counseling residents?) and all research questions pertaining to the construct of compassion fatigue as proposed in chapter 3, cannot adequately be answered by the results of this study because the measurement model of compassion fatigue did not fit the data as expected. In the hypothesized CF-S model (Figure 6), compassion fatigue was represented as an endogenous latent variable. I chose to represent compassion fatigue as a latent variable with the subscales of Job Burnout and STS. This was based on the measurement model as developed by Adams and colleagues (2006). When I attempted to confirm this measurement model, the model was unidentifiable. I utilized EFA to identify two new variables: JB Revised and STS Revised. I again attempted to confirm a new measurement model consisting of the latent variable of compassion fatigue with two new indicators. This model was again unidentifiable and could not be estimated past the two-factor first-order model. The JB Revised and STS Revised were used in the Revised CF-S model as two correlated observed variables (Figure 54).

In this sample’s dataset, the construct of compassion fatigue did not exist. Instead, burnout and STS existed as separate but correlated variables. Therefore, research
questions related to compassion fatigue could not be answered in this study; and, likewise, hypotheses related to compassion fatigue could not be tested. Hypotheses related to compassion fatigue and derived from the Hypothesized CF-S model (Figure 6) were revised to reflect the exogenous variables’ interactions with STS and/or burnout separately (Figure 54). Research questions related to burnout and STS were answered with both the Revised CF-S model (Figure 54) and Revised CBI/STSS model (Figure 55) because both models had the variables of burnout and STS as endogenous variables; however, the instrumentation for measuring these variables differed.

Although compassion fatigue did not exist as a latent variable in this study, future research may have different results. Future researchers who utilize the CF-S instrument should confirm the measurement model prior to conducting further analyses in order to avoid making conclusions based on the assumption of compassion fatigue as a latent variable when this is erroneous. Further research is needed to confirm the existence of compassion fatigue as a two-indicator construct.

This result has implications for how compassion fatigue should be studied. The results of this study imply that burnout and STS function as separate constructs that may have a unidirectional relationship, as burnout may predict STS in counseling residents. The literature pertaining to compassion fatigue, STS, and burnout uses inconsistent language. STS and burnout may be identified as two factors of the construct compassion fatigue or studied as independent constructs. Sometimes STS and compassion fatigue are used interchangeably (e.g., Eastwood & Ecklund, 2008; Galek, Flannelly, Greene, & Kudler, 2011; McKim & Smith, 2013). The results of this study suggest that STS and burnout are not united by a latent variable; instead they measure separate but related
phenomena. These results, if confirmed through replication, have the potential to unify researchers’ language through the study of STS and burnout separately and the elimination of compassion fatigue as an overarching term.

**Work Environment**

The work environment pertains to organizational and interpersonal facets of the workplace. Although there are many aspects of the workplace to explore, I chose to include role stress and servant leadership. Role stress includes role conflict and role ambiguity and is evidenced to have a deleterious effect on counselor wellness (Wallace et al., 2010). I also included servant leadership to assess the supervisory relationship because this construct has not yet been explored in the field of counseling but has been beneficial in promoting employee wellness in other fields (Babakus et al., 2011; Bobbio & Maganelli, 2015; Hunter et al., 2013; Upadyaya et al., 2016). In addition, counseling residents are required to interact regularly with a supervisor, and this relationship was an important intervention point.

**Servant Leadership**

Three of the original four primary research questions pertaining to servant leadership could be analyzed in this study: (a) Does the perceived servant leadership of supervisors negatively predict the burnout of counseling residents? (b) Does the perceived servant leadership of supervisors negatively predict the STS of counseling residents? (c) Does the perceived servant leadership of female supervisors and the perceived servant leadership of male supervisors differ significantly? This section will address these questions and corresponding hypotheses and discuss implications.
Does the perceived servant leadership of supervisors negatively predict the burnout of counseling residents? I hypothesized that servant leadership as measured by the SLS would negatively predict burnout as measured by the JB Revised in the Revised CF-S model (hypothesis 1a; Figure 54) and as measured by the CBI in the Revised CBI/STSS model (hypothesis 2; Figure 55). Servant leadership did not significantly predict burnout in the Revised CF-S model, and servant leadership was not a significant predictor of the latent variable of burnout in the CBI/STSS model. Significant correlations were detected bivariately but could not be detected through multivariate analyses possibly due to multicollinearity, insufficient power, or the presence of more important predictors that negated the impact of servant leadership. In addition, sample size for the models was substantially below the ideal minimum sample size for sufficient power to detect significance. Servant leadership did have a moderate prediction of the NWE subscale of the CBI. This was unsurprising as the subscale describes the work environment and includes interpersonal interactions in the workplace.

Does the perceived servant leadership of supervisors negatively predict STS of counseling residents? I hypothesized that servant leadership as measured by the SLS would significantly and negatively predict STS as measured by the STS Revised in the Revised CF-S model (hypothesis 1b; Figure 54). In addition, I hypothesized that servant leadership as measured by the SLS would negatively predict STS as measured by the one-factor STSS in the Revised CBI/STSS model (hypothesis 3; Figure 55). According to the Final CF-S model, servant leadership was a very weak positive predictor for STS (β = 0.15; Figure 60). In the bivariate analyses, the STS Revised variable had nonsignificant negative correlations with all the subscales of the SLS. When signs change during a
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multivariate analysis, this is most likely due to multicollinearity, or problematically high correlations among other predictor variables (Grewal et al., 2004). On the other hand, servant leadership did not significantly predict STS in the Final CBI/STSS model (see Figure 66). Servant leadership may have had a negligible and nonsignificant impact on STS in the Final CBI/STSS model because of the presence of more important predictors, multicollinearity, or insufficient power.

**Implications for supervision.** Counselor supervisors are in a unique role to promote supervisees’ wellness, especially through a positive working alliance (Sterner, 2009) and service-oriented supervision (McCrea & Bulanda, 2008). Due to budget constraints, supervisors often assume roles beyond clinical supervision, such as administrative supervision, and juggle multiple responsibilities (Tromski-Klingshirn, 2007). This can lead to inconsistent supervisory interactions (Evans et al., 2016). Evans and colleagues (2016) asserted that incorporating a servant leadership style into the clinical supervision of counselors can provide harmony for both administrative and clinical supervisory roles. Considering 50% or more of counseling residents have dual-role supervisors, this need is becoming more urgent (Tromski-Klingshirn, 2007).

Findings from this study included a moderate prediction of the NWE subscale by the SLS in the Final CBI/STSS model (Figure 66). This indicated that supervisors’ servant leadership may positively impact the work environment. Many therapists look to their direct supervisors to develop a positive work environment (Seldon, 2010), and counselors who are unsatisfied with their supervision are much more likely to leave their work environment in search of alternate employment (Campbell, 2002). When
supervisory quality wanes, supervisors may inadvertently contribute to a fatiguing work environment (Kreider, 2014).

According to the philosophical underpinnings of the servant leadership framework, supervisors become servant leaders through an assessment of their own core values and beliefs. Russell and Stone (2002) created a practical model of servant leader development and asserted that the outward actions of servant leaders manifest out of an internal genuine desire to serve and help subordinates. Out of this foundation stems the development of accompanying attributes such as communication, competence, influence, listening, encouraging, and teaching (Russell & Stone, 2002). Next, functional attributes such as integrity, honesty, trust, service, modeling, empowerment, and appreciation of others follows these core values and accompanying attributes (Russell & Stone, 2002). According to Russell and Stone (2002), this process ultimately leads to a positive influence on organizational culture and employees’ attitudes and work behaviors through a synergistic process.

Implications for counselor education. As future mentors, supervisors, and counselor educators, doctoral students can expect to shift between multiple roles with master’s level students currently as doctoral students and in the future as faculty members. Although doctoral students are urged to develop a personal philosophy of teaching, a specific model of supervision, a self-directed research agenda, and a demonstrated commitment to service, doctoral students rarely consider a philosophy of leadership that would seamlessly integrate the multiple roles faculty members engage in as leaders in the field of counseling. Facilitating the development of a leadership style such as servant leadership during a doctoral counselor education program may allow
doctoral students to develop a professional identity as a leader in the field of counseling. Engaging in roles of supervisor, educator, researcher, and/or administrator may naturally flow from this leader identity.

Kiersh and Peters (2017) point out that a discrepancy exists between the needs of followers (support, collaboration, development, mentoring, etc.) and the way students conceptualize leadership (authority, influence, decision-making power, etc.). Kiersh and Peters provided a model of student leadership development that incorporated servant leadership specifically. This model focused on an inward component that included guided self-reflection on personal values, ethics, and beliefs to increase self-awareness, and a thorough ethics training to increase internalization of a moral perspective that would prime an outflow of ethical behavior (Kiersh & Peters, 2017). In addition, the model incorporated an outward focus that involved engagement in service projects, practical engagement in leadership roles, class lectures including guest speakers that exemplify servant leadership, and students’ sharing and hearing self-narratives regarding the beliefs, values, and ethics related to leadership that were discovered during the self-reflection (Kiersh & Peters, 2017). Doctoral students already engaged in multiple role-taking experiences and guided reflection could accompany these experiences with an added focus on developing the inward and outward components of servant leadership.

This approach to servant leadership development may also improve cognitive development. According to Sprinthall and Scott (1989) the deliberate psychological educational (DPE) method increases cognitive development and consists of five core components that have some overlap with Kiersh and Peters’ (2017) servant leader development model. These components include a new role-taking experience that
challenges current methods for meaning-making (Schmidt, McAdams, & Foster, 2009), guided reflection, an appropriate balance between the role-taking experience and the guided reflection (Sprinthall & Scott, 1989), an adequate balance of support and challenge (Schmidt et al., 2009), and continuity of at least 6-12 months (Lambie & Sias, 2009). Incorporating servant leadership with the DPE may enhance doctoral students’ servant leadership development and increase cognitive development.

Servant leadership may provide a more positive working environment and give focus to the multiple roles doctoral students engage in and will engage in as faculty members. Counselor education programs can implement a leadership development model that focuses on developing the inward and outward components of servant leadership and incorporate the DPE to enhance cognitive development of the future counseling leaders, supervisors, and educators. Further research on servant leadership is needed to determine the extent of its impact on counselor wellness.

**Does the perceived servant leadership of female supervisors and the perceived servant leadership of male supervisors differ significantly?** I hypothesized, based on the research by Barbuto and Gifford (2010), that counseling residents’ perceived servant leadership of their supervisors would not differ significantly between male and female supervisors (hypothesis 4). The results indicated that counseling residents did not rate their male and female supervisors significantly differently on most of the SLS subscales except for the Putting Subordinates First scale. Counseling residents with male supervisors \( n = 32 \) provided significantly higher ratings of their supervisors’ ability to put subordinates first than counseling residents with female supervisors \( n = \)
The implications of these results for counseling practice, supervision, and counselor education are discussed below.

**Putting subordinates first.** The Putting Subordinates First subscale measures the leader’s desire to attend to the needs of followers above the leader’s own interest (Liden et al., 2008). There is a sacrificial component of this subscale as a leader who puts subordinates first will break from their own duties and projects to assist supervisees with their work needs (Liden et al., 2008). It also assesses leaders’ demonstrated desire to make work easier for supervisees (Liden et al., 2008). This may include providing needed resources or assisting in problem solving. The results of this study indicated that supervisees perceived male supervisors to perform these tasks significantly better than female supervisors. This is a surprising result in the context of past research by Eagly and Carli’s (2003) on agentic versus communal behaviors. According to previous research, individuals who display agentic behaviors are viewed as authoritative and “utilize resources as a leverage for obtaining a goal” (Barbuto & Gifford, 2010, p. 8). Agentic leadership may be perceived as assertive, task-oriented, or independent (Eagly & Carli, 2003). According to Eagly and Carli (2003), men are more likely to display agentic behaviors that correspond to the socially-constructed masculine gender role. Conversely, communal leadership allows for shared power and is relationally-oriented, empathic, and helpful (Barbuto & Gifford, 2010). Eagly and Carli (2003) found that female leaders were more likely to engage in communal behaviors than male leaders and these behaviors correspond with the socially-constructed female gender role. Servant leadership incorporates agentic and communal leadership qualities to allow leaders to balance people-oriented and task-oriented needs (Barbuto & Gifford, 2010). The cooperative and
socially-oriented Putting Subordinates First subscale is a component of servant leadership that emphasizes communal behaviors. The results of this study indicated that counseling residents perceived male supervisors to more frequently engage in behaviors associated with putting subordinates first than female supervisors, which contradicts the research by Eagly and Carli (2003) that implied female supervisors would be more likely to engage in this communal behavior.

**Servant leadership and gender.** According to Eicher-Catt (2005), the words *servant* and *leader* are already gendered concepts with *servant* being associated with the female gender role and *leader* as the male gender role. Eicher-Catt asserted that the combination of *servant leader* accentuates gender bias with servant (female) as an inferior to leader (male) that disadvantages women. However, multiple researchers have found no difference in followers’ ratings of supervisors’ servant leadership related to the gender of the leader (Barbuto & Gifford, 2010; Barbuto & Hayden, 2011; Laub, 1999). Other researchers found that female leaders were more likely than male leaders to favor a servant leadership style (Al-Mahdy, Al-Harthi, & El-Din, 2016; Fridell, Belcher & Messner, 2009; Van Maele & Van Houtte, 2012).

Hogue (2015) analyzed gender bias related to servant leadership and authoritarian leadership styles. Hogue’s results indicated that followers expect female leaders to display servant leadership attributes and male leaders to display authoritarian leadership. Leadership is progressively being defined through more communal language, which has been theorized to reduce disadvantage engendered to women (Eagly & Carli, 2003). However, Hogue (2015) found that individuals with higher scores on hostile sexism were more likely to maintain a definition of leadership as authoritarian and agentic, and to rate
female leaders more harshly. Women may be less disadvantaged if leadership is perceived strictly by a definition now including communal attributes; however, even if leadership definitions shift, gender bias still persists when perceivers hold sexist attitudes (Hogue, 2015).

**Gender bias in leadership.** More research is needed to determine if the differences between men and women are related to the genre of the servant leadership style or more generally related to gender bias associated with women in leadership roles. According to Eagly (2007) women are currently being praised for strong leadership ability but are disadvantaged when it comes to securing leadership positions over men, as people still prefer male over female leaders (Eagly, 2007). Eagly and Carli (2004) asserted that women are faced with two irreconcilable demands. They are expected to engage in communal behaviors because of their gender role but are also expected to engage in agentic behaviors because of expectations inherent in many leadership roles (Eagly, 2007). Women portraying confidence and assertion that is incompatible with communal expectations may be targets of prejudice. When female leaders perform contrary to their expected gender role (e.g., agentic vs. communal behaviors), they are negatively perceived due to the incongruency (Hogue, 2015). In the current study, counseling residents may have expected their male supervisors to display agentic behaviors, and scores may have been inflated for the male supervisors who engaged in communal behaviors like putting subordinates first. Counseling residents may have expected communal behaviors from female supervisors and, as a result, when female supervisors engaged in communal behaviors like putting subordinates first they were
rated unremarkably. Although progress has been made in gender equality in leadership, considerable progress is still needed to fully accomplish this aim (Eagly, 2007).

Implications for counseling. Biases related to gender, culture, or race are ingrained aspects of beliefs and actions that are difficult to overcome but can be addressed through consistent self-reflection and self-awareness (Bernard & Goodyear, 2014). According to the ACA Code of Ethics, “counselors do not condone or engage in discrimination against…clients, students, employees, supervisees, or research participants based on…gender” (ACA, 2014, Standard C.5). Counselors have an obligation to address biases such as gender bias in themselves. Similarly, supervisors are to address multicultural competencies and aspects of culture, race, and gender with supervisees regularly as an expected topic of supervision (ACES, 2011, Standard 6.a.ii.). Issues of prejudice should also be addressed with counselors in training by counselor educators. Counselor educators are gatekeepers for the profession and guard the public from unethical counseling. By bringing issues of prejudice and bias to the attention of counselors-in-training, issues such as sexism or other forms of discrimination could be addressed prior to entering the counseling workforce.

Role Stress

Role stress was represented by two correlated observed exogenous variables: role conflict and role ambiguity. Role conflict was measured by the Role Conflict subscale of the RSS and role ambiguity was represented by the Ambiguity Revised, an altered subscale of the RSS. The results of the research questions pertaining to the impact of role stress on burnout and STS are summarized below and the implications for counselor supervision and education are discussed.
Does role conflict positively predict burnout? I hypothesized that role conflict as measured by the Role Conflict subscale would positively predict burnout as measured by the JB Revised in the Revised CF-S model (hypothesis 5a; Figure 54) and burnout as measured by the CBI in the Revised CBI/STSS model (hypothesis 6; Figure 55). As expected, role conflict positively predicted burnout in the Final CF-S model (Figure 60), and in the Final CBI/STSS model (Figure 66).

Does role conflict positively predict STS? I hypothesized that role conflict as measured by the Role Conflict subscale of the RSS would positively predict STS as measured by the STS Revised in the Revised CF-S model (hypothesis 5b; Figure 54) and STS as measured by the STSS in the Revised CBI/STSS model (hypothesis 7; Figure 55). Role conflict was a significant positive predictor for STS in the Final CF-S model (Figure 60). Role conflict was a significant positive predictor for STS in the Final CBI/STSS model (Figure 66).

Does role ambiguity positively predict burnout? I hypothesized that role ambiguity as measured by Ambiguity Revised subscale of the RSS would positively predict burnout in the Revised CF-S model (hypothesis 8a; Figure 54) and in the Revised CBI/STSS model (hypothesis 9; Figure 55). Role ambiguity significantly predicted burnout in the Final CF-S model (Figure 60). Role ambiguity was also a significant positive predictor for burnout in the Final CBI/STSS model (Figure 66).

Does role ambiguity positively predict STS? I hypothesized that role ambiguity as measured by the Ambiguity Revised subscale of the RSS would positively predict STS as measured by the STS Revised in the Revised CF-S model (hypothesis 8b; Figure 54) and STS as measured by the STSS in the Revised CBI/STSS model (hypothesis 10;
Figure 55). The Ambiguity Revised did not significantly predict STS in either model. Notably, role ambiguity was moderately and negatively correlated with the latent variable of professional self-care in both models ($r = -0.40$), and this may have dampened the variable’s impact on STS. The following section will discuss implications of these results.

**Implications for counselor education.** Culbreth and colleagues (2005) suggested that counselor educators can better prepare counseling students for the diversity of counseling roles they may engage in after graduation. Better preparation may minimize the disequilibrium resulting from the disparity between the counseling role students believe they will acquire post-graduation and the actual roles they assume (Culbreth et al., 2005). Some counseling roles may expand beyond office-based brief counseling sessions to multiple hours of engagement with clients in an in-home therapeutic context or encompass after-hours crisis intervention or even transportation of clients. Exposing students to the possibility of multiple roles may reduce the potential for role ambiguity and role conflict. Internship and Practicum courses can provide students with exposure to an example of a specific counseling role. Requiring students to include an overview of role expectations and responsibilities of their site assignment in case presentations may increase all students’ exposure to the array of roles a counseling position may entail.

**Implications for supervision.** Individuals may cope with role stress by disengaging from communication with individuals who provide conflicting messages (Van Sell, Brief, & Schuler, 1981). Past research has found that counselor trainees reported a decrease in supervision satisfaction when experiencing increased role stress (Olk & Friedlander, 1992). Supervisees may detach from supervisory experiences when
experiencing role conflict or role ambiguity. Supervisors can decrease conflicting messages by communicating openly and working collaboratively with other supervisors or message-senders. Supervisors can decrease role ambiguity by clearly identifying lines of communication and authority, delineating specific role responsibilities, and refraining from dramatically and frequently altering these expectations.

**Implications for research.** This study confirmed that counseling residents do experience role ambiguity and role conflict in their workplace and these phenomena directly predict burnout and indirectly predict STS. More research is needed regarding role stress in counseling as a dearth of recent research exists on the topic. Another research need is the development of a counselor-specific instrument to measure and assess role ambiguity and role conflict among counselors.

**Implications for counseling practice.** This study found that role ambiguity had a moderate negative relationship with PSCS in both the CF-S and CBI/STSS models. This indicates that individuals with strong professional self-care practices experienced less role ambiguity. Importantly, role ambiguity items were the only reverse scored items on the scale, which may have affected the way participants responded. Nevertheless, research has demonstrated that self-care strategies and mindfulness awareness have improved counselors’ tolerance for ambiguity. Bohecker and colleagues (2014) found that counselors-in-training were more likely to tolerate ambiguous situations after being immersed in a mindfulness-based experiential group. Similarly, another study found counselors-in-training who practiced mindfulness-based self-care strategies were more likely to tolerate ambiguity and were less reactive to workplace stressors (Christopher &
Maris, 2010). Counselors who practice self-care regularly may have an increased sense of well-being and be less sensitive to role ambiguity stress.

**Personal Environment**

The personal environment refers to counselors’ individual characteristics and actions. In this study, professional self-care, gender, and survivor status represented the personal environment of the counseling resident in the structural equation models. Below I review the research questions, hypotheses, and results related to the personal environment and discuss implications.

**Professional Self-Care**

Professional self-care practices have been shown to provide a buffer against compassion fatigue, STS, and burnout (Knight, 2013; Sansbury et al., 2015; Thompson et al., 2014). In this study, four research questions pertaining to professional self-care’s impact on burnout and STS were addressed in the context of two structural equation models. Summary of results and implications follow.

**Does professional self-care negatively predict burnout?** I hypothesized that professional self-care as measured by the PSCS would negatively predict burnout as measured by the JB Revised in the Revised CF-S model (hypothesis 11a; Figure 54) and as measured by the CBI in the Revised CBI/STSS model (hypothesis 12; Figure 55). The PSCS significantly predicted JB Revised in the Final CF-S model ($\beta = -0.40$; Figure 60); and the PSCS significantly predicted the CBI in the Final CBI/STSS model ($\beta = -0.38$; Figure 66). These results are similar to Dorociak and colleagues’ (2017) findings of the relationships between the PSCS and the three dimensions of burnout as measured by the MBI-HSS (Maslach & Jackson, 1996).
**Does professional self-care negatively predict STS?** I hypothesized that professional self-care as measured by the PSCS would negatively predict STS as measured by the STS Revised in the Revised CF-S model (hypothesis 11b; Figure 54) and as measured by the STSS in the Revised CBI/STSS model (hypothesis 13; Figure 55). As expected, the PSCS was a significant negative predictor of STS in the Final CF-S model ($\beta = -0.28$; Figure 60) and in the Final CBI/STSS model ($\beta = -0.42$; Figure 66).

The following reviews the components of the PSCS and discusses the implications of these results for clinical practice, clinical supervision, and counselor education.

**Professional support.** The PSCS emphasizes five domains of professional self-care: professional support, professional development, life balance, cognitive strategies, and daily balance. Professional support involves the avoidance of isolation and the cultivation of relationships with supportive colleagues (Dorociak et al., 2017). Counselors have identified collegial support as a protective agent against burnout (Shoptaw, Stein, and Rawson, 2000). In addition, Slattery and Goodman (2009) explored the impact of coworker support on STS and found that positive relationships with colleagues and clinical supervision were important supports for emotional well-being in the workplace. Administrative or dual-role supervisors may consider providing team-building exercises to enhance coworker bonds and shared experiences such as professional development activities.

**Professional development.** Professional development includes staying up to date in professional literature and participating in professional events (Dorociak et al., 2017). According to Maslach and Jackson (1996), burnout is characterized by a diminished sense of personal accomplishment. Similarly, burnout is characterized by a failure of
counselors to perform their job effectively (Lee et al., 2007). Engagement in professional development activities increases clinical knowledge and may bolster counselor confidence and effectiveness. In a recent study, human services professionals who had more self-efficacy-related beliefs were more likely to experience diminished STS and increased secondary posttraumatic growth (Lotfi-Kashani, Vaziri, Akbari, Kazemi-Zanjani, & Shamkoeyan, 2014). Yearly engagement in professional development activities are required for the maintenance of counseling credentials and licensures. Unlicensed counselors do not have the same requirements. Agencies and supervisors that encourage and offer opportunities for professional development activities may increase the effectiveness of services offered and prevent burnout and STS. Agencies that require counselors to meet billable quotas may be reluctant to allow time off for professional development activities. However, if professional development improves the well-being, effectiveness, and retention of currently employed staff, making this sacrifice may benefit agencies by preventing high expenditures for new counselor recruitment and training (Seldon, 2010).

**Life balance.** The Life Balance subscale of the PSCS assesses counselors’ ability to develop a personal life beyond the workplace. In addition, the deterioration of personal life was a strong contributing factor of the CBI. Maintaining an adequate life balance may be challenging for counseling residents to accomplish, and this places them at risk for the deterioration of their personal lives. Inexperienced counselors such as counseling residents are at risk of enmeshment with clients (Ludick & Figley, 2017); and their stage of development is marked by deepened empathy and awareness of clients’ emotional experiences (McNeil & Stoltenberg, 2016), which poses a challenge for maintaining a life
balance. Interestingly, the CF-S scale had an item normally attributed to the burnout subscale cross-loaded on the STS subscale that is related to life balance (*I feel I am unsuccessful at separating work from my personal life*). Counseling residents who endorsed STS more frequently than burnout may have also experienced a difficulty with life balance simply due to their developmental level. Supervisors can monitor supervisees’ self-care strategies outside of the workplace, or process daily rituals that allow for detaching from work at the end of the day.

**Cognitive strategies.** Cognitive strategies include an acknowledgement of emotional and cognitive processes related to stress and coping, and “a proactive approach to managing challenges” (Dorociak et al., 2017). Dorociak and colleagues (2017) also framed cognitive strategies as cognitive awareness. Thompson and colleagues (2014) found that nonjudgmental awareness and emotion-focused coping strategies were effective at preventing burnout and STS. Supervisors of counseling residents can support supervisee development of cognitive awareness through the incorporation of mindfulness techniques, facilitating in-vivo self-reflection, and recommending relevant literature.

CACREP requirements stipulate that counselor educators assess students according to key dispositions (CACREP, 2016, Standard 4.G.) These dispositions relate to the “values, beliefs, interpersonal functioning, and behaviors that influence the counselor’s personal growth and interactions” (CACREP, 2016, p. 47). Self-awareness may be a key disposition for counselor educators to identify, assess, and promote among counselors in training, so that they are more prepared to face personal and professional impediments to wellness and avoid impairment post-graduation.
Daily balance. Daily Balance is the last subscale of the PSCS. Daily balance refers to managing work demands and finding opportunities for replenishment throughout the work day (Dorociak et al., 2017). According to Stoltenberg and McNeil’s (2016) Integrated Developmental Model (IDM) of supervision, recently graduated counselors are at the second level of development and are transitioning to the third stage. The second level of development is marked by a strong ability to focus on and empathize with clients, which may pose challenges for setting appropriate boundaries with clients and can impact stress management throughout the day (Stoltenberg & McNeil, 2016). Supervisors can help supervisees process the interns’ work environment and daily routines to better understand the amount of empathic energy expended and the level of trauma exposure experienced (Merriman, 2015a). Merriman (2015a) also recommended a developmental approach that included compassion fatigue education. Compassion fatigue education includes processing counseling residents’ work satisfaction, daily stress management techniques, social supports, and other risk and protective factors (Merriman, 2015a).

Compassion fatigue education can be woven into a developmental approach when the challenge of counseling work is met with adequate support and guided reflection (Schmidt et al., 2009). Promoting development to the next stage may enhance supervisees’ ability to balance their daily work. To promote development, supervisors may choose to implement the DPE (Schmidt et al., 2009). The DPE includes five core elements to effectively promote development. These include a new role-taking experience that challenges current frames of reference (Schmidt et al., 2009) and reflection on the meaning of this new experience (Lambie & Sias, 2009). Next, sustained continuity is necessary to promote growth (Sprinthall & Scott, 1989), and finally, an
appropriate balance of support and challenge that matches the supervisee’s current developmental needs (Sprinthall et al., 2001) is necessary to promote development. According to Hunt (1971), promoting cognitive development includes providing an individualized, slight mismatch of an individual’s developmental level.

The third stage of counselor development of the IDM is marked by an enhanced level of self-other awareness. The supervisee at this stage is able to focus on the client, maintain an awareness of personal reactions, and utilize both pieces of information in clinical decision-making processes (Stoltenberg & McNeil, 2016). This can strengthen supervisees’ internal boundaries and help them to make protective choices throughout the day when they identify they are having intense personal reactions to client material.

**Are female counseling residents more likely to be survivors of trauma?**

I hypothesized that survivor status would mediate gender’s relationship with STS. I predicted female counseling residents would be more likely to be survivors of traumatic events in the Revised CF-S model (hypothesis 14; Figure 54) and in the Revised CBI/STSS model (hypothesis 15; Figure 55). I completed t-tests to determine if STS differed by gender and the results indicated that there was no significant difference between men’s and women’s experiences of STS. The result of the chi-square, which included both gender and survivor status, was nonsignificant and indicated that men and women were equally likely to experience a traumatic event. As a result, in both the Final CF-S model (Figure 60) and the CBI/STSS model (Figure 66), counseling resident gender did not have an impact on survivor status or STS. Implications for these results should be drawn with caution. The sample of counseling residents in this study consisted of a substantially smaller proportion of male residents than female residents. This imbalance of group size may have reduced the power in the analysis.
**Implications for practice and supervision.** These results differed from previous findings that women were more likely to experience STS than men (Adams et al., 2008, Ivicic & Motta, 2017, Robinson-Keilig, 2014, Thompson et al., 2014), and that women were more likely to be survivors of traumatic events (Hensel et al., 2015). The results of the current study indicated that male and female counseling residents may experience STS at similar rates and equally need to be monitored for symptoms of STS. A study was conducted exploring counseling trainees’ help-seeking behaviors. Female counseling trainees had significantly more positive attitudes towards help-seeking behaviors than male counseling trainees in the sample (Pfohl, 2011). In addition, the effect size (Cohen’s d) was moderate to large (d = 0.67; Pfohl, 2011). In the same study, gender was also a significant predictor of actual psychological help-seeking behavior, and men were less likely to seek help than women (Pfohl, 2011). Even though male and female counseling residents may experience STS at similar rates, men may be less likely to vocalize concerns than women.

Unfortunately, clinical supervisors may not be facilitative of male supervisees’ help-seeking behavior or female independence. Nelson and Holloway (1990) found that supervisors were more likely to endorse male supervisees’ self-enhancing or assertive statements rather than self-effacing or docile statements. In addition, Hindes and Andrews (2011) found that supervisors have different strategies with their male and female supervisees. In the authors’ study, supervisors were more likely to take a directive approach and provide support and guidance to female rather than male supervisees; whereas supervisors were more likely to ask male rather than female supervisees for their opinion and provide autonomy-promoting responses (Hindes & Andrews, 2011).
addition, gender bias was identified in male supervisors. Male supervisors were more likely to rate supervisees negatively when the supervisee was depicted as female rather than when the supervisee was depicted as male (Hindes & Andrews, 2011). These gender-biased approaches restrict female supervisees from advancing into independent and confident counselors and may prevent male supervisees from asking for help and support when they need it.

Supervisors can create an open and safe space for supervisees by reflecting on their own gender bias and gaining awareness of different strategies they may implement with supervisees based on gender. Supervisors can also help all supervisees process STS related symptoms through self-awareness, a strong SWA, and attunement to the individual differences of supervisees (Bernard & Goodyear, 2014). In addition, trauma-sensitive supervision provides opportunity to discuss the impact of clinical work, validation of feelings, and direct addressing of STS through a strength-based approach (Sommer, 2008). Merriman (2015b) recommended that supervisors provide compassion fatigue education to all supervisees and normalize asking for and accepting help.

**Do survivors of traumatic events experience a higher level of STS than non-survivors?**

The results of this study indicated that men and women did not differ significantly according to survivor status. I hypothesized that survivors of traumatic events would be more likely to experience STS than non-survivors in the Revised CF-S model (hypothesis 16; Figure 54) and in the Revised CBI/STSS model (hypothesis 17; Figure 55). This study found that survivors of traumatic events were more likely to experience STS in the Final CF-S model ($\beta = -0.12$; Figure 60) and the Final CBI/STSS model ($\beta = -0.11$;
Figure 66). This confirmed results from previous research that indicated that personal experiences with trauma affected sensitivity to clients’ traumatic material and created an increased vulnerability to STS (Hensel et al., 2015). It is important to note that the current study found very weak and insubstantial predictions.

In this study, survivors of trauma had a negligible impact on STS in both final models. This may be due to the high incidence of trauma among the study’s participants, which resulted in disparate group sizes. On the other hand, trauma survivors may experience only a minor increase in risk for STS. Because of the small difference in STS among survivors and non-survivors, the variance in STS may be better accounted for by more relevant predictors such as burnout and role conflict. Future research should continue to explore what impact survivor status may have on the development of STS.

**Implications for counselor education.** Most of the sample in the current study were survivors of trauma (72%), which reflected the national average. According to the Sidran Traumatic Stress Institute (2016), 70% of adults are survivors of at least one traumatic event. This percentage increases when prevalence rates are assessed among users of mental health services. Ninety-four percent of community mental health clients report one lifetime event of trauma (Switzer, Dew, Thompson, Goycoolea, Derricott, & Mullins, 1999). Trauma is also ubiquitous across populations and presenting problems, and is relevant to substance abuse, marriage and family, and school counseling specialties (e.g., Gold, 2008; Mendelson, Tandon, O’Brennan, Leaf, & Ialongo, 2015; Morgan, Denison-Vesel, Kobylarz, & Voelkner, 2015; Patton, Lau, Blow, Ranney, Cunningham, & Walton, 2015; Scott, Dennis, & Lurigio, 2015). CACREP (2016) requires counseling programs to train students in trauma-related curricula; however, a recent study found one-
third of the recently-graduated respondents reported no trauma-related counseling skills preparation provided by their counseling program (Wachter Morris & Barrio Minton, 2012). This study also found the number of clock hours of trauma-related preparation was positively correlated with crisis counseling self-efficacy (Watchter Morris et al., 2012). Trauma competencies are recent additions to CACREP standards, and counselor educators may feel hesitant to educate counseling students on a topic they may not have received training for (Watkins Van Asselt, Soli, & Berry, 2016). Considering the high incidence of trauma, and the slight increase in likelihood of counselor survivors to experience STS, education regarding effective trauma training and prevention of STS are a crucial part of counselor education.

**Implications for supervision.** Clinical supervisors can provide trauma-sensitive supervision to supervisees. Sommer (2008) recommended four components of effective trauma-sensitive supervision: a theoretical foundation of trauma therapy, discussions regarding the conscious and unconscious impact of counseling work, a safe and respectful supervisory atmosphere, and direct education of STS and relevant protective factors. Educators and supervisors must also engage in professional development activities including reviewing relevant literature and attending trainings (e.g., conferences, workshops) to gain confidence in trauma competencies and to prepare new counselors for the high population of trauma-related issues they will encounter in practice.

**Client Environment**
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Caseload and Trauma Clients were the two variables representing client environment. Participants were asked to estimate the number of hours per week they are engaged in direct counseling services to quantify caseload size. Participants also estimated the hours per week they spend providing counseling services to survivors of trauma (Trauma Clients).

**Does Caseload Positively Predict Burnout?**

I hypothesized that caseload as measured by the hours per week engaged in direct counseling services would positively predict burnout in the Revised CF-S model (hypothesis 18; Figure 54) and the Revised CBI/STSS model (hypothesis 19; Figure 55). The results of the study indicated that caseload did not significantly predict burnout in either final model (see Figures 60 and 66). This did not corroborate consistent findings in the literature related to the association between high caseloads and increased burnout (Acker & Lawrence, 2009; Knight et al., 2012; Knudsen et al., 2008). Previous studies asked about the number of clients on the counselor’s caseload (Acker & Lawrence, 2009; Knudsen et al., 2008), rather than hours per week. I decided to incorporate hours per week rather than number of clients because a large number of clients does not necessarily imply that all clients are seen at the same frequency. Research does indicate this to be an important variable in understanding burnout. Continued research is needed to understand the role of caseload and workload in counselor burnout.

**Do the Hours Spent Providing Trauma-Related Counseling Positively Predict STS?**

I hypothesized that the hours spent providing trauma-related counseling as represented by the variable, Trauma Clients, would positively predict STS in the Revised CF-S model (hypothesis 20; Figure 54) and in the Revised CBI/STSS model (hypothesis
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21; Figure 54). In the CF-S model and the CBI-STSS model, Trauma Clients did not significantly predict STS (see Figures 60 and 66). This was surprising, because STS directly results from time spent with traumatized clients. This also contradicted Bober and Regehr’s (2006) finding that the number of hours per week counselors spend with trauma survivors was associated with STS symptoms. Similar findings were corroborated by other studies (e.g., Hensel et al., 2015; McKim & Smith-Adcock, 2014). Although this was not a significant finding in this sample, it is still an important variable to consider when investigating STS because the phenomenon presumes indirect exposure to trauma through clients’ traumatic material.

**Trauma Clients**

Trauma Clients and Caseload shared 36% of the variance in both the Final CF-S model (Figure 60) and the Final CBI/STSS model ($r = 0.60$; Figure 66). This was not a hypothesized relationship; however, it can be explained by common method variance. Both variables were assessed by asking participants to report weekly hours. Also, the hours spent engaged with clients offers greater opportunities to interact with trauma survivors. Trauma Clients was assessed by having the counselor identify how many hours they spent with clients who had experienced a traumatic event. Researchers have found that in a clinical population, the number of trauma survivors may be as high as 94% (Switzer et al., 1999). However, counselors may be addressing a presenting problem unrelated to the traumatic event. This may have been a limitation in measuring the level of indirect exposure to trauma, which may have prevented a true understanding of the relationship between STS and Trauma Clients. The relationship between Trauma Clients and STS should be further explored by measuring how many hours counselors spend
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discussing clients’ traumatic events to assess the actual level of indirect trauma exposure. STS is theorized to be a result of prolonged exposure to clients’ traumatic material. However, if no relationship between these two variables exists as the results of this study indicate, then future researchers should explore other antecedents of STS to include a prior history of burnout.

Caseload

The results of this study indicated that the number of hours per week that counselors spend with clients did not impact burnout. This contradicts a consist body of literature that suggests that caseload does precipitate burnout (Bober & Regehr, 2006; Knight, 2010; McKim & Smith-Adcock, 2014). Although caseload size may not readily contribute to burnout, future researchers may want to explore work associated with caseload size such as amount of paperwork and other associated duties (e.g., client transportation, emergency on-call services).

A strong relationship was found in this study between professional self-care and burnout. In addition, role ambiguity and role conflict contributed to burnout and STS. The client environment had no impact on burnout or STS. These results indicate that counselors may not be fatigued by the number and type of clients they are seen. Counselors should focus on developing consistent professional self-care practices and addressing stressors in the work environment to prevent burnout and STS.

Final Research Questions and Hypotheses

The last hypotheses relate to the interactions of the outcome variables and the comparison between the Final CF-S model (Figure 60) and the Final CBI/STSS model.
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(Figure 66). This section reviews the results that address these research questions. Implications of these findings for counselor supervision and education are summarized.

**Are STS and Burnout Positively Correlated?**

In the Revised CF-S model, I hypothesized that STS as measured by the STS Revised and burnout as measured by the JB Revised would be positively correlated. Burnout and STS were predicted by several of the same endogenous variables; therefore, this correlation was implied rather than graphically shown in the Revised CF-S model (hypothesis 22a; Figure 54). Similarly, I hypothesized that STS as measured by the one-factor STSS and burnout as measured by the CBI would be positively correlated (hypothesis 22b). This was also implied rather than graphically depicted (see Figure 55).

The results of this study indicated that STS and burnout may be two separate, yet related, phenomena, rather than two aspects of the overarching construct of compassion fatigue. Results also indicated that burnout may be a predictor of STS. This supported longitudinal research by Shoji and colleagues (2015). Shoji and colleagues investigated the directional relationship between STS and burnout with psychologists, counselors, and social workers who were currently providing counseling services to U.S. military personnel who had experienced indirect trauma exposure. Results indicated that burnout assessed at one point in time predicted STS measured six months later (Shoji et al., 2015). However, STS at time one did not predict burnout assessed at time two (Shoji et al., 2015). Counseling residents with indirect exposure to traumatic material and experiencing burnout may be more vulnerable to develop STS over extended time.

A general stress framework may provide clarity on this unidirectional relationship. According to the conservation of resources (COR) theory, continued
exposure to stressors combined with a depletion of personal and environmental resources are catalysts for emotional exhaustion or burnout (Shoji et al., 2015). Exhaustion further diminishes the resources available to counselors to cope with continued exposure to indirect trauma and stressors (Shoji et al., 2015). The current study indicated that role ambiguity and role conflict are environmental stressors that may diminish resources and lead to the development of burnout. Both stressors also indirectly impact STS through the mediation of burnout (see Figure 60 and 66). In addition, results indicated that professional self-care can provide needed resources for counseling residents to find restoration and protect against the development of burnout. In protecting against burnout, counseling residents may also be shielding themselves from the development of STS. Also, a servant leadership style of supervision had a moderate negative influence on the NWE subscale of the CBI ($\beta = -0.42$; Figure 66). This indicated that servant leadership may provide an environmental resource that influences a more positive work environment. Counseling residents should be aware of the resources and stressors in their personal and professional environments to reduce their vulnerability to burnout and ultimately STS. By tipping the scale in favor of increased resources, counseling residents can increase their sustainment in difficult work.

**Does the Final CBI/STSS Model have a Better Model Fit than the Final CF-S Model?**

I hypothesized that the Final CBI/STSS model would have a better model fit than the Final CF-S model because of the difference in outcome variable measurement (hypothesis 23). The CF-S measurement model had zero degrees of freedom, which I predicted would impact the overall model fit. However, the CF-S measurement model did
not fit the data as anticipated; through EFA I identified two subscales that fit the data best as two observed and correlated variables. I also hypothesized that the Final CBI/STSS model would have a superior fit because the STSS better reflects the operational definition of STS as the equivalent symptoms of PTSD, except that the trauma was experienced indirectly. The STS Revised does not assess specific symptoms related to PTSD as the STSS does. Nevertheless, the Final CF-S model (Figure 60) had a superior fit compared to the Final CBI/STSS model (Figure 66). This indicated that the predictors accounted for the variance in the STS Revised and the JB Revised better than they accounted for the variance in the CBI and the STSS. Perhaps this occurred because the CBI and STSS had more variance to account for than the CF-S, as the CBI is a substantially larger and more complicated measurement model than the observed variable of the JB Revised. The CBI added an additional latent variable to the model, which required more power and a larger sample size to accurately estimate. The Final CBI/STSS model (Figure 66) had a power of 0.16. This negligible power may have resulted in a model that was an inferior fit compared to the Final CF-S model (Figure 60).

**Implications for Supervision**

According to *Best Practices in Clinical Supervision* (ACES, 2011), supervisors are required to engage in and model self-care practices for supervisees and avoid professional stagnation and burnout (Standard 7.b.vi. and Standard 11.d.xiii). If supervisors do not value or practice wellness principles, it will be difficult to transmit these values to supervisees. Clinical supervisors can instill wellness values throughout consistent supervision discussions and joint dialogue regarding what both members of the dyad are currently engaging in to promote professional wellness. Administrative
supervisors can also work to instill wellness as an agency-wide value, monitor supervisees for signs of impairment, and offer practical solutions such as time off, documentation reprieve, or opportunities for personal counseling (Knight, 2010). In addition, allowing time for professional development workshops related to self-care, wellness, or mindfulness strategies is an alternate way to promote wellness as a principle in the organizational culture. It has been said that self-care is not a luxury, but a professional mandate. In fact, engaging in self-care and avoiding impairment is an ethical imperative for supervisors and counselors alike (ACA, 2014, Standard §C Introduction). Modeling and instilling these values in inexperienced counselors early in their careers may prevent unethical counseling services and promote their retention in the field. In addition, supervisors should inquire about and monitor supervisees for signs of STS or burnout, with the knowledge that burnout may develop into STS over time.

Implications for Counselor Education

Counselor educators are also role models in demonstrating wellness values for future counselors. CACREP (2016) requires education related to working with victims of trauma and counselor self-care. Currently, language is lacking within the CACREP 2016 standards that explicitly addresses vicarious trauma and counselor impairment. The high work demands of the mental health field, indirect trauma, and the inexperience of new counselors are all reasons to prioritize the education of burnout, STS, and avoiding impairment. Counseling students also learn through counselor educators’ presentation of material and actions how important wellness is in the counseling profession. Counselor educators can initiate classroom discussions and periodic check-ins related to students’ habitual self-care practices and counseling programs can offer extracurricular workshops
related to the topic. In this way, students may have a strong foundation and intrinsic value of wellness as a preventative measure prior to graduation.

**Limitations**

Several limitations were present in this study that impact the integrity and generalizability of the results. I sent the survey to 5,498 registered interns and a total of 393 respondents accessed and began the survey on Qualtrics for a response rate of 7.15%; however only 241 surveys were usable. This was a non-random sampling method, which negatively affects the sample’s representativeness of the population (Creswell, 2014). In addition, this very low response rate cannot adequately represent the population of counseling residents. Furthermore, the sample had a large representation of white female counseling residents and results of the study may not be readily generalized to individuals outside of this population.

The low response rate yielded a small sample size for the structural equation models. The survey was sent out the week before Thanksgiving and again in the beginning of December during the holiday season; this may have contributed to the low response rate. The a priori power analysis indicated a minimum sample size requirement of 538 participants. With a sample size of 241, an effect size of 0.10, and an alpha level of 0.05, the Revised CF-S model (Figure 54) had a power level of 0.29. With the same sample size, effect size, and alpha level, the Revised CBI/STSS model (Figure 55) had a power level of 0.16. This is far below the desired power level of 0.80. Insufficient power reduces the ability of the statistical test to detect significance when it exists (Warner, 2013). With a small sample size and low power level, results of this study should be
interpreted with caution. Future researchers who attempt to replicate this study should recruit a larger and more diverse sample.

All instruments utilized in the study relied on a Likert scale rating system. This common instrumentation may have created biases in the way participants responded to items on the multiple scales. Common method variance is the variance attributed to the measurement method, rather than the variables the instruments intend to measure (Podsakoff et al., 2003). In addition, participants may have been aware of theoretical relationships between the assessed variables and answered questions with this information in mind. It is possible that this could have resulted in illusory correlations (Podsakoff et al., 2003). Participants may also have responded to items in a socially-acceptable manner, particularly as it relates to the PSCS. Counselors who understand the ethical mandates of self-care may have responded based on social desirability rather than honest self-assessment. Also, the survey was lengthy and participant fatigue may have impacted responses.

Another limitation is that individuals who had greater work-related stress (e.g., burnout, secondary traumatic stress) and a larger workload may have been less likely to participate in the lengthy survey. Similarly, individuals with greater interest in the topic may have been more likely to participate. A risk in online survey distribution is that individuals who choose to respond to the survey may differ systematically from those who choose not to participate. This results in a non-probability sample constitution that does not adequately represent the target population.

Another limitation is that some of the data were non-normally distributed. Although SEM is robust and allows for measurement error, the analyses utilized in the
study were reliant on linear relationships that are best calculated with normally
distributed data. Also, it is important to note that the results of multivariate analyses are
unique to the particular combination of variables utilized. Researchers that add or
eliminate a variable from the combination could anticipate different results than those of
this study.

Servant leadership had negligible interactions with the outcome variables.
Although the construct may have a minor impact on counselor wellness, significance may
have failed to be detected due to multicollinearity, insufficient sample size or power, or
the presence of more important predictors. In addition, the SLS was created for managers
in a corporate work environment rather than for counseling professionals or clinical
supervisors. The wording of some items may not easily parallel the relationship of a
counselor with a supervisor; whereas all other scales were designed for counselors or
helping professionals. With a more targeted instrument, larger sample size, or a different
combination of predictors, servant leadership may be more impactful on counselor
wellness.

In addition, the measurement models of multiple constructs did not fit the data as
expected. Paths theorized in the Hypothesized CF-S model (Figure 6) assumed the
existence of compassion fatigue. However, this measurement model did not fit the data as
expected resulting in compassion fatigue not being present in the Revised CF-S model
(Figure 54) that was tested. The STSS scale also was used as a one-factor model even
though the best fit for the data was a two-factor model. This was because the strong
correlation between the two factors implied that they shared an underlying phenomenon.
However, the two-factor latent variable of STS could not be identified as a two-indicator
measurement model or estimated beyond a first-order model. In addition, the RSS had an erroneously utilized item in place of a correct item. These difficulties in configuring measurement models may have affected the overall model fits.

Finally, the design of this study makes path predictions, but cannot imply causality with certainty. All data were obtained at one point in time, rather than longitudinally, which would better demonstrate the existence of one variable prior to another variable. All inferences of causality were made by analyzing the relationships between variables as established in prior research and by determining the variables that would logically occur prior to the existence of the outcome variables (Keith, 2015).

**Avenues for Future Research**

This study investigated the relevance of a servant leadership supervisory style as a predictor of burnout and STS in the context of other relevant variables in counseling residents’ work, personal, and client environments. Future researchers who investigate servant leadership’s impact on compassion fatigue should keep in mind that compassion fatigue is a multivariate phenomenon, and the perception of one’s supervisor cannot realistically be isolated from other variables present in counselors’ environments. The variables included in the current study’s multivariate analysis seemed to overpower the influence of servant leadership. Future researchers may consider including another combination of variables and using a larger sample.

Also, the SLS and other instruments that assess servant leadership were developed in the context of corporate leadership that is divergent in many ways from counselor clinical supervision. While counseling residents were able to assess their supervisors with the SLS and the instrument held its integrity through a CFA and expected bivariate
relationships with the SLS could be detected, a servant leadership instrument tailored to
the clinical supervisor’s role may be more powerful in accurately assessing the construct
in the counseling profession.

Furthermore, leader gender was relevant to this study’s investigation. Future
researchers may consider assessing attitudes towards supervisors related to other
demographic variables such as age, race, and ethnicity. Results are equivocal regarding
followers’ perceptions of servant leadership regarding supervisors’ gender. Although this
study identified biased results, further research is needed to determine if servant
leadership disadvantages women, or if prejudice against women is present despite the
model of leadership. This could be accomplished by asking respondents to assess their
supervisors according to a variety of leadership styles. Assumedly, personal gender bias
would persist across all leadership styles, whereas an intrinsic bias in the servant
leadership construct may remain consistent across respondents’ ratings with regard to
servant leadership specifically.

This sample represented a high population of white female participants. Although
a large proportion of white females reflect counselor demographics, studies that include
predominantly white participants underrepresent the experiences of minorities. Future
researchers should be intentional about recruiting a more diverse sample to better
represent all ethnicities.

Finally, further clarification of the construct of compassion fatigue is needed. An
intention of the study was to provide clarification regarding whether compassion fatigue
exists as a latent variable with two components: burnout and STS, or whether compassion
fatigue does not exist, with burnout and STS being separate but related constructs. In the
current study, compassion fatigue did not exist as a latent variable and burnout and STS had to be analyzed as separate phenomena. Nevertheless, further research is needed to clarify the construct through replication. Future studies utilizing the CF-S or any measure of compassion fatigue should be intentional about confirming the measurement model prior to conducting further analyses. Otherwise, results may be erroneously interpreted based on the assumed presence of the potentially nonexistent latent variable of compassion fatigue. A two-indicator measure is not ideal for construct measurements and at least three-indicators are recommended (Keith, 2015). Future researchers may consider utilizing the ProQOL (Stamm, 2010), which measures professional quality of life and consists of three factors: STS, burnout, and compassion satisfaction.

**Summary and Conclusion**

This study utilized SEM to test two models based on the professional quality of life model (Stamm, 2010). According to this model, compassion fatigue occurs as a result of variables in counseling residents’ work, personal, and client environments. I incorporated servant leadership of counseling residents’ supervisors as an aspect of counseling residents’ work environment; this was the first study to analyze servant leadership in the field of counseling. The results of this study confirmed some previous research findings, contributed some equivocal findings, and broached the use of formal leadership models in the field of counseling. This study confirmed previous research by indicating that professional self-care is a necessary resource for preventing burnout and STS indirectly. In addition, role ambiguity and role conflict contribute directly to counselor burnout and indirectly to counselor STS, survivors of trauma have a slight increase in risk for STS compared with non-survivors, and burnout can leave counseling
residents vulnerable to the future development of STS. Contrary to previous research, this study did not find a relationship between client contact frequency (Caseload) and burnout, or a relationship between trauma client contact frequency (Trauma Clients) and STS. This study found that servant leadership may contribute to a more positive counseling work environment, and that counseling residents perceived male supervisors to put subordinates’ needs first significantly more than female supervisors. Several limitations were present in this study and more research on compassion fatigue and servant leadership is needed with a larger sample size and a servant leadership instrument that is more applicable to the counseling profession. Counselor supervisors and educators play critical roles in exemplifying self-care and wellness values and in educating counselors regarding counselor impairment.
Appendix A

Institutional Review Board Proposal

Protocol Title

The serving supervisor: Supervisor servant leadership as a protective factor for counseling residents’ burnout and secondary traumatic stress

Purpose of Study

The purpose of the proposed cross-sectional study is to investigate the power of the client environment, personal environment, and work environment to predict compassion fatigue, when the personal environment is represented by professional self-care, gender, and survivor status, the client environment is represented by percent of trauma cases and size of caseload, and the work environment is represented by role ambiguity, role conflict, and perceived servant leadership traits of supervisors. Among others, the proposed study explored the following research questions: (a) Does the perceived servant leadership of supervisors negatively predict compassion fatigue of counseling residents? (b) Does the perceived servant leadership of supervisors negatively predict the counselor burnout of counseling residents? (c) Does the perceived servant leadership of supervisors negatively predict the STS of counseling residents? (d) Does the perceived servant leadership of female supervisors and the perceived servant leadership of male supervisors differ significantly?

Data Collection and Instrumentation

This study utilizes a survey research design with a convenient sample of unlicensed, postgraduate, supervised counselors. Participants will be recruited through a published list found on the Florida Board of Counseling website. All participants will
receive an email through Qualtrics that invites their voluntary participation in the survey. If they complete the study after the first invitation, they will not receive any more communication. If they do not respond, a second email will be sent. If they respond to the second email, they will not receive a third. If they do not respond to the second email, they will receive a third and final email. All of the emails are written based on Tailored Design Method recommendations (Dillman et al., 2007). Participants can click a link in the email to stop receiving the invitations at any time.

The survey was administered through Qualtrics. Participants completed a demographic questionnaire that inquired about licensure status, graduation status, type of counseling, weekly hours of direct client service, weekly hours spent counseling trauma clients, ethnicity, gender, hours of trauma training, survivor of traumatic event status, and age. The other instruments used in the study include the STSS (Bride, Robinson, Yegidis, & Figley, 2004), the Counselor Burnout Inventory (CBI; Lee et al., 2007), the Compassion Fatigue Short Form (CF-S; Adams et al., 2006), the SLS (Liden, R.C., Wayne, S.J., Zhao, H., & Henderson, D. (2008), the Role Stress Scale (Rizzo, House, & Lirtzman, 1970), and the Professional Self-Care Measure (Dorociak, Rupert, Bryant, & Zahniser, 2017).

**Data Analysis**

I will first analyze all measurement data for descriptive statistics including measures of central tendency, standard deviations, minimum and maximum values, and measures of kurtosis and skewness in order to identify any abnormalities in the data. I will also analyze the relationships between individual variables through correlations and bivariate relationships in early diagnostics. I will also run multiple Confirmatory Factor
THE SERVING SUPERVISOR

Analyses (CFA) to identify if all measurement models fit the data as originally theorized by the instrument designers. The proposed theoretical models will then be tested through Structural Equation Modeling (SEM).

In this study, I will use IBM SPSS and the add-on program, Amos 21 (Arbuckle, 2012), to conduct SEM and to determine the impact of supervisor servant leadership on counseling residents’ compassion fatigue, burnout, and STS in the presence of other relevant variables. The $\chi^2$, the CMIN, RMSEA, CFI, and TLI will be interpreted and reported. This will then be repeated for the second hypothesized model.

The two non-nested models can be compared by analyzing the Akaike Information Criterion (AIC), Bayesian Information Criterion (BIC), and the Expected Cross-Validation Index (ECVI). The better-fit will be determined by the model that has the smaller fit index. Because the models differ by endogenous latent variables (CF-Short, CBI, STSS), the relationships between these variables will be explored to include the level of shared variance. I will also determine if the ratings of counseling residents’ male and female supervisors differ significantly and the effect of agency setting on counselor compassion fatigue, burnout, and STS.

Participants

The target population for this study comprises counseling residents in Florida. In this state, counseling residents are referred to as Registered Mental Health Interns (RMHI). Inclusion criteria includes masters-level, unlicensed, and post-graduate counselors currently providing counseling services and receiving supervision. The Florida Board of Counseling has a full published list of the RMHIs’ email addresses.
available for research purposes. I will email the Qualtrics survey to 5,198 of the 5,620 RMHIs who have published email addresses available.

**Privacy and Confidentiality**

Participants will be informed that their participation and involvement in the study is voluntary and they may refuse to participate before the study begins, discontinue involvement at any time, and skip questions that make them feel uncomfortable without penalty. Participants’ responses will remain confidential and anonymous. No identifying information will be collected, and each participant will be assigned an ID number. Also, all participant information will be stored on a secure, password protected computer.

**Results**

Results of the study will not be communicated to participants. However, the results of the study will be submitted for presentations and publications and could be reviewed by participants through these avenues.

**Consent Form**

After a participant visits the survey on the Qualtrics website, they will review a description of the study. At the bottom of this page, they will be asked whether or not they agree to participate. If they agree, they will be directed to the next page to start the survey. The consent form is included below.

You have been invited to participate in a research study titled Supervising from Behind: A Servant Leadership Model for Predicting Compassion Fatigue Among Post-Graduate Unlicensed Counselors being conducted by Colleen Grunhaus, LPC, NCC, ACS from the College of William and Mary.

**Purpose:** The purpose of this study is to explore the effectiveness of a servant leadership
supervisory style in preventing or alleviating compassion fatigue among unlicensed, postgraduate counselors under supervision.

**Incentive for Participation:** Participants that complete the survey will have the option to have their name entered into a raffle to win one of 4 $25 Amazon gift cards.

**Duration of Participation:** The survey will take approximately 15-20 minutes to complete.

**Confidentiality:** The survey is anonymous and your participation is confidential. Please do not type your name anywhere on this survey. Your data will not be associated with your name or any code so that your responses cannot be linked to your name in any way.

**Voluntary Participation:** Your participation in the research is voluntary. You may refuse to participate, discontinue involvement in the study at any time, or skip any questions that may make you feel uncomfortable without any penalty or consequence to you or your relationship with the university.

**Discomforts and Risks:** There are no known risks associated with this study. You will be simply asked to respond to several survey items. However, if any questions do bring up feelings of discomfort that you would like to talk with a professional therapist about, you can find a therapist in your area at https://therapists.psychologytoday.com/rms.

**Training and Experience:** Colleen Grunhaus is a third-year doctoral student at the College of William and Mary. She is currently up to date with her Collaborative Institutional Training Initiative (CITI) training. Colleen has also completed Research Methods, Intermediate Statistics, and Advanced Statistics doctoral level classes.

If you have any questions regarding this study, you can contact Colleen Grunhaus at cmgrunhaus@email.wm.edu at any time. If you have additional questions or concerns regarding your rights as a study participant or are dissatisfied at any time with any aspect
of this study, you may contact Dr. Thomas Ward, chair of the Protection of Human Subjects Committee at the College of William and Mary at tom.ward@wm.edu or by telephone (757 - 221 - 2358). This project was found to comply with appropriate ethical standards and was exempted from the need for formal review by the College of William and Mary protection of human subjects committee (phone 757-221-3966) on ______ and expires on _________.

Thank you for considering to participate in this study! Once you have selected the response below, click the link below labeled “Next Page”.

Do you agree to participate in this study?

Yes (This response will direct you to start the study)

No (This response will close out the study)
Appendix B

Demographic Questionnaire

1. Have you graduated from a Masters-level counseling program?
   a. Yes
   b. No

2. Are you currently employed in a counseling position?
   a. Yes
   b. No

3. Are you currently a licensed counselor?
   a. Yes
   b. No

4. Please estimate the hours of trauma training you have received. __________

5. Including practicum or internship experience in graduate school, how long have you been a counselor? (for example, 1.5 years) ________

6. What is your age? ________

7. Was your counseling program CACREP accredited?
   a. Yes
   b. No

8. Please indicate your gender.
   a. Male
   b. Female
   c. Transgender
   d. Other
9. Please indicate your race.
   a. White
   b. Hispanic, Latino, or Spanish
   c. Black or African American
   d. Asian
   e. American Indian or Alaska Native
   f. Middle Eastern or North African
   g. Native Hawaiian or Other Pacific Islander
   h. 2 or more races (Multi-racial)
   i. Race/ethnicity unknown

10. What best describes your place of employment?
   a. Private Practice
   b. Community Mental Health Outpatient
   c. Intensive In-Home
   d. Residential/Psychiatric Inpatient
   e. Higher Education Academic Setting
   f. Corrections
   g. Employee Assistant Program (EAP)
   h. K-12
   i. Other
Appendix C

Secondary Traumatic Stress Scale

The following is a list of statements made by persons who have been impacted by their work with traumatized clients. Read each statement than indicate how frequently the statement was true for you in the past seven (7) days by circling the corresponding number next to the statement.

NOTE: “Client” is used to indicate persons with whom you have been engaged in a helping relationship. You may substitute another noun that better represents your work such as consumer, patient, recipient, etc.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Never</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Often</th>
<th>Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I felt emotionally numb………………………………………..</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. My heart started pounding when I thought about my work with clients………………………</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. It seemed as if I was reliving the trauma(s) experienced by my client(s)……………………</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. I had trouble sleeping………………………………………</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. I felt discouraged about the future…………………………</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. Reminders of my work with clients upset me………………..</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. I had little interest in being around others………………</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. I felt jumpy………………………………………………</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. I was less active than usual……………………………...</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. I thought about my work with clients when I didn't intend to………………………………</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. I had trouble concentrating……………………………...</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. I avoided people, places, or things that reminded me of my work with clients………………………………</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13. I had disturbing dreams about my work with clients………</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>14. I wanted to avoid working with some clients…………….</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>15. I was easily annoyed………………………………………</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
16. I expected something bad to happen………………….. 1 2 3 4 5

17. I noticed gaps in my memory about client sessions……… 1 2 3 4 5

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Intrusion Subscale (add items 2, 3, 6, 10, 13) Intrusion Score _____
Avoidance Subscale (add items 1, 5, 7, 9, 12, 14, 17) Avoidance Score _____
Arousal Subscale (add items 4, 8, 11, 15, 16) Arousal Score _____
TOTAL (add Intrusion, Arousal, and Avoidance Scores) Total Score _____

# Appendix D

## Counselor Burnout Inventory

<table>
<thead>
<tr>
<th>How Often:</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Never</td>
<td>A few times a year or less</td>
<td>Once a month or less</td>
<td>A few times a month</td>
<td>Once a week</td>
<td>A few times a week</td>
<td>Every day</td>
</tr>
</tbody>
</table>

1. ________ I do not feel like I am making a change in my clients.
2. ________ I am not confident in my counseling skills.
3. ________ I feel frustrated by my effectiveness as a counselor.
4. ________ I feel I am an incompetent counselor.
5. ________ I feel frustrated with the system in my workplace.
6. ________ I feel bogged down by the system in my workplace.
7. ________ I feel negative energy from my supervisor.
8. ________ I am treated unfairly in my workplace.
9. ________ I feel I have poor boundaries between work and my personal life.
10. ________ I feel I do not have enough time to spend with my friends.
11. ________ I feel like I do not have enough time to engage in personal interests.
12. ________ My relationships with family members have been negatively affected by my work as a counselor.
13. ________ I am not interested in my clients and their problems.
14. ________ I have become callous toward clients.
15. ________ I have little empathy for my clients.
16. ________ I am no longer concerned about the welfare of my clients.
17. ________ Due to my job as a counselor, I feel tightness in my back and shoulders.
18. ________ Due to my job as a counselor, I feel overstressed.
19. ________ I feel exhausted due to my work as a counselor.
20. ________ Due to my job as a counselor, I feel tired most of the time.
Incompetence (1-4), Negative Work Environment (5-8), Deterioration in Personal Life (9-12), Devaluing Client (13-16), Exhaustion (17-20)

Appendix E

How Often: 

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Never True</td>
<td>Rarely True</td>
<td>Sometimes True</td>
<td>Usually True</td>
<td>Frequently True</td>
<td>Always True</td>
</tr>
</tbody>
</table>

**Role Stress Scale**

1. ______ I have enough time to complete my work. (Ambiguity)
2. ______ Clear, planned goals and objectives for my job. (Ambiguity)
3. ______ I have to do things that should be done differently. (Conflict)
4. ______ I know that I have divided my time properly. (Ambiguity)
5. ______ I receive an assignment without the manpower to complete it. (Conflict)
6. ______ I know what my responsibilities are. (Ambiguity)
7. ______ I have to buck a rule or policy in order to carry out an assignment.
   (Conflict)
8. ______ I work with two or more groups who operate quite differently. (Conflict)
9. ______ I know exactly what is expected of me. (Ambiguity)
10. ______ I receive incompatible requests from two or more people. (Conflict)
11. ______ I do things that are apt to be accepted by one person and not accepted by others. (Conflict)
12. ______ I receive an assignment without adequate resources and materials to execute it. (Conflict)
13. ______ Explanation is clear of what has to be done. (Ambiguity)
14. ______ I work on unnecessary things. (Conflict)

Appendix F

Servant Leadership Scale (SL-28)

Section A. In the following set of questions, think of your immediate supervisor that is, the person to whom you report directly and who rates your performance.

Please select your response from Strongly Disagree = 1 to Strongly Agree = 7 presented below and enter the corresponding number in the space to the left of each question.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Slightly Disagree</th>
<th>Slightly Disagree</th>
<th>Neutral</th>
<th>Slightly Agree</th>
<th>Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>

___1. My supervisor can tell if something work-related is going wrong.
___2. My supervisor gives me the responsibility to make important decisions about my job.
___3. My supervisor makes my career development a priority.
___4. My supervisor seems to care more about my success than his/her own.
___5. My supervisor holds high ethical standards.
___6. I would seek help from my supervisor if I had a personal problem.
___7. My supervisor emphasizes the importance of giving back to the community.
___8. My supervisor is able to effectively think through complex problems.
___9. My supervisor encourages me to handle important work decisions on my own.
___10. My supervisor is interested in making sure that I achieve my career goals.
___11. My supervisor puts my best interests ahead of his/her own.
___12. My supervisor is always honest.
___13. My supervisor cares about my personal well-being.
___14. My supervisor is always interested in helping people in our community.
___15. My supervisor has a thorough understanding of our organization and its goals.
___16. My supervisor gives me the freedom to handle difficult situations in the way that I feel is best.
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17. My supervisor provides me with work experiences that enable me to develop new skills.
18. My supervisor sacrifices his/her own interests to meet my needs.
19. My supervisor would not compromise ethical principles in order to achieve success.
20. My supervisor takes time to talk to me on a personal level.
21. My supervisor is involved in community activities.
22. My supervisor can solve work problems with new or creative ideas.
23. When I have to make an important decision at work, I do not have to consult my supervisor first.
24. My supervisor wants to know about my career goals.
25. My supervisor does whatever she/he can to make my job easier.
26. My supervisor values honesty more than profits.
27. My supervisor can recognize when I’m disappointed without asking me.
28. I am encouraged by my supervisor to volunteer in the community.

**Item Key (SL-28)**

<table>
<thead>
<tr>
<th>Item #s</th>
<th>Reference/comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, 8, 15, 22</td>
<td>Servant Leadership: Conceptual skills</td>
</tr>
<tr>
<td>2, 9, 16, 23</td>
<td>Servant Leadership: Empowering: our items</td>
</tr>
<tr>
<td>3, 10, 17, 24</td>
<td>Servant Leadership: Helping subordinates grow and. Item #3 is adapted from Ehrhart, PPsych, Spring, 2004</td>
</tr>
<tr>
<td>4, 11, 18, 25</td>
<td>Servant Leadership: Putting subordinates first. Items #11 and #18 adopted from Barbuto &amp; Wheeler, 2006 G&amp;OM.</td>
</tr>
<tr>
<td>5, 12, 19, 26</td>
<td>Servant Leadership: Ethical Behavior. Item #5 is adapted from Ehrhart, PPsych, Spring, 2004.</td>
</tr>
<tr>
<td>6, 13, 20, 27</td>
<td>Servant Leadership: Emotional healing</td>
</tr>
<tr>
<td>7, 14, 21, 28</td>
<td>Servant Leadership: Creating value for the community. Item #7 is adopted from Ehrhart, PPsych, Spring, 2004</td>
</tr>
</tbody>
</table>

My immediate supervisor that is, the person to whom you report directly and who rates your performance is my:

a. Both my clinical and administrative supervisor
b. Only my clinical supervisor
c. Only my administrative supervisor
### Appendix G

**Professional Self-Care Measure**

<table>
<thead>
<tr>
<th>How Often:</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Never</td>
<td>Very</td>
<td>Rarely</td>
<td>Sometimes</td>
<td>Often</td>
<td>Very</td>
<td>Almost</td>
</tr>
<tr>
<td></td>
<td>Rarely</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Always</td>
</tr>
</tbody>
</table>

1. ______ I cultivate professional relationships with my colleagues.
2. ______ I avoid workplace isolation.
3. ______ I share work-related stressors with trusted colleagues.
4. ______ I share positive work-related experiences with colleagues
5. ______ I maintain a professional support system.
6. ______ I participate in activities that promote my professional development.
7. ______ I connect with organizations in my professional community that are important to me.
8. ______ I take part in work-related social and community events.
9. ______ I find ways to stay current in professional knowledge.
10. ______ I maximize time in professional activities I enjoy.
11. ______ I spend time with people whose company I enjoy.
12. ______ I spend time with family or friends.
13. ______ I seek out activities or people that are comforting to me.
14. ______ I find ways to foster a sense of social connection and belonging in my life
15. ______ I try to be aware of my feelings and needs.
16. ______ I monitor my feelings and reactions to clients.
17. ______ I am mindful of triggers that increase professional stress.
18. ______ I make a proactive effort to manage the challenges of my professional work.
19. ______ I take breaks throughout the workday.
20. ______ I take some time for relaxation each day.
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21. _______ I avoid over-commitment to work responsibilities.

Professional Support (1-5), Professional Development (6-10), Life Balance (11-14), Cognitive Strategies (15-18), Daily Balance (19-21)
Appendix H

Compassion Fatigue Scale – Short

Consider the following items about your work/life situation. Write the number that best reflects your experiences using the following rating scale, 1 through 10:

<table>
<thead>
<tr>
<th>Never/Rarely</th>
<th>Sometimes Often</th>
<th>Very</th>
</tr>
</thead>
<tbody>
<tr>
<td>1………..2………..3………..4………..5………..6………..7………..8………..9………..10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

___ a. I have felt trapped by my work.
___ b. I have thoughts that I am not succeeding in achieving my life goals.
___ c. I have had flashbacks connected to my clients.
___ d. I feel that I am a “failure” in my work.
___ e. I experience troubling dreams similar to those of a client of mine.
___ f. I have felt a sense of hopelessness associated with working with clients/patients.
___ g. I have frequently felt weak, tired or rundown as a result of my work as a caregiver.
___ h. I have experienced intrusive thoughts after working with an especially difficult client/patient.
___ i. I have felt depressed as a result of my work.
___ j. I have suddenly and involuntarily recalled a frightening experience while working with a client/patient.
___ k. I feel I am unsuccessful at separating work from my personal life.
___ l. I am losing sleep over a client’s traumatic experiences.
___ m. I have a sense of worthlessness, disillusionment, or resentment associated with my work

[ST-5 = c, e, h, j, l; JB-8 = a, b, d, f, g, i, k, m]

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Vitae

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